Public Health Agency

agenda

104th Meeting of the Public Health Agency Board

Thursday 16 August 2018 at 1:30pm

Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast, BT2 7BS

standing items

No.	Item	Paper	Lead
1 1.30	Welcome and apologies		Chair
2 1.30	Declaration of Interests		Chair
3 1.30	Minutes of Previous Meeting held on 11 June 2018		Chair
4 1.30	Matters Arising		Chair
5 1.35	Chair's Business		Chair
6 1.40	Chief Executive's Business		Chief Executive
7 1.50	Finance Report	**PHA/01/08/18**	Mr Cummings
8. 2.00	Public Health Social Marketing Campaigns – Evidence of Effectiveness	**PHA/02/08/18**	Chair

items for approval

No.	Item	Paper	Lead
9 2.25	Annual Report for the Northern Ireland Diabetic Eye Screening Programme 2016/17	**PHA/03/08/18**	Dr Mairs
10 2.40	Annual Quality Report	**PHA/04/08/18**	Mrs Hinds
11 3.00	ALB Self-Assessment Tool	**PHA/05/08/18**	Chair

items for noting

No.	Item	Paper	Lead
12 3.20	PHA Procurement Plan	**PHA/06/08/18**	Mr McClean

closing items

13 3.40	Any Other Business	Chair
14 3.45	Details of next meeting: *Thursday 20 September 2018 at 1:30pm* *Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast*	

Public Health Agency

minutes

103rd Meeting of the Public Health Agency Board

Monday 11 June 2018 at 1.30pm

Meeting Rooms 1+2, Linum Chambers, Bedford Street, Belfast

Present

Mr Andrew Dougal	-	Chair
Mrs Valerie Watts	-	Interim Chief Executive
Mr Edmond McClean	-	Interim Deputy Chief Executive / Director of Operations
Dr Adrian Mairs	-	Acting Director of Public Health
Ms Eleanor Ross	-	Assistant Director of Nursing (*on behalf of Mrs Hinds*)
Councillor William Ashe	-	Non-Executive Director
Mr John-Patrick Clayton	-	Non-Executive Director
Mr Leslie Drew	-	Non-Executive Director
Ms Deepa Mann-Kler	-	Non-Executive Director
Alderman Paul Porter	-	Non-Executive Director
Professor Nichola Rooney	-	Non-Executive Director
Mr Joseph Stewart	-	Non-Executive Director

In Attendance

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

Apologies

Mrs Mary Hinds	-	Director of Nursing and Allied Health Professionals
Mr Cecil Worthington	-	Acting Director of Social Care and Children, HSCB

53/18 Item 1 – Welcome and Apologies

53/18.1 The Chair welcomed everyone to the meeting. Apologies were noted from Mrs Mary Hinds and Mr Cecil Worthington.

54/18 Item 2 - Declaration of Interests

54/18.1 The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.

55/18 Item 3 – Minutes of previous meeting held on 17 May 2018

55/18.1 The minutes of the previous meeting, held on 17 May 2018, were approved as an accurate record of that meeting, subject to two typographical amendments and an amendment to paragraph 50/18.11.

The sentence, "He said that following a screening test, patients showing symptoms then undergo a diagnostic test." should be amended to read, "He said that following a screening test, patients with a positive test then undergo a diagnostic test."

56/18 Item 4 – Matters Arising

56/18.1 There were no matters arising.

56/18 Item 5 – Chair's Business

56/18.1 The Chair advised that he had responded to a letter from the Permanent Secretary seeking nominations from Non-Executive Directors to sit on workstreams following the publication of the report of the inquiry into hyponatraemia related deaths.

56/18.2 The Chair informed members about an innovation lab to examine the governance of ALBs. He also told members that the Public Sector Chairs' Forum is looking at learning and development for Non-Executives.

57/18 Item 6 –Chief Executive's Business

57/18.1 The Interim Chief Executive began by providing an update on the neurology recall. She recognised that this is an extremely stressful time for many patients and their families and that our thoughts go out to them at this difficult time. She said that the over-riding priority is to ensure that all of the patients who had been on Dr Watt's list prior to his cessation of active practice are reviewed and supported, and we fully recognise the significant efforts, particularly by Belfast Trust, in doing this.

57/18.2 In relation to the HSC patients identified (around 2,500), the Interim Chief Executive advised that 911 people have been seen as part of the recall between 1 May and 6 June 2018 and that the Belfast Trust continues to seek to contact the remaining patients, approximately 99, who have yet to respond to the recall. She added that the Ulster Independent Clinic, in conjunction with the HSC, has confirmed that the final validated number of patients to be recalled to their clinic is 110, and that Hillsborough Private Clinic has confirmed that less than 5 patients required to be recalled.

57/18.3 The Interim Chief Executive reminded members that the Department of Health has also announced the establishment of an independent inquiry panel on the Belfast Trust neurology patient recall which will be chaired by QC Brett Lockhart. She advised that the second panel member is Dr Hugo Mascie-Taylor, an internationally recognised expert, who will provide strong clinical leadership input to the inquiry's work. She added that the terms of reference have been agreed and were published last week.

57/18.4 The Interim Chief Executive said that a regional co-ordination group,

chaired by the HSCB and PHA, comprising Trusts and private healthcare providers, has been established to ensure consistency in approach and to provide assurance to the Department of Health on the steps being taken to review and provide support to affected patients.

57/18.5 The Interim Chief Executive gave members an update on the breast screening incident in England, which resulted in thousands of women aged between 68 and 71 not being invited to their final breast screening appointment between 2009 and May 2018. She noted that Dr Stephen Bergin provided an overview of this incident at the previous Board meeting.

57/18.6 The Interim Chief Executive advised that screening staff in the PHA have been working with colleagues in Public Health England on this issue, as 72 of the affected women are now resident, and registered with a GP, in Northern Ireland. She said that letters were sent to each of these women by PHE on 31st May, and that in accordance with the protocol developed by PHE the 9 women who were under the age of 72 on 1 April 2018 were told in their letter that they would receive an invitation to attend for a "catch up" screen from the Northern Ireland Breast Screening Programme if they had not been invited for screening since registering with a Northern Ireland GP. This applies to 6 women. These invitations have all been sent and the 9 women affected have been offered an appointment with a breast screening unit in Northern Ireland.

57/18.7 The Interim Chief Executive went on to say that a separate letter went to the remaining 63 women offering an apology and advising them that we do not routinely invite women aged 71 or over for breast screening, because the benefits of this are unclear; but that they may wish to consider contacting their local breast screening unit if they want to attend for breast screening. She said that the number of a helpline for more information and clinical advice was also provided to these women and that letters have also been sent to the women's GPs.

57/18.8 The Interim Chief Executive advised that the terms of reference of an independent review into this incident were published by the Secretary of State for Health and Social Care. She said that it is expected that this review will report by November 2018 and that PHA will need to consider if any of the findings or recommendations are of relevance to our Breast Screening Programme.

57/18.9 The Interim Chief Executive informed members that since the last meeting, the HSC Safety Forum in partnership with the Public Health Agency and Health and Social Care Board hosted a regional Serious Adverse Incidents Learning Workshop, which was attended by 165 delegates from across health and social care.

57/18.10 The Interim Chief Executive said that she, and the Chair, had attended the Balmoral Show to support PHA colleagues at the PHA stand in the Government Exhibition area of the Eikon Building. She said that the focus

of this year's stand, which was a resounding success, was on five of the PHA's screening programmes: AAA Screening; Diabetic Eye Screening; Breast Screening; Bowel Screening; and, Cervical Screening. She took the opportunity to acknowledge all the PHA members of staff who manned the stand over the four days – without whose help and time commitment it would not have been possible. She hoped that following the event more people will respond to, and attend, future screening invitations.

58/18 Item 7 – Update from Chair of Governance and Audit Committee Meeting (PHA/01/06/18)

58/18.1 Mr Drew updated members following the last meeting of the Governance and Audit Committee which took place on 6 June. He began by saying that the Committee has considered Internal Audit reports on BSO Shared Services, one of which (Payroll) had been given a limited level of assurance. He said that many of the previous recommendations had not yet been implemented but that the issues were being taken seriously.

58/18.2 Mr Drew said that Internal Audit had carried out five audits within PHA during 2017/18 and gave an overview of the levels of assurance for each audit. He said that one of these audits, management of contracts with the community and voluntary, had seen a limited level of assurance given in relation to procurement, and that there had been discussion on procurement and the need to review PHA's procurement plan. Mr Drew advised that other areas covered by audit included screening programmes, risk management and R&D.

58/18.3 Mr Drew said that Internal Audit had agreed with PHA's assessment against four of the Controls Assurance Standard and that overall, Internal Audit is providing a satisfactory assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.

58/18.4 Mr Drew advised that the Committee had approved the draft Annual Report and Accounts, which are for consideration by the Board, and subject to some minor adjustments within the Governance Statement, these were being recommended to the Board for approval. Within the financial statements, he said that there is a small surplus. He added that the Northern Ireland Audit Office had given an unqualified audit opinion.

58/18.5 Mr Drew said that members had met privately with Internal and External Audit, and that the auditors had expressed no issues with the audit and had commended the co-operation of officers during the audit.

58/18.6 Mr Drew advised that the Committee had considered the suite of policies which were being presented today and were content to approve these.

58/18.7 Members noted the update from the Committee Chair.

59/18 Item 8 – PHA Annual Report and Accounts (PHA/02/06/18)

59/18.1 Mr Cummings presented the draft Annual Report and Accounts saying that they had been approved by Governance and Audit Committee. He noted it remains a confidential document until it has been laid before the Northern Ireland Assembly.

59/18.2 Mr Cummings said that the first section of the Report gave an overview of PHA's activities during 2018/19, before moving into the Governance Statement. He advised that he had received draft wording for the section to be included regarding Neurology and he read this out to members. The Chair and Interim Chief Executive agreed that it was a factual statement.

59/18.3 Mr Cummings returned to the Annual Report and said that following the section on performance, the next section related to remuneration and it detailed staffing level, pay and male/female ratio of staff. He said that the following section contained the financial information, and that the key figure here was that PHA achieved a year-end surplus of £140k, which was within the tolerance level.

59/18.4 Alderman Porter asked if PHA is seeking to reduce the gender imbalance in its workforce. The Interim Chief Executive said that PHA said it has not proactively taken any steps so far. Alderman Porter asked if the staff numbers had shown any significance increase or decrease, but Mr Cummings advised that it had remained static.

59/18.5 Mr Clayton said that it would be useful to extract some of the key messages from the Report to get a better understanding of what PHA does. Mr Drew agreed saying that the Report is a good report, but is not in a user friendly format.

59/18.6 Professor Rooney commented that it would be better if there were better headings, perhaps with updates listed under specific functional areas, rather than directorates. Alderman Porter added that it would be better to read more about outcomes. The Interim Chief Executive noted the comments made by members, but pointed out that the Report is laid out in a stipulated format over which PHA has limited control. She said that PHA will seek to use key messages within the Report to promote the work of the organisation.

59/18.7 Members **APPROVED** the Annual Report and Accounts.

60/18 Item 9 – Draft Investment Plan to incorporate PHA budget 2018/19 (PHA/03/06/18)

60/18.1 Mr Cummings said on 1st May, the PHA had received its opening allocation letter which details the funding the organisation will receive, but included a reduction in the management and administration budget of £500k and three other savings targets. He said that members are being

asked today to approve a letter to be issued to the Department of Health outlining PHA's approach to making the required savings which will minimise the impact of these savings. Mr Cummings explained that up to £900k can be saved from the connected health budget for 2018/19, £700k from not applying pay and price uplifts, and £316k from within the Health Improvement budget. Finally, he said that the letter reflected PHA's continued concern around the pause in its campaigns.

60/18.2 Mr Clayton asked if the £500k reduction in the administration budget would impact on staffing. Mr Cummings said he hoped there would be no implications for PHA, and no staff redundancies, as there is a turnover in vacant posts and there are scrutiny processes in place. Mr Cummings advised that for a couple of years PHA had offered VES to its staff, but it won't be offering a scheme this year.

60/18.3 Professor Rooney said that she was happy with the letter, but she felt that the decision to continue with the suspension of PHA's campaigns did not make sense as it is a statutory duty of PHA to inform the public. Mr Clayton asked if any changes could be made to the letter at this stage. Mr Cummings advised that, due to the timescales involved, the letter has been issued to the Department as a draft. Ms Mann-Kler said that in this situation, it would have been better for members to have had sight of the draft. It was proposed that the correspondence to be issued to the Department of Health should state the Board's concern about the reductions in funding, but particularly with regard to campaigns.

60/18.4 Mr Clayton asked about the proposed £310k reduction against Health Improvement, and asked about the impact of this. He said that there should also be reference made in the letter to any equality implications of PHA withdrawing monies from Health Improvement areas.

60/18.5 Alderman Porter asked whether the reduction in campaigns has had an impact on, for example, screening programmes. Dr Mairs advised that PHA had only carried out one campaign in relation to screening, which was for bowel cancer screening. Ms Mann-Kler asked about a paper that PHA was producing regarding the impact of campaigns. The Interim Chief Executive said that a paper had been done for the Permanent Secretary and she agreed to share this with members.

60/18.6 Mr Clayton asked about the internal process for determining where these savings could be made. Mr Cummings said that for the last number of years there has been slippage in the PHA budget. Alderman Porter said that his concern was that the community and voluntary sector was seen as a soft target. The Interim Chief Executive reassured members that the savings could be achieved with a minimum impact on that sector. Mr Stewart said this refers back to the original point about PHA's responsibility for promoting public health and in doing so in line with its statutory obligations to Section 75 groups.

60/18.7 Subject to minor amendments, members approved the letter to the

Department regarding PHA's savings proposals.

60/18.8 Mr Cummings moved onto the Investment Plan and budget. He said that the budget reflects the savings proposals as outlined in the letter as well as the areas of recurrent investment with the HSC Trusts. He noted that there had been comments from members regarding obtaining greater clarity in terms of the outcomes from the Trusts, and said that this process is evolving. He advised that the rest of the budget follows the normal monthly reporting format, and forms the basis of the monthly reports that members will receive. He added that the next section contained the administration budget.

60/18.9 Mr Drew asked if the Trusts are receiving more money. Mr Cummings explained that contracts are rolled forward and there is an inflationary uplift. Ms Mann-Kler asked how the PHA is promoting innovation. She said that there needs to be greater emphasis on the role of innovation. Mr Cummings said that there is sadly no availability within the overall HSC budget to do this as the overall budget remains in deficit with £101m of savings to be found. He added that an element regarding innovation has been factored into the transformation monies. Ms Mann-Kler asked if this was happening on a UK-wide basis. The Interim Chief Executive said that Ms Mann-Kler's question was a good one, and said that even though there are budget reductions, there are new ways of treatment and innovate techniques, but at the moment we are limping along on a year-by-year basis not knowing what the required savings and that eventually something has to give. She said that it would be a shame if none of the transformation money was used on innovation.

At this point Mr McClean joined the meeting

60/18.10 Mr Drew said that innovation should be self-financing and that there should be an exercise in business process re-engineering. The Chair said that PHA should look at what NHS Improvement and the King's Fund are doing. Mr Drew said that there is a perception that the HSC is not good at capturing and applying knowledge captured from innovation activities and sharing this across the sector. Ms Ross noted that when a service review is undertaken, it always looks at new ways of working and gave the example of a recent piece of work in the area of diabetes. The Chair said that within the PHA Annual Report there are examples of innovation, but is not spelt out as such. Ms Mann-Kler said that there is an organisation called Elemental who undertake transformative work in social prescribing.

60/18.11 Mrs McKissick said that PCC and PHA have worked in partnership within the regional Pain Forum and they are using digital transformation and looking at a supported self-management agenda.

60/18.12 Mr Clayton asked about the deliverability of the transformation agenda within the next 12 months. The Interim Chief Executive said that at this stage it is now a 9 month plan and almost 2,000 staff need to be recruited as part of the implementation. Mr Cummings said that the leads for each

of the initiatives would take into account the time taken to recruit.

60/18.13 The Chair asked if members were content to approve the Investment Plan and budget. Members approved with the exception of Mr Clayton who said that he was not content to approve because he felt that any reductions in PHA's budget would be in conflict with the statutory duties of PHA in terms of promoting public health and reducing health inequalities.

61/18 Item 10 – Corporate Risk Register (PHA/04/06/18)

61/18.1 Mr McClean presented the Corporate Risk Register for the period up to 31 March 2018. He said that there had been no changes following the most recent review.

61/18.2 Mr Drew confirmed that the Governance and Audit Committee had considered the Corporate Risk Register and had noted that Internal Audit had PHA a satisfactory assurance in its most review of PHA's risk management arrangements.

61/18.3 Members noted that risk was going to be the main subject of discussion at the Board workshop on 21 June. Ms Mann-Kler said that part of that discussion should be on PHA's risk appetite.

61/18.4 Members **APPROVED** the Corporate Risk Register.

62/18 Item 11 – PHA Information Governance Policies (updated following implementation of the General Data Protection Regulations) (PHA/05/06/18)

62/18.1 Mr McClean presented the suite of Information Governance policies and advised that these were existing policies which had undergone minor revision following the implementation of GDPR. He advised that they had been approved by the Governance and Audit Committee.

62/18.2 Members **APPROVED** the Information Governance policies.

63/18 Item 12 – PHA Whistleblowing Policy (PHA/06/06/18)

63/18.1 Mr McClean advised that following receipt of a model policy from the Department of Health, PHA had updated its Whistleblowing Policy. He added that awareness training will be delivered for staff.

63/18.2 Ms Mann-Kler said that the policy was straightforward and written in plain language. She said that the only issue discussed at Governance and Audit Committee concerned whether the personal contact details of the designated Non-Executive should appear in the policy, but it was agreed that this was not appropriate and the contact number in the policy should remain.

63/18.3 Members **APPROVED** the Whistleblowing Policy.

64/18 Item 13 – PHA Rural Needs Policy (PHA/07/06/18)

64/18.1 Mr McClean said that members would be aware of the Rural Needs Act which places an obligation on public bodies to take account of the needs of the rural community in developing policies. He said that PHA's Policy is being brought today for approval and that PHA will carry out training for staff in conjunction with other public authorities.

64/18.2 Ms McKissick said that the Patient Client Council welcomes this policy. Ms Mann-Kler asked if there were any additional resources for this work, given the additional responsibility. Mr McClean said that there were no additional resources and that PHA was expected to absorb this. Mr Clayton expressed his concern at there not being additional resources. He added that it should be made more explicit in the body of the policy that there are implications for not carrying out a Rural Needs Assessment, including legal challenge against the PHA. Mr McClean assured members that PHA staff understood the concept of rural proofing and that staff would embrace it.

64/18.3 Members **APPROVED** the Rural Needs Policy.

65/18 Item 14 – Annual Progress Report 2017/18 to the Equality Commission on implementation of Section 75 and the duties under the Disability Discrimination Order (PHA/08/06/18)

65/18.1 Mr McClean introduced Anne Basten from the Equality Unit within BSO to the meeting and asked her to give members an overview of the report which is due for submission to the Equality Commission.

65/18.2 Ms Basten said that she had taken on board feedback from members following last year's report and she began by highlighting areas where there were outcomes showing where PHA has made a difference. She said that these included access to information (including the translation of leaflets and making easy read materials) and access to services (giving examples within screening programmes). Another example Ms Basten gave was PHA's work in relation to the Regional Hospital Passport for people with a learning disability.

65/18.3 Ms Basten advised that there was improved availability of equality data with an example of defined outcomes in the area of health and wellbeing of travellers. She added that there has been training for staff who work with adults with a learning disability.

65/18.4 Ms Basten moved onto compliance and advised that during the last year PHA had completed two Equality Impact Assessments and that five Equality screenings had been published. She said that this was below expectations. Moving forward, she said that this was a priority issue for 2018/19.

65/18.5 The Chair advised that he is a member of a working group relating to

disability, and he asked what PHA is doing to encourage people with disabilities, and people in Section 75 groups in general, to apply for jobs. He noted that PHA works with recruitment agencies and therefore does not have direct control over whether they seek applications from people with disabilities. Ms Basten said that PHA is seeking to look more at its equality monitoring data to see if it is in line with what it would expect. She added that "mystery shoppers" have been used to test out how recruitment agencies deal with people with a disability and in the main, the experience was not positive. She advised that there was a Disability Placement Scheme within the HSC.

65/18.6 Mr Clayton thanked Ms Basten for the report and acknowledged the work that is being done to promote equality, but he expressed concern at the low number of equality screenings. He said that a lot of PHA's work would have an impact, but it appears that the assessments are not there. Ms Basten said that there has been improvement, particularly in the area of procurement as procurement exercises cannot be undertaken without screening taking place. She suggested that when PHA is developing its annual Business Plan it should seek to identify areas where equality screening may be required. Mr McClean echoed what Ms Basten said about the work that is being done as part of procurement in terms of screening and PPI. He added that the number of equality screenings and impact assessments being undertaken should not be viewed as a metric of success.

65/18.7 Ms Mann-Kler thanked Ms Basten for her presentation and asked her what she felt has changed as a result of the work of Section 75. Ms Basten said that the Equality Commission has now initiated its second effectiveness review, which will tie in with the Outcomes Based Accountability approach within the public sector. She added that the Commission has also identified the theme of leadership and it will look to link with the leaders of organisations as part of this review.

65/18.8 Mr Clayton acknowledged Mr McClean's point that success should not be measured in terms of numbers of screenings and EQIAs, but he said that there is a role for PHA to be open in publishing its screenings and informing the population about its decisions.

65/18.9 Members **APPROVED** the submission to the Equality Commission.

66/18 Item 15 – Performance Management Report – Corporate Business Plan Targets for the Period Ending 31 March 2018 (PHA/09/06/18)

66/18.1 Mr McClean said that the year-end Performance Management Report for 2017/18 showed that of the 86 corporate objectives, 70 were rated "green", 13 were rated "amber" and 3 were rated "red". He noted that some of the actions had not been completed due to factors outwith PHA's control.

66/18.2 Professor Rooney asked if any of the non-completed actions would be

rolled forward. Mr McClean confirmed that these actions would be taken into 2018/19. Ms Ross added that the Family Nurse Partnership programme would be receiving funding from the transformation monies.

66/18.3 Mr Clayton asked about the CLARE project and potential Big Lottery funding. Mr McClean said that he would get more information regarding this.

66/18.4 Members noted the Performance Management Report.

67/18 Item 16 – Personal and Public Involvement Update (PHA/10/06/18)

67/18.1 The Chair welcomed Martin Quinn to the meeting and asked him to give the Board an update on PHA's Personal and Public Involvement work.

67/18.2 Mr Quinn said that over the last few months there have been more demands on PHA seeking advice in relation to PPI as HSC bodies seek to ensure that they are getting it right and looking to use PPI as a means of making a tangible difference. He said that he was pleased that PPI has been at the forefront of the recent transformation work as well as in areas such as multi-disciplinary teams and the implementation of the recommendations following the Hyponatraemia Inquiry.

67/18.3 Mr Quinn advised that PHA has a responsibility for PPI training, and that it has been working with other organisations, for example PCC, to develop a short eLearning programme. He said that to date over 1,600 people have completed the training and that there have also been over 100 face to face interactions. He noted that the challenge now is about changing practice and embedding the learning.

67/18.4 Mr Quinn said that the Engage website has been a success with over 1,000 visitors in the last month. He added that the site has been nominated for an award in innovation by the King's Fund.

67/18.5 With regard to monitoring, Mr Quinn advised that PHA did not carry out any monitoring this year as it was agreed that the Trusts would be given time to implement the recommendations of the previous monitoring. He informed members that PHA has been subject to its own internal monitoring this year and a report on this will be brought to a future Board meeting. He added that PHA had also been subject to an Internal Audit review and this had produced a satisfactory level of assurance. He finished by saying that there is a workshop on 20 June regarding reimbursement and remuneration.

67/18.6 Ms Mann-Kler congratulated Mr Quinn on all of the work achieved to date. She said that it was apparent that the team was passionate about its work, and she asked if they could see a culture change taking place. Mr Quinn said that he could see it happening.

67/18.7 Members noted the update on Personal and Public Involvement.

68/18 **Item 17 – Any Other Business**

68/18.1 There was no other business.

69/18 **Item 18 – Details of Next Meeting**

Thursday 16 August 2018 at 1.30pm

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

Signed by Chair:

Date: 16 August 2018

HSC Public Health Agency

Public Health Agency

Finance Report

2018-19

Month 3 - June 2018

PHA Financial Report - Executive Summary

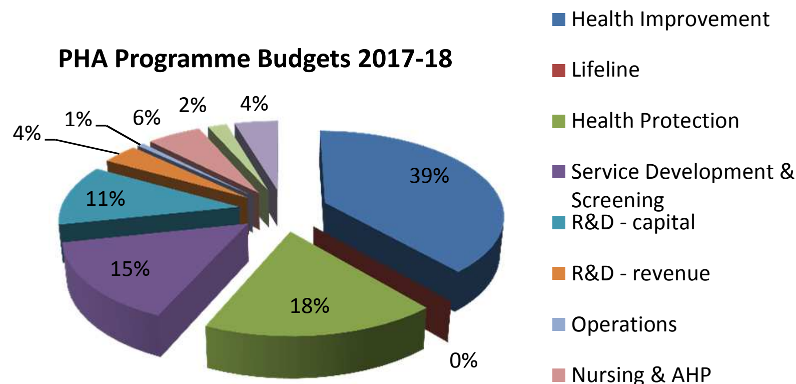
Year to Date Financial Position (page 2)

At the end of month 3 PHA is underspent against its profiled budget by approximately £0.5m. This underspend is primarily within Programme budgets across the Agency, and also includes some underspends on Administration budgets, as shown in more detail on page 5.

Whilst this position is not unusual for this stage of the year due to the difficulty of accurately profiling expenditure, budget managers are being encouraged to closely review their positions to ensure the PHA meets its breakeven obligations at year-end.

Programme Budgets (pages 3&4)

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

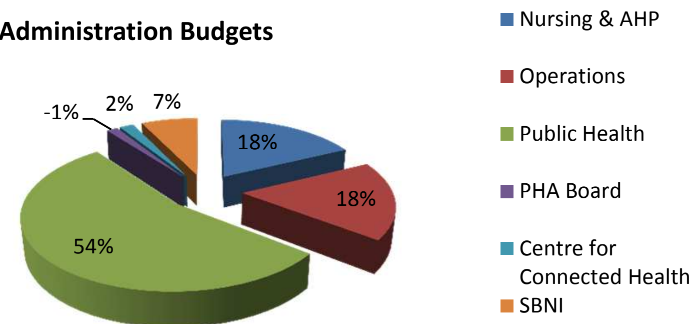


Administration Budgets (page 5)

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

A significant number of vacant posts remain within PHA, and this is creating slippage on the Administration budget.

Management is proactively working to fill vacant posts and to ensure business needs continue to be met.



Full Year Forecast Position & Risks (page 2)

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

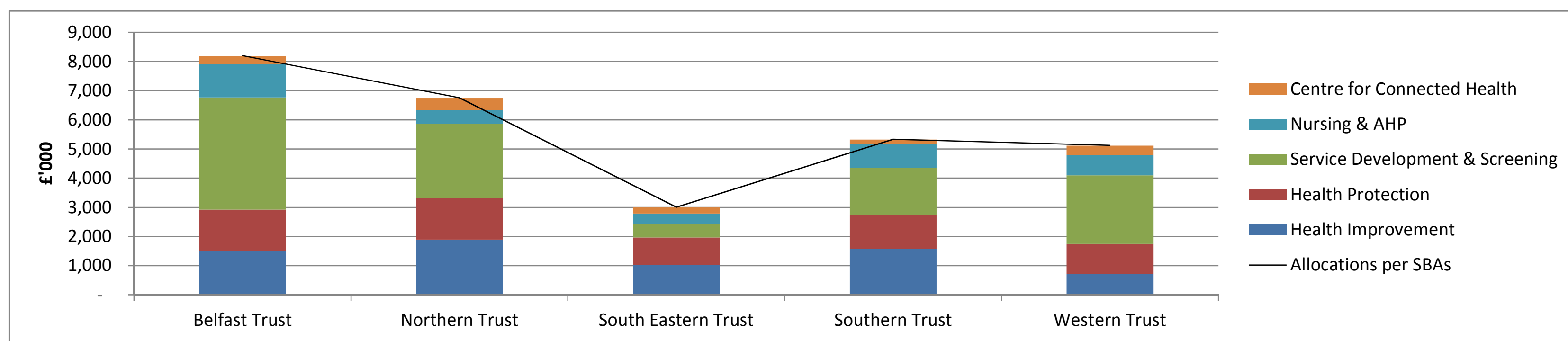
Public Health Agency
2018-19 Summary Position - June 2018

	Annual Budget				Year to Date			
	Programme		Mgt & Admin	Total	Programme		Mgt & Admin	Total
	Trust	PHA Direct			Trust	PHA Direct		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources								
Departmental Revenue Allocation	28,424	52,594	19,493	**100,511**	7,106	5,588	4,649	**17,342**
Revenue Income from Other Sources	-	140	673	**812**	-	89	132	**221**
Total Available Resources	28,424	52,734	20,166	**101,324**	7,106	5,677	4,781	**17,564**
Expenditure								
Trusts	28,424	-	-	**28,424**	7,106	-	-	**7,106**
PHA Direct Programme *	-	52,734	-	**52,734**	-	5,361	-	**5,361**
PHA Administration	-	-	20,166	**20,166**	-	-	4,608	**4,608**
Total Proposed Budgets	28,424	52,734	20,166	**101,324**	7,106	5,361	4,608	**17,075**
Surplus/(Deficit) - Revenue	-	-	-	-	0	316	173	**488**
Cumulative variance (%)					***0.00%***	***5.56%***	***3.61%***	***2.78%***

The year to date financial position for the PHA shows an underspend against profiled budget of approximately £0.5m, mainly due to spend behind profile on PHA Direct Programme budgets (see page 4), and also a year to date underspend on Admininstration budgets (see page 5). It is currently anticipated that the PHA will achieve breakeven for the full year.

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

Programme Expenditure with Trusts



Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	1,498	1,898	1,030	1,587	725	**6,740**	1,685	1,685	-
Health Protection	1,424	1,416	940	1,158	1,019	**5,957**	1,489	1,489	-
Service Development & Screening	3,843	2,554	477	1,613	2,349	**10,836**	2,709	2,709	-
Nursing & AHP	1,150	462	340	798	693	**3,443**	861	861	-
Centre for Connected Health	264	420	204	164	325	**1,377**	344	344	-
Other	24	13	11	12	11	**72**	18	18	-
Total current RRLs	**8,203**	**6,763**	**3,003**	**5,332**	**5,123**	**28,424**	**7,106**	**7,106**	-
Cumulative variance (%)									***0.00%***

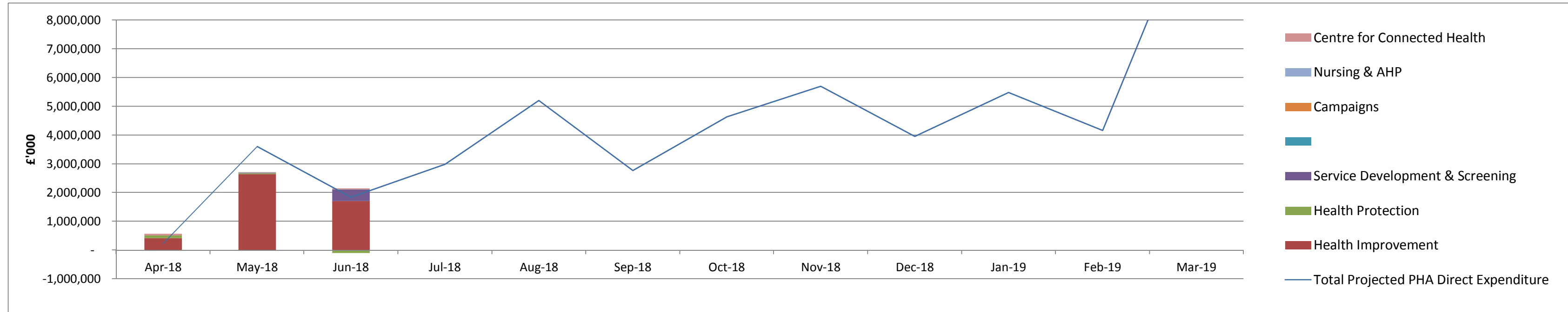
The above table shows the current Trust allocations split by budget area.

During the current month, an exercise to re-align budgets between Trust and PHA Direct budgets has been carried out, and profiles have been amended accordingly. This explains the year to date breakeven position. A breakeven position is also anticipated for the full year.

The Other line relates to general allocations to Trusts for items such as the Apprenticeship Levy and Inflation.

June 2018

PHA Direct Programme Expenditure



	Apr-18 £'000	May-18 £'000	Jun-18 £'000	Jul-18 £'000	Aug-18 £'000	Sep-18 £'000	Oct-18 £'000	Nov-18 £'000	Dec-18 £'000	Jan-19 £'000	Feb-19 £'000	Mar-19 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000	
Projected Expenditure																	
Health Improvement	88	3,053	1,155	2,320	3,234	1,288	2,921	2,691	1,213	3,314	3,108	4,555	**28,939**	4,295	4,770	(475)	*-11.1%*
Health Protection	56	347	93	528	746	888	1,560	1,618	1,023	901	809	1,999	**10,568**	496	23	474	*95.4%*
Service Development & Screening	18	140	524	74	74	528	89	108	449	74	141	832	**3,053**	682	522	160	*23.4%*
Research & Development - revenue	-	-	-	-	-	-	-	1,200	1,200	1,100	-	-	**3,500**	-	2	(2)	*100.0%*
Campaigns	9	9	9	9	9	9	9	9	9	9	9	93	**195**	28	2	26	*92.2%*
Nursing & AHP	17	17	20	17	1,103	17	21	34	20	50	57	471	**1,843**	54	20	35	*63.6%*
Centre for Connected Health	40	40	40	40	40	40	40	40	40	40	40	40	**484**	121	92	29	*23.8%*
Other	-	-	-	-	-	-	-	-	-	-	-	4,152	**4,152**	-	(70)	70	*-100.0%*
Total Projected PHA Direct Expenditure	**227**	**3,607**	**1,842**	**2,988**	**5,207**	**2,770**	**4,641**	**5,700**	**3,955**	**5,489**	**4,165**	**12,142**	**52,734**	**5,677**	**5,361**	316	
Cumulative variance (%)																***5.56%***	
Actual Expenditure	**570**	**2,784**	**2,007**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**5,361**				
Variance	**(343)**	**824**	**(165)**										**316**				

The budgets and profiles are shown after adjusting for retractions and new allocations from DoH.

The year-to-date position shows a £0.3m surplus, which is mainly due to the timing of payments in various budget areas. The £4.2m budget in the Other line reflects Confidence & Supply Transformation funds which are being held centrally pending approval of IPTs and business cases, prior to being issued to the respective budget areas.

June 2018

PHA Administration

2018-19 Directorate Budgets

	Nursing & AHP £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Annual Budget							
Salaries	3,515	2,398	10,895	173	319	733	**18,033**
Goods & Services	173	1,264	348	35	54	759	**2,633**
Savings target				(500)			**(500)**
Total Budget	**3,688**	**3,662**	**11,243**	**(292)**	**373**	**1,491**	**20,166**
Budget profiled to date							
Salaries	843	599	2,708	43	80	139	**4,413**
Goods & Services	39	292	77	(116)	24	51	**368**
Total	**883**	**892**	**2,785** -	**73**	**104**	**191**	**4,781**
Actual expenditure to date							
Salaries	824	586	2,561	26	83	97	**4,177**
Goods & Services	45	271	78	6	2	28	**431**
Total	**869**	**857**	**2,640**	**32**	**86**	**125**	**4,608**
Surplus/(Deficit) to date							
Salaries	20	13	147	17	(4)	43	**236**
Goods & Services	(6)	21	(1)	(122)	22	23	**(63)**
Surplus/(Deficit)	**14**	**34**	**146**	**(105)**	**18**	**66**	**173**
Cumulative variance (%)	*1.54%*	*3.87%*	*5.22%*	*143.93%*	*17.38%*	*0.00%*	***3.61%***

A savings target of £0.5m was applied to the PHA's Administration budget in 2018-19. This is currently held centrally within PHA Board, and will be managed across the Agency through scrutiny and other measures.

The year to date salaries position is showing a surplus which has been generated by a number of vacancies during the year. Senior management continue to monitor this closely in the context of PHA's obligation to achieve a breakeven position for the financial year.

June 2018

Public Health Agency
2017-18 Capital Position

	Annual Budget				Year to Date			
	Programme				Programme			
	Trust	PHA Direct	Mgt & Admin	Total	Trust	PHA Direct	Mgt & Admin	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources								
Capital Grant Allocation & Income	10,204	419	-	**10,623**	-	78	-	**78**
Expenditure								
Capital Expenditure - Trusts	10,204			**10,204**	-			**-**
Capital Expenditure - PHA Direct		419		**419**		27		**27**
	10,204	419	-	**10,623**	-	27	-	**27**
Surplus/(Deficit) - Capital	-	-	-	-	-	51	-	**51**
Cumulative variance (%)					*0.00%*	*65.03%*	*0.00%*	***65.03%***

PHA has received a Capital budget of £10.6m in 2018-19, most of which relates to Research & Development projects in Trusts and other organisations. A small surplus is shown for the year to date, and a breakeven position is anticipated for the full year.

PHA Prompt Payment

Prompt Payment Statistics

	June 2018 Value	June 2018 Volume	Cumulative position as at 30 June 2018 Value	Cumulative position as at 30 June 2018 Volume
Total bills paid (relating to Prompt Payment target)	£2,902,259	430	£8,820,009	1,400
Total bills paid on time (within 30 days or under other agreed terms)	£2,835,402	412	£8,680,743	1,328
Percentage of bills paid on time	**97.7%**	**95.8%**	**98.4%**	**94.9%**

Prompt Payment performance for the year to date shows that on value the PHA is achieving its 30 day target of 95.0%, although on volume performance is slightly below target at 94.9%. PHA is making good progress on ensuring invoices are processed promptly, and efforts to maintain this good performance will continue for the remainder of the year.

The 10 day prompt payment performance remained strong at 91.9% by value for the year to date, which significantly exceeds the 10 day DoH target for 2018-19 of 60%.

Public Health social marketing campaigns - Evidence of effectiveness

As outlined in the previous submissions to the DoH, Marketing is an effective, evidence-based methodology for addressing public health issues. There is a substantial body of evidence that social marketing campaigns can directly and indirectly produce positive changes, or prevent negative changes, in health related behaviours across large populations. This can translate into a major public health impact given the reach of mass media.[i]

Furthermore, NICE guidelines reflect the available evidence base and include recommendations regarding the use of social marketing campaigns within a range of specific guidance notes eg. PH (6) Behaviour change, PH14 smoking – preventing uptake in children and young people, NG (63) Anti-microbial stewardship: challenging risk behaviour to reduce antimicrobial resistance.

This paper provides an insight into the evidence base and characteristics of effective campaigns and findings relating to previous health campaigns that have been delivered in Northern Ireland. It confirms the potential for social marketing campaigns to help deliver Transformation in health behaviours as part of a wider programme of planned activity.

The evidence base

At a macro level, the best empirical evidence of effectiveness can be found in a number of systematic reviews. For example Wakefield, Laken and Hornik's review ' Use of mass media campaigns to change health behaviour', (Lancet 2010, 376:1261-71) concluded that '*mass media campaigns can directly and indirectly produce positive changes or prevent negative changes in health-related behaviours across large populations'.* Their recommendations for national governments included:

1. Mass media campaigns should be included as key components of comprehensive approaches to improving population health behaviours,
2. Sufficient funding must be secured to enable frequent and widespread exposure to campaign messages continuously over time, especially for ongoing behaviours,
3. Adequate access to promoted services and products must be ensured,
4. Changes in health behaviour can be maximised by complementary policy decisions that support opportunities to change, provide disincentives for not changing, and challenge or restrict competing marketing,
5. Campaign messages should be based on sound research about the target group and should be tested during campaign development,
6. Outcomes should undergo rigorous independent assessment and peer-reviewed publication should be sought.

A 2015 systematic literature review looked at the evidence for Mass media campaigns in promoting positive health behaviours. The study identified that 7

out of 10 campaigns persuaded behavioural change. Approximately 3 out of 10 campaigns modified knowledge, and 5 in 10 aimed to revise attitudes in populations. The paper reported that television was the most commonly used tool in Mass Media campaigns, however it highlighted that computer – based tools were most effective, particularly in adolescents. (Primary Health Care 5:190 (2015) Health Promotion campaigns and Mass Media; Looking for Evidence.)

More recently there have been a number of reviews published which have contributed to our understanding of how best to deploy social marketing campaigns by utilising the full range of communication channels available including mass media, within a new and ever expanding digital landscape.

Examples include:

1. Comparing the Cost Effectiveness of Campaigns delivered via various combinations of Television and Online Media. (March 2018 - Frontiers in Public Health) https://www.frontiersin.org/articles/10.3389/fpubh.2018.00083/full
2. A Community guide systematic review (2014) which found that Mass media Health Campaigns combined with health related product distribution eg. quit kits for smoking cessation, pedometers for physical activity etc were effective in improving health behaviours (American Journal of Preventative Behaviour: 47(3) 360-371).

In 2013 Public Health England (PHE) commissioned Matrix, an analytical agency with a strong record in public health and health economics, and the media planning agency MEC to conduct an evidence review for the effectiveness of marketing and develop a new model to determine the issues the national marketing team should best invest in. The scope of the project included:

- Social marketing interventions relating to: health promotion, risk reduction, behaviour/lifestyle change, health improvement, health protection, disease prevention (primary, secondary, tertiary), reducing health inequalities, and health service uptake/access in the health issues
- National social marketing activities, such as: Information/advertising/promotional campaigns, mass media, print media, multimedia, TV/radio, internet, social media.
- Social marketing delivered to: the public/general population, patients, carers, clients

The review concluded that with regards to the evidence of effectiveness in specific health topics:

- There appears to be substantial evidence that social marketing interventions can be effective in changing smoking behaviour;
- Evidence shows that social marketing could be effective in increasing the early detection of cancers;

- Overall it appears that evidence of the effectiveness of social marketing interventions in improving physical activity is supportive;
- Evidence shows social marketing interventions to be effective in increasing healthy eating;
- Evidence shows social marketing interventions to be effective in reducing risky sexual behaviour;
- Overall there appears to be some limited evidence that social marketing interventions could be effective in reducing illicit drug use;
- Overall it appears that evidence of the effectiveness of social marketing interventions in alcohol is inconclusive;

Finally, a recent PHA literature review conducted by a Public Health specialist Registrar into evidence for Social Marketing campaigns in changing health-related behaviour notes that '*Mass Media campaigns have been shown to be effective in increasing knowledge, revising attitudes and persuading change in health behaviours. In particular MMC's are most effective when part of a wider campaign, with sustained funding, and a supportive legislative or policy framework. MMC's are more effective when used in conjunction with a social media component'.*

Overview of Government public health communications effectiveness awards case studies

There are multiple public health advertising cases that have been able to demonstrate impressive returns for their investment on marketing to the high standards of proof required by the IPA Effectiveness Awards.

Below, we've just looked at the calculation of these **returns in purely financial terms**, and **not factored in the range of other, non-financial public goods which these public campaigns created.**

Examples include:

- **Public Health England's 'Stoptober'** anti-smoking campaign which delivered a payback of an estimated £16m of savings to the public purse in the short-term alone from driving an extra 1.5m attempts to quit smoking in England. This campaign was renewed annually for at least four years. The Department of Health has calculated a one year return on marketing investment of **£2.07 and a three-year return of £4.58 per £1 invested in tobacco campaigns** - these figures relate to healthcare savings alone.

- The **Department of Health's 'FAST' Stroke Awareness** Campaign led to increased awareness and faster responses to suspected strokes. Described by the National Audit Office as "highly successful" and as "one of the most successful Government public awareness campaigns ever", it was estimated to have paid back **£5 for every £1 invested in marketing.**

- '**Be Clear on Cancer'**, also by **Public Health England**, was estimated to have already **paid back £1.26 for every £1 invested, within just three months** of the campaign running.

- And by popularising CPR techniques and encouraging bystanders to use them on people experiencing suspected cardiac arrests, the **British Heart Foundation's 'You've Been Vinnied'** is estimated to have **saved at least £48m** for the public purse in return for an investment of £2m.

These public health budget savings have been calculated typically by using the official figures or benchmarks from the Government and/or other recognised bodies such as NICE.

Characteristics of Effective Public Health Advertising:

Use of TV advertising

One of the common characteristics of the cases above is **that they all used memorable TV advertising** *in addition* **to employing other channels from digital and print,** to the ambient media in doctors' surgeries.

This use of TV was driven by the desire to *build awareness and reach of message quickly of a particular health issue and the need for changed behaviour* amongst a very wide group of audiences. These audiences include older people, the elderly and infirm (which often have particularly low levels of digital participation), secondary or supporter audiences to a primary target such as smokers thinking about quitting, or the general public (anyone can be called on to help a stroke or heart attack victim in some circumstances).

Other reasons for using TV/mass media for public health campaigns were:

- TV can normalise medical conditions (**creating a social norming effect:** – Encouraging the perception that those experiencing symptoms aren't alone and this encourages people to seek help, which can lead to earlier diagnoses of time-sensitive conditions such as cancers
- TV advertising lent initiatives **stature and credibility,** helping boost people's confidence to present to their GPs
- **Urgency**- As a perceived 'important' medium, TV helped support the case for those with health issues to do something sooner rather than later.
- **Efficiency** - TV delivered impact at a mass, cost effective scale with low cost per thousand reach..
- **Shared viewing** – TV would be seen, often simultaneously, by a key secondary audience of partners and family
- **Trust and impact** – TV is a trusted medium with high emotional impact and message intrusion and memorability.

In the case of BHF's Vinnie Jones ads, and its related 'Watch Your Own Heart Attack' ad, campaigns became high profile interventions into the wider popular culture, achieving fame and likeability, that helped to get public health messages across.

Digital vs. TV
While digital channels have a supporting role (especially in the conversion journey to help amplify messaging and in particular direct towards follow up information and tools), digital simply doesn't have the impact or reach to engage, which is why use of high-reach, high impact above the line channels is critical – and in particular TV, which spearheads the most successful campaigns.

International cases:

The experience cited in the UK cases above has been mirrored in markets such as Singapore, Canada and New Zealand.

- The **Health Promotion Board Singapore** ran a highly effective smoking cessation campaign which shifted the emphasis from anti-smoking to pro-quitting, encouraging friends and families to get involved by supporting actively smokers' attempts to quit. **This campaign was estimated to have paid back 15:1.**

- The **National Depression Initiative** in New Zealand combined a high profile, celebrity-led TV and PR campaign, fronted by All Blacks Rugby legend, John Kirwan, with an online self-help tool that provided in-depth self-analysis and support for individuals suffering from symptoms of depression. Based on the savings generated by reducing likely visits to GPs and other public health costs, the **campaign was shown to have paid back its investment 5:1.** It has also been the subject of academic studies and a clinical trial.

- The **Heart & Stroke Foundation of Canada** ran the successful '**Make Health Last'** campaign across TV, radio, outdoor and digital channels to encourage Canadians to assess their own behaviour on health issues and change their behaviour accordingly to improve the quality of their later years.

  It led to more than 200,000 Canadians completing an online health assessment, which provided advice and additional steps for those judged as high risk of outcomes such as heart attacks. It is estimated that if only 0.03% of those taking the test improved their habits sufficiently to gain an extra year of quality of life, the campaign would have paid for itself.

Impact of Northern Ireland Campaigns

The table overpage summarises key evaluation findings from recent PHA campaigns. The results have been recorded through quantitative surveys conducted both pre and post campaign deployment using population level representative sampling. Assuming statistical confidence levels of 95% the results have been extrapolated to provide crude estimates of the scale of audiences reached and impacted by the campaigns.

Campaign evaluation results

Campaign	Objectives	Results
Smoking		
A survey of 906 adults aged 16 and over made up of 755 smokers and 151 recent ex-smokers (quit within the last 12 months).	Campaign awareness	87% of smokers/recent ex-smokers aware of the campaign.
	Raise awareness of the health effects of smoking – message *One in every two smokers will die of a tobacco related disease*	Almost three quarters (74%) of smokers/recent ex-smokers agreed with the statement '1 in every 2 smokers will die of a tobacco related disease'. Baseline over half (54%) agreed
	Encourage smokers to think about quitting	A third of current smokers tried to change their smoking behaviour as a result of the campaign with the majority 26% trying to reduce the amount they smoked and 5% trying to quit.
	Encourage smokers to make a quit attempt	23% of ex-smokers (quit within the last 12 months - while campaign was running) said it encouraged them to quit and 46% said it helped them stay quit.
Impact	• **95,372 smokers in NI tried to change their smoking as a result of the campaign** • **14,305 smokers tried to quit as a result of the campaign** • **6,581 recent ex-smokers said campaign encouraged them to quit** • **13,162 recent ex-smokers said it helped them stay quit**	
Flu		
Winter 2011 Uptake rates used to assess campaign impact.	• To encourage those eligible for the flu vaccine to get vaccinated early (October/November). As uptake levels were already above UK targets, any increase in overall uptake volumes would be viewed as a bonus – what we were really interested in was the ***timing*** of the vaccine uptake as this was felt to offer the greatest increased benefit to public health.	• 25% more people vaccinated by end of November 2011 compared to 2010 • Target of 70% of 'at risk' people vaccinated by March 2012 had been exceeded (74.8%) by the end of November 2011. • Uptake for over 65s was just 3% below the full seasonal target (75%) at the end of November 2011.

Impact	• An extra 47,500 people vaccinated by the end of November 2011 compared to previous year	
Stroke/FAST		
Pre and post campaign surveys with a representative sample (1,000+ respondents) of the adult general population of Northern Ireland (aged 16+ years).	Campaign awareness	Recognition of the campaign was high, with 85% of adults aged 16 and over
	To increase awareness of signs of a stroke using FAST acronym • Face fallen on one side • Speech slurred /unable to communicate or talk • Arm - unable to lift	Significant increase in awareness of all signs phase 1 (2011/12) to phase 4 (2015/16) comparison • Face fallen on one side 33% to 84% • Speech slurred /unable to communicate or talk 38% to 69% • Arm - unable to lift 13% to 62%
	• Increase awareness that if someone displays any one of the symptoms of stroke it's a medical emergency call 999	• Unprompted recall of dial 999 if someone is showing the signs of stroke (above) increased from 80% in 2011/12 to 92% in 2015/16.
Impact	Post campaign 2015 there was an increase in the number of adults 16 and over aware of the signs of stroke (comparison with 2011 post campaign results) • 1,201,689 aware ***face fallen on one side*** an increase of 729,597 (472,092 in 2011) • 987,102 aware of ***slurred speech/unable to talk*** an increase of 443,481(543,621 in 2011) • 886,961 aware of ***unable to lift arm*** an increase of 700,985 (185,976 in 2011) • 1,316,135 aware ***call 999 stroke is a medical emergency*** an increase of 171,670 (1,144,466 in 2011) The same campaign ran in England and a return on marketing investment of £28 for every £1 spent on marketing was calculated.	
Breast cancer campaign		
Pre and post campaign surveys of over 1000 women aged 16 and over.	Campaign awareness	• Recognition of the campaign was high, with 80% aware of the campaign advertising.
	Campaign impact	• 90% thought campaign advertising was thought provoking

		• 85% finding it relevant to them
	• To improve knowledge and awareness of the signs and symptoms of breast cancer	Apart from lump there was an increase in unprompted recall/recognition of symptoms featured in the campaign Unprompted recall • Lump 66% to 63% (increased to 95% on prompting) • Skin changes like dimpling or puckering 22% to 29% (increased to 88% on prompting) • Discharge or bleeding nipples 21% to 31% (increased to 91% on prompting) • Turned in or inverted nipples 13% to 18% (increased to 86% on prompting)
	• To reduce attitudinal barriers preventing individuals from seeking clinical advice as early as possible when specific symptoms and signs are noticed resulting in earlier presentation.	• An additional 63 women were diagnosed with breast cancer following being placed on a GP urgent referral pathway around the campaign period compared to the previous year, an increase of 44%. • The proportion of GP urgent referrals subsequently diagnosed with breast cancer (conversion rate) decreased from 10.4% to 7.8% between the two time periods. Prior to the campaigns there was an expectation that referral thresholds for investigating would be lowered and that conversion rates might go down correspondingly. This effect has often been seen in the English Be Clear on Cancer campaigns. • T**he proportion of confirmed breast cancer cases identified via the GP urgent referral pathway (detection rate) increased from 37.9% to 44.9% between the two time periods**.
Sexual health		
Survey of 751, 16-34 year olds. 21% of the sample (162	Campaign awareness	68% of 16-34 year olds were aware of the campaign. Campaign recognition was even higher among those

out of 761) were categorised as 'At risk' (*they had participated in risky sexual behaviour in their most recent sexual experience or had multiple partners and unprotected sex in the last year*).		considered 'at risk' - 83% were aware of the campaign
	• Increase awareness of the risks associated with unprotected sex	• 87% of those aware of the campaign found it to be very or somewhat thought provoking.
	• Encourage the target audience to think about their sexual health.	• Two-fifths (40%) of those aware of the campaign said it had encouraged them to think about their sexual health. • 51% of those at risk and aware of the campaign said it had encouraged them to think about their sexual health.
	• Improve attitudes towards using protection.	• 14% of those aware of the campaign said it made them buy/carry or use condoms. • 29% of those at risk and aware of the campaign said it made them buy/carry or use condoms.
Impact	• 318,919 16-34 year olds exposed to the campaign • 127,567 16-34 year olds said the campaign encouraged them to think about their sexual health • 44,649 16-34 year olds said the campaign made them buy/carry or use condoms	
Organ donation		
Pre and post campaign surveys with a representative sample (1,000+ respondents) of the adult general population of Northern Ireland (aged 16+ years). 2015 campaign evaluation	Campaign awareness	Recognition of the campaign was high, with 72% aware of the campaign advertising.
	• Increase support for organ donation	Support increased • As organ donation saves lives we should all register to be organ donors increased from pre campaign 55% to 66% post campaign
	• Increase the number of people who have discussed their wishes regarding organ donation with their family or close friends.	• The number of people who have discussed their wishes regarding organ donation with their family or close friends increased from 38% to 41%.
	• Increase the proportion of people registered on the ODR	• Increase in proportion of people registered on the ODR from 31% to 35%.
Impact	• 944,184 adults support organ donation an increase of 157,364 post campaign • 586,539 adults discussed their organ donation wishes with the family or close friends an increase of 42,917 post campaign	

Mental health		
Pre and post campaign surveys with a representative sample (1,000+ respondents) of the adult general population of Northern Ireland (aged 16+ years).	Campaign awareness	Recognition of the campaign was high, with 74% aware of the campaign advertising.

	• Increase knowledge of ways to promote and protect mental health.
	• Raise awareness of the sources of help and support available, and encourage those with a mental health problem to take appropriate action.
		• Just over one third (38.6%) of those who were exposed to the campaign said that they did something as a result of seeing the campaign. The actions included:
		  • Think about their mental health (29.2%).
		  • 15.1% said that they asked someone else if they were OK because they were concerned about their mental health
		  • One in ten (10.8%) said they visited the changeyourmindni.org website and 15.2% said they visited the mindingyourhead.info website as a result of being exposed to the campaign.

	• Encouraging others to open up and seek help for mental health problems.	• There was an increase (75% to 88%) among those who had known that someone close to them had a mental health problem and who had approached the person to see if they were OK
	• Increase positive attitudes towards those experiencing mental health problems and reduce fear and distrust.	• 45% of respondents in the pre-campaign survey said they had been treated negatively because of their mental health problem and this decreased to 41.8% of respondents post-campaign
Impact	• 408,632 people took some action in relation to mental health as a result of the campaign • 159,763 people said the campaign encouraged them to ask someone if they were OK because they were concerned about the person's mental health	
Obesity - Measure-up/Small changes		
Pre and post campaign	Campaign awareness	Recognition of the campaign was high, with 89% aware of the campaign advertising.

surveys with a representative sample (1,000+ respondents) of the adult general population of Northern Ireland (aged 16+ years).	• Increase the proportion of people who correctly identify their weight status particularly among those who are overweight/obese; Note Health Survey and campaign tracking surveys show the majority of adults are above a healthy weight but a large proportion underestimate their weight status	More respondents are now able to describe their BMI status accurately particularly those who are currently overweight or obese. • The proportion of respondents underestimating their BMI status decreased from 51% at pre-campaign, to 42% in 2013. • The percentage of overweight individuals describing themselves as an 'acceptable or healthy weight' decreased from 64% pre-campaign to 46% post-campaign. • The proportion of obese respondents who recognised they were obese nearly doubled from 11% to 21.1%. • Considerably fewer obese individuals perceived themselves as having an acceptable BMI – dropping from 22% to 11%.
	• Encourage people who are overweight or obese to make changes in relation to nutrition and physical activity that will help reduce their weight.	• Almost two out of every five (39%) tried to lose weight in the last six months. • The most popular way in which respondents had tried to lose weight was to limit portion sizes, with 45% of respondents who had tried to lose wieght having done this.
Impact	• 128,753 people not underestimating their BMI status post campaign	

Summary

The health benefits are clear. Sustained Social marketing campaigns provide the public with information and triggers that can lead to a healthier society. The evidence strongly favours the argument that Campaigns are very effective in achieving policy goals through behavioural change over time but often need sustained funding to do so, and are more likely to be effective if complementary policy or legal frameworks are

in place. They form a key part of public health interventions and are proven to be extremely cost effective contributing to long term savings across multiple programmes of care.

[i] See, for example: - Mass media interventions: effects on health services utilisation. Grilli R, Ramsay C, Minozzi S. Cochrane Database Syst Rev. 2002;(1):CD000389 - A Review of the Effectiveness of Mass Media Interventions which both Encourage Quit Attempts and Reinforce Current and Recent Attempts to Quit Smoking – NICE – http://www.nice.org.uk/nicemedia/live/11676/34642/34642.pdf How effective and cost-effective was the national mass media smoking cessation campaign 'Stoptober'? Brown J, Kotz D, Michie S, Stapleton J, Walmsley M, West R. Drug Alcohol Depend. 2014 Feb 1;135:52-8. doi: 10.1016/j.drugalcdep.2013.11.003. Epub 2013 Nov 2

HSC Public Health Agency

board paper

Annual Report for the Northern Ireland Diabetic Eye Screening Programme 2016/17

date 16 August 2018 **item** 9 **reference** PHA/03/08/18

presented by Dr Adrian Mairs, Acting Director of Public Health

action required For approval

Summary

The Annual Report for the Northern Ireland Diabetic Eye Screening Programme (DESP) covers the period 01/04/2016 to 31/03/2017.

This was a year of considerable change for the programme following a review of the programme undertaken by RQIA in 2015. Such changes were in relation to Phase 1 of the programme's modernisation programme; key activities included:

- Training of existing photographers to undertake primary grading and the instilling of eye drops – this historically was carried out by practice nurses within primary care;
- Centralisation of the call/recall function within the screening office at Belfast Trust;
- Upgrade of the patient management system, OptoMize;
- Introduction of direct referral to Hospital Eye Services, helping to reduce delays and improve accuracy of the referral process.

The report also includes the key performance data for the DESP programme. In 2016/17, the population eligible for screening was 91,232; screening uptake was 69.2%.

This is the first of eight annual reports for 2016/17 to be published by the Young Person and Adult Screening Programme: reports will be placed on the Public Health Agency website and circulated to key stakeholders.

Equality Impact Assessment

Not applicable.

Recommendation

The Board is asked to **APPROVE** the Diabetic Eye Screening Programme Report.

Annual Report

2016-17

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Section 1 – Summary

The Diabetic Retinopathy Screening Programme (DRSP) for Northern Ireland was established in 2008. In 2015 the programme name changed to the Diabetic Eye Screening Programme (DESP).

The programme is commissioned and quality assured by the Public Health Agency (PHA) in collaboration with Belfast Health and Social Care Trust (BHSCT) who are responsible for the management and delivery of the programme. The two organisations work closely together to provide an effective, safe and accessible service. Screening is delivered locally in line with national quality standards and protocols. This report summarises the performance of the programme against key standards for the financial year 2016/17.

This report covers a period of considerable change for the Northern Ireland Diabetic Eye Screening Programme. Work continued relating to the programme of modernisation which commenced as a result of RQIA recommendations; some of the major pieces of work which took place in 2016/17 were;

- Training of existing photographers to enable them to not only carry out the digital photography needed for screening but also the initial grading of these images, along with the instilling of eye drops
- Reduction in reliance on general practice with practice nurses no longer required to instil eye drops
- The centralisation of the call/recall function within the screening office, again reducing the burden on general practice
- Upgrade of OptoMize, the screening patient management system to allow for improved call/recall functions and participant management

- Introduction of direct referral to Hospital Eye Services (HES), allowing reduced delays and improve accuracy in the referral process, whilst ensuring the participant's general practitioner (GP) and Diabetologist are kept informed.

Some of the key performance measures in 2016/17;

- 69.2% (45,845/66,271) of all those invited for diabetic eye screening across Northern Ireland attended
- 262 of the 337 GP practices in Northern Ireland (77.8%) had their eligible diabetic participants screened in 2016/17.
- Of the 262 practices screened, 247 (were screened in 15 months or less

Further information on screening performance is available in section 6.

Section 2 - Introduction

The Northern Ireland Diabetic Eye Screening Programme (NIDESP) aims to detect diabetic eye disease at an early stage and prevent sight loss in those with diabetes aged 12 years and over in Northern Ireland. The programme is currently undergoing a modernisation project to ensure that it remains a sustainable service and continues to improve in line with national standards.

Diabetic eye disease remains one of the leading causes of blindness in people of working age in the UK.[1] It is a potential complication of diabetes which can cause sight loss. Diabetic retinopathy occurs when the high blood sugar levels associated with diabetes cause damage to the small blood vessels at the back of the eyes called the retina. These vessels can then leak blood into the retina or become blocked. This can affect sight. When changes related to diabetes occur at the centre of the retina (the macula), this can also affect sight, and is known as diabetic maculopathy.

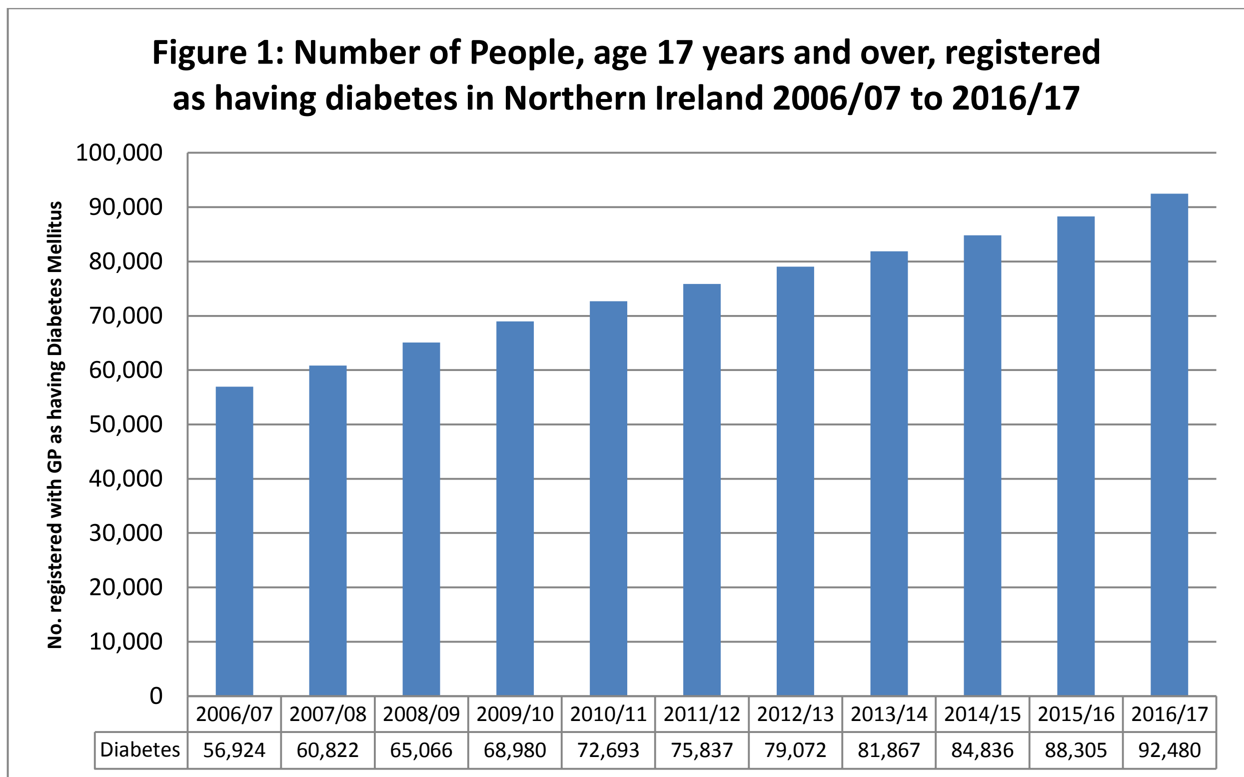
2.1 Rationale for screening

Research has shown that if the changes associated with diabetic eye disease are identified early, for example through screening, and treated appropriately, blindness can be prevented in the majority of people. Screening is important because the early stages of diabetic eye disease usually do not cause any signs or symptoms.

2.2 Public Health Challenge

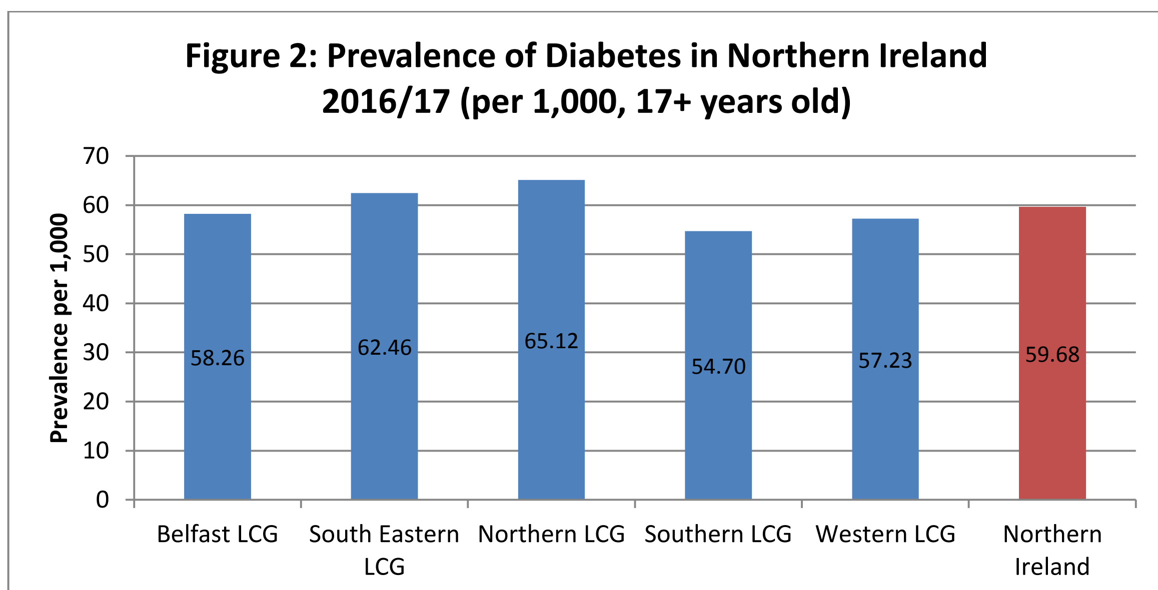
Reflecting trends worldwide, the number of people living with diabetes continues to grow each year in Northern Ireland, as shown in figure 1.

[1] Diabetes UK https://www.diabetes.org.uk/retinopathy



Source: QOF datasets 'Raw Disease Prevalence Data for Northern Ireland', www.health-ni.gov.uk/publications

According to QOF (Quality Outcome Framework) diabetes mellitus had a prevalence of 40.35 per 1,000 in 2006/07, amongst those aged 17 and older registered with a GP, however by 2016/17 this had increased to 59.68 per 1,000[2]. This prevalence varies across each of the LCG (Local Commissioning Group) areas as shown in Figure 2.



[2] Based on QOF data accessed at https://www.health-ni.gov.uk/publications/201718-raw-disease-prevalence-trend-data-northern-ireland

Section 3 - Programme Delivery

In most areas of Northern Ireland the diabetic eye screening appointment takes place in the participant's GP surgery. In the Western Health and Social Care Trust (WHSCT) screening occurs in one of six allocated hospitals or health centres. The regional diabetic screening programme team in BHSCT and PHA retain oversight and overall responsibility for the management and quality assurance of the process in all trust areas.

3.1 Who is eligible for diabetic eye screening?

Diabetic eye screening is available to all persons diagnosed with diabetes aged 12 years and over, the only exception is people who have no light perception in either eye. Once a person has been diagnosed with diabetes (excluding gestational diabetes) they should be screened for life. Those already under the care of an ophthalmology specialist for diabetic eye disease are suspended from screening.

3.2 The Invitation Process

The invitation process begins with a list of all those with diabetes within a practice being extracted by Apollo Medical on behalf of the screening programme. The screening team will work with each GP practice to arrange a suitable date, in advance of the time when the practice is due to be screened. The screening team will then issue invitation letters to all eligible participants.

3.3 What happens at diabetic eye screening?

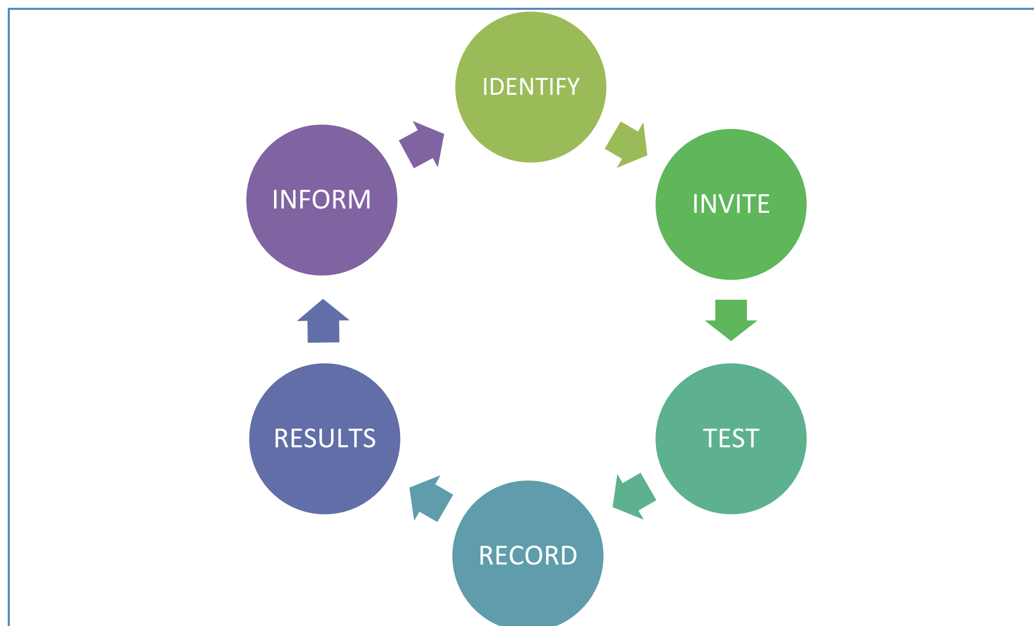
At the screening appointment, two or more photographs are taken of each eye using a special camera. The test is painless and takes about 15 minutes. If a person is over 50 years of age, eye drops are instilled about 15 minutes

before the test, to dilate their pupils. This helps to take a good quality photograph.

3.4 How does the diabetic eye screening programme work?

The retinal imaging is only one part of the screening programme. The programme is a process that consists of a series of key steps summarised in figure 3.

Figure 3: DESP Screening Cycle



The screening process begins by identifying those who are eligible to be screened. These participants are then invited for screening, the screening

test is performed (as outlined above), and the images taken are recorded and then graded giving results. The participant is sent a letter informing them of the results and a copy is sent to their GP. If the test detects an abnormality the participant is referred directly to Hospital Eye Services for further management, which may include treatment. Results requiring prompt referral will be flagged as urgent by DESP staff along the image capture and grading pathways, and are fast tracked through the grading system. Appendix 1 provides further details of the screening process. Monitoring and quality assurance against nationally agreed standards also occurs at each step in the process.

3.5 Mop-Up Clinics

To ensure all those eligible for screening are invited, participants newly diagnosed with diabetes are referred directly to the programme at the time of diagnosis. The aim is to offer these participants an appointment for their first screening encounter, within three months of the referral being received. These appointments are provided at ‘mop-up’ clinics, which also provide appointments for people with longstanding diabetes who move into Northern Ireland from elsewhere and also, where possible, those who were unable to attend their allocated screening appointment.

Section 4 - Modernisation Project

In 2015 the Northern Ireland Diabetic Retinopathy Screening Programme (DRSP) officially changed its name to the Diabetic Eye Screening Programme (DESP). This was in recognition that the programme is designed to detect a range of diabetic eye conditions, including maculopathy, at an early stage. It was also felt to represent a memorable, self-explanatory brand that is easily recognisable by the lay population.

A modernisation programme is currently underway to ensure that the DESP remains a sustainable service and continues to improve in line with national standards.

4.1 Phase 1

Within 2016/17 the programme focused on Phase 1 of the modernisation project, which included developing the capacity to implement a new bespoke diabetic eye screening IT system, OptoMize, and strengthening the management of the programme and its quality assurance.

The introduction of OptoMize in October 2015 enabled changes to the screening process whereby determining eligibility and generating invitations, communication of results and referrals now occurs centrally. This reduced the total number of steps involved, making the process less labour intensive for general practice. Another change to help alleviate the burden on general practice was the training of the screener/grader to administer eye drops when necessary rather than having to enlist the services of practice nurses.

The type of invitation issued to participants also changed in 2016/17 from an open invitation to a closed invitation. This meant that instead of participants receiving a letter asking them to contact the screening office to make an

appointment, they were issued with a fixed date and time. However if the appointment issued does not suit participants can arrange an alternative appointment through contacting the screening office.

Test and Training was also introduced in 2016/17. This is a grading qualification which the NHS DESP had introduced in the last number of years and which all graders should complete. It enables staff to improve their skills in detecting signs of disease on images.

In October 2016 western area optometrists were able to use the same screening software and complete image grading directly onto the OptoMize system.

4.2 Future Development

Phase 2a of the DESP modernisation programme will concentrate on the introduction of surveillance clinics. These clinics will mean that those who require closer monitoring but not treatment, will receive more frequent eye examinations (every 3, 6 or 9 months) via the screening service, and will not have to be referred to Hospital Eye Services.

Phase 2b will consider changes to the current model of service delivery to ensure sustainability into the future. It will focus on the provision of retinal photography to the eligible population. In 2016/17 preparatory work was carried out in the form of a survey of GP attitudes to the programme and a stakeholder workshop to develop a list of potential model options.

Phase 3 will be the introduction of variable screening intervals as recommended by the National Screening Committee. This would mean that those who are at low risk will be invited for screening every two years, rather than every year, with those at high risk continuing to be screened every year.

Section 5 – Highlights of 2016/17

As previously mentioned 2016/17 was a year of considerable activity and change in the programme.

5.1 New Clinical Lead

One of the key changes was the appointment of a new Clinical Lead, Professor Tunde Peto. She is also the Head of the Belfast Reading Centre, Clinical Professor of Ophthalmology at Queens University Belfast and President of the British Association of Retinal Screeners. Tunde came to Northern Ireland from the DES programme in Tower Hamlets, London. She is highly respected in her field and is heavily involved in working with developing countries to establish eye screening programmes. Since her appointment in the summer of 2016, she has lead a number of significant changes and improvements to the programme.

5.2 NIDESP Stakeholder Workshop, January 2016

The programme held a stakeholder workshop 'Options for Delivering the NI Diabetic Eye Screening Programme', on Wednesday 27th January 2016. The aim of this workshop was to consider and develop a variety of service delivery models to help inform the initial stages of phase 2b of the modernisation project (see section 4.2 for further details). The event was attended by interested individuals from a variety of sectors such as HSC trusts, primary care, HSC Board, the Irish screening programme, PHA, RQIA, voluntary/charitable organisations and users of the service. Feedback from the day was very positive.

5.3 World Sight Day, October 2016

The first World Sight Day Conference to be held in Northern Ireland was on Thursday 13th October 2016 at the Centre for Experimental Medicine, QUB.

This event covered subjects such as current issues and development in screening and treatment pathways, diabetes care provision in Northern Ireland, and current research in diabetic eye disease. It also included an interactive MDT discussion with those in attendance. The day proved very popular, and will now be repeated on an annual basis.

5.4 Patient Survey

A participant survey was completed in June 2016 with randomly selected participants who had not responded to their invitation letter. The purpose of the survey was to get a better understanding of the reasons for non-participation. Over 500 participants were contacted; 100 agreed to participate. One of the key messages from this survey was that 61% indicated they would be more likely to attend for screening if they were provided with a fixed appointment (i.e. specified date and time) rather than the practice at the time of open appointments (i.e. participants were asked to ring to make a suitable appointment).

Section 6 - Programme Performance

The data contained in this report should be considered against a backdrop of significant change, both to the programme as previously discussed, but also to the upgrade of the OptoMize system. In addition, as of the end of 2016/17 Eyecap data, i.e. historical data on existing screening participants had not yet been uploaded onto OptoMize. This meant that all participants were considered as newly diagnosed.

To allow for the significant changes outlined in sections 4 and 5, it should also be noted that there were no screening appointments carried out for three months between December 2016 and February 2017.

6.1 Eligible Population

In 2016/17 the number of people in Northern Ireland aged 12 years and older, living with diabetes was 91,291[3]. Within this population there were 59 people classed as ineligible, i.e. those that have no light perception in both eyes.

A further 1,055 were excluded from screening.

- 788 were informed opt-out
- 267 medically unfit

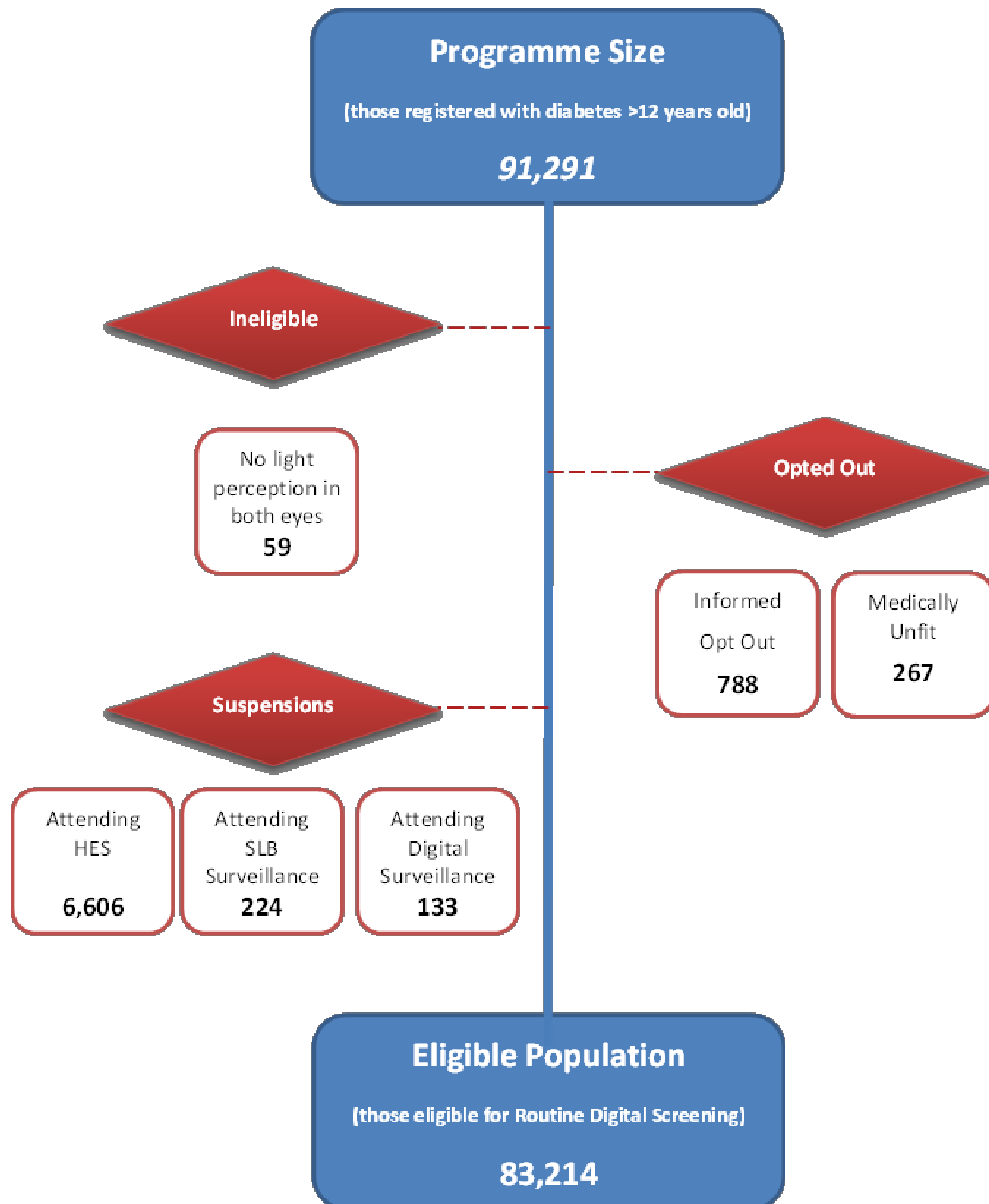
There were 6,963 participants suspended from the programme due to the following reasons

- 6,606 attending Hospital Eye Services (HES)
- 224 attending Slit Lamp Biomicroscopy Surveillance pilots
- 133 attending Digital Photography Surveillance pilots

[3] OptoMize Programme Performance Report

This equates to 83,214 participants eligible for routine digital screening (RDS).

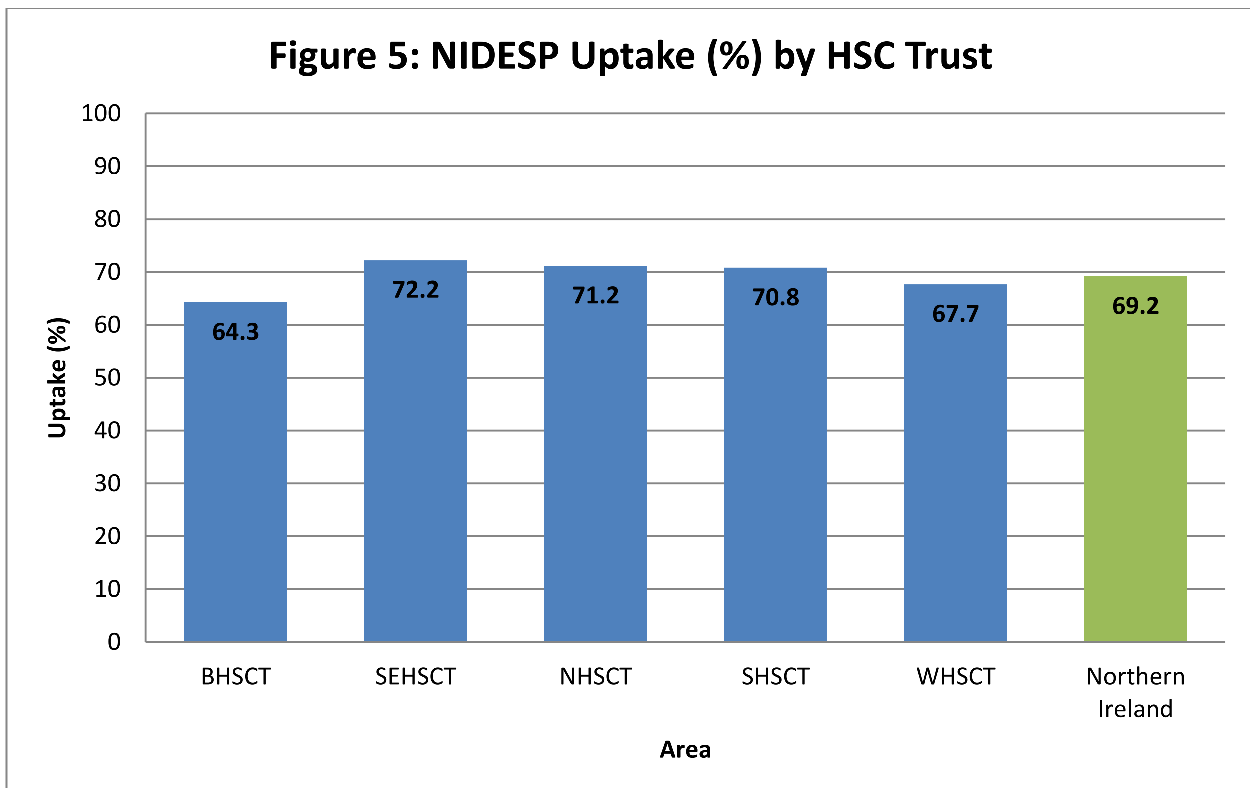
Figure 4: Eligible Population for NIDESP 2016/17



6.2 Invitation and Attendance

In total 66,271 people were invited for RDS, with 45,845 attending for diabetic eye screening across Northern Ireland in 2016/17.

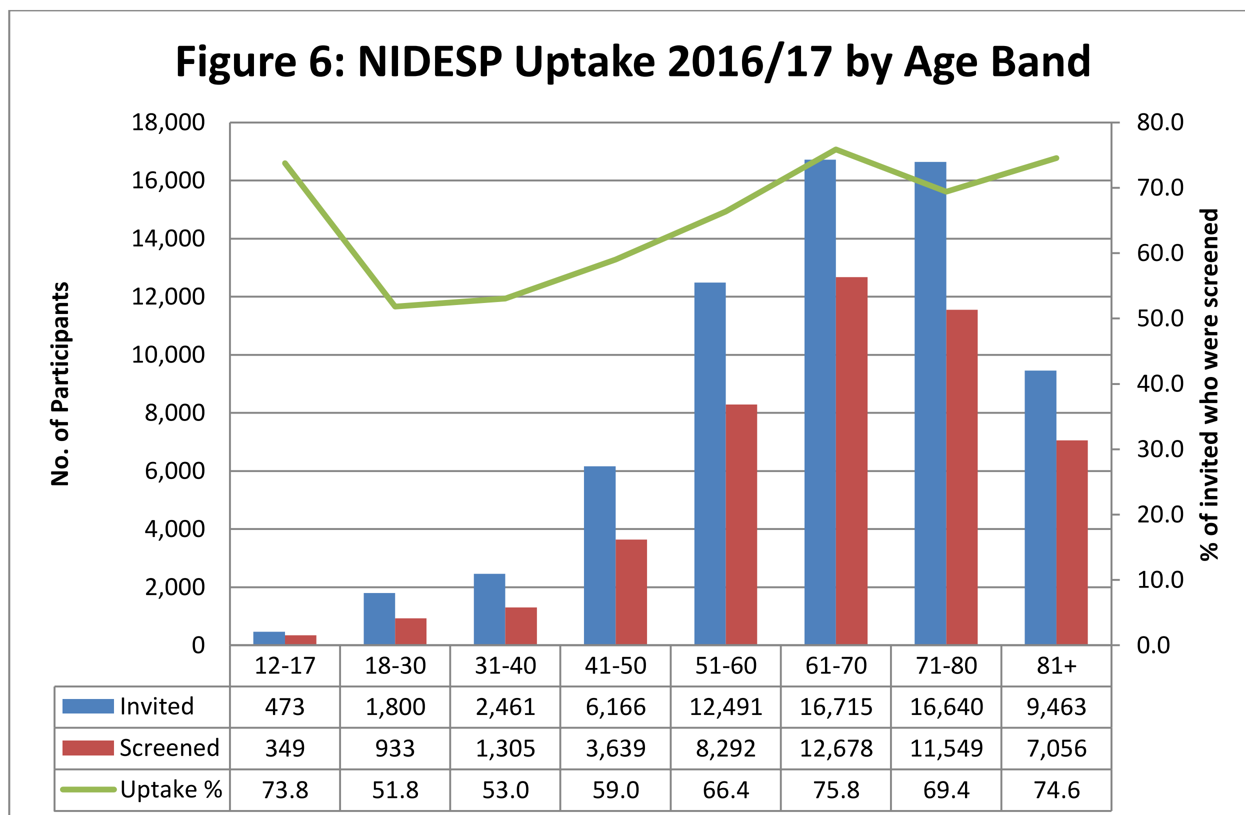
When reviewed by trust area, it can be seen that the South Eastern Trust had the highest uptake with 72.2% and the Belfast Trust the lowest with 64.3% of those invited being screened. The overall Northern Ireland figure is 69.2%.



Type 2 diabetes is more likely to affect those over the age of 40 and Type 1 usually starts below the age of 40, however, overall, around 90% have Type 2. The expectation therefore would be that the vast majority of those eligible for diabetic eye screening are over the age of 40. This can be seen in figure 5 below. The age group most likely to attend for screening is those aged 61-70.

The programme will need to explore the variation in uptake amongst the age bands and also the socio-economic gradient. This will help the programme to

understand why some people attend for screening whilst others do not and how ultimately how best to help participants make an informed decision on whether attending for screening is right for them.



	12-17	18-30	31-40	41-50	51-60	61-70	71-80	81+
Invited	473	1,800	2,461	6,166	12,491	16,715	16,640	9,463
Screened	349	933	1,305	3,639	8,292	12,678	11,549	7,056
Uptake %	73.8	51.8	53.0	59.0	66.4	75.8	69.4	74.6

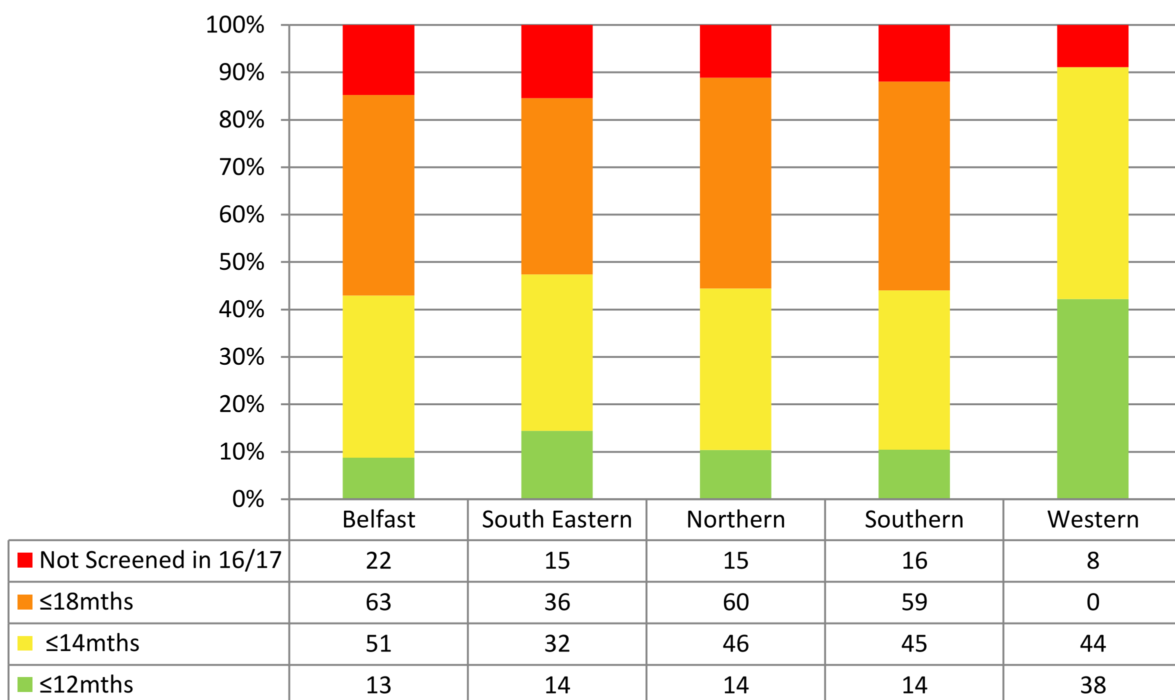
6.3 Practice screening interval

The practice screening interval is the time taken between each screening clinic at a given GP practice. According to national standard this should be within 12 months of the previous visit (+/- 6 weeks). The average interval for Northern Ireland in 2016/17 was 13 months. Of the 262 practices visited by the programme (out of a possible 337) within the period 01/04/2016 to 31/03/2017, 247 were seen within 15 months.

There are many factors which affect the screening programme's ability to meet the 12 months screening interval. However the primary reason for delay is that the NIDESP is not in control of the timely availability of suitable accommodation. The way in which the programme is currently delivered in

the Belfast, South Eastern, Northern and Southern areas means that GP practices are required to provide a room in their premises for a set number of days during a specified period of time. This can prove very challenging for practices, particularly given the increasing size of the eligible screening population, meaning that rooms are required for longer.

Figure 7: NIDESP 2016/17 Screening Interval by LCG Area (%)



	Belfast	South Eastern	Northern	Southern	Western
Not Screened in 16/17	22	15	15	16	8
≤18mths	63	36	60	59	0
≤14mths	51	32	46	45	44
≤12mths	13	14	14	14	38

In Figure 7 it can been seen that the ability to meet the screening interval standard within the western area is increased compared to the rest of the region. This is primarily due to the way in which the service is delivered, in fixed sites where NIDESP has more control over the availability of accommodation and the scheduling of clinics.

As alluded to on page 11, the work of phase 2b of the modernisation project will help to address this issue. It will review the way in which the programme is currently delivered, assess alternatives and ensure that the service delivery

model chosen will be able to provide a sustainable, safe and high quality service into the future.

Until the Northern Ireland programme is delivered in a way which allows screening to be organised by individual rather than at practice level, it will not be possible to accurately benchmark data against the standards for screening interval.

6.4 Image quality (minimising harm)

Poor image quality in one or both eyes can result in the screening test needing repeated with associated unnecessary delays for participants affected. In 2016/17 5.7% (2,599) of participants screened were affected by poor image quality in one or both eyes. This was within the minimum standard of <7% and within the achievable standard range of 2.5% - 6.3%.

Section 7 – Conclusion and Next Steps

Despite a challenging year with many programme changes, service improvements and initiatives, the NIDESP is committed to continuing to improve the programme, to pursuing the highest quality service for its eligible population.

In 2017/18 the work of the modernisation project will continue;

- Piloting of surveillance clinics prior to full implementation in 2018/19
- Development of digital photography surveillance information leaflet and information on slit lamp biomicroscopy
- Progression of phase 2b with the development of the option appraisal and consultation with stakeholders on the model options available

Work will also begin to look the differences in uptake amongst the different socio-economic and demographic (e.g. age, gender, location) groups and ways to ensure that all participants are able to make an informed decision about whether to attend for screening.

New national quality standards will be adopted by the Northern Ireland programme from 1st April 2017. One of the key changes will be the inclusion of standards on digital surveillance, slit lamp biomicroscopy and screening of pregnant women. Some of the acceptable and achievable standard levels will change along with the revised of standard definitions.

Appendix 1- Diabetic Eye Screening Programme - Screening process

Appendix 2 - Summary of Key Performance Data

Description	Acceptable Threshold	Achievable Threshold	Northern Ireland
Eligible Population ***(total programme size minus those with no light perception in both eyes)***			**91,232** *(91,291 - 59)*
No. Excluded ***(those who have opted out or been declared medically unfit)***			1,055
No. Suspended ***(those attending Hospital Eye Services or Surveillance Pilots)***			6,963
Participants Eligible for Routine Digital Screening (RDS)			**83,214**
Participants Invited ***(for RDS during the reported time period)***			**66,271**
Participants Screened			**45,845**
Coverage ***Percentage of eligible population invited for screening (including those suspended and excluded)***			**79.6%** *(66,271/83,214) *100*
Uptake ***(Proportion of those offered RDS who attend a digital event)***	≥70%	≥80%	**69.2%** *(45,845/66,271) *100*
Ungradables ***(Percentage of patients where image has been obtained but final grading outcome is ungradable)***	<7%	2.5% - 6.3%	**5.7%** *(2,598/45,845) *100*
No. GP Practices in NI			337
No. GP Practices Screened within 2016/17[4]			262
% of Practices Screened in 2016/17			**77.8%**

[4] Screening will be provided to the eligible population across all GP practices, however the programme may not be able to provide screening to all practices within the 12 month period e.g. 01/04/2016 to 31/03/17.

HSC Public Health Agency

board paper

Annual Quality Report

date 16 August 2018 **item** 10 **reference** PHA/04/08/18

presented by Mrs Mary Hinds, Director of Nursing, Midwifery and Allied Health Professions

action required For approval

Summary

The PHA and HSCB are required by the DoH to produce an Annual Quality Report in line with the implementation of the Q2020 Strategy. This is outlined within the PHA Business Plan under section 4 'All health and well-being services should be safe and high quality' action 9.

This is the PHA and HSCBs fifth Annual Quality Report. The aim of the report is to share information and demonstrate improvements both to those who use health and social care services and those who deliver them.

The DoH issued guidance on the content of the Annual Report and the expected timescales for completion and submission has been confirmed as September 2018 for formal publication in November 'World Quality Day' in conjunction with all HSC Trust and ALB Annual Quality reports.

The report has been written under the following 5 strategic goals:

- Transforming the Culture
- Strengthening the workforce
- Measuring the improvement
- Raising the standards
- Integrating the care

Similar to previous reports, a short infographic section will be included at the beginning of the report to highlight some of the content in a visual format. The text which will be used for the infographic has been included within the first section of the report.

Equality Impact Assessment

Not applicable.

Recommendation

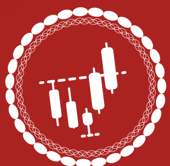
The Board is asked to **APPROVE** the Annual Quality Report.

Health and Social Care Board
and **Public Health Agency**

Transforming the culture

Strengthening the workforce

Measuring improvements



Raising the standards

Integrating the care

Annual Quality Report
2017/18

HSC Health and Social Care Board

HSC Public Health Agency

QUALITY 2020

Foreword

I am very pleased to present the fifth Annual Quality Report of the Health and Social Care Board (HSCB) and Public Health Agency (PHA).

This report highlights a variety of work that has taken place over the last year, demonstrating our firm commitment to driving improvements in safety, outcomes, access, efficiency and patient satisfaction. While it is impossible to include information about every service the HSCB and PHA provide, nevertheless it is my hope that this report goes some way to reassure our patients, clients and the public of our commitment to continuous improvement and delivering high quality treatment and care.

During 2017/18 there was an important focus on quality improvement and improving outcomes for patients/clients within each of our directorates. I am particularly pleased to note the range of improvements which have been implemented as a result of, for example, the Dementia Together NI project. With the extensive public information campaign #STILL ME, the delivery of a range of training and education programmes and the recruitment of dementia champions and navigators across the HSC, the project has far exceeded all expectations.

Regionally, we have seen continuous progress in the management of clinical networks and I am delighted to share the work of the imaging services accreditation scheme, which, through the modernising radiology clinical network, has been commended as an exemplar model for collaborative working. Similarly, measuring improvement has remained an key area of focus and last year we continued to provide support to HSC Trusts and other HSC bodies on a range of key quality improvement priorities, which collectively resulted in, for example, a reduction in moderate to major/catastrophic falls across the region.

Our commitment to the co-production of services has been evident through the various improvements implemented as a result of 10,000 More Voices and the continuous growth of recovery colleges across the region. Similarly, through the integration of care we have seen a range of transformed and enhanced services being delivered, +exhibiting strong inter-professional communication links between both primary and secondary care.

Finally, I would like to thank all the staff for their continuing efforts over the past year and I am particularly proud of what we have achieved together. As the HSC continues to face financial and operational pressures, the HSCB/PHA will focus on continually improving quality of care for people using their services and to put our patients, clients and staff at the heart of everything we do.

Transforming the culture

361 Serious Adverse Incident Reviews Completed

Regional learning methods approved:

- **12** reminder of best practice guidance letters
- **8** professional letters
- **42** newsletter articles
- **56** specialist group referrals
- **9** featured at the regional SAI learning event
- **2** thematic reviews commissioned

5 Recovery Colleges fully operational

2,422 Stories Collected

Overall Total **12,720**

Strengthening the workforce

HSC staff...

32% trained at level 1 of the **Q2020 Attributes Framework**

2,826 trained in the use of the **Delirium Assessment & Management Tool**

Personal and Public Involvement (PPI)

23% completed the Engage & Involve PPI Training Programme

The Q Community in NI up to **123 members**

Q is an initiative which connects people who have quality improvement expertise across the United Kingdom

Roll out of

in 30 clinical areas

Project ECHO is a tele-monitoring programme designed to address the growing demand for secondary care services

Measuring improvements

Regional Quality Improvement Plan priority areas focused on:

Pressure ulcer prevention

Falls prevention

National Early Warning Scores

Mixed gender accommodation

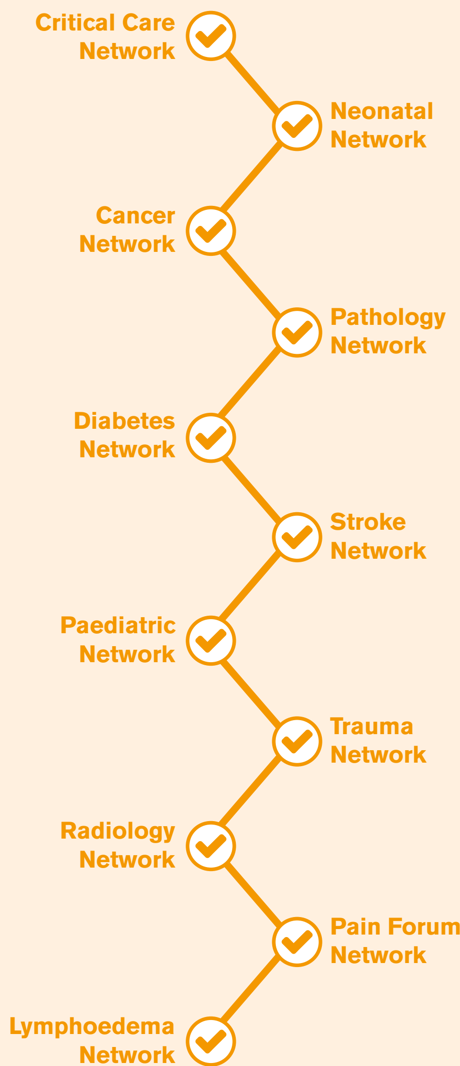
59 Technology Appraisals issued

Continued monitoring the implementation of

170 Clinical Guidelines

Raising the standards

Regional Clinical Networks implemented to achieve regional consistency in care & drive quality improvement, including:



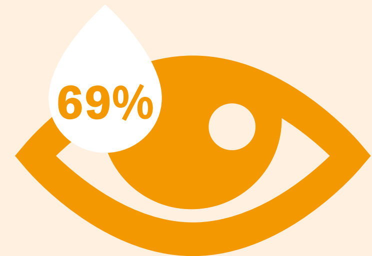
Development of 'Quality Improvement Collaboratives', including:

- Maternity collaborative
- Sepsis collaborative
- Mental Health collaborative
- Paediatric Collaborative

8 antenatal, newborn & adult screening programmes commissioned & quality assured:

1. Antenatal infection
2. Newborn blood spot
3. Newborn hearing
4. Abdominal Aortic Aneurysm
5. Bowel cancer
6. Breast cancer
7. Cervical cancer
8. Diabetic eye

1,407 downloads of the Learning Disability Hospital Passport from the PHA website



6,000 Learning Disability Hospital Passports & guidance notes distributed

As a result of the **Developing Eyecare Partnership** 69% fewer patients were referred for suspect ocular hypertension

Mental Health 1+1 Project

Project launched with 3 bi-lingual staff - 4-year pilot programme supporting the **mental health & wellbeing needs of Black & Minority Ethnic communities**

Integrating the care

The A-Z Health Conditions Platform was developed providing a suite of health information, supporting people to make decisions in relation to their personal illness & chronic conditions

3,464 key information summaries successfully completed by GPs enabling important accurate information to be quickly identified in an unscheduled care setting

26% increase in Health Service patients receiving specialist oral surgery care within primary care compared to the previous year, as a direct result of the Oral Surgery Personal Dental Services Pilot

In April 2018, **3,656 patients** received a home oxygen concentrator via the home oxygen service

22% increase in the number of children whose language development was age appropriate, as a direct result of the supporting speech, language & communication programme in Sure Start

Contents

Transforming the culture

1.1 Introduction
1.2 Who we are
1.3 Leadership & governance of quality
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Theme one

Transforming the culture

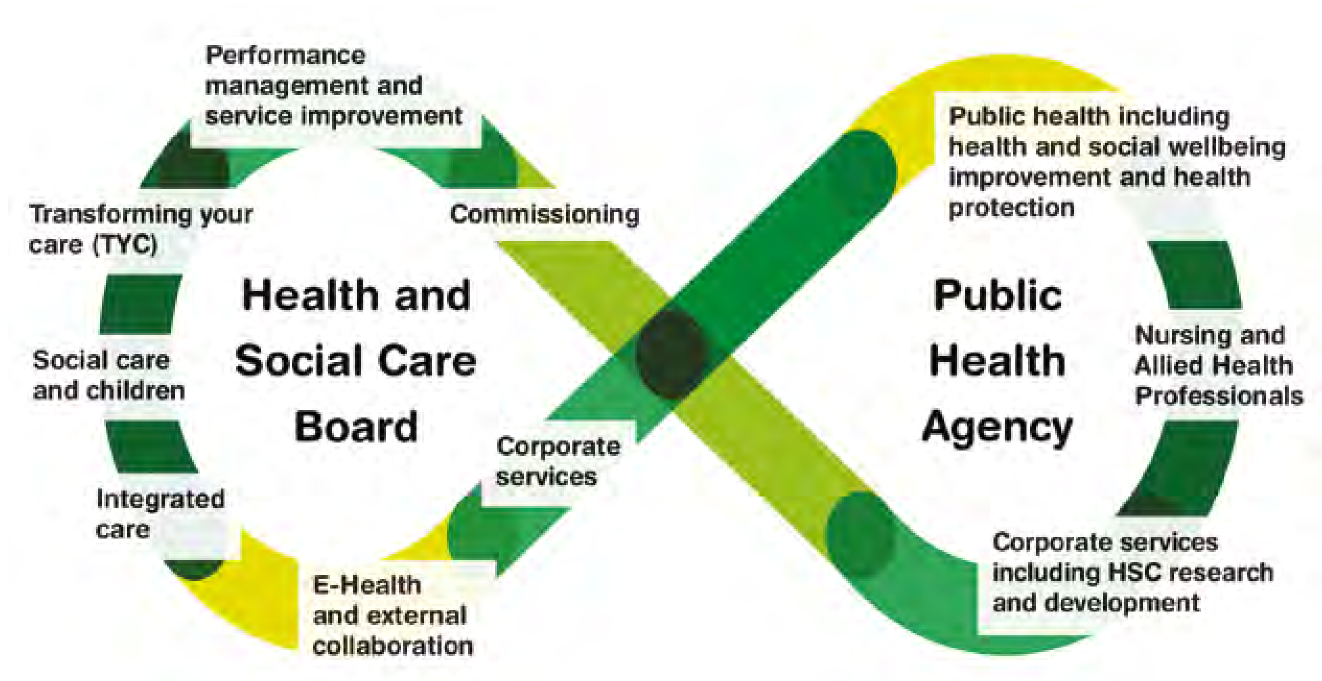
Transforming the culture

1.1 Introduction

The HSCB and PHA both recognise that for the quality of care and services to be of the highest standard, the culture of an organisation must be open, honest, transparent and, in particular, patient and client focused. Key to transforming organisational culture is the willingness of the senior team to lead from the front in motivating staff and, prioritising patient and client care, while embracing change in the rapid moving climate of Health and Social Care (HSC).

1.2 Who we are

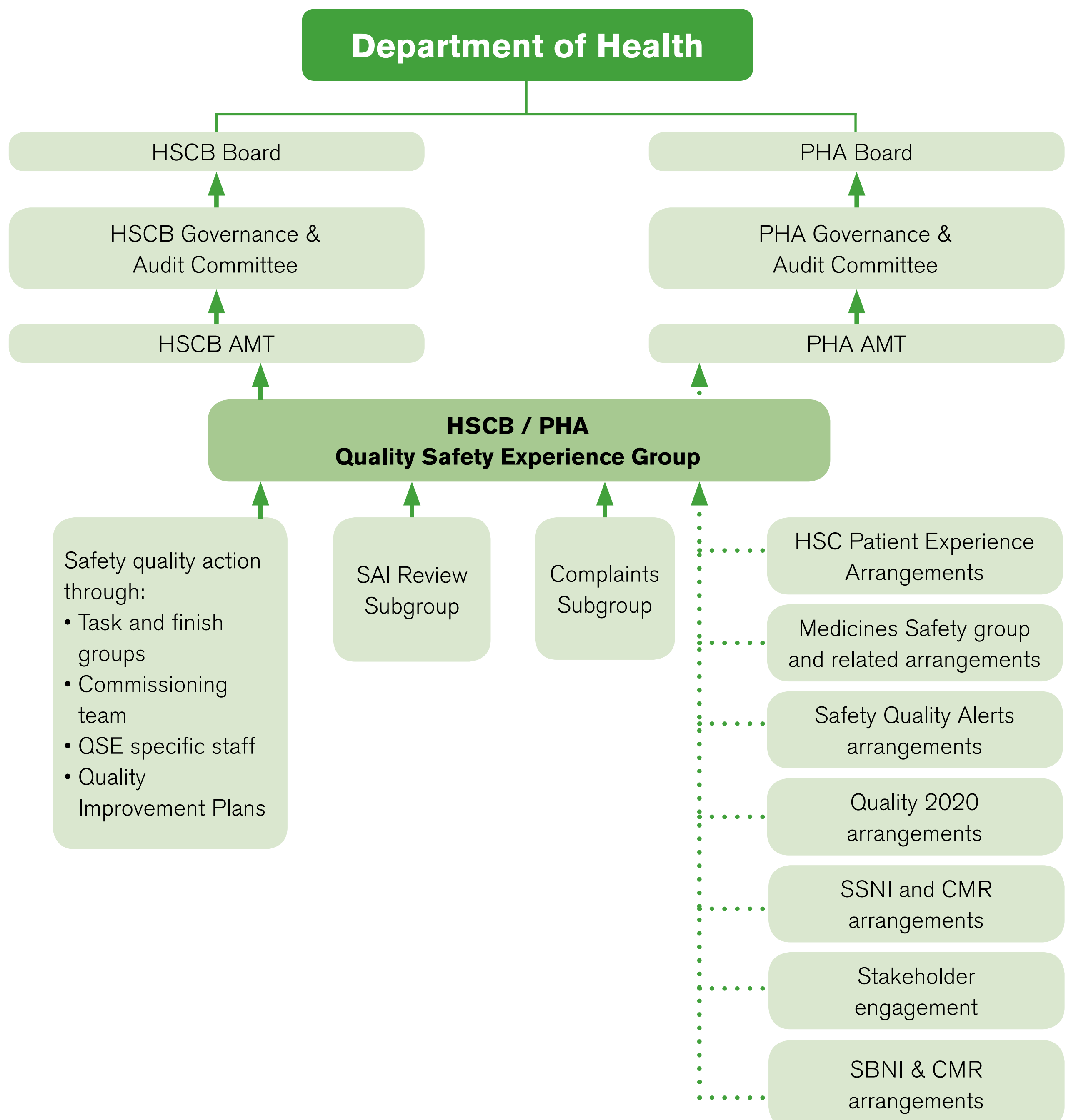
The HSCB and PHA are considered arm's-lengths bodies within HSC. The organisations have a different range of roles and responsibilities, as reflected in their directorate structure. Ensuring that HSC services are safe, high quality, effective and meet people's needs is a core function of the HSCB and PHA. The two organisations work collaboratively to improve the quality of services delivered and work towards the Quality 2020 vision "to be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in Health and Social Care".



1.3 Leadership & governance

Within the HSCB and PHA, the **Quality, Safety and Experience (QSE) Group** monitors and reports on safety, effectiveness and the patient client experience. A number of other groups contribute to the work of improving the safety and quality of services as shown in the overview of the PHA/HSCB QSE governance and assurance structure.

The Safety Quality Alerts Team, Regional Complaints Group, Serious Adverse Incident Group, Designated Review Officer (DRO) professional groups, and the Safety Forum, report to, and support the work of QSE.



1.4 Learning

Regional learning from serious adverse incidents

The key aim of the Serious Adverse Incident (SAI) process is to improve patient and client safety and reduce the risk of recurrence, not only within the reporting organisation, but across the HSC.

For the majority of SAIs reported, local learning will be identified and actioned by the reporting organisation. However, as the HSCB/PHA have a role in reviewing all SAIs they may also identify regional learning for dissemination across the HSC through a number of mechanisms.

During the reporting period 361 SAIs were closed by the HSCB/PHA following review. The following methods of regional learning were approved from SAIs closed in 2017/18:

12	**reminders of best practice guidance letters**
8	**professional letters**
42	**newsletter articles were identified**
56	**were referred to other specialist groups**
2	**thematic reviews were commissioned**
9	**were featured at learning events (SAI learning event)**

Listed below are four examples of regional learning identified last year:

- **Management of needlestick injuries in patients presenting to emergency departments**

This SAI related to a community pharmacy staff member who sustained a needlestick injury during the course of their duties. As a result, a reminder of best practice guidance letter was issued to the HSC and the HSCB and PHA worked with Trusts to ensure:

- Emergency departments within Trusts have a clear policy on managing people who present with needlestick injuries;
- All members of staff who may be involved in the management of patients presenting with a needlestick injury are aware of, and have received training in the Trust policy.

- **Acute management of diarrhoea related to cancer treatment**

A number of SAIs occurred in which people receiving systemic anti-cancer therapy were admitted to hospital with diarrhoea and subsequently died. A common feature in the incidents reported was that the seriousness of the patient's diarrhoea was not necessarily recognised and appropriate inpatient treatment was consequently delayed.

As a result, a reminder of best practice guidance letter was issued reminding Trusts of the requirements under current guidance and requesting this be brought to the attention of relevant staff.

• Choking on food

Last year a thematic review of choking on food led by the HSCB/PHA in conjunction with key stakeholders was distributed to the HSC. The themes identified through analysis reinforce a need for co-ordinated efforts to facilitate learning and inform future quality improvement work with an aim of prevention or reduction of risk of choking in future. A number of key messages relating to the areas below are identified within the report. These include:

- Raising awareness
- Communication to staff delivering care directly
- Terminology
- Roles and responsibilities
- Education and training
- Reporting
- Support to staff

In response to the choking on food thematic review, a multidisciplinary and multiagency Adult Swallowing Difficulties Regional Steering Group has been established. The group uses a co-production approach and has four workstreams including awareness, identification; assessment and management and International Dysphagia Diet Standardisation Initiative (IDDSI) implementation.

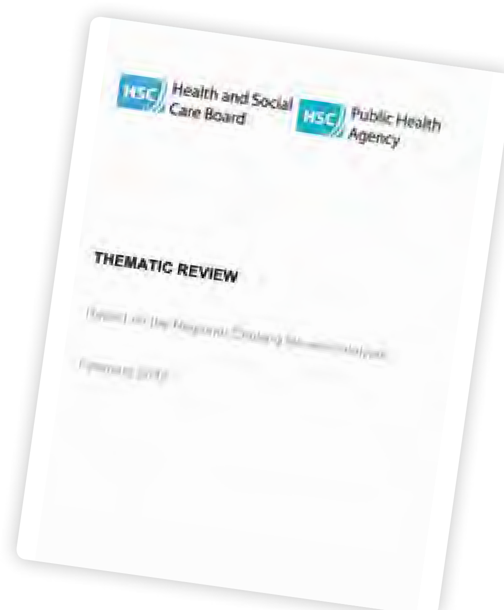
Funding has been agreed to support a number of specific actions within the work. Engagement activities have taken place to inform the work going forward. These include:

• Focus groups / workshops

Two focus groups & a regional workshop have been held to listen to issues from nursing/ residential homes, domiciliary care sector and Trust staff in relation to the identification and management of adults with dysphagia, including staff training needs.

• Public awareness raising

Information stands were held across the region in hospitals on European Swallow Awareness Day on 14th March 2018. Speech and language therapists (SLT) and SLT students provided information on swallowing difficulties and catering departments provided samples of a dysphagia diet. A short survey was also completed to gain information on the public's knowledge of dysphagia.



- **Fire risk associated with use of product to treat head lice**

This case involved a child treated for head lice who suffered severe burns following application of a treatment product and subsequent exposure to a source of ignition. Unfortunately due to the combustible nature of the treatment product the child's face and scalp. The child suffered 3rd degree burns to the face and neck. Although there are written warnings included with the product, these may not have been brought to the attention of the recipient by pharmacy staff.

As a result a Reminder of Best Practice Guidance letter was issued to the HSC with specific actions for Trusts, HSCB, GP practices, community pharmacies and the Regulation and Quality Improvement Authority (RQIA).

For further information on learning from SAIs please see following link **http://www.hscboard.hscni.net/publications/sai-learning-reports/**

Regional learning from complaints

The HSCB/PHA review complaints received from Trusts, family practitioner services (FPS), and those received directly by HSCB and PHA. For the majority of complaints, local learning will be identified and actioned by the reporting organisation. In some cases, the HSCB/PHA may also identify regional learning.

Areas of concern, patterns and trends from complaints are shared with relevant professional groups. This ensures that issues raised by complaints inform key areas of work on the quality of patient experience and safety, including thematic reviews and strategy and policy development.

Setting the context: during 2017/18
- **Trusts received 5814 complaints**
- **HSCB received 240 complaints regarding Family Practitioner Services**
- **HSCB acted as 'honest broker' in 54 complaints regarding Family Practitioner Services.**

Top 3 categories of complaints
1) **Quality of treatment and care**
2) **Staff attitude/behaviour**
3) **Communication/information**

During 2017/18, the HSCB hosted its fourth annual Learning From Complaints event, which focused on the themes of palliative care and the coordination of discharge packages. Both issues consistently feature in a significant number of complaints across primary and secondary care.

Palliative care is appropriate for people with a progressive or life limiting condition, regardless of age. Dame Cicely Saunder quote – *How people die remain in the memories of those who live on.* Therefore complaints regarding palliative care is appropriate for people with a progressive or life limiting condition. Timely communication of information between patients, families, carers and HSC providers is therefore paramount in improving patient and carer experience of palliative and end of life care. The timing of discharge also needs appropriate consideration, with referrals to district/palliative care made in a timely fashion.

Key messages from the day included; recommendations identified by the Patient Client Council (PCC) to improve interactions between clinicians, patients and their families; how complaints have influenced the discharge policies across the WHSCT emergency departments; how complaints have made a difference to the Regional Palliative Care Programme and consideration given to the theme of "moral distress" within intensive care and the associated impact this has on relatives, doctors and nurses.

To raise awareness of these issues and to highlight learning and good practice, feedback from this event was compiled and disseminated to the HSC.

For further information relating to complaints can be accessed at **http://www.hscboard.hscni.net/publications/complaints-publications/**

Learning from experience:

Learning from patient and client experience is a key indicator of quality of care and is integral to the implementation of Q2020 across the region. The HSCB/PHA lead the implementation of the 10,000 More Voices initiative for Northern Ireland. The rich source of information from the stories received through the 10,000 More Voices initiative continues to provide opportunities for learning , reflection and informing improvement work, for example:

- Stories from the individual 10,000 More Voices projects are reviewed on a weekly basis – this provides an opportunity for the relevant staff to highlight areas of good practice as well as considering any immediate learning or action that needs to be taken.
- Findings and results from 10,000 More Voices projects are presented at analysis and interpretation workshops at which key stakeholders, including service users work collaboratively to themes and trends. Following this, recommendations are developed, alongside local and regional action plans.

- Stories are used to inform education and training, including local induction programmes as well as pre and post registration education for medical, nursing and allied health professional students.

- 10,000 More Voices is now an integral part of quality improvement, informing 'Always Events' and quality improvement programmes within HSC Trusts.

To date over **12,000** stories have been collected, across a broad range of service areas, including: eye care services, hospital discharge, delirium and adult safeguarding.

Further information and completed project reports can be accessed at: **http://10000morevoices.hscni.net/**

10,000 More Voices Team at their celebration event in March 2018

When I heard about 10,000 More Voices I felt it was important to tell our story, I hope that by doing so other families will be listened to or receive better explanations in these circumstances…… If as you say our story is used to shape future healthcare, improve services and educate staff then I am content that this opportunity is available."

Thank you for taking time to listen to 10,000 Voices or even me.

Personal and Public Involvement (PPI) Involving you, improving care

PPI is the active and effective involvement of service users, carers and the public in the commissioning, development and delivery of HSC services. Co-production is considered the pinnacle of such involvement. The PHA leads on the implementation of PPI in Health and Social Care. Recognising that core to quality improvement work is the involvement of service users and carers, a number of initiatives have been progressed in 2017/18. These include:

1.5 Involvement & co-production

Personal and public involvement (PPI)

- **Improving involvement in transformation -** Working closely with a number of the transformation workstreams, the PHA has provided guidance to ensure service users and carers are effectively and meaningfully involved in transforming HSC at all levels.

- **Improving access to information to improve involvement practices -** The PHA lead the co-production of the Engage website and e-learning resource for service users and carers. This has led to a significant improvement in the quality, availability and consistency of PPI information available. The PHA was also a partner in the quality improvement community of practice for PPI which has developed checklists for staff undertaking improvement work alongside service users and carers getting involved in this work.

- **Improving knowledge and skills –** The PHA continues to promote and deliver the Engage and Involve training programme, elements of which are now being delivered as part of quality improvement training in some HSC Trusts. In addition, innovative and high quality training for involvement, including an involvement leadership programme and specialist training for consultation has been commissioned.

- **Improving HSC performance for PPI -** The PHA continue to undertake performance monitoring for PPI across HSCT which focuses on what is working well and what can be improved. The HSCB / PHA were also subject to external PPI monitoring during this period.

- **Improving involvement standards – leading the way -** The PPI standards, developed by the PHA, have been used as the pathfinder for National Research Standards. The PHA has been working with the National Institute of Health Research (NIHR) and PPI leads from England, Scotland, Wales on this initiative.

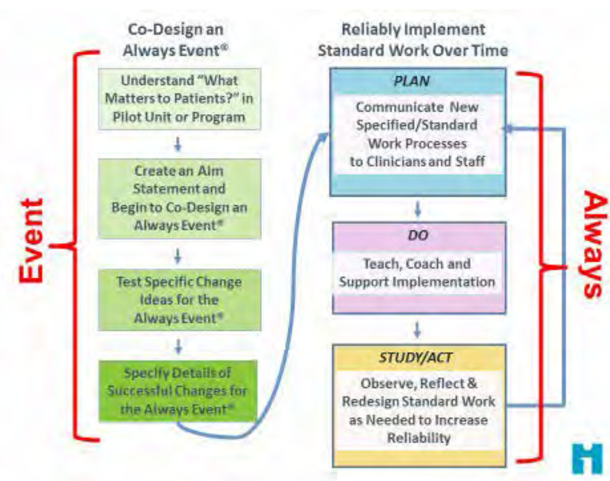
Meaningful involvement across our services remains critical improvements in safety and quality. The PHA will continue to advance these core areas of responsibility in partnership with service users and carers.

Further information on PPI is available at **http://engage.hscni.net/**

Implementation of Always Events in Northern Ireland

Always Events are defined as those aspects of the care experience that should always occur when patients, their family members or other care partners, and service users interact with health care professionals and the health and social care delivery system.

During 2017/18, the HSCB/PHA, through the regional Patient Client Experience Steering Group, have led the implementation of Always Events in each HSC Trust.



Using feedback from 10,000 More Voices, each Trusts identified a key area and pilot wards in which to test the methodology. A number of key improvements have been noted during the testing.

Belfast Health and Social Care Trust (BHSCT) will ALWAYS meet the World Health Organisation's Noise at Night recommendation

- Trust has linked with estates/labs department to review the use & frequency of the pneumatic chute system, replacing the foam padding on existing pods.
- Noise at night checklists have been introduced into the pilot wards.
- A traffic light noise monitor has been introduced into pilot wards.
- Apps were made available for staff to measure noise levels on ongoing basis.
- Posters & leaflets have been developed to remind people of human noise that can be reduced – building on the Trust animation "there is nothing like a good night sleep".

Northern Health and Social Care Trust (NHSCT) Mealtime matters: our pledge - we will ALWAYS protect patients mealtimes

- Core components of what should **always** happen at mealtimes have been established.
- A mealtimes bundle poster has been designed detailing the roles and responsibilities of nursing and catering staff at every mealtime.
- Electronic menu system has been introduced.
- A scale and spread plan was been developed with a view to total Trust-wide implementation by March 2019.

Southern Health and Social Care Trust (SHSCT) - I will ALWAYS be supported to communicate at the Outpatients Department Ramone Ward, Craigavon Area Hospital.

- Yellow with black writing signage introduced in outpatients department and at front entrance to Craigavon Area Hospital.
- Sensory awareness training for all staff has been co-produced by deaf service users and staff. This will also be co-delivered by the deaf service users.
- Yellow name badges introduced in the department and for eye care clinic staff.
- 'I am deaf' card has been introduced to increase awareness of a deaf patient awaiting appointment with details of interpreter services on the reverse.
- Sonido digital hearing system is now in place – posters and leaflets have been developed to raise awareness.

South Eastern Health and Social Care Trust (SEHSCT) - *To improve pain management satisfaction to 90% or greater throughout the inpatient setting.*

- ABCDE approach to pain assessment and management developed / pathway & logo 'Prioritise Pain' developed.
- Launch of project in pilot wards. Promotional posters, pens, balloons were used and information was shared using social media and staff newsletters etc.
- Pain score standardised in pilot wards.
- Successful pain study day for registered nurses hosted by Trust pain team. Some initial results indicate:
  - 76% increase compliance in recording of pain score on revised NEWS chart;
  - 93.4% of patients reported that they were always/frequently asked about their pain;
  - 18% increase in staff knowledge in relation to pain management in pilot wards following the project;
  - Increase in number of referrals to the hospital acute team.

Western Health and Social Care Trust (WHSCT) Family presence: promoting a shared person centred approach to visiting times and participation within the hospital.

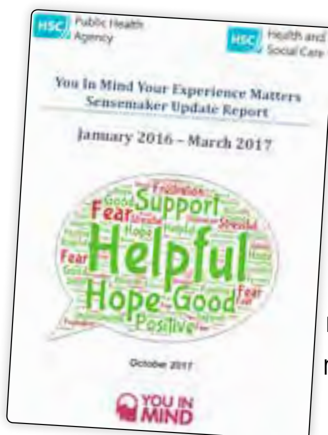
- Standardisation of core information to promote family presence which includes information on how to best support patients and clients, information relating to illnesses, helping with food and drink, car parking, and visiting times.
- Personalised ward based posters & leaflets designed and distributed.
- The Trust has linked closely with the *John's Campaign: for the right to stay with people with dementia in hospital* and promotes dementia friendly wards.

You in Mind 'Your Experience Matters' Sensemaker Re-Audit Report

In June 2017 the HSCB / PHA launched the 'You in Mind – Your Experience Matters' report on the re-audit of experience relating to mental health services. The survey, used to gather experience, was developed by service users and carers from each HSCT area using story telling methodology, enabling a more person centred / co-produced approach to improving experience.

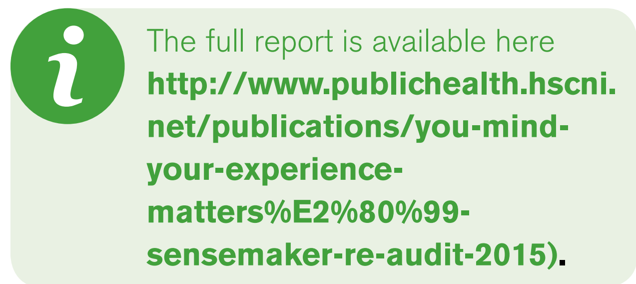
Overall, the re-audit data suggests that there was a positive shift in how people perceive mental health care services. Approximately one third of all respondents said that they are hopeful for the future. For the majority of respondents, recovery focused practice was identified as an important part of their treatment.

Although it is recognised that there is still much to do, it is important to celebrate and acknowledge the positive work which has taken place across Northern Ireland. The launch event provided an opportunity to demonstrate the significant and valuable changes that have taken place in services across the region since the first report was published in 2012. Some examples of service/organisational change being implemented as a direct result of the Sensemaker re-audit findings include:



- SEHSCT - Developing an outcomes framework for the Recovery College.
- NHSCT - Maternal mental health and wellbeing workshop.
- BHSCT - Physical health care pathway in acute wards.
- WHSCT - Service user involvement in planning their care and treatment.
- SHSCT - Transforming the workforce & employment of peer support workers.

Regionally, Recovery services continue to improve within mental health with minimal financial investment. This is a result of the Trusts undertaking the journey together, initially with facilitation from Implementing Recovery Through Organisational Change (ImROC) and continues with a regional steering group lead by the PHA.



The full report is available here **http://www.publichealth.hscni.net/publications/you-mind-your-experience-matters%E2%80%99-sensemaker-re-audit-2015).**

Recovery newsletter

The PHA in collaboration with HSCB continues to work with Recovery Colleges and the ImROC Regional Group to co-produce a bi-annual newsletter. There have been five newsletters published providing a snapshot of peer support working, co-production, Recovery College activities and articles and poems from service users about their recovery journey.

The latest newsletter (Issue 5) was published at the end of March 2018 and highlights the establishment of the regional peer support workers into statutory mental health services. Also included in the newsletter is the launch of the European Union (EU) investment of €7.6 million in mental health recovery secured by the Co-operation and Working Together (CAWT) health and social care partnership.

Copies of the Recovery newsletters can be accessed on the following link: **http://www.publichealth.hscni.net/publications/recovery-newsletter**

Recovery

Promoting hope, choice and opportunity

Regional Peer Support Workers Forum – embedding and developing the peer support worker role across the region

Service framework for Mental Health and Wellbeing 2018-21 (public consultation stage)

The draft service framework for Mental Health and Wellbeing 2018-21 is the regionally agreed model for mental health care in Northern Ireland. It sets out the standards of care and treatment that individuals, their carers and wider family can expect to receive from HSC. The HSCB/PHA are leading the development of this service framework which reflects the principles and values of the 'You In Mind' Regional Mental Health Care Pathway, launched in 2014. The pathway recognises that all treatment and care needs to be highly personalised and recovery orientated.

The 'You In Mind' care pathway explains how people can access mental health care and details the quality of service they can expect from the point of referral to the point that services are no longer required. It describes how mental health professionals will work in partnership with people to access mental health services, though assessment, diagnosis, care and treatment, self-management, and recovery. It outlines how care decisions are made with and for people. It places people, families, partners and nominated friends at the heart of all decision-making.

Transforming the culture

#EndPJparalysis
PHA is leading, supported by the HSCB, Northern Ireland's participation in the nationwide 70 day, #EndPJparalysis challenge. The campaign has been endorsed by Professor Charlotte McArdle and aims to get people up, dressed and moving about, thus giving patients back one million days of their time that would otherwise be spent in a bed in hospital gowns or PJs. #EndPJparalysis is a means of valuing patients' time so they return sooner to loved ones staff may never meet, to homes staff will never visit, to spend more of their last 1000 days in a place that is not a hospital. The challenge is about embedding that into normal practice.

At the midway point of the campaign there are a variety of areas from all Trusts taking part in the campaign with almost 5000 patients up dressed and moving. PHA has secured repeat visits from #EndPJParalysis creator Professor Dolan in June 2018. Professor Dolan will deliver his TODAY programme which further highlights why we should focus on time being the most important currency in Healthcare. This follows on from five similar workshops held across Northern Ireland in January 2018 with very positive feedback.

Benefits of #endPJparalysis include:

- Reduced length of stay (< 1.5 days in Nottingham University Hospital Trauma and Orthopaedic Ward)
- Reduced loss of mobility, deconditioning and risk of falls (37% in same Nottingham University Hospital Trauma and Orthopaedic Ward)
- Reduced food wastage due to greater patient mobility and energy need
- Reduced risk of needing institutional care on discharge
- Enhanced wellbeing of patients and staff

Theme two

Strengthening the workforce

2.1 Introduction

The HSCB and PHA, who collectively employ over 800 staff, are determined to invest in the development of their staff and the creation of a working environment that enables everyone to make their best contribution. The organisations' diverse range of responsibilities, coupled with current demographic changes and economic climate, requires a sustained focus on improving quality. The HSCB/PHA recognise the importance of the workplace as a setting to promote health and wellbeing. Similarly, the process of working together across all divisions has been important in understanding complexities and developing a commitment from staff to embed improvement techniques in daily activities.

2.2 Supporting HSCB/PHA staff

Promoting health and wellbeing in the HSCB/PHA as a workplace

During 2017/18 the HSCB/PHA have led the implementation of a number of programmes to assist in promoting health and wellbeing for staff such as:

(a) Lesbian, Gay, Bisexual and Transgender (LGBT) Forum

A forum for lesbian, gay, bisexual and transgender staff continues to provide confidential support for LGBT staff and students in the HSC workplace. An e-learning module has been developed and widely promoted within HSC settings, The dedicated website to support LGBT staff in HSC now includes an online gallery of staff who are 'out at work'.

For more info - **http://www.lgbtstaff.hscni.net/**

(b) My Mood Matters/Living Life to the Full

Staff in the HSCB/PHA have been offered the opportunity to attend the My Mood Matters and Living Life to the Full programmes. Staff evaluation of both programmes has been very positive.

(c) Physical activity

Staff are encouraged to increase their physical activity during the working day by promoting the use of stairs, lunchtime walks and gym facilities. An upgrade to the gym facilities in Linenhall Street, Belfast and the introduction of the 'take the stairs' initiative also helped boost opportunities for physical activity. This was further rolled out to Tower Hill, Armagh and County Hall Ballymena sites HSCB/PHA sites. The 'take the stairs' initiative; saw an increase in upward journeys using the stairs by 81% and an increase in downward journeys by 86%. A toolkit has now been developed that can help other workplaces introduce this simple, effective and low cost measure. A short video was developed to raise awareness of the scheme.

(d) Staff wellness day

A wellness day for staff was held in February 2018. This event proved to be highly popular with a range of activities and advice available including: cookery demonstrations; Belfast City Council bike scheme; active travel; Tapestry Staff Disability Forum; trade unions; Pure Gym; Here NI and the Rainbow Project.

(e) HSC Healthier Workplaces Network

The PHA in conjunction with the HSCB has established a HSC Healthier Workplaces Network. This Network aims to develop improved and consistent workplace health programmes aligned to HR and other policies and which bring increased focus to valuing staff and the advantages that a diverse workforce can bring to organisations. The Network's four subgroups are now addressing the following areas: common measures and indicators; ageing workforce; a healthy workplaces charter; and on-line tools and apps.

For further information and access to the materials see **http://www.choosetolivebetter.com/content/getting-active**

2.3 Project ECHO – innovation & learning for the HSC

What is ECHO?

ECHO (Extension for Community Healthcare Outcomes) is a pioneering tele-monitoring programme designed to address growing demand for secondary care services. Using video-conferencing technology, participants benefit by sharing evidence-based best practice guidance and case-based learning. The model provides an affordable solution to addressing growing need in the UK for training and support. The approach is seen as an effective way of® improving access to specialist supported care and ultimately improving patient outcomes.

Project ECHO

Project ECHO seeks to develop clinician capacity to safely and effectively treat common, chronic, complex diseases. The HSCB/PHA in partnership with Hospice UK, are currently rolling out the ECHO model in 30 clinical areas to include **elective care, prison health, optometry/ophthalmology and dementia**. The model is a method to help improve the reach and availability of a wide range of under pressure health care services across Northern Ireland.

It is hoped that, through working with Integrated Care Partnerships (ICPs) and associated networks, new ways of delivering service which better fit the need for more chronic care irrespective of postcode will be developed, thus freeing up capacity for more complex issues in our acute centres.

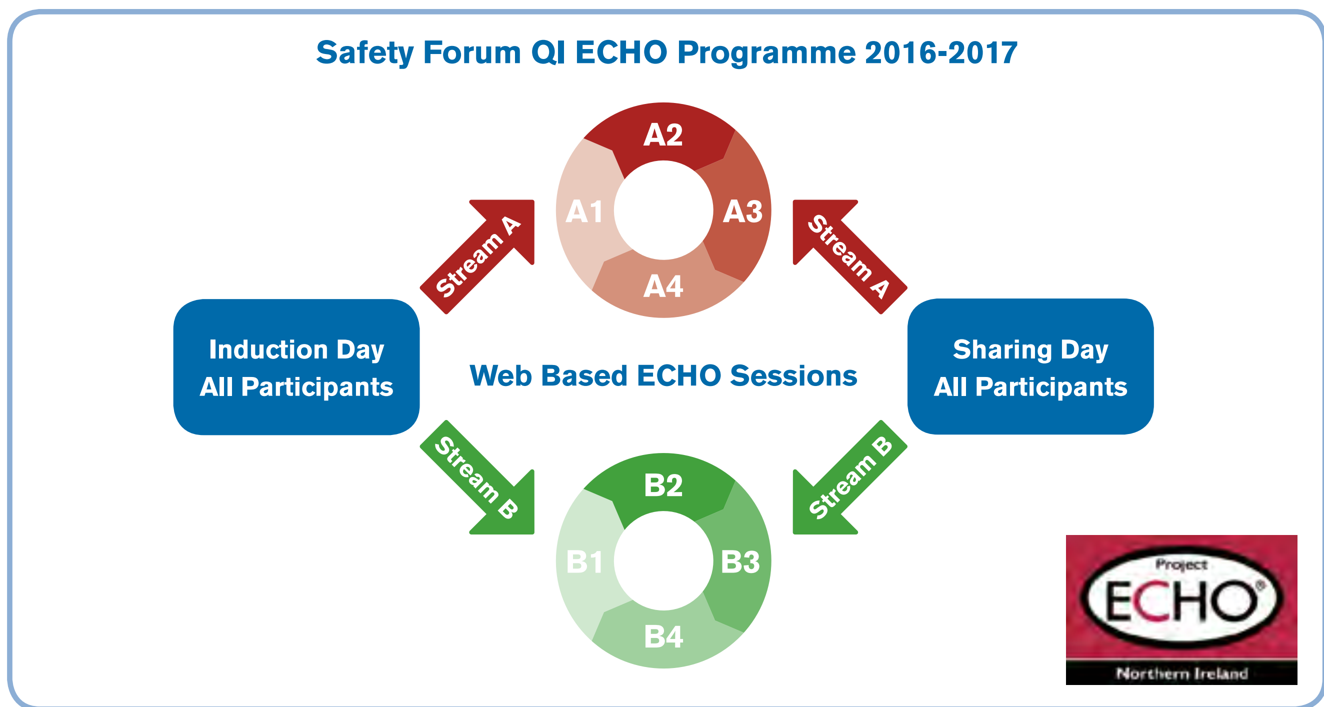
Project ECHO
"Moving Knowledge not People"

Quality improvement ECHO

Last year the HSC Safety Forum led its first quality improvement (QI) ECHO programme which provided Trusts with training in QI methodology, supporting the development and success of current or proposed Trust-based QI projects.

The range a range of quality improvement projects within the programme included:

- Learning disability project aimed to increase time spent on physical activity and fun opportunities to improve health and wellbeing. Activity levels increased from 48 minutes per child per week to 200 minutes.
- An outpatient team that aimed to reduce inappropriate urine sampling achieved a reduction in testing by 80%,
- A podiatry team exceeded their initial aim of increasing clinical capacity by increasing appropriate discharges from 5%-25%
- A mental health project aimed to increase the uptake and offer of carers' assessments in the community. The project demonstrated a 70% increase in carers' assessments completed



2.4 Sharing quality improvement

Q Community

Q is an initiative connecting people who have HSC improvement expertise across the United Kingdom. It is being led by the Health Foundation supported locally by the HSC Safety Forum based in the PHA.

The Q community is made of up a diverse range of people including those at the front line of health and social care, patient leaders, managers, commissioners, researchers, policymakers and others.

In 2017/18 a recruitment programme was undertaken in Northern Ireland. This programme was successful in attracting over 90 new members far exceeding initial expectations. New and existing members (123 in total) were invited to a welcome event in Titanic Belfast to learn from each other and from invited guests. This was followed up by a networking event in March 2018. In addition members have had access to a range of online resources, specialist training, networks and site visits across the United Kingdom. Members attended the national Q event in Liverpool, a site visit to explore artificial intelligence and problem solving and specialist patient experience training. Learning from these visits has been shared with the wider Q community through a series of reflective blogs.

PHA Safety Forum Awards 2017

The PHA, through the HSC Safety Forum invited organisations to nominate individuals or teams for the 3rd Northern Ireland Safety Forum Awards. The annual awards recognise and showcase the excellent work undertaken across the HSC system to drive improvement in quality of care and to strengthen patient safety

Four teams from across HSC were presented with their awards at a quality improvement event at the end of March. An award was made in each of four categories:

- Partnership working/co-production
- Innovation/transformation in care
- Integrated care
- Building reliable care

From the four categories, one overall winner was chosen. The winners covered a breadth of subjects, showed clear evidence of teamwork and tangible improvements to care.

2.5 Education and training for HSC

Primary care

Nursing: Last year the HSCB/PHA funded a bespoke foundation course, delivered by the HSC Clinical Education Centre (CEC), in line with the GP Nursing Framework, for general practice nurses (GPN) and healthcare assistants (HCA). The training was designed to meet the complex and changing service needs of patients in primary care settings. In total 141 GPN and HCAs accessed and positively evaluated the training. It is planned to roll out these regional training programmes in 2018.

Additional resources were secured to facilitate GPNs accessing post registration courses in local universities. In addition, courses were made available for general practice nurses via the Royal College of Nursing (RCN) and CEC. Additional courses included transformational leadership and cervical cytology.

In 2017/18, five Advanced Nurse Practitioners (ANP) have been working successfully in the Down GP Federation. Numbers are expected to increase over the next two years. This supports the career pathway of GPN to ANP level in primary care.

A regional network for GPNs has been established across Northern Ireland. A series of network events took place focusing on the management of long term conditions. Communication strategies for sharing correspondence, information on training and professional updates have been successfully re-established via the primary care intranet, the websites and social media.

Following a workforce review, a proposal has been developed that identifies the need for additional GPNs and HCAs to meet the increasing demands and pressures faced in general practice.

GP training numbers: The HSCB lead on the development of business cases to evidence the requirement to increase the GP training numbers. In response to workforce capacity concerns the number of GP training places has been increased from 65 (2015/16) to 95 (2017/18).

In a move to support retention of qualified GPs, there were 25 places on a two year retainer scheme covering 2016/17 and 2017/18. These GPs are attached to a practice and also commit to a number of out of hours sessions. In total 28 GPs took part in the scheme. Of the nine who left the scheme before their two year attachment was complete, five left to take up permanent GP jobs, either salaried or as a partner. A new cohort of retainer places will be available starting in 2018/19.

Dementia

As part of the implementation of the Dementia Together NI strategy a variety of training and education programmes have been delivered throughout Northern Ireland. These include:

- Development of the Dementia Learning and Development Framework has been used by local universities to inform course development / content for social workers and nurses
- A number of stand-alone training resources have been developed. in collaboration with the Northern Ireland Social Care Council (NISCC) including the development of a training app for domiciliary care staff and an online training resource for adult residential / nursing and day care staff on dementia, delirium and palliative care.
- In total 260 staff from across the statutory and independent sectors completed the dementia champion programme. This six month programme which included direct teaching and on-line learning required participants to complete a service improvement project within their area of work.
- One thousand copies of a training pack entitled 'Barbara's Story' were issued to HSC facilities, GPs, pharmacists, opticians, dentists, prison staff, PSNI and the Northern Ireland Ambulance Service (NIAS).
- More than 500 copies of a training pack entitled 'Supporting Derek' were issued to HSC staff working with people with learning disabilities.
- Development of a range of other bespoke training programmes for HSC staff including CLEAR (a model to assess and address unmet need) and the virtual dementia bus.
- HSC staff trained in the use of the delirium assessment and management tool totalled 2826. Forty staff have completed the relevant *train the trainer* programme.

Staff working with older people

- **Regional multi-professional educational awareness programme for the identification and management of frailty**

Frailty is a condition in which multiple body systems gradually lose their in-built reserves. Older people with frailty are at substantially increased risk of adverse outcomes including falls, disability, hospitalisation, nursing home admission and mortality. Early recognition of frailty and targeted interventions and management can significantly improve health outcomes for frail older adults. Staff knowledge and skills in relation to the identification and management of frailty is fundamental to achieving best outcomes. In order to improve HSC staff awareness in relation frailty the PHA commissioned the CEC to:

- Develop and pilot a face to face multi-disciplinary Frailty Educational Awareness Training programme.
- Develop an ELearning Frailty Educational Awareness Training programme.

This regional multi-professional educational awareness programme was designed to enhance health professional's knowledge and understanding of frailty with a view to improving prevention, identification, management and therefore outcomes for these older adults. Ninety three health professionals from across all disciplines attended this training with excellent feedback. The plan going forward is to roll this training out across the HSC.

- **Loneliness aide-memoire for older people**

It is recognised that loneliness in older people is a public health issue affecting their health and well-being. A recent Age NI survey highlighted that:

- One in three older people in Northern Ireland said that they are lonely
- 100,000 older people in Northern Ireland say that television is their main form of company
- 26,000 older people in Northern Ireland feel trapped in their own homes

As a result of these facts, Allied Health Professionals (AHPs) across Northern Ireland have worked with Age NI to develop an aide-memoire for HSC staff to raise awareness of older people and loneliness. The aim is to make a difference to an older person who is lonely by looking, listening and asking to see if they are lonely. In this way people can be directed towards agencies who can help. Some reasons for loneliness may include bereavement, retirement, living alone, lack of money, not having transport to get out and about. The aide memoire encourages staff to be aware of these factors in their daily interactions with older people.

Age NI engaged with older people to hear their views on the development of the aide memoire, through a workshop at which older people, AHPs, representatives from PHA, Age NI, HSCB and Translink had the opportunity to contribute to table and larger group discussions. The aide-memoire provides useful contact details including:

- Age NI the leading charity for older people in Northern Ireland;
- Silverline helpline for older people for information, friendship and advice; and
- Translink for practical advice on transport queries.

Staff are also advised to approach appropriate Trust contacts for local information.

"An older person in Northern Ireland described loneliness as "An ache in your heart so bad that it physically hurts. Longing for someone who cares."

- **Rethinking Frailty Symposium**

The PHA held a 'Rethinking Frailty' Symposium which provided an opportunity for the first time in Northern Ireland to bring together a wide range of stakeholders to look at and discuss all aspects of frailty and consider how best to take forward work in this area that would enable healthier and more fulfilling lives.

More than 100 people attended the event with representation from HSC, HSCB voluntary and community organisations, other statutory organisations and most importantly people with lived experience of frailty. Presentations addressed current regional and national perspectives in relation to the identification and management of frailty. This work captured the views of older people on frailty and what matters to them. This symposium has marked the beginning of significant work across Northern Ireland which aims to engage with all relevant stake holders to agree a common understanding of frailty and to improve the experience and health outcomes for all individuals who are frail or at risk of frailty.

Adult learning disability

In line with the Learning Disability Service Framework, the HSCB/PHA aim to ensure that services for adults with a learning disability provide the opportunity for people to enjoy personal and sexual relationships while protecting vulnerable adults from abuse. They have led the development of the operational protocol: 'Adults with Learning Disabilities: Personal and Sexual Relationships' which is being implemented by the Trusts. Last year, the HSCB/PHA commissioned the Family Planning Association (FPA) to provide training to support Trust staff with the implementation of the operational protocol. To date over 300 HSCT staff have received awareness raising (level 1) training from FPA. Approximately 30 Trust staff from across Northern Ireland have received Level 2 Peer Educator training to provide support and guidance to peers and colleagues on how to implement the protocols within their Trust. Year three of the training is currently been implemented by FPA.

Nursing

Following obtaining a grant award for 2017/18 from the Burdett Trust for Nursing, the PHA is leading a regional initiative that aims to improve nurse retention and recruitment in care of older people's settings in Northern Ireland. This innovative and collaborative approach is delivering a programme of development activities including team coaching, practice support, supervision and professional and personal effectiveness. The PHA leads for the project have successfully participated in national events associated with the Burdett Trust stipulations for the grant award. The evaluation of the project has seen very positive results to date.

Implementation groups are now established within each of the Trusts to provide support and guidance. In addition to quantitative information including staffing levels, vacancies, absence rates etc, qualitative baseline information has also been obtained including:

Values Clarification Exercise (VCE)- Understanding the values, beliefs and views that staff hold about working with older people including what staff think is important, and what staff feel should happen. This has been used to verify or inform local ward mission statements and develop training programmes.

- **Workplace Culture Critical Analysis Tool (WCCAT) -** The WCCAT has been developed to help people involved in the development of practice to undertake observational studies of work place settings in order to inform changes in practice. Examples of good and not so good practices have been observed and results shared with the ward managers and some of the other ward staff.
- **Nursing Workplace Satisfaction Questionnaire (NWSQ) -** used to evaluate nurse satisfaction with a new team model of nursing care delivery.

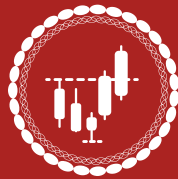
In addition, a bespoke training programme for staff in the 11 pilot wards commenced in January 2018. This programme has been tailored to meet the individual needs of staff. The programme includes: induction and preceptorship programmes, delivery of action learning sets by AGE NI peer facilitators, use of specialist nurses, training on resilience, assertiveness and coaching. The sustainability of this project will be further reviewed as part of the transformation agenda in nursing homes next year.

2.6 Delivering Care: A policy framework for nursing & midwifery workforce planning

Delivering Care is a policy framework aimed to support the provision of high quality care which is safe and effective in hospital and community settings. Initiated in 2012, it has used a phased approach to determine staffing ranges for the nursing and midwifery workforce in a range of major specialities. The PHA and HSCB, in partnership with Trusts and other key stakeholders lead the implementation of the eight phases underway.

Workforce Phase	Staffing Model	Status
Phase 1: Acute medical and surgical wards	Staffing range	Funding for this phase has been secured and is in the process of phased implementation across designated wards in all HSCTs
Phase 1A: Elective care treatment care environments	Recommended range for 24/7 wards including day and short stay wards	Guidelines currently being scoped in HSCT 2018
Phase 2: Type 1 emergency departments	Nurse to annual attendance ratio	Recommendations endorsed by CNO. 1st phase of implementation due in 2018.
Phase 3: District nursing	Population based model	1st phase of implementation due in 2018 dependent on resources
Phase 4: Health visiting	Population based model – caseload weighting	1st phase of implementation due in 2018.
Phase 5: Mental health	Acute – nurse/bed ratio community – caseload and population based model	Phase 5A completed for acute inpatient mental health facilities. A number of workshops have been facilitated by the PHA and the expert reference group. The proposed recommendations around the staffing ranges for the category of inpatient environments have been shared for endorsement with the CNO. Phase 5b community staffing model to be progressed mid-2018
Phase 6: Neonatal nursing	Based on level of activity	Final proposals underway
Phase 7: Primary care nursing	Population based model from the GPN framework 2016	Finalised and with the CNO for endorsement 2018
Phase 8	Independent sector nursing homes	This phase is underway in 2018.

Theme three



Measuring Improvement

3.1 Introduction

The HSCB and PHA recognise that gathering information and examining data is important in assessing performance. They also recognise that it is vital that lessons from the information are learned, areas of high performance are duplicated and areas of lower performance are supported to improve. Last year the HSCB and PHA continued to promote the use of accredited improvement techniques to drive improvements and have worked with Trusts and other HSC bodies to provide support to improve outcome measurements in a range of quality indicators.

3.2 Quality improvement plans

The quality improvement plans (QIPs) focus on key priority areas to improve outcomes for patients and service users. The HSCB and PHA support Trusts on a range of initiatives to assist with the achievement of the QIP targets and facilitate a regional platform to enable good practice to be shared throughout Northern Ireland.

In 2017/18 QIP target areas were:

- **Pressure ulcer prevention;**
- **Falls prevention;**
- **National Early Warning Scores (NEWS);**
- **Mixed gender accommodation.**

Pressure ulcer prevention

The PHA along with HSCB supports Trusts through the Regional Pressure Ulcer Prevention Group to implement SKIN (an evidenced based collection of interventions proven to prevent pressure ulcers) in all hospitals in Northern Ireland. This group provides advice and support and shares regional learning across Northern Ireland. It focuses on strategies for pressure ulcer prevention and management across the Trusts.

Last year the focus was on the prevention of avoidable grade 3 & 4 pressure ulcers. These create deeper cavity wounds which can result in increased pain and suffering to patients.

Regionally a variation in the rate of avoidable grade 3 and 4 pressure ulcers was noted with a range of 0.01 to 0.33 between Trusts. For the purpose of quality improvement work, Trusts continually review their data to compare improvement over time and to learn from local variation.

In recognition of the need for continual evaluation and improvement, and to ensure that potential regional variation in recording and reporting of data across Northern Ireland is minimised, the PHA, in collaboration with the HSCB and Trusts are:

- Undertaking an improvement project in relation to measurement, display and interpretation of improvement data;
- Reviewing the current operational definitions including current regional application of same;

- Reviewing the process for root cause analysis and process for obtaining bed day figures which reflect exactly the wards & clinical areas within which pressure ulcer data is collated and submitted to PHA;
- Developing a regionally agreed schedule for validation of data;
- Working with Trusts to ensure local and regional learning is identified and shared.

Falls prevention

During 2017/18 the PHA and HSCB through the Regional Falls Prevention Group have supported Trusts to implement and spread the Royal College of Physicians 'Fallsafe' bundle, an evidence based collection of interventions proven to reduce falls; in inpatient settings.

Trusts measure compliance against the Falls Safe Bundle and report to the PHA and HSCB on a quarterly basis. The Regional Falls Prevention Group provides advice, support and shares regional learning across Northern Ireland and focuses on strategies for falls prevention and management across the Trusts.

The Business Services Organisation (BSO) internal audit team carried out an audit of learning from serious adverse incidents (SAIs) and from falls across HSC organisations. This audit found that definitions were not consistent with the Trusts' classifications of falls and recommended that the current definitions should be brought into line with the regional incident grading matrix. There was regional agreement that this should commence from April 2017.

During 2017/18 the focus was on prevention of the number and rates of falls incidents classified as causing moderate to major/catastrophic.

Regionally, for this period there has been a reduction in falls incidents resulting in moderate to major/catastrophic, the rate during 2017/18 is between **0.08** and **0.09** per 1,000 bed days.

NEWS (National Early Warning Scores)

As part of its leadership role, the HSC Safety Forum has led the regional implementation of NEWS in Trusts, including appropriate escalation arrangements to improve care of the deteriorating patient. This tool helps professional staff identify early deterioration in a patient's condition. Abnormal scores prompt specific actions and/or referral to greater expertise. Part of this work involved facilitating Trusts to clearly define their expectations regarding intervention when NEWS are abnormal. Trusts are committed to ensuring escalation of NEWS is a priority and have worked with the HSCB and PHA to measure compliance with accurately completed NEWS charts.

Mixed gender accommodation (MGA)

HSC is committed to the delivery of person centred care. International and national evidence has highlighted that the provision of single gender accommodation has been identified by patients and relatives/carers as having significant impact on maintaining privacy and dignity whilst in hospital. There is therefore an expectation that men and women will not be required to sleep in the same area.

In line with the DoH Guiding Principles for Mixed Gender Accommodation, each Trust has developed a policy for the management of MGA in hospital. During 2017/18 the PHA has engaged with Trusts to review the current processes for recording MGA to agree operational definitions and develop a regional monitoring template for reporting occurrences. Trusts have been using the Institute for Healthcare Improvement (IHI) improvement methodology to test and evaluate the revised monitoring process. Initially on a small scale within a small number of wards per hospital site, with view to scale and spreading during 2018/19.

3.3 Key performance indicators (KPI)

A regional group has led the development of high level KPIs for nursing and midwifery to measure, monitor and evidence the impact and unique contribution the nursing has on the quality of patient and client care. There are three domains which many Trusts are currently presenting via dashboard systems, which allow data sets to be viewed collectively across all wards and departments.

Examples of indicators

Organisational: absence rates; normative staffing ranges and vacancy rates.

Safe and effective care: incidence of falls, pressure ulcers, omitted or delayed medications, absconding etc.

Patient experience: consistent delivery of care against identified need; involvement of the person receiving care in decisions made about their nursing care; time spent by nurses with the patient.

Below are two examples of KPIs which are measured within mental health and learning disability services:

- **Anti-absconding KPI**

Research evidence has demonstrated that patients who abscond from inpatient mental health settings have increased risk of harm to self and others, suicide, self-harm, and self-neglect.

The anti-absconding intervention draws on empirical research into patient and staff experience of absconding and outlines effective practice based activities that can be employed by staff to reduce episodes of absconding.

In May 2014, the South Eastern Health and Social Care Trust (SEHSCT) initiated a pilot of the East London and City Mental Health Trust Anti-Absconding Work Book. The results from the pilot were extremely encouraging, showing a reduction in absconding rates of 70% as compared to the base line audit. Following the success of the pilot, the PHA/HSCB worked with all Trusts to develop the first regional mental health KPI, focused on the anti-absconding intervention.

Data is collated using an agreed audit tool and reported quarterly to the HSCB/PHA. Year two data is now complete and Trusts are working on increasing compliance with all elements of the KPI Intervention with evidence suggesting that compliance with the KPI is having an impact on reducing incidents of absconding.

The PHA working closely with the HSCB hosted a regional learning event in October 2017. The event facilitated the sharing of learning from year one of the implementation of the Anti-Absconding KPI intervention and reflection on the experiences of front line staff, service users and carers.

Following presentations from each Trust participants had an opportunity to take part in group activity designed to encourage staff to think about what it is like for patients, who are often admitted without having had the time to prepare for the admission, and the impact this can have on them. Participants were then asked to discuss how they could facilitate home and social contact for patients which might help reduce the risk of absconding. Feedback from those who attended the event was very positive and the regional learning identified has been used to inform the ongoing implementation of the KPI.

• Review of Psychological Therapy Training in Nursing

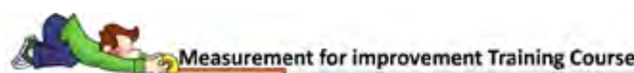
The provision of evidence based psychological therapies is fundamental in enabling psychological and personal recovery.

As set out in the 'You In Mind' Regional Mental Health Care Pathway, and other relevant guidance, mental health nurses are required to embed evidence based psychological therapies and recovery practice in the provision of all treatment and patient centred care.

In order to establish a baseline of psychological therapy practice across mental health nursing an audit tool was developed to test the psychological therapies KPI. Two cycles of data collection were completed as a pilot. This identified the need to establish the accredited training of registered in mental nursing across NI.

In October 2017, the PHA commissioned the HSC Clinical Education Centre (CEC) to carry out an audit which included training record audits and an online survey with staff working across all mental health settings and facilities in Northern Ireland. The findings of the audit have informed the next stages for the KPI.

3.4 Measurement for improvement masterclasses



During 2017/18 the HSC Safety Forum hosted a series of "Measurement for Improvement" masterclasses, facilitated by Paul Rafferty. These interactive sessions challenged participants to ask the following questions:

- Why measure?
- Is there an art to measurement?
- How can we illustrate and analyse variation?
- What are the steps for effective measurement?

Participants had the opportunity to explore the functionality of Excel and to bring along their own data to discuss and improve presentation. The technical skills were balanced with the clear message that data can win or lose hearts depending on how it is used to engage people. Feedback from the 50 participants, who were from a range of clinical and administrative positions, was extremely positive and further sessions are planned for 2018/19.

3.5 Implementation of National Institute for Health and Care Excellence (NICE) guidance

NICE is a non Departmental Public Body responsible for providing national guidance and advice to improve health and social care.

NICE
National Institute for
Health and Care Excellence

NICE produces different types of guidance, including:

- Technology Appraisals (new drugs, medical treatments and therapies);
- Clinical Guidelines (recommendations on the appropriate treatment and care of people with specific diseases and conditions); and
- Public Health Guidance (recommendations for populations and individuals on activities, policies and strategies that can help prevent disease or improve health).

The HSCB/PHA have put in place processes to take forward the implementation of Technology Appraisals, Clinical Guidelines and Public Health Guidance published by NICE and endorsed by the DoH.

During 2017/18, the HSCB/PHA issued 59 Technology Appraisals to the HSC and continues to monitor the implementation of 170 Clinical Guidelines which have been issued to the service.

The implementation of NICE guidance can often be the driver for change in a wide range of areas, as it provides commissioners, clinicians and other health care professionals with evidence based methodologies to improve and sustain higher quality outcomes for patients and clients.

More information about the Technology Appraisals and Clinical Guidelines that are being implemented can be found on the HSCB NICE webpage. **(http://www.hscboard.hscni.net/nice/)**

A
P
Act
Step 8: Standardize the improvement or develop a new theory
Step 9: Establish future plans
Plan
Step 1: Getting started
Step 2: Assemble the team
Step 3: Examine current approach
Step 4: Identify potential solutions
Step 5: Develop an improvement theory
Study
Step 7: Use data to study the result
Do
Step 6: Test the theory for improvement
S
D

Theme four

Raising the standards

4.1 Introduction

The HSCB and PHA have established a framework of clear evidence-based standards and best practice guidance which is used in the planning, commissioning and delivery of services in Northern Ireland. The HSCB and PHA are continuously striving for excellence and raising the standards of care and the quality of services delivered. Below are examples of outcome quality improvement secured, through a number of interventions.

4.2 Managed clinical networks

The purpose of a managed clinical network is to provide a regional platform to achieve consistency in care and drive quality improvement within the network and beyond with a family centred approach. The HSCB/ PHA lead the implementation of a number of clinical networks, some of which include:

- **Paediatric Network**
- **Critical Care Network**
- **Neonatal Network**
- **Pathology Network**
- **Stroke Network**
- **Cancer Network**
- **Trauma Network**
- **Diabetes Network**
- **Radiology Network**
- **Pain Forum Network**
- **Lymphoedema Network**

Below are two examples of how standards of health and social care have been improved through the work of the Northern Ireland Trauma Network.

Northern Ireland Major Trauma Network

The Northern Ireland Major Trauma Network supports the coordination of regional trauma services enabling patients with serious injury to receive timely, skilled, high quality hospital care, including rehabilitation and repatriation. In collaboration with all HSC, the Network is taking a whole system approach to developing processes and services to reduce mortality and morbidity rates for patients assessed as 'major trauma'.

In 2017/18 the Network Manager, Regional Clinical Lead and Local Clinical Leads (representing each HSCT) were appointed, as were a team of Trauma Audit Data Coordinators. Monthly meetings of the Network Board have provided strategic direction to the Network in line with its aims and objectives and the HSC Chief Executives' Forum supported the principle of a regional bypass and repatriation protocol.

A model for a designated Major Trauma Centre (MTC) has been agreed that includes a consultant-led trauma ward with additional intensive care beds that will support the introduction of a regional bypass protocol. This protocol has been developed in conjunction with the Belfast Health and Social Care Trust and HSCB/PHA and reflects NICE guidance for major trauma services and National Trauma Quality Indicators (TQUINS).

Raising the standards

Over 80 colleagues from trauma related specialties within the Trusts attended the Major Trauma Network's stakeholder engagement event in 2017. This provided an opportunity for people to learn about the Network and give feedback on suggested priorities to help develop the Network's first annual plan.

A Network Clinical Advisory Group (CAG) has agreed a Major Trauma Triage Tool and regional clinical protocols. This includes protocols for Whole Body Computed Tomography (CT), Traumatic Cardiac Arrest, Massive Blood Loss and a standardised Emergency Department Trauma document.

The Network's Nursing & AHP group provide multidisciplinary input and has undertaken a review of trauma training across Northern Ireland and developed a programme to support ward-based staff involved in providing care to patients following repatriation from the MTC's trauma ward.

In late 2017/18 service user representatives from the HSCB's Unscheduled Care Clinical Reference Group were engaged on the development of guidance and patient information relating to the Network's bypass and repatriation protocols.

A workshop on Supporting the Concept of Damage Control Surgery was held for surgical colleagues with expert speakers providing perspectives from various specialties on this subject. This supports regional preparedness for a mass casualty response as well as individual trauma cases. Future work on this will be to encourage clinical skills training for surgical colleagues.

Important work commenced in 2017/18 to submit trauma data to the national database of the Trauma Audit Research Network (TARN). TARN monitors and measures standards of care and patient outcomes for trauma in the region and by hospital site. Two Northern Ireland TARN clinical reports were received providing core data on trauma, a focus on head and spinal injuries and abdominal and thoracic injuries. This information will be used for service improvement and to underpin the Network's programme of work to improve standards of care and reduce mortality and morbidity for seriously injured patients.

Modernising Radiology Clinical Network (MRCN)

The HSCB/PHA established the MRCN in 2013 following the 2011 RQIA investigations into unreported plain film examinations. The Network's primary role was to oversee implementation of the recommendations outlined in the reports. The Network currently functions as a clinical advisory and implementation collaborative aimed at ensuring high quality, safe and sustainable diagnostic imaging services for the people of Northern Ireland. It is led by a Network Manager from the HSCB, supported by a Consultant in Public Health.

Diagnostic imaging is an integral part of modern healthcare and provides approximately 1.8million investigations in Northern Ireland each year. Imaging services play a role in diagnosing and screening for virtually all major illnesses and contribute to the planning of treatment. There is increasing recognition of the need to place imaging early in care pathways to reduce the time to diagnosis and treatment and to improve efficiency and effectiveness.

Some of the key achievements in 2017/18 include:

- Continued collaboration with the DoH in the recently published review of imaging services. The MRCN was represented at all of the public consultation events for the review.
- Detailed workforce review of radiologists, radiographers and assistant practitioners which will inform the regional workforce exercise being led by the DoH.
- Securing annual increases in the number of training places for consultant radiologists, which has seen the scheme recurrently expanded from 37 to 49.
- Development of a new regional pathway to expedite CT staging of new known cancers.
- Continued collaboration with other cancer / clinical reference groups.
- Appointment of the first consultant radiographer in Northern Ireland to the breast service in the Western Health and Social Care Trust.
- Continued investment in training radiographers to optimise the skills of advanced practice radiographers.
- Collaboration with colleagues from the University of Ulster to inform the undergraduate training requirements for advanced nurse practitioners in radiation protection for referring rights.
- Fully operational regional programme of Imaging Services Accreditation Scheme (ISAS) accreditation outlined below.

Imaging Services Accreditation Scheme (ISAS)

The Society and College of Radiographers (SCoR) and Royal College of Radiologists (RCR) have worked together to develop ISAS to provide assurance that diagnostic imaging services offer patients consistently high quality services, delivered by competent staff, working in safe environments.

ISAS is based on current professional guidance updated annually and is independently assessed by the United Kingdom Accreditation Service (UKAS).

The ISAS scheme focuses primarily on the patient and their pathway through the imaging system. This includes how they access care, how they are cared for after their discharge and the quality of the services provided for them.

The Modernising Radiology Clinical Network (MRCN) considers ISAS to be fundamentally important for the future safe, effective provision of quality imaging services for the people of Northern Ireland.

A regional approach to deliver ISAS has been agreed in order to optimise opportunities for sharing learning across Trusts. A lead ISAS radiographer and lead ISAS radiologist have been appointed in each Trust and a regional lead from the HSCB oversees the programme.

A special interest group for diagnostic imaging has also been established which will consider relevant clinical guidance, audits and standards relating to diagnostic imaging as well as actively contribute to future revisions of the ISAS standard itself. This is a positive development for Northern Ireland and a real opportunity to participate and contribute to clinical development across the UK.

The regional ISAS programme has been commended as an exemplar model for collaborative working and a number of heath economies in England are now adopting the network approach to ISAS based on the Northern Ireland model.

4.3 Collaborative working

Mental Health Collaborative

The Mental Health Quality Improvement Collaborative, led by the HSC Safety Forum, continues to grow in strength. Since 2016 the work of the Collaborative has been focusing on the learning from the Thematic Review of Mental Health SAI Reports relating to Patient Suicides.

Templates have been developed by Trusts for safety briefings and the use of structured communication tools such as SBARD (Situation, background, assessment, recommendation, decision). These are now being tested, embedded and spread across mental health facilities in the Trusts.

The Collaborative also developed a core set of principles for reflective practice along with self-assessment questions and measures and Trusts are reporting success with these sessions.

To measure improvement in the overall culture, a Staff Safety Climate Survey was adopted. This was carried out in 2016 (baseline) and in 2017. In the 2017 survey more than 50% of the survey questions demonstrated positive increases in responses given.

Further developing the work of the Collaborative, the next topic will focus on communication with carers and, whilst in the early stages, there is already strong user and carer involvement.

Maternity Collaborative

In 2017/18 the Maternity Collaborative, led by the HSC Safety Forum has continued to support improvements in maternity services across Northern Ireland. The focus of the work has been safety in the intrapartum period of care. To support this work the HSC Safety Forum facilitated bringing the UK Practical Obstetric Multi-Professional Training (PROMPT) team to Northern Ireland to deliver the PROMPT programme in 2017. PROMPT is an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working.

In total there were 52 participants from Northern Ireland joined by 24 colleagues from the Republic of Ireland.

To reduce variation and improve patient safety, the Collaborative have continued work on cardiotocography (CTG) evaluation and management of sepsis. The Collaborative has also agreed a regional dosing regimen for the administration of oxytocin, for use in the induction or augmentation of labour. This has now been incorporated into all Trust policies and guidelines.

The work of the Collaborative has been recognised as an exemplar of good practice in an international publication entitled 'Healthcare Systems Improvement Across the Globe' (Braithwaite 2017). Additionally, the SAI process, which is administered by the HSCB, runs a regional group for maternity SAI's. The learning identified through this process is referred to the HSC Safety forum Maternity Quality Improvement Collaborative to ensure regional consistency when implementing learning.

Sepsis Collaborative

Improving sepsis care in Northern Ireland has been recognised as a strategic priority by the DoH. A regional quality improvement group has been established to take this forward.

In 2017/18 a new Sepsis Collaborative was established, led by the HSC Safety Forum, to scale and spread implementation of the Sepsis Six care bundle. Sepsis Six is the name given to a collection of medical therapies designed to reduce mortality of patients with sepsis. Sepsis is a life threatening condition that arises when organ failure occurs in the context of infection. The focus of the work is on early recognition and treatment of sepsis in emergency departments, acute medical and surgical, intensive care and high dependency settings. A workshop was held in March 2018 where a range of health professionals from all Trusts had an opportunity to listen to Dr Vida Hamilton, National Clinical Lead for Sepsis, Health Service Executive, discuss the work to improve sepsis care in the Republic of Ireland.

The sepsis work in Northern Ireland is being deliberatively linked to the regional antibiotic governance agenda given how important it is that these two strands of work coexist effectively.

All Island Collaborative: Enhanced Care Guidelines

An All Island Collaborative Task Group has been set up by the Chief Nursing Officers in Northern Ireland and the Republic of Ireland, to take forward a piece of work to develop key principles for enhanced care that will be applied in both jurisdictions. The PHA has been involved in this collaborative initiative and has provided funding for the progression of the Northern Ireland pilot site. This work has been developed in line with the principles of Quadruple Aim. The Quadruple Aim model suggests that healthcare institutions simultaneously pursue four dimensions of performance. Namely:

- Improving the health of the population;
- Enhancing the patient experience;
- Reducing costs; and
- Improving the work life of healthcare providers, clinicians and staff

Enhanced care refers to the requirement of care outside of normal staffing levels. It is an activity where an allocated member of staff is constantly aware of the precise whereabouts of a patient through visual observation or hearing. Enhanced care should benefit both the patient and the staff involved. It is crucial that therapeutic activities appropriate to the patients' needs are undertaken as part of the enhanced care process.

Through collaborative working and aligning best practice guidance, the All Island Collaborative seeks to:

- Provide information through the development of a national all island guideline on shared key principles and outcome measures based on best practice;
- Provide guidance for the use of enhanced care observations that meets agreed patient needs, is cost effective and justifiable in each jurisdiction;
- Improve quality of care by ensuing that staffing and intervention reflect patient need;
- Support use of enhanced care in acute hospital and continuing care settings across the island of Ireland;
- Ensure decision making processes around assessment, alternative interventions, recording, and reassessment and monitoring of enhanced care are in place;
- Develop, test and implement local guidance to assess need and maintain safe patient care in each jurisdiction;
- Reduce the number of incidents relating to patient safety enhanced observations eg falls, complex behaviours etc.

4.4 Strategy Implementation

Q2020

The PHA linking closely with HSCB, Trusts and Arm's Length Bodies lead the regional implementation of the Q2020 Strategy on behalf of the DoH. A number of taskgroups have been established to take forward work aligned to the Strategy. The focus for 2017/18 has been in the following areas:

- **Developing Professional Leadership** – this regional task group, chaired by Professor Charlotte McArdle, DoH, last year focused on standardising level 2 & level 3 training programmes aligned to the Q2020 Attributes framework.

- **Supporting staff involved in SAIs and other incidents** – this regional task group was chaired by Dr Cathy Jack, Belfast Health and Social Care Trust and Bob Brown, Western Health and Social Care Trust. Last year the group focused on understanding the level of support that was available to staff following an incident, and explored the concept of Schwartz rounds, in order to inform the development of a model of support for staff.

- **Strengthening our response to adverse incidents** – this task group, lead by Director of Nursing in Southern Health and Social Care Trust, focused on testing models to identify and implement learning following adverse incident within the Trust.

- **Developing a model for the development of Always Events in NI.** Last year the regional group, chaired by Mary McElroy, PHA focused on piloting an Always event in each Trust based on feedback from patient and client experience.

- **Improving patient safety through multi-disciplinary simulation & human factors training.** This regional group, chaired by Dr Mike Morrow, Northern Ireland Medical and Dental Training Agency and Caroline Lee, Clinical Education Centre focused on the development and testing of faculty relating to human factors and de-briefing last year. Additionally, the NI Simulation and Human Factors Network (NISHFN) continued to evolve, establishing specialist interest groups pertaining to human factors and paediatrics.

- Last year work began, led by Dr Mark Roberts, Safety Forum which aimed to ultimately **reduce the reoccurrence of the 3 main categories of Never Events**. This work will be progressed during 2018/19.

The PHA /HSCB hosted a regional Q2020 Event in November 2017 to coincide with world quality day. The aim of the event was share the work ongoing relating to Q2020 with the HSC. The event provided an opportunity to highlight the positive work which is on-going in relation to Quality 2020 and the wider quality agenda and provided a platform to share, learn and generate new ideas in relation to quality improvement.

Dementia Together NI

The HSCB and PHA led the regional implementation of the Dementia Together NI (DTNI) project which ended in March 2018. This three year project far exceeded all expectations and targets.

The Dementia Together NI project received a number of prestigious awards and all four strands of the project have been independently evaluated by external evaluators and the findings were very positive.

Awareness raising, information and support

- Development of a public information website.
- Publication and distribution of 11 information booklets covering subjects as diverse as communicating effectively with a person with a dementia and choosing a care home to dental care, sight loss and planning ahead with dementia.
- Appointment of ten (Band 6) dementia navigators and development of operational guidance based on the findings of an external evaluation of the initiative.
- Appointment of 19 dementia companions in acute hospitals
- #STILLME, an extensive and effective public awareness campaign that included TV, radio outdoor, press, online and social advertising.
- Information developed for GPs and available on the GP intranet.

Short-breaks and support to carers

- Design (in collaboration with service users) and delivery of five short break pilot schemes. Schemes included extended domiciliary care services, befriending, night services and the provision of short vacations to 229 individuals.
- One hundred and eighty individual training courses provided information, training and support to 2463 informal carers.

Future of Dementia Together NI

Building on the success of the project, proposals have been submitted to the DoH in relation to the following, all of which are at various stages of development or implementation:]

- Publication (including promotional materials) and implementation of an agreed regional Dementia Care Pathway including the roll out of the Occupational Therapy Cognitive Rehabilitation Model which was initiated through the regional memory services collaborative. All Trusts have begun to look at how this pathway can be implemented and identifying the resources required.

- On-going work of the Delivering Social Change Phase 2 Dementia Project to develop improved e-health and social care systems and the collection and analysis of dementia care data. This project also includes a raft of research programmes over the next three years.

- Improvements in dementia care in hospitals including implementation of recommendations from the audit of dementia care in acute hospitals and the roll out of John's Campaign.

- Improved locality planning processes to ensure meaningful engagement with local communities to build sustainable models for dementia care as new commissioning structures and processes are established.
- On-going work to embed the Learning and Development Framework and promote staff development within Dementia Care services.

- Promote research in three main areas - *cause*, *cure* and *care.*

Further information in relation to Dementia
http://www.hscboard.hscni.net/dementia/
www.NIDirect.gov.uk/dementia

Promoting Physical and Sensory Disability Strategy

The Physical and Sensory Disability (PSD) Strategy Implementation Group have operated on a co-production model. During 2017/18 a range of improvements which resulted in co-produced support for service users and staff have progressed including:

Regional communication support services
- Following extensive public consultation transition plans commenced in 2017/18 to transfer current communication support services for deaf and hard of hearing people to a regional shared service supplied by the Business Services Organisation

Sensory support service DVD
- Belfast Health and Social Care Trust Sensory Support Team produced a regional DVD on behalf of the PSD Strategy Implementation Group to provide information on sensory disability, possible causes and effects and supports. Service user's co- produced the DVD and shared their experiences of Sensory Support Team services.

Social networking services
- Social networking services were commissioned last year for people with physical and sensory disability. These services enable sustained community engagement for disabled people with the view to helping prevent disabled people needing care and support in the first place or from developing long-term dependencies on health and social care provision. All Trusts have implemented this initiative.

4.5 Improving partnerships

Developing eye-care partnerships

The Developing Eyecare Partnerships (DEP) strategy was launched in 2012 and led to a five year project to improve the commissioning and provision of eyecare services in Northern Ireland. The HSCB/PHA are jointly implementing the strategy. Below are some of the reported impacts of the work of the DEP project.

- **Patient**
  I thought I had to go to the hospital to have my red eye checked but now I can go to my local optometrist.

- **GP**
  Patients had come to me, then the optometrist, back to me, then to the hospital. Now they can go straight to their optometrist and onto the hospital for treatment.

- **The ophthalmologist**
  I can now offer care to more glaucoma patients due to the extension of the roles of allied health professionals.

- **Nurse specialist**
  I can now provide additional care to patients in the macular clinic as I have been trained in giving intravitreal injections.

- **Optometrist**
  I can now view the details of my patients eye problem, straight from their electronic care record so that, like their GP and hospital clinic staff I can involve the patient in their care more.

THE DEP EFFECT

The Developing Eyecare Partnerships strategy was launched in 2012 and led to a five year project to improve the commissioning and provision of eyecare services in Northern Ireland.

Below are some of the reported impacts of the work of the DEP Project. For a copy of the final project report, please contact Ophthalmic Services within the Health and Social Care Board.

1 **THE PATIENT**
I thought I had to go to the hospital to have my red eye checked but now I can go to my local optometrist.

2 **THE GP**
Patients had to come to me, then the optometrist, back to me, then to the hospital. Now they can go to straight to their optometrist and on to the hospital for treatment.

3 **THE OPHTHALMOLOGIST**
I can now offer care to more glaucoma patients due to the extension of the roles of allied health professionals.

4 **THE NURSE SPECIALIST**
I can now provide additional care to patients in the macular clinic as I have been trained in giving intravitreal injections.

5 **THE OPTOMETRIST**
I can now view the details of my patient's eye problem straight from their Electronic Care Record so that, like their GP and hospital clinic staff, I can involve the patient in their care more.

6 **THE SENSORY SUPPORT TEAM**
Patients in Northern Ireland are no longer "registered blind" so it is easier for us to offer vital support without causing anxiety.

7 **THE EYE CASUALTY TEAM**
Optometrists now work alongside ophthalmologists in eye casualty which speeds things up for the patients.

8 **THE HSC TRUST MANAGER**
Collective management of eyecare services has led to smarter use of resources.

The Developing Eyecare Partnerships (DEP) Project 2012-2017 was led by the Health and Social Care Board and the Public Health Agency on behalf of the Department of Health for Northern Ireland.

- **The sensory support team**
  Patients in Northern Ireland are no longer 'registered blind' so it is easier for us to offer vital support without causing anxiety.

- **The eye casualty team**
  Optometrists now work alongside ophthalmologists in eye casualty which speeds things up for patients.

- **The HSC trust manager**
  Collective management of eye-care services has led to smarter use of resources.

For further information
http://www.hscboard.hscni.net/our-work/integrated-care/ophthalmic-services/developing-eye-care-partnerships/

Palliative Care in Partnership

Palliative Care is about improving the quality of life for those with needs and improving the experience of those important to them. The Regional Palliative Care Programme – *Palliative Care in Partnership*, is led by the HSCB/PHA and brings together people with palliative care needs, those who care from them, clinicians and other professions, service providers, planners and DoH to ensure the delivery of a whole system, holistic approach to support and care. Ensuring that "what matters to me" is addressed for each person with palliative care needs, whether the need be physical, psychological, social or spiritual.

You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to live until you die.

Dame Cecily Saunders

For some people, where they are cared for, matters to them. Given the choice most people would prefer to be cared for in their own home (which include residential and nursing home) at the end of life. In 2016, 47% of all deaths occurred in hospital, compared with 52% on 2010. The Programme aims to support a greater number of people who wish to be supported in their own home. In order to achieve this aim, Palliative Care in Partnership Programme is working to:

- **Raise awareness of palliative care which includes events during palliative care week in September.**
  Last year's theme was 'What have you heard? which aimed to clarify some myths about palliative care.

- **Implement processes to have proactive earlier identification of palliative care need.**
  Currently there are 46 GP practices engaged in an early identification prototype project with plans to expand to all practices in the coming year.

- **Allocate those with identified palliative care need a keyworker to help co-ordinate care across the system.**
  Typically the keyworker will be the persons District Nurse. Some resources have been allocated towards District Nursing. Districts Nurses have also undertaken additional training to enable them support people with palliative care needs and those important to them as part of their role.

- **Provide tools to enable the opportunity for the public to have advance care planning conversations and record them if they wish to do so.**
  In partnership with Macmillan Cancer Support the partnership has developed a free resource for the public to help them understand more about making plans for the future eg such as making a will, funeral plan or their wishes and preferences for care at end of life. In addition approximately 1000 staff have been trained in advance care planning.

- **Improved access to generalist and specialist palliative care services**.
  There has been additional specialist palliative care posts across the region to ensure those with complex palliative and end of life care needs can be supported. Tools and guidance have been developed to support specialist palliative care professions such as the management of symptoms in palliative care & the role of the specialist palliative care professional.

4.6 Population Screening in Northern Ireland

Early diagnosis through screening can lead to improved outcomes for a number of health conditions. The PHA is responsible for commissioning and quality assurance (QA) of eight antenatal, newborn and adult screening programmes:

Antenatal and newborn screening programmes:

- Antenatal infection
- Newborn blood spot
- Newborn hearing

Adult screening programmes:

- Abdominal Aortic Aneurysm
- Bowel cancer
- Breast cancer
- Cervical cancer
- Diabetic Eye

The key aim of population screening programmes in Northern Ireland is the early detection of disease as early detection often produces better outcomes for patients. The programmes demonstrate and reflect the highest levels of service quality as set out in national guidance and specifications. In addition, assuring the quality of screening is a fundamental objective embedded within all population screening programmes. This remained a key task of the PHA within 2017/18. Rigorous checks and measures have, and continue to be, in place. Where necessary, recommendations to improve practice have been provided to HSC providers.

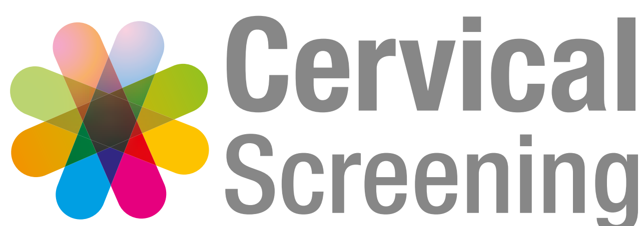
• Cancer screening

Early detection of disease through population screening programmes often produces better outcomes. However, it is recognised that deprivation is associated with lower rates of participation in cancer screening. The PHA awarded a three year contract to the Women's Resource and Development Agency (WRDA) to raise awareness and promote informed choice in uptake of the cancer screening programmes. In 2017/18, peer facilitators delivered 127 educational awareness sessions to participants from disadvantaged, diverse and sometimes remote backgrounds. This included Africa House Women's Group, Kates Bridge Rural Support Group, Rathlin Development and Community Association, and Shankill Sure Start.

• Cervical screening

During 2017/18, the PHA worked with laboratories and primary care colleagues in the HSCB to take forward a number of initiatives to support the quality of the cervical screening service being delivered at primary care level. This included:

- Developing a process which enabled sample takers to record their own unique code against each sample. This improved the process for audit of individual performance, such as activity levels and inadequate rates and will allow audit reports to be generated for each primary care practice or clinic. The PHA also collaborated with primary care colleagues in the HSCB to develop an audit tool to support practices in undertaking audits and to help assure the quality of cervical samples being taken within practices.
- Developing a regional practice protocol for the provision of cervical screening services which was shared with all GP practices. The template may be adapted for use in each general practice and is aligned with current national and regional policy, standards and guidance for cervical screening. The intention is that this protocol will assist in standardising the service delivered at primary care level across Northern Ireland.



• Abdominal aortic aneurysm screening

Working with service users to explain individual programme aims and to increase uptake is clearly important. Within Abdominal Aortic Aneurysm (AAA) screening, service user engagement is facilitated through a range of recurring and targeted mechanisms. This includes the programme's annual service user event which brings together service users and programme providers to receive updates on programme performance, recent service developments suggested by service users and potential areas for improvement. Three patient representatives contribute to the programme's commissioning group to further support Personal and Public Involvement (PPI) and co-production initiatives related to the continued advancement of AAA screening in Northern Ireland.

• Training and development for screening

A key element of work has been to support and facilitate the ongoing training and personal development of staff within population screening programmes. For example, within the Diabetic Eye Screening Programme staff have undertaken eye screener-specific training. Likewise, staff within the AAA and Breast Cancer Screening Programmes have benefited from peer review training (professional and clinical advisor training) alongside colleagues from similar English NHS Screening Programmes. This is integral to maintaining excellence and high standards of programme delivery. It also ensures staff are trained and equipped to both undertake and participate in external quality assurance visits - the key benchmark for population-based screening programmes.

For further information on screening programmes please see **http://www.publichealth.hscni.net/directorate-public-health/service-development-and-screening/screening**

4.7 Working with marginalised communities

Black and Minority Ethnic (BME) Groups

The health of migrants and Black and Minority Ethnic groups is an important area of focus, because of the poorer pattern of health experienced by these groups. Whilst many minority ethnic communities have close social networks and strong cultural beliefs and practices which can promote health and social wellbeing, it is also known that their experience has led to patterns of health inequality.

In April 2012, the PHA in collaboration with the HSCB, commissioned the BHSCT to provide the Northern Ireland New Entrant Service (NINES) by building on their existing Tuberculosis (TB) screening and BCG vaccination programme for 'at risk children'.

NINES offer a range of clinics which include:

- an holistic assessment of the health and well-being needs of new entrants
- continuing the TB screening and targeted BCG programmes
- increasing uptake of vaccinations (other than BCG)
- assisting with primary care registration
- supporting transition to mainstream services
- signposting to appropriate health services.

Raising the standards

It has been essential to work closely with BME communities to increase engagement and participation and develop appropriate health promotion and peer education programmes to improve equity of service and the quality of care provided. Housing, poverty, community relations and education have a significant impact upon health and wellbeing and, in order to assist in addressing these issues, the NINES team has developed multi-agency links with other statutory and voluntary organisations.

A new 4 year pilot programme funded by PHA, *'Mental Health 1+1 Project'*, supports the mental health and emotional wellbeing needs of BME communities. Three bi-lingual workers have been appointed to deliver support to local BME communities.

The project also aims to raise awareness within BME communities of wider services available beyond the project, and to make service providers aware of the need to adapt approaches to increase access from BME Communities. The project has highlighted that for European clients (clients predominantly Polish, Portuguese, Lithuanian) with little or no English, the main issue appears to be the language barrier, rather than a significant difference of cultural perspective on mental health. For African and East Timorean clients (predominantly Portuguese speaking) and for Chinese (both Cantonese & Mandarin speakers), a key cultural issue has been familiarising the client with the concept of mental health and emotional wellbeing, as something that they should and could enjoy.

Since 2012, the PHA has funded STEP (South Tyrone Empowerment Programme) to develop, manage and sustain an inclusive, collaborative, regional minority ethnic health and social wellbeing, good practice and information sharing network. A website has been developed which allows members to share good practice and keep up to date with BME activity. This, alongside regular e-alerts, seminars and an annual conference, focuses on members' needs and current issues which impact upon our BME population. This work builds on the strengths of members and has been an important mechanism for developing connections and improving outcomes.

For further information on STEP programme see **www.strongertogetherni.org**

Travellers

It is difficult to accurately assess how many Travellers are currently living in Northern Ireland. The All Ireland Travellers Health Study (AITHS) carried out in 2010 estimate a population of 3,905 Travellers living in 1,562 families. The study also shows that the age profile of the Traveller community in Northern Ireland is markedly different from that of the general population, with 75% of people under the age of 30 years. Only 1% of Travellers are over 65 years compared to over 15% of non-Travellers. There are significant differences in life expectancy and other health and wellbeing outcomes for Travellers.

Consequently, addressing improvements in the circumstances in which Travellers live, learn and work, as well as improving access to services is essential. The Travelling community experience prejudice and racism in almost every aspect of life. This experience has a very detrimental effect on health and wellbeing.

The PHA and HSCB convened a Travellers Health and Wellbeing Forum in October 2010. The Forum, which includes Trusts, Education Authority, Traveller Support Groups, voluntary sector organisations and the HSCB/PHA, is committed to progress the recommendations outlined within the *All Ireland Travellers Health Study*, particularly with regard to health and wellbeing. This is achieved through the development of a yearly action plan with the Forum meeting four times a year to report on progress and agree new priorities. A particular emphasis has also been given to emotional health and wellbeing and PHA commission *Aware NI* to deliver regional mental health and emotional wellbeing programmes for Travellers. The Forum also works with other agencies and seeks to influence a more coordinated approach to meeting need alongside informing mainstream services so that access is improved.

In addition to the Forum, the PHA commission services from the Southern, Western and Belfast Trusts to deliver a range of programmes to address the needs of Travellers.

Services include:

- community development
- family support
- health programmes
- training and education
- signposting to services such as smoking cessation, cancer screening
- drug & alcohol services
- support to engage in local services e.g. Healthy Living Centres
- cultural awareness training
- support to engage in conflict resolution within families and communities

Event speakers pictured at the Dementia Together NI celebratory event. Back row (from L-R): Eleanor Ross, PHA, Seamus McErlean, hscb, Chris Matthews, DoH, Tara Collins, Dementia NI, and Professor Assumpta Ryan, Ulster University. Front row (from L-R): Jerome Dawson, DoH, Andrew Dougal, PHA, Lorna Conn, HSCB and Sarah Penney, Ulster University.

Above pictured at the Q2020 Event in November 2017. L-R Dr Carolyn Harper, PHA, Dr Michael McBride, DoH, Carol McCullough, service user representative, Prof Charlotte McArdle, DoH, Mary Hinds, PHA.

Theme five

Integrating the care

5.1 Introduction

The HSCB and PHA are committed to ensuring the integrated HSC system in Northern Ireland is effective and that there is seamless movement across all professional boundaries and sectors of care. A number of key improvements were led by the HSCB/PHA last year. This made a significant contribution to raising the quality of care and outcomes experienced by patients, clients and their families.

5.2 Centre for Connected Health and Social Care

The Centre for Connected Health and Social Care (CCHSC), located within the HSCB and PHA, promotes the use of technology and innovation in the HSC system in Northern Ireland. The primary purpose of CCHSC is to improve patient/client experience and to provide better quality and more effective care.

During the year the CCHSC continued to contribute to improving health and wellbeing through a number of partnership activities including:

e-Health and Care strategy

CCHSC has led the implementation of the eHealth and Care Strategy, ensuring that the strategic aims of the HSCB/PHA are fully reflected contributing to all of the workstreams, with a focus on supporting people, sharing information and fostering innovation projects. The CCHSC has also been supporting work on the 'encompass' programme, supporting various engagement activities and developing the Personal Public Involvement model to support involvement of patients, carers and the public.

HSC Online

A health conditions A-Z platform is being developed which will provide a comprehensive suite of health information, supporting people to make decisions in relation to their personal illness and chronic conditions. Hosted by *Nidirect*, the HSCB eHealth initiative developed in conjunction with the PHA will promote self-management where appropriate, and help people decide whether their condition has reached the threshold where advice or clinical assessment is required. It will link to signposting of appropriate services, assisting people in accessing services they require. Links will be provided to GP practices to book appointments online and order prescriptions, where these services have been made available by practices. In parallel, work will continue migrating content currently hosted on HSCB/PHA websites, to the N*idirect* platform.

eHealth and Data Analytics Dementia Pathfinder Programme

CCHSC has been delivering the eHealth and Data Analytics Dementia Pathfinder Programme of work. The programme can be divided into two distinct areas:

- **eHealth projects** comprising of:
  - a **patient portal** and **app** for people with a diagnosis of dementia and their carers linked to the Northern Ireland Electronic Care Record (NIECR), as well as providing the IT infrastructure and security to support such portals and apps;
  - the development of a new patient care pathway, through the support of "**Project ECHO**" for dementia;
  - a local enhanced service for the completion of **key information summaries (KIS)** in the NIECR for the majority of dementia patients. This will mean that the patients will be recognised and flagged as having dementia across the electronic system.
- **Data analytics** projects comprising of:
  - **Setting up of data analytics platform and team** to undertake a scoping study to develop data analytics capability within health and social care;
  - **Commissioning Queen's University Belfast research** to develop a strong academic research base, ensuring clinical input and data analytics expertise is at the heart of the programme and can link, learn and disseminate information to the data analytics team from international and best practice approaches;
  - **Dementia analytics and research projects** - to commission ten dementia analytics projects exploring issues critical to patient outcomes and service planning and to assist in service development and design.

EU Engagement and projects

CCHSC is a member of DoH-led EU Engagement Forum set up to inform strategic directions and co-ordinate information about EU funding streams and networks. CCHSC led by HSCB / PHA works with Trusts, universities and industry to pursue both UK and EU funding opportunities to support HSCNI's contribution to the work of the European Innovation Partnership on Active and Healthy Ageing (EIP AHA).

5.3 Integrating care at home

24 hour District Nursing care

During 2018, *A District Nursing Framework 2018-2026 - 24 Hour District Nursing Care No Matter Where You Live* was launched. The Framework aims to provide the strategic direction for the provision of district nursing services in Northern Ireland. It paves the way for developing a service that is innovative, collaborative and transformed, available 24 hours a day, seven days a week, no matter where the patient lives. An outcomes based approach has been adopted for the four principles in the framework, which are

- Person centred;
- Efficient and effective;
- Expert;
- Integrated and population based around General Practice.

A number of improvement priorities, actions and indicators of success have been identified for each of the four principles. The PHA will be responsible for taking forward the implementation plan linking closely with HSCB and other stakeholders to progress the outcomes in this Framework, using a collective leadership approach.

Prof Charlotte McArdle, DOH Chief Nursing Officer:

"I believe this Framework sets the way forward for all of us to work together to deliver a world class district nursing service. I am confident that the implementation of the Framework will have a valuable impact on delivering safe and effective person centre care by district nurses and their teams in community settings."

Transformation of the home oxygen service

Oxygen therapy is vital in supporting adults and children with breathing difficulties, including those with long-term medical conditions such as cystic fibrosis and chronic obstructive pulmonary disease (COPD). Access to oxygen at home helps users to manage their symptoms so that they can live effectively in the community, rather than needing to be cared for in hospital.

The provision of oxygen therapy involves a range of health professionals in secondary and primary care settings who contribute to the patient's journey of care from initial clinical assessment to the supply of oxygen at home. Currently there are approximately 4,000 patients on oxygen therapy at home in Northern Ireland.

Old service model

In Northern Ireland, oxygen therapy can be prescribed by GPs. The GPs assess the clinical needs of patients and determine the appropriate oxygen flow rate and hours of use per day. The service model required a large amount of communication between secondary care to advise GPs on prescribing. The service does not make any provision for the modern modalities to supply long term oxygen, nor does it make provision for a four hour response rate to allow discharge from hospital, offer a tapped install service to allow a safer installation of oxygen, or offer a 24/7 call-out service.

Transformed service model

Advances in oxygen technology, especially portable and transportable concentrators and liquid oxygen mean that patients with high oxygen demands can be supported to live at home, be active and have greater freedom and autonomy in managing their oxygen needs. In April 2017, 3752 patients received a home oxygen concentrator via the specialist oxygen contract. This may have been a standard, portable, transportable or self-fill concentrator. The average number of new patients per month is 210.

Community pharmacy hidden carers pilot

The Community Pharmacy Hidden Carers pilot began in the South Eastern Local Commissioning Group (LCG) area. Evidence shows that many carers become isolated through the demands of their caring role and are twice as likely as those who are not in a caring role to suffer from ill health. The aim of the pilot was to use community pharmacists to identify those carers who were not currently in touch with services and therefore unidentified. The role of the community pharmacist was to promote the Carers Support Service and thereby enable carers presenting at pharmacies to avail of the services.

Forty four pharmacies in the LCG area took part in the pilot and mandatory training sessions were held. An evaluation of the pilot was undertaken and the results showed that there were 61 referrals across the participating pharmacies. Thirteen of the carers were contacted for detailed feedback of the service. Ten of those contracted reported that they would not have known that the Carer Support Service was available if they had not been identified by the pharmacist. The evaluation recognised the value of community pharmacies in identifying hidden carers and recommended continuation of the pilot in the area and consideration of rollout across other areas. The service has been extended for a further six months across the South Eastern LCG. Both the Northern and the Western Trusts have identified funding to commence the project. The Southern Health and Social Care Trust hope to introduce the service and provisional discussions have also been held with Belfast Health and Social Care Trust.

5.4 Local enhanced services

Key Information Summaries

HSCB developed a Northern Ireland local enhanced service to introduce and train GPs in the use of key information summaries in 2017/18. The key information summary (KIS) is a summary of medical history and patient wishes. It allows GPs to record useful data about their patients which is then visible on the electronic care record (ECR) in unscheduled care settings such as GP out-of-hours and emergency departments. The information contained in the KIS helps to ensure improved patient safety and continuity of care. It allows accurate information to be quickly identified in an emergency and avoids key information having to be repeated several times.

Patients with dementia were identified as a group who would particularly benefit from use of the KIS therefore there was a particular focus on this group of patients.

A total of 152 GP practices were contracted to provide the KIS enhanced service in 2017/18 and have all completed the relevant training. The contracting GP practices are expected to have completed 5781 KIS assessments by the end of June 2018 with KIS assessments completed on 50% of their registered dementia patients. This will equate to 3374 assessments on dementia patients by the end of June 2018. By 31st March 2018 a total of 3464 KIS assessments had been successfully completed by GPs.

Oral Surgery - Personal Dental Services Pilot 2017/18

In 2017/18 an oral surgery Personal Dental Services (PDS) pilot was established to improve patient access to specialist oral surgery treatment within primary care and to reduce demand on secondary care. Within primary care in Northern Ireland there are six specialist high street oral surgery (HSOS) practices which treat health service patients on referral from general dental practitioners. However, in recent years HSOS activity under the health service has declined dramatically with providers citing economic reasons.

The oral surgery contractual arrangement being piloted offers HSOS practices a more viable business model but at the same time requires from them a greater commitment to health service provision. The pilot benefits the wider HSC through reduced pressure on secondary care, more effective use of Trust resources, increased value for money and greater financial control and predictability.

Outcomes are positive for patients as well as overall waiting times are reduced. Although in its infancy and still being evaluated, the pilot has clearly been successful in reversing the downward trend in the high street oral surgery service.

Additional key 2017/18 pilot outcomes include:

- Approximately 3000 more patients in 2017/18 received specialist oral surgery care within primary care than during 2016/17 (an increase of 26%).
- Equity in patient access has improved as service provision has increased across all five LCG areas.
- 1271 fewer oral surgery referrals were made to secondary care during the pilot period than in the same months of the previous year (a reduction of 12%).

A second phase of the oral surgery pilot is currently ongoing to allow for continued primary care oral surgery service provision, more extensive pilot evaluation and potential further refinements to the future service model.

Management of *Clostridium difficle* in the independent sector care and residential home setting

Laboratories in Northern Ireland notify the PHA of all *clostidium difficle* infections. On notification a reporting proforma is completed which contains information about the patient and associated risk factors, including antibiotic history in the last four weeks. Following completion of the proforma prompt Infection Prevention and Control (IPC) is given in relation to isolation of those infected, hand hygiene, appropriate use of personnel protective equipment, environmental and equipment cleaning and decontamination. A guidance pack containing the advice is also emailed to the facility.

A twice weekly risk assessment review of all notifications is completed where they are risk assessed and decisions are made about the ongoing management. These meetings aim to provide assurance about IPC practice and can include;

- The provision of further expert advice and support via telephone or through the completion of support visits to the facility. The visit can also be used to gather information about IPC practice.

- Sharing of audit tools to help provide assurance of IPC and control practice such as hand hygiene and equipment audit.
- Support through teaching sessions for staff in relation to IPC – including the theory and practice.
- Providing a link between independent sector care home, GPs, Trusts and the Regulation Quality Improvement Authority (RQIA). These links ensure the direct dialogue of all stakeholders, continuity of approach will enhance resident safety.
- Encourage compliance with antimicrobial stewardship through awareness of Northern Ireland primary care guidance and through direct access to HSCB pharmacy colleagues.

A root cause analysis is carried out where appropriate, following a confirmed case of *clostridium difficle* infection. This analysis can identify factors that may have contributed to the person acquiring the infection. Learning is then shared with the relevant agencies.

5.5 Criminal Justice Healthcare

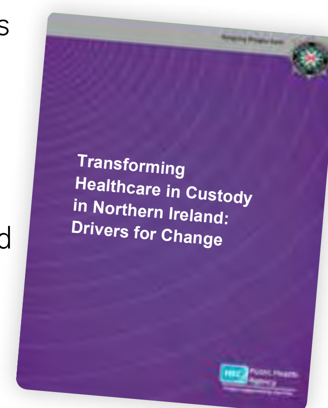
The DoH and Department of Justice (DoJ) consulted on a draft joint healthcare/criminal justice strategy in 2017/18. The PHA and HSCB were instrumental in driving forward a number of recommendations for the regional action plan. Progress has included:

- An associated services multidisciplinary team for prison healthcare has been reconstituted; a mandate and work plan has been agreed.
- As part of commissioning team, work has been ongoing to formulate a plan to outline the requirements for the future service.
- As part of a ten point plan, proposals have been made to the DoH to take forward a number of transformation proposals to build on and progress the health needs assessment in prison environments.

During 2017/18 a multidisciplinary workforce review has been initiated and this will be evaluated in line with the service requirements, demand and supply of the recommended workforce for prison healthcare.

Joint PHA and PSNI Police Custody Pathfinder

A number of consultations and a regional workshop has taken place with key stakeholders to progress recommendations for the development of a Trust led model for healthcare in custody. The PHA in conjunction with DoH, DoJ and PSNI and the Belfast Health and Social Care Trust is leading work to develop a Trust led model for healthcare in custody. A joint funding envelope has been agreed to progress and test the model through a nurse led pathfinder in 2018.



The specification for the pathfinder has been successfully established with a plan to have this in place by September 2018. In parallel to this the regional roll out for nurse led services in custody suites is being progressed by a regional Task and Finish group co-chaired by PHA and PSNI.

5.6 Integrating the care for Learning disability services

Annual health check: patient pathway to support the development of a health and wellbeing plan

Health and wellbeing plans identify the personal health and wellbeing needs of individuals and describe the actions to empower individuals to make healthy choices to improve their health. Within the learning disability services a core quality indicator specifies that each person with a learning disability who receives an annual health check should have a health and wellbeing plan in place.

A patient pathway has been developed as well as detailed guidance in order to assist Trusts with the implementation of individual health and wellbeing plans for adults with a learning disability. The pathway and guidance will facilitate a consistent regional introduction to the development and implementation of health and wellbeing plans. A multi-disciplinary approach will describe roles and responsibilities and ensure the plans become integral and routine to existing assessment, care planning and review processes.

HSC Hospital passport for people with learning disability

The PHA has worked with HSCB and Trusts, education providers, people with a learning disability and their families and carers, to design the Hospital Passport and guidance notes for staff.

This involved consultations with a wide range of individuals with a learning disability, healthcare staff, voluntary organisations involved in the support and delivery of services to people with a learning disability, and family and carers.

The purpose of the Hospital Passport is to provide important information about the person with a learning disability. This information will help staff in general hospital settings make reasonable adjustments in order to support safe and effective care. This in turn will improve patient/client experience of care and treatment.

HSC Hospital Passport

For people with a learning disability in contact with a general hospital

Your Hospital Passport will help to let hospital staff know all about your abilities and needs.

This will help them give you better care when you are in hospital.

Please ensure that your information is up to date.

To staff:

Please read this regional Hospital Passport and make reasonable adjustments *before* you undertake any assessment, examination, treatment or care.

Try to make this passport easily available to all staff involved in care.

HSC Health and Social Care

The Passport was launched in May 2017, with copies being distributed to each of the Trusts and to a number of the larger community and voluntary sector organisations working with people with learning disabilities across Northern Ireland.

In August 2017 following feedback received from healthcare professionals and carers the Passport was also made available in an accessible format. Individuals can type onto the document, print or save to a mobile device. The PHA has also provided a PPI award to an Association for Real Change (ARC) project called *Telling It Like It Is* (TILII). TILII is an organisation that works with individuals with a learning disability, who assisted with the evaluation of the Passport. TILII has engaged with peers to develop an easy read evaluation tool that can be used as part of the wider PHA evaluation.

Both the Passport and guidance notes are also available to download from the PHA website. **http://www.publichealth.hscni.net/publications/hsc-hospital-passport-and-guidance-notes**

5.7 Quality improvement: babies, children & families

Getting Ready for Baby

The Early Intervention Transformation Programme (EITP) aims to improve outcomes for children and young people across Northern Ireland through embedding early intervention approaches. There are a total of three workstreams within EITP. Workstream one is divided in to two areas

1. Getting Ready for Baby
2. Getting Ready for Toddler.

Getting Ready for Baby is a new way of delivering care and supporting first time parents through pregnancy, labour and birth and preparing for the early days of baby's life. It links antenatal appointments and parenting group support for the first time in Northern

Ireland. This means that first time mothers will be part of an antenatal parenting group that meet at various points during pregnancy and will also receive antenatal care at this visit.

Getting Ready for Baby helps new parents get to know and develop a relationship with their baby using the Solihull Approach, an evidence based programme focused on emotional health and wellbeing. Getting Ready for Baby is currently only for first-time mothers with no major health issues.

Extensive data collection has been ongoing and the programme has received excellent feedback from a number of sources using questionnaires to evaluate. Feedback comments included:

> "The assurance of knowing others are experiencing the same ups and downs as you makes pregnancy much easier. You will leave armed with knowledge, confidence and a support group for life. The midwives are fantastic and will guide you through this wonderful time".

3+ Review

Work Stream One of EITP has designed an evidence informed approach to the 3+ Health Review using an integrated health and education review for children in their pre-school year. Whilst this is intended to be a holistic review, particular focus is on social, emotional and behavioural development.

As part of the programme the health visiting service will work together with nursery school principals and pre-school leaders to offer a 3+ Health Review for children attending pre-school education. The 3+ Health Review requires the parent/carer to complete a questionnaire and attend a short interview at the pre-school setting with the health visitor. The pre-school leader/nursery school teacher also has the opportunity to highlight any concerns or issues. It is designed to be easy to complete by parents at home or in the pre-school education setting with minimal support.

The 3+ Review has been well received by parents and this has been highlighted in the parent questionnaires.

EITP Publications

The PHA worked with a number of key professionals across Northern Ireland to standardise child development public health information which was supported by the EITP.

A targeted consultation supported by Parenting NI, was conducted alingside the development of these messages to ensure they were appropriate to service user needs. This information has been distributed to Trusts, GP practices, Early Years settings and libraries to ensure messages are cascaded to help improve the health and well-being of children.

http://www.publichealth.hscni.net/publications/playing-parents-number-one-three-posters

http://www.publichealth.hscni.net/publications/helping-your-baby-learn-talk

http://www.publichealth.hscni.net/publications/helping-your-child-learn-talk

Safe sleeping

As a result of the findings of the Northern Ireland Infant Death Thematic Review (2015) we have a better understanding of sudden and unexpected infant death in Northern Ireland.

The PHA used the findings from the thematic review to highlight the key messages which aimed to prevent further deaths, and improve the health, safety and wellbeing of children. In consultation with practitioners from the key disciplines across the Trusts two new resources have been developed to assist practitioners to provide consistent messages about safe sleeping regularly both in the antenatal period and postnatally. The resources include a Parent Information Card and a Risk Assessment Tool.

Children with Special Educational Needs

The PHA hosted a number of regional workshops with staff from Trusts, the Education Authority and Department of Education to improve health input to the educational statutory assessment process. From these events a number of recommendations and actions have been put in place which will ensure regional standardisation of health advice in the statutory assessment process. This will ensure that children with Special Educational Needs (SEN) are identified and assessed in a timely manner, and advice provided within the statutory assessment process is provided within the specified timeframe. There was a high level of co-operation between health and education in ensuring this work meets the legislative requirements of the Children's Services Co-operation Act (Northern Ireland) 2015 to improve children's wellbeing.

Supporting speech, language and communication (SLC) in Sure Start

There are 39 Sure Start projects delivering services in the 25% most deprived areas in Northern Ireland. The supporting speech, language and communication (SLC) programme in Sure Start aims to:

- support parents and staff to provide language rich environments;
- support early identification of SLC need; and
- ensure timely access to appropriate additional support.

To achieve the aims of the SLC programme, the PHA, working with key stakeholders, implemented *Wellcomm*, a speech and language screening tool in order to:

- help with the early identification of speech, language and communication needs
- help identify the appropriate type of SLC support
- monitor the SLC progress of the children

The Wellcomm Screening tool uses a red, amber, green scoring system to indicate if a child's language is age appropriate (green), has some difficulties (amber) or is delayed (red). It was administered in Sept/Oct 2016 prior to the SLC development programme being implemented and then re-administered in May/June 2017 following the SLC development programme.

SLC Programme Target	Achieved
100% of eligible children 2-3 year old will be screened using the Wellcomm Screening tool.	96%
Wellcomm Screening will be carried out by Early Years staff in 100% of 2-3 year old.	97%
To ensure consistency in the accuracy of screening, annual regionally agreed Wellcomm training will be delivered by SLTs in 100% of Sure Start projects.	100%
There is consultation with SLT regarding all children who score red on Sept/Oct screen and these children are signposted to appropriate services.	Achieved within each local area

Did the SLC programme improve the outcome for 2 3year old children?

For further information
please contact

Grainne Cushley
Q2020
Project Manager
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Glossary of terms used in infographic

10,000 more voices – The PHA lead the implementation of 10,000 more voices throughout Northern Ireland. 10,000 more voices is an initiative aimed at listening to patients / clients/carers and staff experience of Health and Social Care Services. This information is used to inform local and regional improvements, commissioning of services and the development of education and training programmes.

Always Events - Always Events are defined as those aspects of the care experience that should **ALWAYS** occur when patients, their family members or other care partners, and service users interact with health care professionals and the health and social care delivery system. The HSCB/PHA, through the regional Patient Client Experience Steering Group, have led the implementation of Always Events in each HSC Trust. They have used information from 10,000 More Voices to inform Always Events in areas such as *noise at night, acute pain management, mealtimes, communication and family presence.*

Antenatal, New-born and adult screening programmes - The key aim of population screening programmes in Northern Ireland is the early detection of disease as this often produces better outcomes for patients. The PHA is responsible for commissioning and quality assurance (QA) of eight antenatal, newborn and adult screening programmes.

Attributes Framework – The Attributes Framework, launched in 2014, is a self-assessment framework focused on assessing knowledge, skills and attitudes in relation to leadership for quality improvement. The assessment framework has 4 levels. The PHA are responsible to monitoring the regional uptake of the level 1 e-learning programmes aligned to the Attributes Framework

Clinical Networks - A managed clinical network aims to provide a regional platform to achieve consistency in care and drive quality improvement within the network and beyond with a family centred approach. The HSCB/PHA lead the implementation of a number of clinical networks.

Collaboratives - A collaborative is a short-term learning system, run over 12-18 months that brings together a number of provider multidisciplinary teams to seek improvement in a focused topic area. The PHA lead the regional implementation of a range of collaborative's including mental health, maternity, sepsis.

Delirium Assessment & management tool – delirium is used to describe a state of sudden confusion and changes in a person's behaviour and alertness. The training tool was developed, as part of the implementation of Dementia Together NI Strategy,

to provide staff with the skills to appropriately assess and manage patients with delirium.

Developing eye-care partnerships - The Developing Eyecare Partnerships (DEP) Strategy was launched in 2012 and led to a five year project to improve the commissioning and provision of eyecare services in Northern Ireland. The HSCB/PHA are leading the implementation the strategy. There have been a range of improvements and outcomes which are outlined within the report.

Learning Disability passport - The purpose of the Hospital Passport is to provide important information about the person with a learning disability. This information will help staff in general hospital settings make reasonable adjustments in order to support safe and effective care. The PHA has worked with HSCB and Trusts, education providers, people with a learning disability and their families and carers, to design the Hospital Passport and guidance notes for staff.

Mental Health 1+1 project - A new 4 year pilot programme funded by PHA*, Mental Health 1+1 Project'*, supports the mental health and emotional wellbeing needs of Black, Minority Ethnic (BME) communities. The project also aims to raise awareness within BME communities of wider services available beyond the project, and to make service providers aware of the need to adapt approaches to increase access from BME Communities.

NICE Process - NICE produces different types of guidance, including Technology Appraisals (new drugs, medical treatments and therapies); Clinical Guidelines (recommendations on the appropriate treatment and care of people with specific diseases and conditions); and Public Health Guidance (recommendations for populations and individuals on activities, policies and strategies that can help prevent disease or improve health). The HSCB/PHA have a processes to take forward the implementation of Technology Appraisals, Clinical Guidelines and Public Health Guidance published by NICE and endorsed by the DoH.

Project ECHO – ECHO (Extension for Community Healthcare Outcomes) is a tele-monitoring programme designed to address the growing demand for secondary care services. Using video-conferencing technology, participants benefit by sharing evidence-based best practice guidance and case-based learning relating to common, chronic, complex diseases. The HSCB supported by the PHA and Hospice UK, are currently rolling out the ECHO model in 30 clinical areas to include elective care, prison health, optometry/ophthalmology and dementia.

Q - Q is an initiative which connects people who have quality improvement expertise across the United Kingdom. It is being led by the Health Foundation supported locally by the HSC Safety Forum based in the PHA. The PHA Safety Forum lead a yearly recruitment programme to add new members to the network

Quality Improvement Plan (QIP) - QIPs focus on key priority areas to improve quality and outcomes for patients and service users. The HSCB and PHA support Trusts on a range of initiatives to assist with the achievement of the QIP targets and facilitate a regional platform to enable good practice to be shared throughout Northern Ireland.

Recovery College - The PHA working closely with the HSCB support the implementation of recovery colleges throughout the region. A recovery college allows people using mental health services, their carers and the providers of those services to learn more about and develop recovery skills together. These study and training facilities provide a range of courses based on the principles of further education.

Serious Adverse Incident (SAI) – the HSCB/PHA have a responsibility to review and identify learning following serious adverse incident review investigations. The report infographic provides a numerical overview of the SAIs reviewed and learning identified. The full text report outlines a few examples of regional learning identified as a result of the HSCB/PHA SAI process.

HSC Public Health Agency

board paper

ALB Self-Assessment Tool

date 16 August 2018 **item** 11 **reference** PHA/05/08/18

presented by Mr Andrew Dougal, Chair

action required For approval

Summary

The Public Health Agency is required to complete an annual self-assessment tool. In previous years it was a requirement to send the completed tool to the Department of Health, but while this is not the case, reference is made to it in PHA's Governance Statement.

The tool is in the same format as previous years, with the good practice section in the first half of the document and then PHA's responses to that in the second half. There is also a case study.

Equality Impact Assessment

Not applicable.

Recommendation

The Board is asked to **APPROVE** the ALB Self-Assessment tool.

Department of
Health
www.health-ni.gov.uk

BOARD GOVERNANCE SELF ASSESSMENT TOOL

For use by Department of Health Sponsored Arms Length Bodies

Updated 16th June 2016

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Introduction

This self-assessment tool is intended to help Arm's Length Bodies (ALBs) improve the effectiveness of their Board and provide the Board members with assurance that it is conducting its business in accordance with best practice.

The public need to be confident that ALBs are efficient and delivering high quality services. The primary responsibility for ensuring that an ALB has an effective system of internal control and delivers on its functions; other statutory responsibilities; and the priorities, commitments, objectives, targets and other requirements communicated to it by the Department rests with the ALB's board. The board is the most senior group in the ALB and provides important oversight of how public money is spent.

It is widely recognised that good governance leads to good management, good performance, good stewardship of public money, good public engagement and, ultimately, good outcomes. Good governance is not judged by 'nothing going wrong'. Even in the best boards and organisations bad things happen and board effectiveness is demonstrated by the appropriateness of the response when difficulties arise.

Good governance best practice requires Boards to carry out a board effectiveness evaluation annually, and with independent input at least once every three years.

This checklist has been developed by reviewing various governance tools already in use across the UK and the structure and format is based primarily on Department of Health governance tools. The checklist does not impose any new governance requirements on Department of Health sponsored ALBs.

The document sets out the structure, content and process for completing and independently validating a Board Governance Self-Assessment (the self-assessment) for Arms Length Bodies of the Department of Health.

The Self-Assessment should be completed by all ALB Boards and requires them to self-assess their current Board capacity and capability supported by appropriate evidence which may then be externally validated.

Application of the Board Governance Self-Assessment

It is recommended that all Board members of ALBs familiarise themselves with the structure, content and process for completing the self-assessment.

The self-assessment process is designed to provide assurance in relation to various leading indicators of Board governance and covers 4 key stages:

1. Complete the self-assessment
2. Approval of the self-assessment by the ALB Board and sign-off by the ALB Chair;
3. Report produced; and
4. Independent verification.

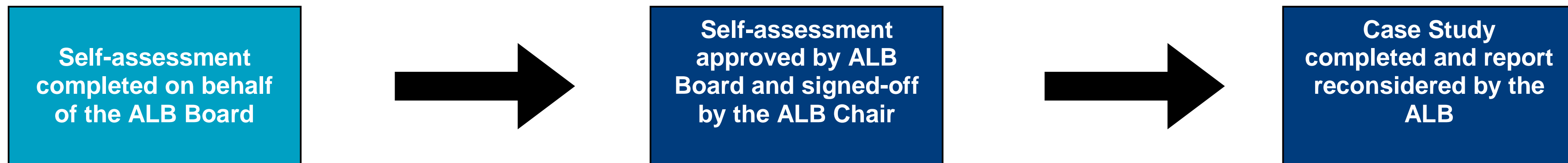
Complete the self-assessment: It is recommended that responsibility for completing the self-assessment sits with the Board and is completed section by section with identification of any key risks and good practice that the Board can evidence. The Board must collectively consider the evidence and reach a consensus on the ratings. The Chair of the Board will act as moderator. A submission document is attached for the Board to record its responses and evidence, and to capture its self-assessment rating.

Refer to the scoring criteria identified on page 7 to apply self assessment ratings.

Approval of the self-assessment by ALB Board and sign off by the Chair: The ALB Board's RAG ratings should be debated and agreed at a formal Board meeting. A note of the discussion should be formally recorded in the Board minutes and ultimately signed off by the ALB Chair on behalf of the Board.

Independent verification: The Board's ratings should be independently verified on average every three years. The views of the verifier should be provided in a report back to the Board. This report will include their independent view on the accuracy of the Board's ratings and where necessary, provide recommendations for improvement.

Overview



The Board Governance self-assessment is designed to provide assurance in relation to various leading indicators of effective Board governance. These indicators are:

1. Board composition and commitment (e.g. Balance of skills, knowledge and experience);
2. Board evaluation, development and learning (e.g. The Board has a development programme in place);
3. Board insight and foresight (e.g. Performance Reporting);
4. Board engagement and involvement (e.g. Communicating priorities and expectations);
5. Board impact case studies (e.g. A case study that describes how the Board has responded to a recent financial issue).

Each indicator is divided into various sections. Each section contains Board governance good practice statements and risks.

There are three steps to the completion of the Board Governance self-assessment tool.

Step 1

The Board is required to complete sections 1 to 4 of the self-assessment using the electronic Template. The Board should RAG rate each section based on the criteria outlined below. In addition, the Board should provide as much evidence and/or explanation as is required to support their rating. Evidence can be in the form of documentation that demonstrates that they comply with the good practice or Action Plans that describe how and when they will comply with the good practice. In a small number of instances, it is possible that a Board either cannot or may have decided not to adopt a particular practice. In cases like these the Board should explain why they have not adopted the practice or

cannot adopt the practice. The Board should also complete the Summary of Results template which includes identifying areas where additional training/guidance and/or assurance is required.

Step 2

In addition to the RAG rating and evidence described above, the Board is required to complete a minimum of 1 of 3 mini case studies on;

- A Performance failure in the area of quality, resources (Finance, HR, Estates) or Service Delivery; or
- Organisational culture change; or
- Organisational Strategy

The Board should use the electronic template provided and the case study should be kept concise and to the point. The case studies are described in further detail in the Board Impact section.

Step 3

Boards should revisit sections 1 to 4 after completing the case study. This will facilitate Boards in reconsidering if there are any additional reds flags they wish to record and allow the identification of any areas which require additional training/guidance and/or further assurance. Boards should ensure the overall summary table is updated as required.

Scoring Criteria

The scoring criteria for each section is as follows:

Green if the following applies:

- All good practices are in place unless the Board is able to reasonably explain why it is unable or has chosen not to adopt a particular good practice.
- No Red Flags identified.

Amber/ **Green** if the following applies:

- Some elements of good practice in place.
- Where good practice is currently not being achieved, there are either:
    - robust Action Plans in place that are on track to achieve good practice; or
    - the Board is able to reasonably explain why it is unable or has chosen not to adopt a good practice and is controlling the risks created by non-compliance.
- One Red Flag identified but a robust Action Plan is in place and is on track to remove the Red Flag or mitigate it.

Amber/ **Red** if the following applies:

- Some elements of good practice in place.
- Where good practice is currently not being achieved:
    - Action Plans are not in place, not robust or not on track;
    - the Board is not able to explain why it is unable or has chosen not to adopt a good practice; or
    - the Board is not controlling the risks created by non-compliance.
- Two or more Red Flags identified but robust Action Plans are in place to remove the Red Flags or mitigate them.

Red if the following applies:

- Action Plans to remove or mitigate the risk(s) presented by one or more Red Flags are either not in place, not robust or not on track

Please note: The various green flags (best practice) and red flags risks (governance risks/failures) are not exhaustive and organisations may identify other examples of best practice or risk/failure. Where Red Flags are indicated, the Board should describe the actions that are either in place to remove the Red Flags (e.g. a recruitment timetable where an ALB currently has an interim Chair) or mitigate the risk presented by the Red Flags (e.g.

where Board members are new to the organisation there is evidence of robust induction programmes in place).

The ALB Board's RAG ratings on the self assessment should be debated and agreed by the Board at a formal Board meeting. A note of the discussion should be formally recorded in the Board minutes and then signed-off by the Chair on behalf of the Board.

1. Board composition and commitment

1. Board composition and commitment overview

This section focuses on Board composition and commitment, and specifically the following areas:

1. Board positions and size
2. Balance and calibre of Board members
3. Role of the Board
4. Committees of the Board
5. Board member commitment

1. Board composition and commitment

1.1 Board positions and size

Red Flag	Good Practice
1. The Chair and/or CE are currently interim or the position(s) vacant. 2. There has been a high turnover in Board membership in the previous two years (i.e. 50% or more of the Board are new compared to two years ago). 3. The number of people who routinely attend Board meetings hampers effective discussion and decision-making.	1. The size of the Board (including voting and non-voting members of the Board) and Board committees is appropriate for the requirements of the business. All voting positions are substantively filled. 2. The Board ensures that it is provided with appropriate advice, guidance and support to enable it to effectively discharge it responsibilities. 3. It is clear who on the Board is entitled to vote. 4. The composition of the Board and Board committees accords with the requirements of the relevant Establishment Order or other legislation, and/or the ALB's Standing Orders. 5. Where necessary, the appointment term of NEDs is staggered so they are not all due for re-appointment or to leave the Board within a short space of time.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Standing Orders • Board Minutes • Job Descriptions • Biographical information on each member of the Board.

1. Board composition and commitment

1.2 Balance and calibre of Board members

Red Flag	Good Practice
1. There are no NEDs with a recent and relevant financial background. 2. There is no NED with current or recent (i.e. within the previous 2 years) experience in the private/ commercial sector. 3. The majority of Board members are in their first Board position. 4. The majority of Board members are new to the organisation (i.e. within their first 18 months). 5. The balance in numbers of Executives and Non Executives is incorrect. 6. There are insufficient numbers of Non Executives to be able to operate committees.	1. The Board can clearly explain why the current balance of skills, experience and knowledge amongst Board members is appropriate to effectively govern the ALB over the next 3-5 years. In particular, this includes consideration of the value that each NED will provide in helping the Board to effectively oversee the implementation of the ALB's business plan. 2. The Board has an appropriate blend of NEDs e.g. from the public, private and voluntary sectors. 3. The Board has had due regard under *Section 75 of the Northern Ireland Act 1998 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.* 4. There is at least one NED with a background specific to the business of the ALB. 5. Where appropriate, the Board includes people with relevant technical and professional expertise. 6. There is an appropriate balance between Board members (both Executive and NEDs) that are new to the Board (i.e. within their first 18 months) and those that have served on the Board for longer. 7. The majority of the Board are experienced Board members. 8. The Chair of the Board has a demonstrable and recent track record of successfully leading a large and complex organisation, preferably in a regulated environment. 9. The Chair of the Board has previous non-executive experience. 10. At least one member of the Audit Committee has recent and relevant financial experience.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board Skills audit • Biographical information on each member of the Board

1. Board composition and commitment

1.3 Role of the Board

Red Flag	Good Practice
1. The Chair looks constantly to the Chief Executive to speak or give a lead on issues. 2. The Board tends to focus on details and not on strategy and performance. 3. The Board become involved in operational areas. 4. The Board is unable to take a decision without the Chief Executive's recommendation. 5. The Board allows the Chief Executive to dictate the Agenda. 6. Regularly, one individual Board member dominates the debates or has an excessive influence on Board decision making.	1. The role and responsibilities of the Board have been clearly defined and communicated to all members. 2. There is a clear understanding of the roles of Executive officers and Non Executive Board members. 3. The Board takes collective responsibility for the performance of the ALB. 4. NEDs are independent of management. 5. The Chair has a positive relationship with Sponsor Branch of the Department. 6. The Board holds management to account for its performance through purposeful, challenge and scrutiny. 7. The Board operates as an effective team. 8. The Board shares corporate responsibility for all decisions taken and makes decisions based on clear evidence. 9. Board members respect confidentiality and sensitive information. 10. The Board governs, Executives manage. 11. Individual Board members contribute fully to Board deliberations and exercise a healthy challenge function. 12. The Chair is a useful source of advice and guidance for Board members on any aspect of the Board. 13. The Chair leads meetings well, with a clear focus on the issues facing the ALB, and allows full and open discussions before major decisions are taken. 14. The Board considers the concerns and needs of all stakeholders and actively manages it's relationships with them. 15. The Board is aware of and annually approves a scheme of delegation to its committees. 16. The Board is provided with timely and robust post-evaluation reviews on all major projects and programmes.

Examples of evidence that could be submitted to support the Board's RAG rating.	• Terms of Reference • Board minutes • Job descriptions • Scheme of Delegation • Induction programme

1. Board composition and commitment

1.4 Committees of the Board

Red Flag	Good Practice
1. The Board notes the minutes of Committee meetings and reports, instead of discussing same. 2. Committee members do not receive performance management appraisals in relation to their Committee role. 3. There are no terms of reference for the Committee. 4. Non Executives are unaware of their differing roles between the Board and Committee. 5. The Agenda for Committee meetings is changed without proper discussion and/or at the behest of the Executive team.	1. Clear terms of reference are drawn up for each Committee including whether it has powers to make decisions or only make recommendations to the Board. 2. Certain tasks or functions are delegated to the Committee but the Board as a whole is aware that it carries the ultimate responsibility for the actions of its Committees. 3. Schemes of delegation from the Board to the Committees are in place. 4. There are clear lines of reporting and accountability in respect of each Committee back to the Board. 5. The Board agrees, with the Committees, what assurances it requires and when, to feed its annual business cycle. 6. The Board receives regular reports from the Committees which summarises the key issues as well as decisions or recommendations made. 7. The Board undertakes a formal and rigorous annual evaluation of the performance of its Committees. 8. It is clearly documented who is responsible for reporting back to the Board.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Scheme of delegation • TOR • Board minutes • Annual Evaluation Reports

1. Board composition and commitment

1.5 Board member commitment

Red Flag	Good Practice
1. There is a record of Board and Committee meetings not being quorate. 2. There is regular non-attendance by one or more Board members at Board or Committee meetings. 3. Attendance at the Board or Committee meetings is inconsistent (i.e. the same Board members do not consistently attend meetings). 4. There is evidence of Board members not behaving consistently with the behaviours expected of them and this remaining unresolved. 5. The Board or Committee has not achieved full attendance at at least one meeting within the last 12 months.	1. Board members have a good attendance record at all formal Board and Committee meetings and at Board events. 2. The Board has discussed the time commitment required for Board (including Committee) business and Board development, and Board members have committed to set aside this time. 3. Board members have received a copy of the Department's Code of Conduct and Code of Accountability for Board Members of Health and Social Care Bodies or the Northern Ireland Fire and Rescue Service. Compliance with the code is routinely monitored by the Chair. 4. Board meetings and Committee meetings are scheduled at least 6 months in advance.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board attendance record • Induction programme • Board member annual appraisals • Board Schedule

2. Board evaluation, development and learning

2. Board evaluation, development and learning overview

This section focuses on Board evaluation, development and learning, and specifically the following areas:

1. Effective Board-level evaluation;

2. Whole Board Development Programme;

3. Board induction, succession and contingency planning;

4. Board member appraisal and personal development.

2. Board evaluation, development and learning

2.1 Effective Board level evaluation

<table>
<tr><th>Red Flag</th><th>Good Practice</th></tr>
<tr><td>
1. No formal Board Governance Self-Assessment has been undertaken within the last 12 months.
2. The Board Governance Self-Assessment has not been independently evaluated within the last 3 years.
3. Where the Board has undertaken a self assessment, only the perspectives of Board members were considered and not those outside the Board (e.g. staff, etc).
4. Where the Board has undertaken a self assessment, only one evaluation method was used (e.g. only a survey of Board members was undertaken).
</td><td>
1. A formal Board Governance Self-Assessment has been conducted within the previous 12 months.
2. The Board can clearly identify a number of changes/ improvements in Board and Committee effectiveness as a result of the formal self assessments that have been undertaken.
3. The Board has had an independent evaluation of its effectiveness and the effectiveness of its committees within the last 3 years by a 3rd party that has a good track record in undertaking Board effectiveness evaluations.
4. In undertaking its self assessment, the Board has used an approach that includes various evaluation methods. In particular, the Board has considered the perspective of a representative sample of staff and key external stakeholders (e.g. commissioners, service users and clients) on whether or not they perceive the Board to be effective.
5. The focus of the self assessment included traditional ‘hard’ (e.g. Board information, governance structure) and ‘soft’ dimensions of effectiveness. In the case of the latter, the evaluation considered as a minimum:
• The knowledge, experience and skills required to effectively govern the organisation and whether or not the Board’s membership currently has this;
• How effectively meetings of the Board are chaired;
• The effectiveness of challenge provided by Board members;
• Role clarity between the Chair and CE, Executive Directors and NEDs, between the Board and management and between the Board and its various committees;
• Whether the Board’s agenda is appropriately balanced between: strategy and current performance; finance and quality; making decisions and noting/ receiving information; matters internal to the organisation and external considerations; and business conducted at public board meetings and that done in confidential session.
• The quality of relationships between Board members, including the Chair and CE. In particular, whether or not any one Board member has a tendency to dominate Board discussions and the level of mutual trust and respect between members.
</td></tr>
</table>

Examples of evidence that could be submitted to support the Board's RAG rating.	- Report on the outcomes of the most recent Board evaluation and examples of changes/ improvements made in the Board and Committees as a result of an evaluation - The Board Scheme of Delegation/ Reservation of Powers

2. Board evaluation, development and learning

2.2 Whole Board development programme

<table>
<tr><th>Red Flag</th><th>Good Practice</th></tr>
<tr><td>1. The Board does not currently have a Board development programme in place for both Executive and Non-Executive Board Members.
2. The Board Development Programme is not aligned to helping the Board comply with the requirements of the Management Statement and/or fulfil its statutory responsibilities.</td><td>1. The Board has a programme of development in place. The programme seeks to directly address the findings of the Board's annual self assessment and contains the following elements: understanding the relationship between the Minister, the Department and their organisation, e.g. as documented in the Management Statement; development specific to the business of their organisation; and reflecting on the effectiveness of the Board and its supporting governance arrangements.
2. Understanding the relationship between the Minister, Department and the ALB - Board members have an appreciation of the role of the Board and NEDs, and of the Department's expectations in relation to those roles and responsibilities.
3. Development specific to the ALB's governance arrangements – the Board is or has been engaged in the development of action plans to address governance issues arising from previous self-assessments/independent evaluations, Internal Audit reports, serious adverse incident reports and other significant control issues.
4. Reflecting on the effectiveness of the Board and its supporting governance arrangements -The development programme includes time for the Board as a whole to reflect upon, and where necessary improve:
• The focus and balance of Board time;
• The quality and value of the Board's contribution and added value to the delivery of the business of the ALB;
• How the Board responded to any service, financial or governance failures;
• Whether the Board's subcommittees are operating effectively and providing sufficient assurances to the Board;
• The robustness of the ALB's risk management processes;
• The reliability, validity and comprehensiveness of information received by the Board.
5. Time is 'protected' for undertaking this programme and it is well attended.
6. The Board has considered, at a high-level, the potential development needs of the Board to meet future challenges.</td></tr>
<tr><td>Examples of evidence that could be submitted to support the Board's RAG rating.</td><td>• The Board Development Programme
• Attendance record at the Board Development Programme</td></tr>
</table>

2. Board evaluation, development and learning

2.3 Board induction, succession and contingency planning

Red Flag	Good Practice
1. Board members have not attended the "On Board" training course within 3 months of appointment. 2. There are no documented arrangements for chairing Board and committee meetings if the Chair is unavailable. 3. There are no documented arrangements for the organisation to be represented at a senior level at Board meetings if the CE is unavailable. 4. NED appointment terms are not sufficiently staggered.	1. All members of the Board, both Executive and Non-Executive, are appropriately inducted into their role as a Board member. Induction is tailored to the individual Director and includes access to external training courses where appropriate. As a minimum, it includes an introduction to the role of the Board, the role expectations of NEDs and Executive Directors, the statutory duties of Board members and the business of the ALB. 2. Induction for Board members is conducted on a timely basis. 3. Where Board members are new to the organisation, they have received a comprehensive corporate induction which includes an overview of the services provided by the ALB, the organisation's structure, ALB values and meetings with key leaders. 4. Deputising arrangements for the Chair and CE have been formally documented. 5. The Board has considered the skills it requires to govern the organisation effectively in the future and the implications of key Board-level leaders leaving the organisation. Accordingly, there are demonstrable succession plans in place for all key Board positions.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Succession plans • Induction programmes • Standing Order

2. Board evaluation, development and learning

2.4 Board member appraisal and personal development

Red Flag	Good Practice
1. There is not a robust performance appraisal process in place at Board level that includes consideration of the perspectives of other Board members on the quality of an individual's contribution (i.e. contributions of every member of the Board (including Executive Directors) on an annual basis and documents the process of formal feedback being given and received. 2. Individual Board members have not received any formal training or professional development relating to their Board role. 3. Appraisals are perceived to be a 'tick box' exercise. 4. The Chair does not consider the differing roles of Board members and Committee members.	1. The effectiveness of each Non-Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis by the Chair 2. The effectiveness of each Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis in accordance with the appraisal process prescribed by their organisation. 3. There is a comprehensive appraisal process in place to evaluate the effectiveness of the Chair of the Board that is led by the relevant Deputy Secretary (and countersigned by the Permanent Secretary). 4. Each Board member (including each Executive Director) has objectives specific to their Board role that are reviewed on an annual basis. 5. Each Board member has a Personal Development Plan that is directly relevant to the successful delivery of their Board role. 6. As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level. 7. Where appropriate, Board members comply with the requirements of their respective professional bodies in relation to continuing professional development and/or certification.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Performance appraisal process used by the Board • Personal Development Plans • Board member objectives • Evidence of attendance at training events and conferences • Board minutes that evidence Executive Directors contributing outside their functional role and challenging other Executive Directors.

3. Board insight and foresight

3. Board insight and foresight overview

This section focuses on Board information, and specifically the following areas:

1.Board Performance Reporting

2.Efficiency and productivity

3.Environmental and strategic focus

4.Quality of Board papers and timeliness of information

3. Board insight and foresight

3.1 Board performance reporting

<table>
<tr><th>Red Flag</th><th>Good Practice</th></tr>
<tr><td>1. Significant unplanned variances in performance have occurred.

2. Performance failures were brought to the Board’s attention by an external party and/or not in a timely manner.

3. Finance and Quality reports are considered in isolation from one another.

4. The Board does not have an action log.

5. Key risks are not reported/escalated up to the Board.</td><td>1. The Board has debated and agreed a set of quality and financial performance indicators that are relevant to the Board given the context within which it is operating and what it is trying to achieve. Indicators should relate to priorities, objectives, targets and requirements set by the Dept.

2. The Board receives a performance report which is readily understandable for all members and includes:
• performance of the ALB against a range of performance measures including quality, performance, activity and finance and enables links to be made;
• Variances from plan are clearly highlighted and explained ;
• Key trends and findings are outlined and commented on ;
• Future performance is projected and associated risks and mitigating measures;
• Key quality information is triangulated (e.g. complaints, standards, Dept targets, serious adverse incidents, limited audit assurance) so that Board members can accurately describe where problematic services lines are ;Benchmarking of performance to comparable organisations is included where possible.

3. The Board receives a brief verbal update on key issues arising from each Committee meeting from the relevant Chair. This is supported by a written summary of key items discussed by the Committee and decisions made.

4. The Board regularly discusses the key risks facing the ALB and the plans in place to manage or mitigate them.

5. An action log is taken at Board meetings. Accountable individuals and challenging/demanding timelines are assigned. Progress against actions is actively monitored. Slips in timelines are clearly identifiable through the action log and individuals are held to account.</td></tr>
<tr><td>Examples of evidence that could be submitted to support the Board’s RAG rating.</td><td>• Board Performance Report
• Board Action Log
• Example Board agendas and minutes highlighting committee discussions by the Board.</td></tr>
</table>

3. Board insight and foresight

3.2 Efficiency and Productivity

Red Flag	Good Practice
1. The Board does not receive performance information relating to progress against efficiency and productivity plans. 2. There is no process currently in place to prospectively assess the risk(s) to quality of services presented by efficiency and productivity plans. 3. Efficiency plans are based on a percentage reduction across all services rather than a properly targeted assessment of need. 4. The Board does not have a Board Assurance Framework (BAF).	1. The Board is assured that there is a robust process for prospectively assessing the risk(s) to quality of services and the potential knock-on impact on the wider health and social care community of implementing efficiency and productivity plans. 2. The Board can provide examples of efficiency and productivity plans that have been rejected or significantly modified due to their potential impact on quality of service. 3. The Board receives information on all efficiency and productivity plans on a regular basis**.** Schemes are allocated to Directors and are RAG rated to highlight where performance is not in line with plan. The risk(s) to non-achievement is clearly stated and contingency measures are articulated. 4. There is a process in place to monitor the ongoing risks to service delivery for each plan, including a programme of formal post implementation reviews.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Efficiency and Productivity plans • Reports to the Board on the plans • Post implementation reviews

3. Board insight and foresight

3.3 Environmental and strategic focus

Red Flag	Good Practice
1. The Board does not have a clear understanding of Executive/Departmental priorities and its statutory responsibilities, business plan etc. 2. The Board's annual programme of work does not set aside time for the Board to consider environmental and strategic risks to the ALB. 3. The Board does not formally review progress towards delivering its strategies.	1. The Chief Executive presents a report to every Board meeting detailing important changes or issues in the external environment (e.g. policy changes, quality and financial risks). The impact on strategic direction is debated and, where relevant, updates are made to the ALB's risk registers and Board Assurance Framework (BAF). 2. The Board has reviewed lessons learned from SAIs, reports on discharge of statutory responsibilities, negative reports from independent regulators etc and has considered the impact upon them. Actions arising from this exercise are captured and progress is followed up. 3. The Board has conducted or updated an analysis of the ALB's performance within the last year to inform the development of the Business Plan. 4. The Board has agreed a set of corporate objectives and associated milestones that enable the Board to monitor progress against implementing its vision and strategy for the ALB. Performance against these corporate objectives and milestones are reported to the board on a quarterly basis. 5. The Board's annual programme of work sets aside time for the Board to consider environmental and strategic risks to the ALB. Strategic risks to the ALB are actively monitored through the Board Assurance Framework (BAF).
Examples of evidence that could be submitted to support the Board's RAG rating.	• CE report • Evidence of the Board reviewing lessons learnt in relation to enquiries • Outcomes of an external stakeholder mapping exercise • Corporate objectives and associated milestones and how these are monitored • Board Annual programme of work • BAF • Risk register

3. Board insight and foresight

3.4 Quality of Board papers and timeliness of information

Red Flag	Good Practice
1. Board members do not have the opportunity to read papers e.g. reports are regularly tabled on the day of the Board meeting and members do not have the opportunity to review or read prior to the meeting. The volume of papers is impractical for proper reviewing. 2. Board discussions are focused on understanding the Board papers as opposed to making decisions. 3. The Board does not routinely receive assurances in relation to Data Quality or where reports are received, they have highlighted material concerns in the quality of data reporting. 4. Information presented to the Board lacks clarity, or relevance; is inaccurate or untimely; or is presented without a clear purpose, e.g. is it for noting, discussion or decision. 5. The Board does not discuss or challenge the quality of the information presented or, scrutiny and challenge is only applied to certain types of information of which the Board have knowledge and/or experience, e.g. financial information	1. The Board can demonstrate that it has actively considered the timing of the Board and Committee meetings and presentation of Board and Committee papers in relation to month and year end procedures and key dates to ensure that information presented is as up-to-date as possible and that the Board is reviewing information and making decisions at the right time. 2. A timetable for sending out papers to members is in place and adhered to. 3. Each paper clearly states what the Board is being asked to do (e.g. noting, approving, decision, and discussion). 4. Board members have access to reports to demonstrate performance against key objectives and there is a defined procedure for bringing significant issues to the Board's attention outside of formal meetings. 5. Board papers outline the decisions or proposals that Executive Directors have made or propose. This is supported; where appropriate, by: an appraisal of the relevant alternative options; the rationale for choosing the preferred option; and a clear outline of the process undertaken to arrive at the preferred option, including the degree of scrutiny that the paper has been through. 6. The Board is routinely provided with data quality updates. These updates include external assurance reports that data quality is being upheld in practice and are underpinned by a programme of clinical and/or internal audit to test the controls that are in place. 7. The Board can provide examples of where it has explored the underlying data quality of performance measures. This ensures that the data used to rate performance is of sufficient quality. 8. The Board has defined the information it requires to enable effective oversight and control of the organisation, and the standards to which that information should be collected and quality assured. 9. Board members can demonstrate that they understand the information presented to them,

	including how that information was collected and quality assured, and any limitations that this may impose. 10. Any documentation being presented complies with Departmental guidance, where appropriate e.g. business cases, implementation plans.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Documented information requirements • Data quality assurance process • Evidence of challenge e.g. from Board minutes • Board meeting timetable • Process for submitting and issuing Board papers • In-month reports • Board papers • Data Quality updates

3. Board insight and foresight

3.5 Assurance and risk management

Red Flag	Good Practice
1. The Board does not receive assurance on the management of risks facing the ALB. 2. The Board has not identified its assurance requirements, or receives assurance from a limited number of sources. 3. Assurance provided to the Board is not balanced across the portfolio of risk, with a predominant focus on financial risk or areas that have historically been problematic. 4. The Board has not reviewed the ALB's governance arrangements regularly.	1. The Board has developed and implemented a process for identification, assessment and management of the risks facing the ALB. This should include a description of the level of risk that the Board expects to be managed at each level of the ALB and also procedures for escalating risks to the Board. 2. The Board has identified the assurance information they require, including assurance on the management of key risks, and how this information will be quality assured. 3. The Board has identified and makes use of the full range of available sources of assurance, e.g. Internal/External Audit, RQIA, etc 4. The Board has a process for regularly reviewing the governance arrangements and practices against established Departmental or other standards e.g. the Good Governance Standard for Public Services. 5. The Board has developed and implemented a Clinical and Social Care Risk assessment and management policy across the ALB, where appropriate. 6. An executive member of the Board has been delegated responsibility for all actions relating to professional regulation and revalidation of all applicable staff.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Risk management policy and procedures • Risk register • Evidence of review of risks, e.g. Board minutes • Evidence of review of governance structures, e.g. Board minutes • Board Assurance Framework (BAF) • Clinical and Social care governance policy

4. Board engagement and involvement

4. Board engagement and involvement overview

This section focuses on Board engagement and involvement, and specifically the following areas:

1.External Stakeholders

2.Internal Stakeholders

3.Board profile and visibility

4. Board engagement and involvement

4.1 External stakeholders

The statutory duty of involvement and consultation commits ALBs to developing PPI consultation schemes. These schemes detail how the ALB will consult and involve service users in the planning and delivery of services. The statutory duty of involvement and consultation does not apply to, NISCC, NIPEC, BSO and NIFRS. However, the Department would encourage all ALBs to put appropriate and proportionate measures in place to ensure that their service delivery arrangements are informed by views of those who use their services.

Under Section 75 (NI Act 1998) all ALBs have existing obligations and commitments to consult with the public, service users and carers in the planning, delivery and monitoring of services. Under Section 49a of the Disability Discrimination Act NI (1995) ALBs have a duty to promote the involvement of disabled people in public life.

Red Flag	Good Practice
1. The development of the Business Plan has only involved the Board and a limited number of ALB staff. 2. The ALB has poor relationships with external stakeholders, with examples including clients, client organisations etc. 3. Feedback from clients is negative e.g. complaints, surveys and findings from regulatory and review reports. 4. The ALB has failed to manage adverse negative publicity effectively in relation to the services it provides in the last 12 months. 5. The Board has not overseen a system for receiving, acting on and reporting	1. Where relevant, the Board has an approved PPI consultation scheme which formally outlines and embeds their commitment to the involvement of service users and their carers in the planning and delivery of services. 2. A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of service users, commissioners and the wider public, including 'hard to reach' groups like non-English speakers and service users with a learning disability. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice. 3. The Board can evidence how key external stakeholders (e.g. service users, commissioners and MLAs) have been engaged in the development of their business plans for the ALB and provide examples of where their views have been included and not included in the Business Plan. 4. The Board has ensured that various communication methods have been deployed to ensure that key external stakeholders understand the key messages within the Business Plan.

outcomes of complaints.	5. The Board promotes the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that they provide 6. The ALB has constructive and effective relationships with its key stakeholders.
Examples of evidence that could be submitted to support the Board's RAG rating.	• PPI Consultation Scheme • Complaints • Customer Survey • Regulatory and Review reports

4. Board engagement and involvement

4.2 Internal stakeholders

Red Flag	Good Practice
1. The ALBs latest staff survey results are poor. 2. There are unresolved staff issues that are significant (e.g. the Board or individual Board members have received 'votes of no confidence', the ALB does not have productive relationships with staff side/trade unions etc.). 3. There are significant unresolved quality issues. 4. There is a high turn over of staff. 5. Best practise is not shared within the ALB.	1. A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of staff, including 'hard to reach' groups like night staff and weekend workers. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice. 2. The Board can evidence how staff have been engaged in the development of their Corporate & Business Plans and provide examples of where their views have been included and not included. 3. The Board ensures that staff understand the ALB's key priorities and how they contribute as individual staff members to delivering these priorities. 4. The ALB uses various ways to celebrate services that have an excellent reputation and acknowledge staff that have made an outstanding contribution to service delivery and the running of the ALB. 5. The Board has communicated a clear set of values/behaviours and how staff that do not behave consistent with these valves will be managed. Examples can be provided of how management have responded to staff that have not behaved consistent with the ALB's stated values/behaviours. 6. There are processes in place to ensure that staff are informed about major risks that might impact on customers, staff and the ALB's reputation and understand their personal responsibilities in relation to minimising and managing these key risks.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Staff Survey • Grievance and disciplinary procedures • Whistle blowing procedures • Code of conduct for staff • Internal engagement or communications strategy/ plan.

4. Board engagement and involvement

4.3 Board profile and visibility

Red Flag	Good Practice
1. With the exception of Board meetings held in public, there are no formal processes in place to raise the profile and visibility of the Board. 2. Attendance by Board members is poor at events/meetings that enable the Board to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions).	1. There is a structured programme of events/meetings that enable NEDs to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions) that is well attended by Board members and has led to improvements being made. 2. There is a structured programme of meetings and events that increase the profile of key Board members, in particular, the Chair and the CE, amongst external stakeholders. 3. Board members attend and/or present at high profile events. 4. NEDs routinely meet stakeholders and service users. 5. The Board ensures that its decision-making is transparent. There are processes in place that enable stakeholders to easily find out how and why key decisions have been made by the Board without reverting to freedom of information requests. 6. As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board programme of events/ quality walkabouts with evidence of improvements made • Active participation at high-profile events • Evidence that Board minutes are publicly available and summary reports are provided from private Board meetings

5. Board Governance Self- Assessment Submission

Name of ALB – Public Health Agency

Date of Board Meeting at which Submission was discussed – 16 August 2018

Approved by Andrew Dougal (ALB Chair)

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2018

1.1 Board positions and size

	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Amber	The PHA Board is undergoing some transition. One NED is finishing on 31 March 2018 and another on 6 April 2018. However, the Permanent Secretary has granted approval for the appointment of three new Non-Executive Directors and they will take up post during April 2018. This will mean that all positions will be filled.	The non-executive directors have been undertaking an extensive program of induction. They are most anxious to understand the business and the programs for which the agency is responsible. All non-executive directors are anxious to play a key role in influencing the strategy, policies and outcomes of the work of the agency.		
GP2 Green	The Board is content that it is provided with the appropriate guidance, support and advice to effectively discharge its responsibilities. This is done through its present membership and if required, others have been invited to attend to ensure informed decisions.			
GP3 Green	The process for voting, and who the voting members are is outlined in Standing Order			

	5.2.17. Members are aware of their responsibilities in this area from induction and through guidance from the chair.			
GP4 Green	The composition of the Board is set out in the Standing Orders and accords with the establishing legislation. The responsibility for appointing non-executive board members lies with the Public Appointments Unit for approval by the Minister, therefore ensuring that the composition is in accordance with legislation is outside the remit of PHA. Executive Board Members are in line with DoH requirements. Membership of Board and committees complies with the terms of reference set out in the PHA Standing orders.			
GP5 Green	The non-executives on the Board have variation in terms of appointment. This can be evidenced in the letters of appointment, updated in relation to their second term. Terms of appointment are determined by the Minister.	The process of appointments from requisition to interviews can take 12 months. It is therefore appropriate that the process begins 15 months before the date of any vacancy.		

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2018

1.2 Balance and calibre of Board members

	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The current balance of skills, knowledge and experience amongst Board members is appropriate to effectively govern the PHA. A member with financial experience was appointed to the Board from 1 July 2015. With the addition of three new members the board has a legal background and to all those members, senior level human resources experience in one member and trade union and legal practice in the trade union member. One member has extensive experience in clinical psychology.			
GP2 Green	The PHA board members have backgrounds from the public, private and voluntary sectors as well as local councillors. (biographical information on Board members in Annual Report). Members terms of appointment and renewal dates are staggered.			

GP3 Green	Non Executive Board members are appointed through the PAU, who have responsibility for complying with Section 75. Executive Board members are appointed through the HSC recruitment and selection processes which are compliant with Section 75. The Board understands its responsibility in relation to Section 75 and regularly meets with Equality staff to ensure compliance of its statutory obligations and good practice. Members of the board are most anxious that they have a greater grasp of the work on section 75 and on the effectiveness And the efficiency of the equality proofing work.			
GP4 Green	Several non executive directors have a background related to health care/ health improvement. Non-executive backgrounds also include governace and financial management. (biographical information on Board members in Annual Report)			
GP5 Green	As per legislation, the board is constituted from local government and lay members. The Board includes people with relevant technical and professional expertise.			

GP6 Green	There is a balance between Executive and non-Executive members which ensures an excellent mix of skills and knowledge etc			
GP7 Green	Board members (both executive/non-executive) have served on boards for a number of years, some at the level of Chair. (biographical information on Board members in Annual Report)			
GP8 Green	The Chair has 32 years' experience of working in a large voluntary organisation in the health sector at Chief Executive level.			
GP9 Green	The Chair has 10 years' non-executive experience in the private sector and other voluntary organisations e.g. UK Health Forum.			
GP10 Green	There is a member appointed to the Board with financial experience.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		

RF3		
RF4		
RF5		
RF6		

1. Board composition and commitment   ALB Name - Public Health Agency   Date – 31 March 2018

1.3 Role of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The role and responsibility of the board is outlined within Standing Orders. Members will have a copy of Standing Orders as part of their induction. Standing Orders are reviewed annually with the last update approved at the Board meeting of March 2018.			
GP2 Green	Ministerial policies and expectations are communicated to members, through Board meetings, workshops and the issue of papers. This is also included in the business planning and strategy processes which include full Board involvement. The closure of HSCB and the future of PHA will be of greater focus to PHA Board members during 2018/19, given that PHA may take on new functions e.g. social care.			

GP3 Green	There is a clear understanding of the role of Executive Officers and non-executive Board members as this is outlined in job descriptions and the scheme of delegation within Standing Orders.	Non-executive directors will be supplied with copies of the job descriptions of all four executive directors and the job Descriptions of other directors who attend the agency board meetings.		
GP4 Green	The Board recognises fully its collective responsibility in relation to the performance of the PHA. This is outlined in Standing Orders, Management Statement / Financial Memorandum and in the induction process.			
GP5 Green	NEDs are totally independent of management but work with Executive Directors when required.			
GP6 Green	The previous Chairs have had a positive relationship with the Minister and sponsor department. The current Chair has not yet had the opportunity to meet with the Minister since his appointment but is anxious to do so. However, given the current political situation, this is not possible at present.			
GP7 Green	At Board and Committee meetings, NEDs regularly and constructively challenge members on the papers and verbal updates given. This can			

	be seen in the minutes of the meetings.			
GP8 Green	The PHA Board works as an effective team. Work is currently being undertaken to improve even further the effective functioning of the board.			
GP9 Green	The PHA board shares corporate responsibility for decisions taken and makes its decisions based on best evidence available.			
GP10 Green	Board members are aware of which papers are brought to public sessions and which are brought to confidential sessions and the need to respect confidentiality and sensitive information.			
GP11 Green	Yes, Executive Directors have responsibility for operational management of the PHA, while the PHA board governs as set out in the PHA Standing Orders.			
GP12 Green	The Board members contribute openly and fully to deliberations and exercise a healthy challenge function.			
GP13 Green	The Chair acts as first port of call for any advice, help or			

	support. If he is not able to provide the help himself, he will refer members on as appropriate.			
GP14 Green	The Chair maintains a clear focus on the important issues facing the Board and facilitates the Board discussions so that all members are heard, engaged and actively involved in debate and constructive challenge prior to making a Board decision.			
GP15 Green	The PHA considers the needs of all its stakeholders and fully participates in partnership and public involvement to ensure excellent relationships.			
GP16 Green	The PHA Board clearly understands the scheme of delegation; it is brought to the Governance and Audit Committee and Board for review and approval annually			
GP17 Green	The Board receives timely and robust post-evaluation documentation, when appropriate, in relation to major projects.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		

RF2		
RF3		
RF4		
RF5		
RF6		

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2018

1.4 Committees of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	Terms of reference for board Committees are clear and specified in Standing Orders. They are systematically reviewed.	There is a need to clarify the functions of the Remuneration Committee. The chair has written to the Department of health requesting that it clarifies some of the functions of this committee and that it might be permitted to have a more extensive role in human resources policies and organisation development.		
GP2 Green	Tasks, functions and responsibilities are delegated to appropriate committees as per Standing Orders, but the members of Board in totality recognise that they carry the ultimate responsibility for the actions of Committees. The Chair often reminds members of their liabilities as Directors.			
GP3 Green	The scheme of delegation is outlined in Standing Orders.			
GP4 Green	There are clear lines of reporting and accountability in respect of each Committee with			

	the Board receiving full minutes and a verbal update.			
GP5 Green	There is an Assurance Framework in place that covers the Board, and its Committees, and this is reviewed and approved by the Governance and Audit Committee and also the board.			
GP6 Green	The Committee Chair provides a verbal update to the board at the meeting following the Committee meeting. This can be seen in the board minutes. Minutes of the committee meetings are brought to the next board meeting after their approval. PHA will attempt to synchronise Committees so that they give more timely updates to the PHA Board.			
GP7 Green	The Governance and Audit Committee has undertaken the Audit Committee Self-Assessment for a number of years taking action to address gaps. An annual GAC Report is included in the Annual Report.			
GP8 Green	The terms of reference for the Governance and Audit Committee and Remuneration			

	Committee highlight who is responsible for reporting to Board. The terms of reference are included within Standing Orders.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2018

1.5 Board member commitment

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	An attendance record is maintained by the Secretariat. Attendance is generally very good for board and committee meetings. The Chair has discussed with members need for improvement in attendance on a number of occasions.	The chair has asked that attendance at all meetings and workshops is recorded.		
GP2 Green	Members' commitment is 5 days per month which is broken down as 1 day for board meeting, 1 day for committee meetings and general background reading, 1 day for workshops, 1 day for reading papers and 1 day available for any other ad hoc events and launches			
GP3 Green	Board members have all received a copy of the DHSSPS Code of Conduct and Code of Accountability. Compliance is included in the Chair's annual appraisal of			

	NEDs.			
GP4 Green	An annual schedule of meetings is prepared and agreed with members in relation to Board meetings, workshops and strategic days. Schedules are also in place for Governance and Audit and Remuneration Committees and other specific meetings.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		

2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2018

2.1 Effective Board level evaluation

	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The PHA Board completed its annual self-assessment in 2016/17.	The PHA Board will continue to undertake the DHSSPS ALB Board self-assessment annually.		
GP2 Green	The PHA Board continues to review itself to ensure improvement and development. To assist with Board effectiveness members were each issued with a copy of the recent Northern Ireland Audit Office publication, "Board Effectiveness: A Good Practice Guide" (Nov 2016).	The PHA Board will continue to use the self-assessment and other tools as a basis for identifying further improvements / changes.		
GP3 Green	The PHA Board undertook a Board effectiveness programme in early 2017. This was undertaken by On Board training.	An action plan was developed as a result of the Board effectiveness programme and this will be monitored during 2018/19.		
GP4 Red	The PHA Board had several sessions, either individually or collectively with David Nicholl from On Board Training, who provided constructive challenge	The PHA Board will consider undertaking a survey as part of an assessment of its performance.		

	to members. However, no staff perspective was considered as part of the completion of the self-assessment.			
GP5 Green	The current self-assessment has covered those questions/areas included in the DHSSPS checklist, both 'hard' and 'soft' dimensions of effectiveness. As part of the Board effectivess programme carried out by On Board Training, Non-Executive and Executive members had the opportunity to give their views on each of the areas included in the NIAO Report through a bespoke questionnaire. Members had the opportunity to discuss this individually and as part of a group.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3	The Board will undertake a survey of those outside the Board as part of its self-assessment in 2018/19.	
RF4		

2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2018

2.2 Whole Board development programme

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Amber	As a follow up to the review of Board effectiveness Board members will consider an overall Board development plan. An Action Plan was drawn up which will be monitored during 2018/19.	The Board Development Plan will be developed and monitored during 2018/19.		
GP2 Green	The relationship between the Minister, Department and ALB board members is included in the Management Statement, which is brought to a board meeting annually. The Management Statement and Financial Memorandum was updated by the Department of Health in 2016, with the updated version signed by the Interim Chief Executive.	The board looks forward to the outcomes of the innovation lab on the role of ALBs.		
GP3 Green	Reports on action plans to address governance issues arising from internal audit reports or other significant			

	control issues are reported to the GAC. GAC minutes are brought to the PHA board, and the Chair of the GAC also provides a verbal update to board members. The GAC also prepares an Annual Report.			
GP4 Amber	This will be covered as part of the Board Development Programme referenced at GP1 above.			
GP5 Amber	This will be covered as part of the Board Development Programme referenced at GP1 above.			
GP6 Amber	This will be covered as part of the Board Development Programme referenced at GP1 above.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		

2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2018

2.3 Board induction, succession and contingency planning

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	All Board members have had induction which includes attendance at the On Board training course. Specific induction is also provided for new members of the Governance and Audit Committee.	The chair and another non-executive director will take a refresher course on governance and audit on the 14th of September 2018.		
GP2 Green	Induction is undertaken as soon as possible after appointment.			
GP3 Amber	At the induction, new members will receive a pack of relevant corporate and strategic documentation. As part of the Board effectiveness review, it was suggested that non-Executive should receive a “refresher” on the role of the PHA and the responsibilities of Directors.	Induction will be reviewed as part of the action plan emanating from the Board effectiveness review.		

GP4 Amber	Deputising arrangements are specified within Standing Orders. An Interim Deputy Chief Executive has been appointed, but the role of Deputy Chair is currently vacant as the previous Deputy has resigned from the Board.	This will be reviewed in 2018/19.		
GP5 Green	Appropriate action has been taken by the PHA. The Chair will liaise with PAU to ensure that any future vacancies do not impact on the governance of the PHA.	In the context of changes within the HSC, a sub-Committee will look at succession planning.		

Red Flags	**Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag**	**Notes/Comments**
RF1		
RF2		
RF3		
RF4		

2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2018

2.4 Board member appraisal and personal development

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	Annual appraisals are carried out by the Chair in line with the requirements of the PAU. The new Chair has initiated a series of more regular 1:1 meetings with members.	A number of meetings of the non-executive directors has taken place in recent months in order to advance board effectiveness.		
GP2 Green	The Chief Executive carries out appraisals with Executive Directors. The performance of the Chief Executive and Executive Directors is discussed at the Remuneration Committee.			
GP3 Green	The Chair receives an appraisal from a Deputy Secretary and this is signed off by the Permanent Secretary			
GP4 Amber	As part of the appraisal system, this is clearly discussed and specified to ensure continuous development. Not all will have been given specific responsibilities, this will			

	be reviewed by the Chair.			
GP5 Green	Board members appraisals allow members to highlight development needs.	It is proposed by the Chair that 1:1 meetings shall be held at least annually with members to ensure communication and any issues can be openly discussed.		
GP6 Green	This is covered through the appraisal system and PDPs, as well as through Director/Chief Executive away days. Relevant training/awareness is also built in where particular needs arise during the year.			
GP7 Green	Where appropriate, this is the case.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		

3. Board insight and foresight

ALB Name - Public Health Agency Date – 31 March 2018

3.1 Board performance reporting

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The Board receives regular financial and performance monitoring reports, the layout of which has been shaped by the business needs of the Board and for ease of use by NEDs. This sets out • performance against a range of performance measures including quality, performance, activity and finance and enables links to be made; • Variances from plan are clearly highlighted, explained and mitigating actions identified • Issues regarding future performance are highlighted The PHA Corporate Strategy, Annual Business Plan including commissioning direction targets (evidence, board papers & internal audit report) set the parameters for performance reporting.			

GP2 Green	The board receives a quarterly performance report outlining progress against objectives in the Business Plan. It also receives monthly financial report and updates on Commissioning Directions.			
GP3 Green	The Committee Chairs provide updates to the Board following each Committee meetings as specified in Standing Orders. The approved minutes of each Committee are brought to the Board for noting.	The Committees will be reviewed as part of the review of Board effectiveness.		
GP4 Green	The Corporate Risk Register is openly discussed and challenges on same are made at the Governance and Audit Committee. The Corporate Risk Register is brought to the Board annually, or more frequently at the request of the Governance and Audit Committee. The Board is reviewing how corporate risks outside the control of PHA might better be managed. Long standing risks are regularly reviewed to ensure they remain within PHA's risk appetite.			
GP5 Green	Actions are recorded in the minutes of board meetings against named officers and			

	updates reported on at the following meeting.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		

3. Board insight and foresight

ALB Name - Public Health Agency Date – 31 March 2018

3.2 Efficiency and Productivity

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The Board is assured that there are robust processes for assessing risks and the potential knock on or impact these could have on the health and social care family.			
GP2	Not applicable			
GP3	Not applicable			
GP4	Not applicable			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		

3. Board insight and foresight

ALB Name - Public Health Agency Date – 31 March 2018

3.3 Environmental and strategic focus

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The Chief Executive presents a report at every Board meeting. This, if required, will cover areas such as the external environment, policy changes and any other areas as required.			
GP2 Green	The board considers the impact of any actions arising from findings as well as the learning outcomes to ensure continuous organisational improvement.			
GP3 Green	The Board actively contributes to the development of the Business Plan through its workshop and strategic days. When all parties / stakeholders etc. have been consulted with, it is brought to the Board for formal approval.			
GP4 Green	As GP3 above, and reports are brought to the board on a quarterly basis as outlined in section 3.1 (GP2). There is			

	also an Assurance Framework which outlines what reports are required to be brought to the board and a corporate calendar outlining when these will be brought to the board			
GP5 Green	The Board's annual programme of work allows for time for the board to consider environmental and strategic risks, (including confidential board meetings, board workshops and board away day). Where relevant the Assurance Framework will be amended to include additional reporting, and/or amendments brought back through Executive Directors for the Risk Register. The Chair emphasised the importance of the external environment as a key influence in the development of the Corporate Plan.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		

3. Board insight and foresight ALB Name - Public Health Agency Date – 31 March 2018

3.4 Quality of Board papers and timeliness of information

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	A plan of Board and Committee meetings is set annually to ensure diary management, for example Board meetings are normally scheduled for the third Thursday of each month. Deadlines such as Annual Reports and Accounts and Governance Statements are also taken account of to ensure completion in a timely manner. The Chair also meets with the Chief Executive and Secretariat two weeks before meetings to discus the agenda and any other current issues.			
GP2 Green	Board and Committee papers are issued at least one week in advance of the meeting to ensure adequate time for reading etc. It is hoped that during 2018/19 the Board will go fully			

	“paperless” as i-pads have been procured and given out to members.			
GP3 Green	Board papers have a cover sheet which clearly outlines what decision is required of the Board i.e. noting or approval. The format of Board cover sheets will be reviewed in the light of the Board effectiveness programme and the recent NIAO report.	There is a need for a consistent format for the design and composition of all reports to the board. There may be a need for further learning and development for authors of reports so that board members receive only that information which it needs to perform its functions effectively.Focused and disciplined reports will greatly empower non-executives in carrying out their role.		
GP4 Green	Quarterly performance reports are brought to the board. If members wish to raise a specific item at a board meeting, they can do so. The PHA has clearly defined procedures for bringing significant issues to the Board’s attention outside the formal monthly meetings.			
GP5 Green	Board papers include the relevant information in respect of proposals or decisions that have been proposed or made. They also state if they have been considered by the Executive Team, or other board committee before they are brought to the board.			

GP6 Green	The Board is presented with quality updates. The PHA has a robust mechanism for ensuring the collection and analysing of data. Board members regularly question and challenge data to ensure quality and understanding of same when both verbal and formal papers are brought to Board meetings. Also, the Governance and Audit Committee have the opportunity to challenge and question data provided. Internal and External Audit consider data quality in relevant audits.			
GP7 Green	Board minutes clearly demonstrate where members have challenged and questioned information brought in relation to performance management and the grading of same.			
GP8 Green	The Assurance Framework outlines clearly the information being brought to the Board for approval/noting etc. Board members discuss the information status at various workshops.			

GP9 Green	Board members can clearly demonstrate that they understand information presented and openly challenge the collection and presentation of same.			
GP10 Green	The PHA takes all steps to ensure that documentation presented to the Board complies with DoH guidance where appropriate.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		

3. Board insight and foresight

ALB Name - Public Health Agency Date – 31 March 2018

3.5 Assurance and risk management

	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The PHA has a clear strategy and policy and procedures in relation to risk management and emerging risks which have been approved by the GAC. These are regularly reviewed and are also supported by operational procedures. This clearly includes the level of risk, risk appetite and how risks escalate from directorate risk register to Corporate Risk Register, as well as reporting arrangements to GAC and PHA Board.	The Governance and Audit Committee has suggested that there should be a Board workshop in 2018/19 which focuses on risk management.		
GP2 Green	There is an Assurance Framework in place which outlines the key sources of assurances and how these will be reported to the board. The risk register is brought to the GAC each quarter, where it is scrutinised. It is also brought to the Board annually.			

GP3 Green	The Assurance Framework identifies a range of sources of assurance for the board, including internal and external audit.			
GP4 Green	The Board regularly reviews/updates governance arrangements and practices against DoH standards, good practice and good governance standards for public service.			
GP5 Green	Given the nature of the PHA functions it does not have a separate clinical and social care risk assessment and management. All types of risk are included in the Directorate and Corporate risk registers and are subject to systematic review.			
GP6 Green	The Director of Public Health is responsible for professional issues in respect of medical staff, and the Director of Nursing and AHP for nursing and AHP staff.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		

RF3		
RF4		

4. Board engagement and involvement ALB Name - Public Health Agency Date – 31 March 2018

4.1 External stakeholders

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The PHA has an approved PPI consultation scheme and has had service users present to the Board.	The board must consider if it is possible to include a requirement on PPI in job descriptions and in annual appraisals.PPI is a statutory requirement. In order to fulfil this it must be seen to be an integral part of every health service job.		
GP2 Green	A variety of methods are used across the PHA to engage with service users and the wider public. Board members can attend a range of activities/events/conferences of voluntary, community organisations as well as other HSC events. The Chair and Chief Executive report at monthly board meetings in respect of events etc they have attended. Executive Directors will also have direct contact with a range of external stakeholders.			

	It is the plan to consult with those users who are in “hard to reach” groups.			
GP3 Green	When the PHA developed its Corporate Plan for the period 2017/21, this involved a public consultation exercise, part of which saw two stakeholder events which offered an opportunity for stakeholders to attend and give their views on PHA’s future strategic direction.			
GP4 Green	The PHA Business Plan is available in a number of formats to ensure access to a wide range of stakeholders. The Business Plan is in a format that has been tried and tested to ensure a wide range of stakeholders understand the work of the PHA.			
GP5 Green	The PHA ensures that the learning from SAIs is disseminated and where appropriate influences the commissioning of services			
GP6 Green	PHA Board / Agency has very constructive and effective relationships with a range of key stakeholders.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		

4. Board engagement and involvement ALB Name - Public Health Agency Date – 31 March 2018

4.2 Internal stakeholders

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	The organisation culture is reviewed by the Remuneration committee bi-annually and discussed at confidential session. Follow up actions in respect of organisational culture are discussed at committee/board. Staff events are regularly held. There are also "away days" held in different directorates. There are other mechanisms for staff to input their views, e.g. through OWD or the Staff Health and Wellbeing Group. The Board receives an Annual Report from the Director of Human Resources and are updated, when appropriate, on emerging issues.			
GP2	Staff are involved in the development of corporate and directorate business plans at directorate/function level. This			

	information is then fed through to the corporate business plan.			
GP3	This is communicated through Directors to their teams, and is the basis for appraisals.			
GP4	The Board regularly thanks individuals and departments at Board meetings or other group functions, it acknowledges contributions and achievements as and when appropriate. A new weekly staff newsletter, inPHA, was launched in June 2016 and this highlights and acknowledges achievements of PHA staff.			
GP5	The PHA Board and Agency have clear values and behaviours that have been communicated to staff not only in internal meetings by management, but clearly in policies and procedures.			
GP6	Staff are informed about major risks etc through a range of channels, including emails from the Chief Executive, and through Chief Executive and Directorate briefings.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		

RF2		
RF3		

4. Board engagement and involvement ALB Name - Public Health Agency Date – 31 March 2018

4.3 Board profile and visibility

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	Board members attend a range of events and launches across the PHA. Board workshops provide the opportunity for staff to present to board members and discuss programme areas in more depth and with a wider range of staff involved than would be possible at a formal board meeting.			
GP2 Green	Board members, and in particular the Chair and Chief Executive attend a range of meetings and events with external stakeholders.			
GP3 Green	Board members regularly attend events which would include high profile events.			
GP4 Green	NEDs regularly meet stakeholders and service users through events / presentations etc.			

GP5 Green	The Board holds its meetings in public, and only has a small number of confidential sessions, with very specific, sensitive and/or urgent agendas. Board agendas and minutes are published on the PHA website.			
GP6 Green	Yes			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		

Summary Results **ALB Name - Public Health Agency** **Date – 31 March 2018**

1.Board composition and commitment		
Area	Self Assessment Rating	Additional Notes
1.1 Board positions and size	**Green**	
1.2 Balance and calibre of Board members	**Green**	
1.3 Role of the Board	**Green**	
1.4 Committees of the Board	**Green**	
1.5 Board member commitment	**Green**	

2.Board evaluation, development and learning		
Area	Self Assessment Rating	Additional Notes
2.1 Effective Board level evaluation	**Amber**	
2.2 Whole Board development programme	**Amber**	
2.3 Board induction, succession and contingency planning	**Green**	
2.4 Board member appraisal and personal development	**Green**	

3.Board insight and foresight		
Area	Self Assessment Rating	Additional Notes
3.1 Board performance reporting	**Green**	
3.2 Efficiency and Productivity	**Green**	
3.3 Environmental and strategic focus	**Green**	
3.4 Quality of Board papers and timeliness of information	**Green**	

3.5 Assurance and risk management	Green	

4. Board engagement and involvement		
Area	Self Assessment Rating	Additional Notes
4.1 External stakeholders	Green	
4.2 Internal stakeholders	Green	
4.3 Board profile and visibility	Green	

5. Board impact case studies		
Area	Self Assessment Rating	Additional Notes
5.1		
5.2		
5.3		

Areas where additional training/guidance is required		
Area	Self Assessment Rating	Additional Notes

Areas where additional assurance is required		
Area	Self Assessment Rating	Additional Notes

6. Board impact case studies

6. Board impact case studies

Overview

This section focuses on the impact that the Board is having on the ALB and considers a recent case study in one of the following areas:

1. Performance failure in the area of quality, resources (Finance, HR, Estates) or Service Delivery;

2. Organisational culture change; and

3. Organisational strategy.

6. Board impact case studies

6.1 Measuring the impact of the Board using a case study approach

This section focuses on the impact that the Board is having on the ALB, it's clients, including other organisations, patients, carers and the public. The Board is required to submit one of three brief case studies:

1. A recent case study briefly outlining how the Board has responded to a performance failure in the area of quality, resources (Finance, HR, Estates) or service delivery. In putting together the case study, the Board should describe:
    - Whether or not the issue was brought to the Board's attention in a timely manner;
    - The Board's understanding of the issue and how it came to that understanding;
    - The challenge/ scrutiny process around plans to resolve the issue;
    - The learning and improvements made to the Board's governance arrangements as a direct result of the issue, in particular how the Board is assured that the failure will not re-occur.

2. A recent case study on the Board's role in bringing about a change of culture within the ALB. This case study should clearly identify:
    - The area of focus (e.g. increasing the culture of incident reporting; encouraging innovation; raising quality standards);
    - The reasons why the Board wanted to focus on this area;
    - How the Board was assured that the plan(s) to bring about a change of culture in this area were robust and realistic;
    - Assurances received by the Board that the plan(s) were implemented and delivered the desired change in culture.

3. A recent case study that describes how the Board has positively shaped the vision and strategy of the ALB. This should include how the NEDs were involved in particular in shaping the strategy.

Note: Recent refers to any appropriate case study that has occurred within the past 18 months.

6. Board impact case studies ALB Name - Public Health Agency Date – 31 March 2018

6.1 Case Study 1

Performance issues in the area of quality, resources (finance, HR, Estates) or Service Delivery	
Brief description of issue	The PHA's budget for 2017/18 saw a £0.1m recurring retraction made to its management and administration budget. This followed reductions of £2.8m in 2015/16 and £1.6m in 2016/17. PHA's campaigns budget of £1.2m was also retracted non-recurrently. This resulted in the PHA having to develop savings plans to ensure that it was able to forecast a break even outturn for the financial year.
Outline Board's understanding of the issue and how it arrived at this	Following the receipt of the allocation letter in July 2017, a presentation briefing was made at the next Board meeting (August 2017) with opportunity for discussion. The Board had previously been advised that PHA had submitted proposals to the Department of Health for scenarios of reductions of 2, 5, 10 or 15%, but that it was expressed to the Department that there was very little scope for further reduction in PHA's core budget.
Outline the challenge/scrutiny process involved	The PHA Board was kept regularly informed on PHA's progress to achieve a break even position within the constraints with opportunity for scrutiny/challenge. The issue was also placed on PHA's Corporate Risk Register and regularly discussed at the Governance and Audit Committee.
Outline how the issue was resolved	Through close monitoring of the budget and scrutiny processes for recruitment of all vacant posts PHA was able to achieve a year-end break even position. The retraction of the campaigns budget was of particular concern to the Board. Following discussion with DoH, PHA was able to use identified in-year slippage to run a campaign that had already been prepared and required only the media buying.
Summarise the key learning points	Providing regular updates to the Board kept members informed and allowed the Board to have oversight of the issue.
Summarise the key improvements made to the governance arrangements directly as a result of above	The Board was kept regularly informed of any issues, either through the Chief Executive or the Director of Finance. This was through the regular Board Finance Reports, and additional briefings as appropriate. The issue was included on the PHA Corporate Risk Register and there was regular discussion at the Governance and Audit Committee.

6. Board impact case studies ALB Name - Public Health Agency Date – 31 March 2018

6.2 Case Study 2

Organisational Culture Change	
Brief description of area of focus	
Outline reasons/ rationale for why the Board wanted to focus on this area	
Outline how the Board was assured that the plan/ (s) in place were robust and realistic	
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	

6. Board impact case studies

ALB Name..Date.................

6.3 Case Study 3

Organisational strategy	Title:
Brief description of area of focus	
Outline reasons / rationale for why the Board wanted to focus on this area	
Outline how the Board was assured that the plan/ (s) in place were robust and realistic	
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	
Specifically explain how the NEDs were involved	

HSC Public Health Agency

board paper

PHA Procurement Plan

date 16 August 2018 **item** 12 **reference** PHA/06/08/18

presented by Mr Edmond McClean, Deputy Chief Executive

action required For noting

Summary

This paper provides an update for the PHA board on progress with implementation of the Social Care Procurement Plan during 2017/18 and highlights the priorities to be progressed in 2018/19.

In 2017/18 PHA completed the re-tendering of the Youth Engagement service and successfully managed the transfer of the Lifeline service to Belfast Trust. Progress with awarding new tenders for suicide prevention services has been impacted by the delay in the publication of the new regional Protect Life 2 strategy.

In 2018/19, PHA will continue to focus on progressing the re-tendering of contracts linked to Protect Life and Use of Place. A number of new under threshold procurements will also need to be managed urgently linked to the Confidence and Supply Transformation funding and the Early Intervention Transformation programme (on behalf of SBNI).

PHA will also need to begin planning for the re-tendering of services, where contracts are due to expire, such as Self Harm services and the Delivering Social Change contracts.

Equality Impact Assessment

Not applicable.

Recommendation

The Board is asked to **NOTE** the PHA Procurement Plan.

Update on PHA Social Care Procurement Plan

This paper provides an update for Members on implementation of the PHA Social Care Procurement Plan (SCPP) during 2017/18 and identifies the priorities to be progressed in 2018/19.

In 2017/18, a total of 264 contracts with a value of £20.2m were identified on the PHA Social Care Procurement Plan for review.

To date, the PHA has completed the procurement process on 75 contracts with an annual value of £11.5m.

190 rolling contracts with a value of circa £8.7m remain to be fully reviewed and procured, where required. 125 of these contracts (with a value of circa £5.8m) are currently being reviewed under the processes approved by PHA board for the Protect Life 2 and Use of Place procurements.

Review of 2017/18

During 2017/18, PHA focused on reviewing contracts in the following areas:

Service Area	Estimated Annual Value of Tender £(M)	Existing Contracts
Lifeline	£3.5	1
Protect Life 2 (Suicide prevention)	£2.8	70
Use of Place (includes community infrastructure / Healthy Living Centres and Horticulture and allotment programmes	£3.0	53
One Stop Shops	£0.9	8

A summary of the progress achieved is detailed below.

Lifeline

Following notification from the contract holder that they did not want to continue to deliver the Lifeline service beyond 31 March 2018, PHA initiated a process to re-tender the service on an interim basis. Following extensive engagement with the market and 2 attempts to award a new contract, no suitable providers were identified. Given the need to ensure the service continued to be delivered beyond 31 March 2018, it was agreed that Belfast Trust would take on the delivery of the service for an interim period of 18 months. Staff have subsequently been TUPE'd across to Belfast Trust and the service is now fully operational.

Protect Life 2

PHA has been progressing its plans to re-tender the services linked to the delivery of the Protect Life Strategy. A Project Initiation document was approved by PHA board and the Project Team has been established to take this work forward. Unfortunately, progressing the pre-planning work required to undertake the tender process has been restricted to date, as publication of the new protect Life 2 Strategy by DoH has been delayed. Further to approval from DoH, PHA was able to hold 12 Public Consultation meetings in March/April 2018 to discuss how the key priorities identified in the draft Strategy could best be addressed in developing new services. In total 367 stakeholders attended the sessions, representing 125 different organisations. The feedback from this consultation will form a key part of the PHA's considerations in determining how future services should be shaped.

Given the delay in the publication of the new Strategy the initial timeline of March 2019 for the re-tendering of services is no longer achievable and will need to be reviewed once there is clarification on the timelines for publication of the new regional strategy.

Use of Place

Further to approval of the Project Initiation document by PHA board, a Project Team has been established. The Team is currently taking forward the initial pre-planning work required to identify the most effective models of service to be supported and to understand the consequences on the existing services of any planned changes. Initial assessment of the services being delivered under this programme area (eg Healthy Living Centres, Community Development infrastructure) would indicate that a formal procurement process for all re-providing future services may not be the most effective process for achieving the best outcomes. For some areas of service it may be better to use a grant award approach.

Further to discussions with key stakeholders and in light of the recent document issued by TIG on the 'Expansion of Community Development Approaches' a paper setting out the proposed way forward will be developed.

Youth Engagement Services (previously called One Stop Shops)

The tender for the Youth Engagement Service was completed during 2017/18 and new contracts awarded in 7 of the 8 areas with an overall value of £0.83m. No provider was appointed to take on the service in the Derry/Londonderry area and the existing service provider will continue to provide the service until a new contract is awarded. It is anticipated that a new tender process will be completed by December 2018.

Other Developments in 2017/18

In light of the increasing focus being placed by DoH on the level of contract monitoring that should be undertaken by ALBs when managing contracts with external organisations, formal training in contract management was provided to 30 PHA staff.

During 2017/18, PHA worked closely with colleagues in HSCB, Legal and PaLS to understand how the new Regulations regarding data protection (General Data Protection Regulations), implemented from 28 May 2018, should be addressed both in relation to existing contracts and future contract awards. All existing contracts will be reviewed during 2018/19 and terms and conditions updated to reflect the GDPR requirements.

The PHA has reviewed its procurement processes to ensure that the requirements of the Rural Needs Act 2016 are adequately addressed in progressing all future procurements.

The PHA has continued to contribute to regional procurement policy development through inputting to the Regional Procurement Board, Social Care Procurement Implementation Project Board and the Procurement and Contract Network.

Procurement Priorities 2018/19

During 2018/19, PHA will continue to focus on progressing the re-tendering of contracts linked to Protect Life and Use of Place. A number of new under threshold procurements will also need to be managed urgently linked to the Confidence and Supply Transformation funding and the Early Intervention Transformation programme (on behalf of SBNI). PHA will also need to begin planning for the re-tendering of services, where contracts are due to expire, such as Self Harm that are due for renewal in October 2019 and the Delivering Social Change contracts.

Given the limited progress that has been made with reviewing the remaining roll forward contracts over the past 2 years, the need to begin the process of re-tendering existing tendered contracts and in light of the expected transfer of additional contracts from the Social Care function to the PHA, it is proposed that PHA reviews the existing approach it takes to planning and implementing procurements to assess how future demands for procurement can best be managed and resourced across the organisation. A separate paper setting out some of the issues that need to be addressed will be shared with PHA board for consideration.

PHA board is asked **to Note** the paper.