agenda

107th Meeting of the Public Health Agency Board

Thursday 15 November 2018 at 1:30pm

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

standing items

1 1.30	Welcome and apologies		Chair
2 1.30	Declaration of Interests		Chair
3 1.30	Minutes of Previous Meeting held on 18 October 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/01/11/18**	Mr Cummings

items for noting

8 2.00	Update on Our Future Foyle Initiative	**PHA/02/11/18**	Dr Mairs
9 2.30	NI Abdominal Aortic Aneurysm (AAA) Screening Programme Annual Report 2016/17	**PHA/03/11/18**	Dr Mairs
10 2.50	Annual Immunisation Report for Northern Ireland 2017/18	**PHA/04/11/18**	Dr Mairs
11 3.10	Annual Business Plan Mid-Year Monitoring Report	**PHA/05/11/18**	Mr McClean

closing items

12 3.25	Any Other Business		Chair

13 Details of next meeting:

3.30

Thursday 20 December 2018 at 1:30pm

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

HSC Public Health Agency

minutes

106th Meeting of the Public Health Agency Board

Thursday 18 October 2018 at 1.30pm

Fifth Floor Meeting Room, 12/22 Linenhall 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
Mrs Mary Hinds	-	Director of Nursing and Allied Health Professionals
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 Simon Christie	-	Assistant Director of Finance, HSCB
Ms Marie Roulston	-	Director of Social Care and Children, HSCB
Ms Nicola Woods	-	Boardroom Apprentice
Mr Robert Graham	-	Secretariat

Apologies

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

98/18	**Item 1 – Welcome and Apologies**
98/18.1	The Chair welcomed everyone to the meeting. Apologies were noted from Mr Paul Cummings and Mrs Joanne McKissick.
99/18	**Item 2 - Declaration of Interests**
99/18.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.
100/18	**Item 3 – Minutes of previous meeting held on 20 September 2018**
100/18.1	The minutes of the previous meeting, held on 20 September 2018, were approved as an accurate record of that meeting.

101/18 **Item 4 – Matters Arising**

92/18.3 Waiting Lists

101/18.1 Councillor Ashe reflected on the discussion at the last meeting regarding waiting lists following the publication of a report by the Patient Client Council and he asked when the Public Health Agency will take a view on this issue. Dr Mairs said that the report does not say that the length of waiting lists is a public health issue, but he acknowledged that there is an impact on people's physical and emotional wellbeing. He added that waiting lists is not an issue for PHA, but for HSCB, but that PHA works in tandem with HSCB. The Chair said that at the last meeting, Mr Cummings had indicated that there was £30m of funding available for waiting list initiatives, and he asked whether there was any further confidence and supply money available that could be used. The Interim Chief Executive agreed that £30m has been identified, but she added that no further monies will be made available. She advised that the Permanent Secretary had been informed that no further money could be spent at this stage on areas where staff were required to be recruited. Dr Mairs added that spending money on waiting lists is not seen as transformational. He added that RQIA is currently undertaking a review of outpatient clinics and that when RQIA spoke to PHA, PHA advised RQIA of its concerns about the health and wellbeing of individuals on waiting lists.

101/18.2 Alderman Porter noted that there is a European directive whereby individuals can access healthcare services abroad and reclaim some of the costs from the HSC. He asked why this opportunity was not offered to patients to reduce waiting lists. Mr Christie said that many people would not be aware of such an initiative. He added that if patients travel outside of Northern Ireland and reclaim the costs then there will be less resources available within Northern Ireland. He said that the issue in Northern Ireland is the capacity to deliver. Mr McClean suggested that it would be useful to take this discussion offline and research this area more fully.

101/18.3 Councillor Ashe reiterated his view that waiting lists are getting out of control and that the PHA Board needs to take a view on the issue.

102/18 **Item 5 – Chair's Business**

102/18.1 The Chair presented his Report and highlighted the length of time it can take for issues highlighted in research to come into established practice, citing the example of flour being fortified with folic acid which was suggested almost 30 years ago as a means of reducing the number of babies born with disabilities such as spina bifida. It took 11 years for clot bursting drugs for stroke to be introduced in Northern Ireland.

102/18.2 The Chair informed members that he had attended three meetings of the "duty of candour" workstream following the publication of O'Hara report into hyponatraemia-related deaths.

102/18.3 The Chair advised that he has taken on role of chairing the HSC disability champions group, and that he hoped to meet with the Chief Executive of Disability Action shortly.

103/18 Item 6 – Chief Executive's Business

103/18.1 The Interim Chief Executive informed the Board that last week Mr Brendan Bonner, Acting Head of Health and Social Wellbeing Improvement delivered a presentation to the Permanent Secretaries Group (PSG) on the Our Future Foyle initiative. She explained that this initiative is being established to address suicide prevention on the river Foyle and is a £25m creative and innovative solution comprising of 5 key elements to address the cognitive suicidal behaviours associated with the river Foyle. She advised that the project is seen as a flagship initiative to trigger a City Deal for Derry-Londonderry and is a collaboration between the PHA and the Royal College of Art and Design, and that the solutions involve a mixture of physical and soft barriers, use of technology and innovation, job creation, training and arts and culture.

103/18.2 The Interim Chief Executive said that the project was given a very positive response from the PSG who were impressed with the proposed creative solutions and partnership approach. She added that there was a commitment to support the development of the project in the context of PfG and Transformation.

103/18.3 The Interim Chief Executive added that both the Permanent Secretary and the Chief Medical Officer wrote to Brendan personally after the meeting to express their appreciation of the presentation and the work he has done in this very important area.

103/18.4 The Interim Chief Executive advised that Ed McClean and Sharon Gallagher (Director for Transformation, Department of Health) presented to a joint meeting between the Society of Local Authority Chief Executives (SOLACE) and PSG on Delivering Together, Making Life Better and Community Planning. She said that the purpose of the presentation was to consider the linkages between these strategies and how through deepened partnership we can extend the reach of the strategies. She added that the local Council Chief Executives are invited to join the meeting of HSC Trust Chief Executives for discussion on how both groups can work jointly to deliver health and wellbeing outcomes.

103/18.5 Professor Rooney asked about the funding of the Our Future Foyle initiative. The Interim Chief Executive advised that PHA is part funding it. Mr McClean said that this work is the practical outworking of a range of measures designed to take a more innovative approach in PHA's work in this area and it also looks at issues such as employment and self-esteem. Professor Rooney noted that there are many groups involved in this type of work, and she asked about providing support for PHA staff who work in this area. Mr McClean said that PHA is very mindful of this.

103/18.6 Mr Clayton asked for an update on the closure of HSCB. He said that he was aware of working groups being established and risk assessments being undertaken. The Interim Chief Executive advised that she had attended a meeting of the Oversight Board earlier today. She noted that the trade unions were not happy that they had not been involved in the risk assessments, but she explained that these had been carried out by the Department of Health. She explained that the working groups had been set up to be co-chaired by a representative from the Department and a representative from HSCB, usually a Director. She said that it was now almost 3 years since the then Minister announced that the HSCB would be closing, and there remains no clarity on when this will happen given the lack of an Assembly, and any legislative timetable.

103/18.7 Mr Clayton said that the uncertainty for staff was concerning. He asked whether there was a role for the PHA Board and if PHA could view the risk assessments. The Interim Chief Executive said that she would report these comments back to the Department.

103/18.8 The Chair asked whether there were any other issues, apart from the legislative time pressure, which would impact on the date of closure of HSCB. The Interim Chief Executive said that the Department may choose to do a stock-take, but her main concern is that during this period of uncertainly staff are leaving the organisation, it is more difficult to attract and retain staff, but that the day-to-day activity continues unabated, with additional work coming to the PHA.

104/18 Item 7 – Finance Report (PHA/01/10/18)

104/18.1 Mr Christie advised that the Finance Report for the period up to 31 August showed a surplus of £900k in programme expenditure and £400k in management and administration, but he explained that the former is due to timing issues and the latter to vacancies. He assured members that the year-end outlook remains a break even one. In relation to capital spend, he advised that there is an underspend of £800k, but again this is a timing issue. He commended PHA's prompt payment performance.

104/18.2 Mr Drew asked how soon PHA will be a position to determine what its total underspend will be and how it plans to prioritise that spending in-year. The Chair also asked about campaigns. Mr Christie advised that there may be the potential to run a campaign, but this would require permission from the Department of Health. He added that an in-depth analysis of all budget lines is currently taking place to look at all areas of potential slippage and a report on this may be brought to the next Board meeting. Furthermore, he said that a meeting of all budget managers will be taking place on 4 December.

104/18.3 Mr McClean explained that in addition to seeking out areas of potential underspend, there is also potential for PHA to increase levels of activity with current providers. The Chair reminded members that at the last Board meeting it was stated that in order to allow enough time for the

launch of any media campaigns it would be necessary to make decisions within the next month. He added that in view of the fact that we are now more than six months through the current financial year it was imperative that steps were taken now to identify media campaigns for broadcast later in the year, especially those which did not need design work.

104/18.4 Alderman Porter noted that each year PHA challenges any cuts to its budget, but at this stage of the year finds itself in an underspend position. Mr McClean explained that part of the underspend arises when an initiative does not commence on schedule. He added that some PHA funding can only be utilised in specific areas. Mr Christie said that he believed that there is a well thought and controlled process whereby PHA uses it funding. He pointed out that 1% of PHA's budget is £1m so there will always be a challenge.

104/18.5 Mr Clayton asked about the management and administration budget. He noted that PHA has already faced a reduction in that budget and that if PHA re-profiles funding this year to the programme budget, there may be a view that this funding is not required. He asked whether there were any additional monitoring rounds. The Interim Chief Executive explained that PHA is in a situation where it is trying to utilise the confidence and supply money as well as ask staff to carry out an analysis of budgets for potential slippage. She said that for the HSC overall, it is the responsibility of the Permanent Secretary to balance that budget, and he may ask ALBs for potential slippage. Mr Christie said that he was not aware of any potential monitoring rounds, but he would expect the PHA to live within the resources that it has. He added that although PHA has had to take a reduction of £500k in its management and administration budget, it has always put up a robust argument for why it should not be subject to any further reductions.

104/18.6 The Chair said that Mr Christie had been appointed as Director of Finance for Ards and North Down Council, and that after 16 years his departure would be a severe loss to the HSC.

104/18.7 The Chair recalled that last year Mr Christie had played a seminal role in designing a learning and development programme on financial information for Non-Executive Directors and had also produced a glossary of financial terms used in the HSC. The Chair stated that both these would continue to be an enduring resource for learning and development of Non-Executives.

104/18.8 The Chair said that he was speaking for all the Non-Executive Directors on the Board of the Agency when he expressed profound appreciation to Mr Christie for his empathy, forbearance and unfailing courtesy.

104/18.9 The Board noted the Finance Report.

105/18	**Item 8 – Update from Governance and Audit Committee (PHA/02/10/18)**
105/18.1	Mr Drew updated members on the last meeting of the Governance and Audit Committee which took place on 4 October. He began by saying that Internal Audit had carried out a follow up audit on Payroll Shared Services, but that the outcome of this would not be available until the next meeting.
105/18.2	Mr Drew said that members had considered the Quality Improvement Plan Report and gave an overview of the four areas that had been covered in the Report. He moved on to the Internal Audit work and advised that the outcome of four reports, in the areas of PPI, vaccinations, travel and risk management had been reported with all receiving a satisfactory level of assurance.
105/18.3	In terms of the PPI audit, Mr Drew said that the auditors had noted that there is not a clear system of measuring outcomes. He added that a self-assessment from a Trust was outstanding and needed to be followed up. Within the audit of the vaccinations programme, Mr Drew noted that there is not an overarching policy in place for the management of these programmes. The travel audit highlighted the need for a regional booking form, but Mr Drew's concern related to the number of audit days spent on this audit and the impact on other planned PHA work.
105/18.4	Mr Drew advised that Internal Audit had given an update on the implementation of previous recommendations and had presented their Mid-Year Assurance Statement.
105/18.5	Mr Drew said that the Committee received an update on a long running fraud case but assured the Board that there were no issues with the work commissioned from the PHA, and the potential fraud related to a link with another government department.
105/18.6	Mr Drew advised that the PHA Corporate Risk Register had been reviewed, and that four new risks have been added. He said that the PHA Assurance Framework has also been updated, and that the Committee had received an update on the new arrangements in place following the standing down of the Controls Assurance Standards.
105/18.7	Mr Drew gave an update in relation to information governance and passed on Mr Stewart's concerns about poor attendance at the previous Information Governance Steering Group meeting. He also passed on concerns about the numbers of staff who had not yet completed their mandatory e-learning training.
105/18.8	Mr Drew finished his overview by saying that the Committee had considered the SBNI Declaration of Assurance.
105/18.9	Ms Mann-Kler advised as the named and lead non-executive director for

	the PHA Whistleblowing Policy, she has attended the required training to fulfil her duties in this role.
105/18.10	Ms Woods asked about procurement and noted that out of 170 procurement exercises, only 6 had been completed. Mr McClean said that there is a rolling procurement plan and acknowledged there are some delays. He explained that as the Protect Life 2 Strategy has not been launched, the services required to be procured may change. He added that there are also capacity issues for PHA, particularly in the pre-procurement / engagement stage. He said that he and Ms Roulston would be looking to work more closely and pool resources, but added that this area will continue to grow and present a challenge to PHA.
105/18.11	The Board noted the update from the Committee Chair.
106/18	**Item 9 – PHA Mid-Year Assurance Statement (PHA/03/10/18)**
106/18.1	The Interim Chief Executive explained that the Public Health Agency is required to submit a Mid-Year Assurance Statement to the Department of Health and that the statement being presented today was approved by the Agency Management Team on 25 September and by the Governance and Audit Committee on 4 October. She explained that the draft Statement was submitted to the Department as a draft last week to comply with the Department's deadline of 12 October, but will be forwarded as final, subject to approval by the Board today.
106/18.2	The Interim Chief Executive said that the Statement is largely similar to the previous Governance Statement with minimal change, and that members will note that all of the internal audit reports which have been finalised so far in 2018/19 have received a satisfactory level of compliance.
106/18.3	Mr Stewart noted that at the Governance and Audit Committee there had been discussion about Payroll Shared Services, and that the issues highlighted in the Mid-Year Assurance Statement may not be resolved in the near future.
106/18.4	The Board **APPROVED** the PHA Mid-Year Assurance Statement.
107/18	**Item 10 – Quality Improvement Plan Report (PHA/04/10/18)**
107/18.1	Mrs Hinds presented the Quality Improvement Plan Report. As indicated by Mr Drew earlier in the meeting, this Report had been considered by the Governance and Audit Committee and covered four key areas which had been identified as safety and quality priorities, namely: prevention of pressure ulcers, reduction of harm from falls, compliance with accurately completed NEWS (National Early Warning Scores) charts, and mixed gender accommodation.
107/18.2	Mrs Hinds said that instances of pressure ulcers had increased in the

Northern Trust, but that the figures were beginning to reduce. Ms Mann-Kler asked what had caused the increase. Mrs Hinds explained that within the Trust it was possible to drill down to see figures for individual wards and this highlighted two wards, in one of which there were issues regarding clinical practice, and the other ward had issues relating to environment. Mrs Hinds advised that there is a lot of work going on regionally in the area of pressure sores and that there was an event held last Friday which looked at the area of movement.

107/18.3 Mrs Hinds highlighted the importance of reviewing the independent sector, and she said that Ms Kathy Fodey, Senior Programme Manager, is doing a lot of work with providers in the areas of safety, quality and training. Mr Clayton said that he was pleased to hear that there is work being done in the independent sector.

107/18.4 Mr Clayton noted the concerns about the system for recording data relating to falls within the Southern Trust. Mrs Hinds advised that there is now a consistent method of reporting falls, and that they are no longer reported as SAIs. She added that this meant that the learning from any falls incident can be disseminated more quickly.

107/18.5 Mr Drew said that it was encouraging to see the improvements being made based on learning from previous incidents. Mrs Hinds said that nurses are now making more use of the data presented in Run Charts.

107/18.6 Members noted the Quality Improvement Report.

108/18 Item 11 – Progress Update on Making Life Better, Community Planning and Programme for Government (PHA/05/10/18)

108/18.1 Mr McClean said that PHA has a role in working with the 11 local Councils to implement community planning actions, and he highlighted the three examples in the report relating to mental health, age friendly and physical activity.

108/18.2 In terms of Making Life Better, Mr McClean explained that there is a number of areas where there is alignment between the work PHA is doing to implement MLB and also Programme for Government. He referenced the work done with local libraries and museums to make better use of those facilities as neutral spaces. Mr McClean added that an HSC partnership has been developed, and one of its tasks will be to establish a network.

108/18.3 The Chair had noted in the publication “The Health Gap” by Michael Marmot that he also understood the importance of civic leaders and community leaders in advancing public health. He believed that the Agency should encourage Mayors, Deputy Mayors and Chairs of Councils to adopt public health as a major theme during the term of office.

108/18.4 Alderman Porter explained that within his local area, organisations are working to make better use of land to create facilities, but that the owners

	of the land are charging for the land. Mr McClean conceded that it will take time, and that there will be challenges, but he had been impressed by the goodwill and support he has seen from Councillors in some areas.
108/18.5	Ms Mann-Kler said that there is a joined up approach with government agencies working together for the benefit of the health of citizens and that the use of libraries as a neutral space is encouraging, but she noted that there has been a spate of library closures. She asked if PHA sees the Councils' action plans and if the Councils have the necessary skillset to implement them. Mr McClean said that progress is being made, but that there are some challenges which will remain. He said the joined up working is better than it was, but it's not perfect. He added that PHA can now better understand what it is trying to achieve, and is better aligned to achieve it in a meaningful way by being more collaborative, more creative and more open in terms of using its resources. However, he noted that the challenge is understanding where PHA has added value.
108/18.6	Mr McClean said that PHA has developed good partnerships with Libraries NI and Sport NI, but there is a challenge for PHA to exploit available opportunities. He noted that only 48 staff in PHA have had practical experience of community planning. He said that a review of community plans has been pushed back to November.
108/18.7	Councillor Ashe said that local Councils do not have the resources or the expertise for community planning, and that there is a long way to go in terms of co-operation. Mr McClean acknowledged that there will be initial difficulties, but Councillor Ashe said Councils have had 11 years to prepare for community planning.
108/18.8	Mr Clayton noted that there had been a lot of discussion about Councils and the linkages with PHA, but he asked about linkages between PHA and other government departments, and in particular their attitudes toward issues such as population health outcomes and inequalities. He asked what links there are with Delivering Together. Mr McClean said there are links with Delivering Together and that the HSCB is also represented in community by Louise McMahon and the Local Commissioning Group Chairs. In terms of health inequalities, he advised that there was a lot of data which fed into community plans, and thematic plans focusing on areas such as avoidable deaths. He said that the challenge is not to focus on the data, but to look at more effective interventions, but some of these are outwith the remit of PHA.
108/18.9	The Board noted the update on Making Life Better, Programme for Government and community planning.
109/18	**Item 12 – Any Other Business**
109/18.1	There was no other business.

110/18 **Item 13 – Details of Next Meeting**

Thursday 15 November 2018 at 1.30pm

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

Signed by Chair:

Date: 15 November 2018

Public Health Agency

Finance Report

2018-19

Month 6 - September 2018

PHA Financial Report - Executive Summary

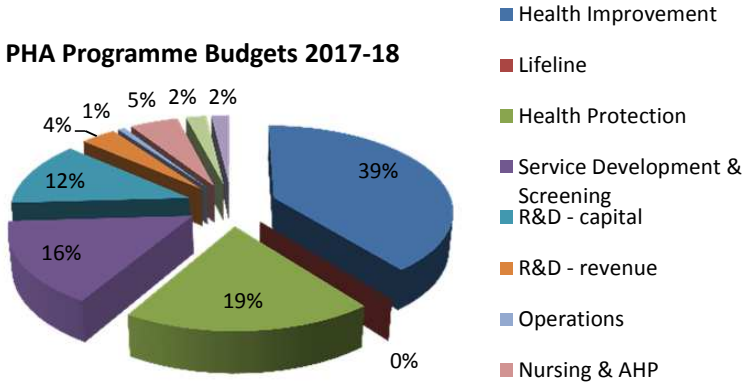
Year to Date Financial Position (page 2)

At the end of month 6 PHA is underspent against its profiled budget by approximately £1.6m. 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.

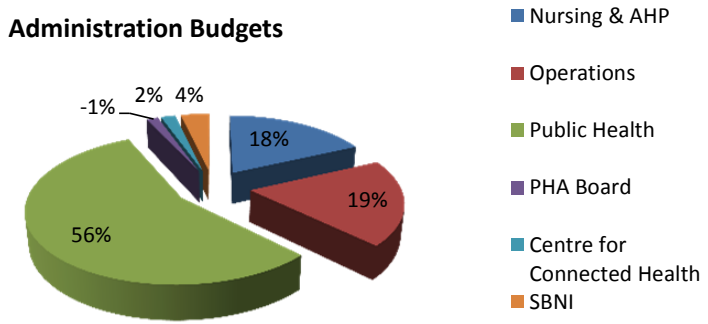


Administration Budgets (page 5)

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. Slippage is expected to arise from Administration budgets in particular, however management expect this to be used to fund a range of in-year pressures and initiatives. Confidence and Supply Transformation Funds have an allocation retraction of £0.5m assumed against them at the end of September.

Public Health Agency
2018-19 Summary Position - September 2018

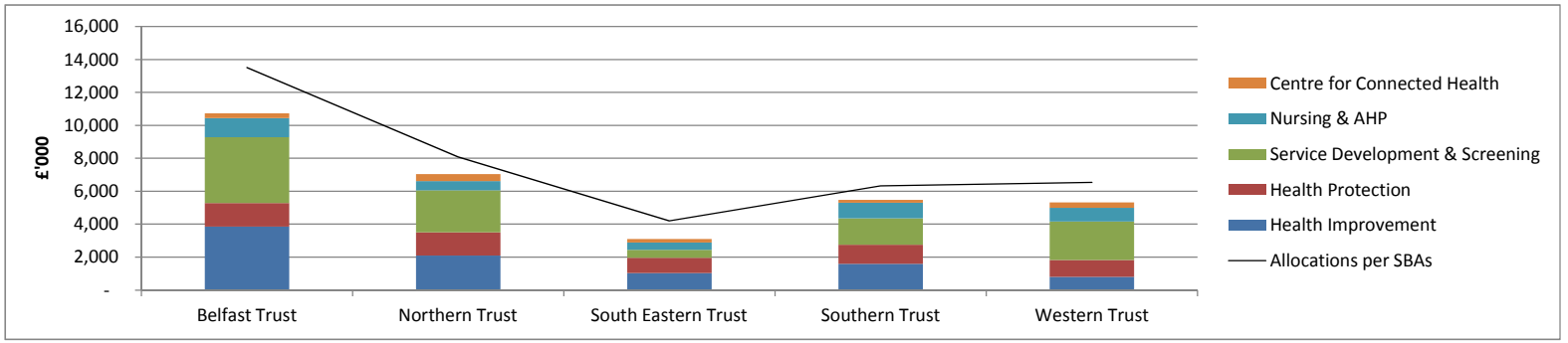
	Annual Budget					Year to Date				
	Programme		Ringfenced	Mgt &	Total	Programme		Ringfenced	Mgt &	Total
	Trust	PHA Direct	Trust & Direct	Admin		Trust	PHA Direct	Trust & Direct	Admin	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources										
Departmental Revenue Allocation	31,726	43,664	8,291	18,726	**102,407**	14,713	14,541	1,783	9,317	**40,354**
Revenue Income from Other Sources	28	193		611	**832**	14	179	-	316	**509**
Departmental Allocation Retraction			(534)		**(534)**					
Total Available Resources	31,754	43,857	7,757	19,337	**102,705**	14,727	14,720	1,783	9,633	**40,864**
Expenditure										
Trusts	31,754	-	2,275	-	**34,029**	15,877	-	1,138	-	**17,015**
PHA Direct Programme *	-	44,387	5,482	-	**49,869**	-	12,401	616	-	**13,017**
PHA Administration	-	-		18,807	**18,807**	-	-		9,233	**9,233**
Total Proposed Budgets	31,754	44,387	7,757	18,807	**102,705**	15,877	12,401	1,753	9,233	**39,264**
Surplus/(Deficit) - Revenue	0	(530)	(0)	530	0	(1,150)	2,319	30	400	**1,599**
Cumulative variance (%)						***-7.81%***	***15.75%***	***1.68%***	***4.16%***	***3.91%***

The year to date financial position for the PHA shows an underspend against profiled budget of approximately £1.6m, mainly due to spend behind profile on PHA Direct Programme budgets (see page 4), and also a year to date underspend on Administration budgets (see page 5). It is currently anticipated that the PHA will achieve breakeven for the full year.

An allocation retraction by the DHSSPS for £0.5m (Confidence and Supply Transformation Funds) has been assumed against ringfenced budgets at this point.

** 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	3,853	2,096	1,030	1,587	801	**9,368**	3,534	4,684	(1,150)
Health Protection	1,424	1,416	940	1,158	1,019	**5,958**	2,979	2,979	0
Service Development & Screening	4,004	2,554	477	1,613	2,349	**10,997**	5,499	5,499	0
Nursing & AHP	1,162	560	451	950	827	**3,949**	1,975	1,975	0
Centre for Connected Health	297	420	204	164	325	**1,410**	705	705	0
Other	24	13	11	12	11	**72**	36	36	0
Total current RRLs	**10,764**	**7,059**	**3,114**	**5,484**	**5,333**	**31,754**	**14,727**	**15,877**	(1,150)
Cumulative variance (%)									***-7.81%***

	Belfast Trust £'000	Northern Trust £'000	South Eastern £'000	Southern Trust £'000	Western Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / £'000
Ringfenced	**527**	**400**	**548**	**369**	**432**	**2,275**	**1,138**	**1,138**	0
									0.00%

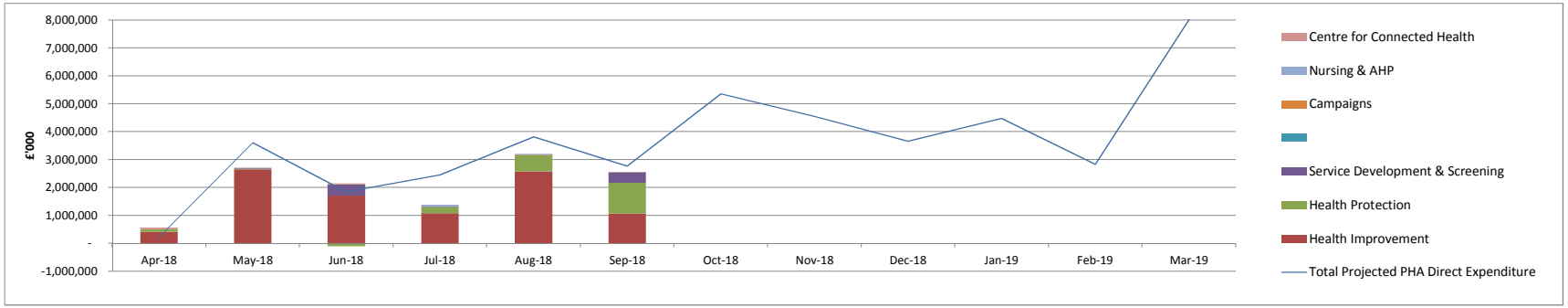
The above table shows the current Trust allocations split by budget area.

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. A transfer to BHSCT for Lifeline Contract is still awaiting completion and has resulted in a overspend position to date. A transfer for year end has been assumed resulting in a breakeven position being anticipated for the full year.

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

Ringfenced funds allocated to Trusts have been assumed at breakeven.

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	2,225	3,121	1,291	2,240	1,938	1,021	2,290	2,376	3,891	**24,688**	10,931	9,507	1,424	*13.0%*
Health Protection	56	347	93	78	446	888	2,960	1,817	1,023	1,001	709	1,149	**10,567**	1,908	1,929	- 21	*-1.1%*
Service Development & Screening	18	140	524	74	74	528	89	- 182	449	74	- 149	832	**2,472**	1,358	1,041	317	*23.4%*
Research & Development - revenue	-	-	-	-	-	-	-	1,100	1,100	1,011	-	-	**3,211**	-	3	(3)	*0.0%*
Campaigns	9	9	9	9	9	9	9	9	9	9	9	93	**195**	56	11	45	*-100.0%*
Nursing & AHP	17	17	20	24	130	16	17	- 157	20	50	- 135	435	**454**	224	89	135	*60.3%*
Centre for Connected Health	40	40	40	40	40	40	40	24	40	40	24	40	**451**	242	92	150	*61.9%*
Other	-	-	-	-	-	-	-	-	-	-	-	1,577	**1,577**	0	(271)	271	*100.0%*
Total Projected PHA Direct Expenditure	**227**	**3,607**	**1,842**	**2,450**	**3,820**	**2,773**	**5,356**	**4,549**	**3,663**	**4,475**	**2,834**	**8,018**	**43,615**	**14,720**	**12,401**	2,319	
Cumulative variance (%)																***15.75%***	
Actual Expenditure	**570**	**2,784**	**2,007**	**1,380**	**3,097**	**2,563**	**-**	**-**	**-**	**-**	**-**	**-**	**12,401**				
Variance	**(343)**	**824**	**(165)**	**1,071**	**723**	**210**							**2,319**				

	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
Total Projected Ringfenced PHA Direct Expenditure	**-**	**3**	**19**	**501**	**146**	**(24)**	**148**	**126**	**99**	**100**	**108**	**4,255**	**5,482**	**646**	**616**	**30**
4.64%																
Actual Expenditure	**-**	**170**	**55**	**299**	**24**	**68**							**616**			
Variance	**-**	**(167)**	**(35)**	**202**	**122**	**(92)**							**30**			

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

The year-to-date position shows a £2.319m surplus, which is due to funds £1.150m for Lifeline (Trust Overspend) shown as a surplus at September and also due to timing of payments in various budget areas. The £1.6m budget in the Other line reflects funds which are being held centrally pending approval of IPTs and business cases, prior to being issued to the respective budget areas.

Non Trust Ringfenced funds are showing a surplus of £0.030m at the end of month 6. A breakeven position is anticipated at year end based on an assumed allocation retraction of £0.534m from Confidence and Supply Transformation Funds.

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	3,470	2,605	10,888	173	319	484	**17,938**
Goods & Services	177	1,269	361	35	54	246	**2,143**
Savings target				(500)			**(500)**
Total Budget	**3,646**	**3,874**	**11,249**	**(292)**	**373**	**730**	**19,581**
Budget profiled to date							
Salaries	1,656	1,302	5,431	87	159	242	**8,877**
Goods & Services	81	586	185	(232)	34	104	**757**
Total	**1,737**	**1,887**	**5,616**	**(146)**	**193**	**346**	**9,633**
Actual expenditure to date							
Salaries	1,610	1,207	5,167	57	167	144	**8,351**
Goods & Services	116	495	174	8	10	79	**882**
Total	**1,726**	**1,703**	**5,341**	**65**	**176**	**223**	**9,233**
Surplus/(Deficit) to date							
Salaries	46	94	264	30	(7)	98	**525**
Goods & Services	(35)	90	11	(240)	24	25	**(125)**
Surplus/(Deficit)	**11**	**185**	**276**	**(210)**	**17**	**123**	**400**
Cumulative variance (%)	*0.61%*	*9.78%*	*4.91%*	*144.24%*	*8.92%*	*35.53%*	***4.16%***

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. SBNI budget is ringfenced and any underspend will be returned to DoH prior to year end.

September 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	7,070	3,581	-	**10,651**	3,535	1,668	-	**5,203**
Expenditure								
Capital Expenditure - Trusts	7,070			**7,070**	3,535			**3,535**
Capital Expenditure - PHA Direct		3,581		**3,581**		906		**906**
	7,070	3,581	-	**10,651**	3,535	906	-	**4,441**
Surplus/(Deficit) - Capital	-	-	-	-	-	761	-	**761**
Cumulative variance (%)					*0.00%*	*45.67%*	*0.00%*	***14.64%***

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 surplus of £0.7m is shown for the year to date, and a breakeven position is anticipated for the full year.

PHA Prompt Payment

Prompt Payment Statistics

	September 2018 Value	September 2018 Volume	Cumulative position as at 30 September 2018 Value	Cumulative position as at 30 September 2018 Volume
Total bills paid (relating to Prompt Payment target)	£3,368,126	312	£18,915,115	2,509
Total bills paid on time (within 30 days or under other agreed terms)	£3,291,642	295	£18,681,172	2,378
Percentage of bills paid on time	**97.7%**	**94.6%**	**98.8%**	**94.8%**

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 94.8%. 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 93.4% by value for the year to date, which significantly exceeds the 10 day DoH target for 2018-19 of 60%.

HSC Public Health Agency

board paper

Update on Our Future Foyle Initiative

date	15 November 2018	**item**	8	**reference**	PHA/02/11/18

presented by Dr Adrian Mairs, Acting Director of Public Health

action required For noting

Summary

Our Future Foyle is a creative and innovative project developed by the PHA, in partnership with the Royal College of Arts and Design, to address the cognitive triggers that results in death by suicide around the River Foyle in Derry~Londonderry.

The developmental stage has been completed and an action plan has been developed which includes three significant initiatives Foyle Reeds, Foyle Bubbles and Foyle Experience, with a total value of £25m.

The project was a flagship initiative under the Derry City and Strabane Community Planning Strategic Action Plan, it was also identified by ADOG as a key project under the draft PFG. The project proposals were recently presented to the PSG and got a very positive commitment from all Departments in terms of a way forward.

SIB are working on the technical and core business cases, supported by DfC, DfI and PHA. The planning application has now been submitted for the Foyle Reeds project and this was also the focus of the launch of a public media awareness programme, featured on BBC, UTV and a range of international, national and local media outlets. More significantly the project has been included as one the primary submissions to the Cabinet as part of Derry Cities bid for “City Deal” status. As part of that submission the Chancellor required a detailed project outline submission in terms of how the proposal meets their City Deal criteria in terms of transformation, growth/regeneration and digital innovation, the full submission is 112 pages but attached is a summary of the Executive Summary.

Equality Impact Assessment

Not applicable.

Recommendation

The Board is asked to **NOTE** the update on Our Future Foyle.

HSC Public Health Agency

board paper

NI Abdominal Aortic Aneurysm (AAA) Screening Programme Annual Report 2016/17

date	15 November 2018	**item**	9	**reference**	PHA/03/11/18

presented by Dr Adrian Mairs, Acting Director of Public Health

action required For noting

Summary

This is the fifth annual report for the Northern Ireland Abdominal Aortic Aneurysm (AAA) Screening Programme since it was introduced in June 2012. It has been produced jointly by the Belfast Health and Social Care Trust (the programme provider) and the Public Health Agency (which is responsible for commissioning and quality assurance).

All men registered with a GP in Northern Ireland are invited for screening in the year they turn 65. Men over the age of 65, who have never been screened before, can self-refer.

Overall performance of the programme remained high (refer to Section 5 for more detail). Of note:

- Almost **9,000** men in their 65th year were invited to attend for screening
- Uptake remained high with **84%** of those invited attending for screening, up slightly from the previous year's 83%
- **830** men over 65 who had never been screened before self-referred to the programme and were screened
- **107** men screened had a newly detected AAA
- **24** men had a large aneurysm and were referred to the vascular team to consider treatment options

The 2015-16 annual report set out a number of future developments for the programme to focus on in 2016-17. Progress on this work is also outlined within the report regarding:

- Progress on securing an **External Quality Assurance** visit to the Northern Ireland AAA Screening Programme from Public Health England.
- Updates to **Information leaflet translations**.
- Provision of an **easy read information leaflet** on AAA Screening for adults with a learning disability.
- Continued promotion of the programme at available opportunities including attending **Men's Sheds, Healthy Living Fairs and Positive Ageing events.**

- Ongoing partnership working with **Healthy Living Centres.**
- Screening in both **Magilligan and Maghaberry prison.**

- Use of local events through the year to raise the programme's profile eg at Belfast Trust's '**Safetember'** event.
- Joint working **with GPs and other primary care teams** to raise awareness of the programme and promote the self-referral pathway.
- The introduction of **screening in John Mitchel Place** in the centre of Newry.
- **Uploading all results letters for men with a detected AAA to their own individual Electronic Care Record (ECR).**

Equality Impact Assessment

Not applicable.

Recommendation

The Board is asked to **NOTE** the Abdominal Aortic Aneurysm Annual Report for 2016/17.

Northern Ireland
Abdominal Aortic Aneurysm (AAA) Screening Programme

Annual Report 2016-17

Abdominal Aortic Aneurysm Screening

HSC Public Health Agency

HSC Belfast Health and Social Care Trust

About this publication

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- Chief Executive - Public Health Agency
- Director of Public Health - Public Health Agency
- Assistant Director of Screening and Professional Standards - Public Health Agency
- NI AAA Screening Programme Team - Public Health Agency
- NI AAA Screening Programme Co-ordinating Group

Contents

Appendices

Section 1:

Summary and Highlights for 2016-17

This is the fifth annual report for the Northern Ireland Abdominal Aortic Aneurysm (AAA) Screening Programme since it was introduced in June 2012. It has been produced jointly by the Belfast Health and Social Care Trust and the Public Health Agency.

The Belfast Health and Social Care Trust is responsible for the management and delivery of the programme, whilst the Public Health Agency (PHA) is responsible for commissioning and quality assuring it. The two organisations work closely together to provide an effective, safe and accessible service.

All men registered with a GP in Northern Ireland are invited for screening in the year they turn 65. Men over the age of 65, who have never been screened before, can self-refer by contacting the screening programme office on 02890 631828.

Throughout 2016-17, the programme continued to work on developing existing services. The 2015-16 annual report set out a number of core objectives for the programme. These objectives have either been met in full or are on target, as evidenced throughout this report.

Overall performance of the programme remained high (refer to Section 5 for more detail). Of note:

- Almost **9,000** men in their 65th year were invited to attend for screening
- Uptake remained high with **84%** of those invited attending for screening, up slightly from the previous year's 83%
- **830** men over 65 who had never been screened before self-referred to the programme and were screened
- **107** men screened had a newly detected AAA
- **24** men had a large aneurysm and were referred to the vascular team to consider treatment options

The 2015-16 annual report set out a number of future developments for the programme to focus on in 2016-17. Progress on this work is outlined below.

- A date is being secured for English NHS AAA Screening Programme colleagues to undertake an **External Quality Assurance** visit to the Northern Ireland AAA Screening Programme.

- **Information leaflet translations** have been updated, including the general information leaflet and the three results leaflets (for men screen-detected with a small, medium or large AAA). These can be found in printable PDF format on the programme website – www.aaascreening.info. The languages available are: Chinese complex, Chinese simple, Polish and Portuguese. Slovakian and Lithuanian translations of the former versions of the leaflets remain available. A link to the English AAA Screening Programme's general invitation leaflet in additional language formats is also included.

- An **easy read information leaflet** on AAA Screening for adults with a learning disability was finalised in Spring 2017 in conjunction with a wide range of stakeholders, including service users.

- Continued promotion of the programme at available opportunities including attending **Men's Sheds, Healthy Living Fairs and Positive Ageing events;** between October and December 2016, the programme also made contact with and sent promotional materials to almost 20 groups who specifically **work within ethnic minority communities**.

- Partnership working continued with the **Healthy Living Centres** with the programme running a further seven screening clinics within identified local areas between April and October 2016.

- The programme continued to liaise with both **Magilligan and Maghaberry prisons** to offer screening to eligible men. Throughout the year, a number of men eligible for screening attended their local clinic accompanied by prison staff. A specific clinic also took place within Maghaberry prison in April 2016.

- Programme staff used local events throughout the year to continue to promote the programme. One example of this was during the Belfast Trust's 'Safetember' event in September 2016 when staff set up **promotional stands** for the programme in the foyers of four hospital sites.

- Throughout the year, the programme continued to **work with GPs and other primary care teams** to raise awareness of the programme and promote the self-referral pathway. Over 35% of all self-referrals during 2016-17 were as a direct result of information provided by GPs and other health professionals - men were advised by their GP to contact the programme or they contacted us after seeing a poster in the GP surgery / hospital / pharmacy.

- 2016-17 saw the introduction of **screening in John Mitchel Place** in the centre of Newry; it had been specifically identified as a geographical area with a significant population who would be eligible for screening, rather than these men having to travel to either Bessbrook or Kilkeel.

- From August 2016, the screening programme started to **upload all results letters for men with a detected AAA to their own individual Electronic Care Record (ECR)**; this ensures that all healthcare providers who review a patient's ECR will see an alert highlighting that the man has an AAA.

Section 2:

Introduction

As the new public health lead for the NI AAA Screening Programme, I would first like to pay tribute to my predecessor, Dr Adrian Mairs. He made a significant contribution both to the implementation of the programme in 2012 and its subsequent consolidation and development. Now in its fifth year of screening, I am delighted to be part of a team of highly skilled and dedicated individuals delivering a first-class screening programme. On their behalf, we wish Adrian continued success in his new role as Assistant Director for Screening and Professional Standards within the PHA.

The programme continues to make a huge difference to the lives of men screen-detected with an AAA through its surveillance and treatment pathways. This positive impact has been maximized by the engagement of service users in ongoing personal and public involvement and co-production activities from the programme's inception. It is also only through collaborative working with service users that we continue to be able to update existing information resources and produce new ones. This year that has included production of a new alert card for men diagnosed with a small or medium AAA. An easy read information leaflet has also been developed for people with learning difficulties or those who may find reading and writing difficult.

I hope you enjoy reading more about additional developments within the programme. Please also let us know if there are areas of particular interest you would like to be considered for next year's report.

As Clinical Lead for the NI AAA Screening Programme, I am pleased to present this annual report outlining some of the work that has taken place during 2016-17.

The continued success of the programme requires the support and hard work of the screening staff and a wide range of healthcare individuals to ensure our service users receive an excellent service.

Men diagnosed with a large AAA requiring intervention can be reassured that they will receive careful assessment and treatment in the Regional Vascular Unit in the Belfast Trust. The unit currently performs the largest volume of infra-renal AAA repairs in the UK with excellent outcomes published annually in the National Vascular Registry and available on the HQIP website (https://www.hqip.org.uk/).

The annual Service User events have provided a welcome opportunity for staff to receive feedback on many aspects of the service and have resulted in improvements in a variety of areas particularly with regard to information before and after surgery.

We are very grateful to our local GPs for their engagement with the programme, particularly their help with additional cardiovascular secondary prevention measures recommended for service users.

Finally a word of thanks to our clinical teams who continue to deliver quality healthcare in a timely manner, despite the current strain on resources in our local NHS.

Mr Paul Blair
Consultant Vascular Surgeon / Clinical Lead NI AAA Screening Programme

Section 3:

Background and Programme Objectives

What is an AAA?

The aorta is the main vessel that circulates blood from the heart, through the abdomen to the rest of the body. Over time, the walls of the aorta can weaken, causing it to balloon out. This results in an abdominal aortic aneurysm (AAA).

AAAs usually cause no symptoms, therefore most people who have one will not feel anything. As the aneurysm grows so too does the risk of it rupturing if left untreated. Rapidly expanding or ruptured aneurysms do produce symptoms (typically severe abdominal, back or flank pain, low blood pressure or shock and a mass in the abdomen which pulsates; however only a minority of patients have all of these features). Patients with a ruptured AAA have a very low chance of survival. In contrast, those detected who undergo planned surgery for a non-ruptured AAA have an excellent rate of survival.

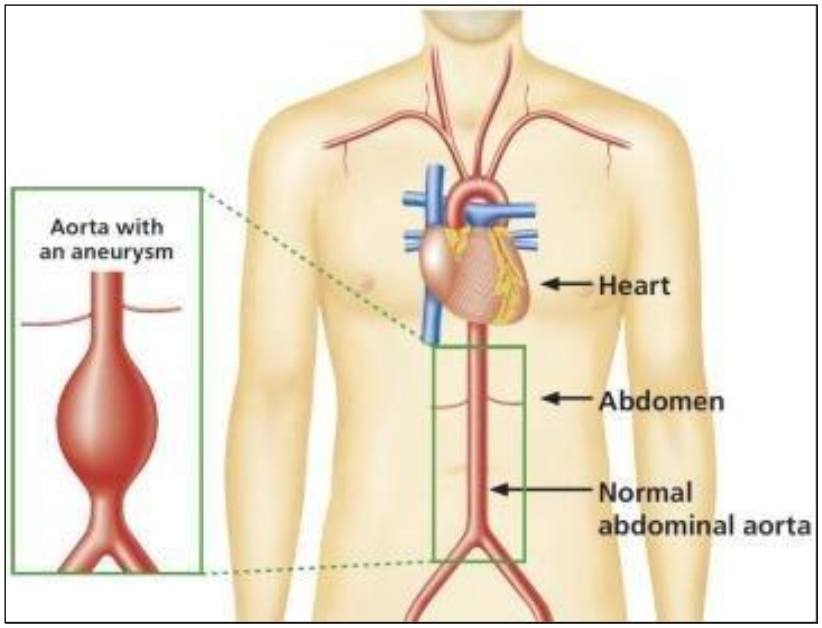


Image courtesy of English NHS AAA Screening Programme

AAAs are more common in men aged 65 and older. Other factors known to increase the risk of developing an AAA are smoking, high blood pressure and high blood cholesterol. Close relatives of someone who has been diagnosed with an AAA are also more likely to develop one.

Aim of the Northern Ireland AAA Screening Programme

The overall aim of the Northern Ireland AAA Screening Programme is to reduce deaths from ruptured abdominal aortic aneurysms through early detection, monitoring and treatment.

On average, compared to men, women are six times less likely to develop an AAA. In addition, women tend to develop an AAA ten years later than men. The NI AAA Screening Programme is therefore targeted at men in keeping with the recommendations of the UK National Screening Committee.[1]

Programme Objectives

The Public Health Agency and the Belfast Health and Social Care Trust work together to meet the programme's core objectives. These include:

- Monitoring delivery of the programme against national quality standards and taking appropriate action where performance is not on target
- Ensuring appropriate failsafe systems are in place at each stage of the screening process
- Ensuring all staff are appropriately trained on all aspects of the programme, including the Health and Social Care organisations' mandatory training
- Actively engaging with stakeholders at relevant events and opportunities, particularly in those geographical areas where uptake rates are lower than the programme average
- Continuing to explore opportunities for Personal and Public Involvement (PPI)
- Ensuring information materials remain relevant and up-to-date, with a particular emphasis on promoting self-referral for men aged 65 or over who have never attended for AAA screening
- Ongoing review and development of the Northern Ireland AAA Screening Programme website, with engagement of stakeholders as appropriate
- Continuing to develop and formalise an appropriate quality assurance structure and function in collaboration with the English NHS AAA Screening Programme

[1] Abdominal aortic aneurysm: the UK NSC policy on abdominal aortic aneurysm screening in men over 65. UK Screening Portal. Available at: www.screening.nhs.uk/aaa Accessed 24 August 2017.

- Continuing to build on existing relations with the other three UK AAA Screening Programmes (England, Scotland and Wales)

- Identifying and addressing health inequalities to ensure all eligible men can make an informed decision about whether or not to attend for screening

- Identifying and disseminating examples of regional and national best practice with regard to all elements of programme delivery

- Promoting and participating in research initiatives, as appropriate

Section 4:

Programme Delivery and the Screening Pathway

The programme is run by a multidisciplinary team of staff (see **Appendix 1**). All staff play an important role at various stages in the screening pathway.

The programme office is based in the Royal Victoria Hospital within the Belfast Trust.

Seven screening technicians run clinics on a daily basis. During 2016-17, there were 23 clinic locations across Northern Ireland, including health and wellbeing centres and community hospitals (see **Appendix 2**).

Eligibility for Screening

All men in Northern Ireland who are registered with a GP are eligible for screening in the year they turn 65 (1 April to 31 March). This includes those men in prison or other secure accommodation. Any man who already has a known AAA can transfer to the care of the screening programme. However, if a man has previously had surgery for an AAA he does not require screening.

Men over the age of 65 and registered with a GP, who have not previously been scanned as part of the programme or been told they have an aneurysm, are also eligible for screening. These men can contact the screening programme office on 02890 631828 to request an appointment.

Details of all men registered with their GP who are eligible to be invited for screening are transferred to the Belfast Trust IT system on an annual basis. Daily updates are then automatically provided with changes to any demographic information.

The Screening Pathway

Appendix 3 provides an overview of the whole screening pathway. The key stages within the pathway are:

- Screening Invitation
- The Scan
- The Result
- Surveillance
- Referral and Treatment

Screening Invitation

The programme office sends all eligible men an invitation letter to attend a local screening clinic. This includes those men registered with a GP during the year in which they turn 65 and those eligible men over the age of 65 who have self-referred to the screening programme.)

Invitations for men on surveillance are also sent:

- Men who have a small aneurysm detected will be invited back every *twelve months* for a surveillance scan.
- Men who have a medium aneurysm detected will be invited back every *three months* for a surveillance scan.

The Scan

The screening test involves a simple ultrasound scan of the abdomen. It is quick and painless. The screening technician measures the widest part of the abdominal aorta. The whole process usually lasts less than fifteen minutes.

The Result

All men will be informed of their results verbally at the clinic. Both the man and his GP will then be sent a letter confirming the result. If a man is identified as having an aneurysm his GP practice will also be informed by telephone the same day.

There are **FIVE** possible results from screening:

- **NORMAL**: **aortic diameter less than 3cm**

Over 98% of men will have a normal result. This means that the aorta is not enlarged (there is no aneurysm). No treatment or monitoring is needed and the men will be discharged from the screening programme. They will not need to be screened again.

- **SMALL AAA**: **aortic diameter measuring between 3cm and 4.4cm**

Men who have a small aneurysm detected will be invited back every twelve months for a surveillance scan to monitor the size of the aneurysm. Some small aneurysms will grow in size over time and become medium or large aneurysms.

- **MEDIUM AAA**: **aortic diameter measuring between 4.5cm and 5.4cm**

Men who have a medium aneurysm detected will be invited back every three months for a surveillance scan to monitor the size of the aneurysm. Some medium-sized aneurysms will grow over time to become large aneurysms.

- **LARGE AAA**: **aortic diameter measuring 5.5cm or over**

Men who have a large aneurysm detected are referred to a vascular surgeon within the Royal Victoria Hospital at the Belfast Health and Social Care Trust for further investigation and to discuss treatment options. All men referred are required to be seen at outpatients within two weeks of the initial scan.

- **NON-VISUALISATION**: sometimes the aorta cannot be fully visualised and a man will be invited to come back on a different day for another scan.

Surveillance

As indicated above, if a man has either a small or medium-sized aneurysm he will be invited back for surveillance appointments on a regular basis to monitor its size.

Men under surveillance are also offered an appointment with a vascular nurse specialist for additional support and advice. The nurse will contact every man who has an AAA detected within two working days and offer either a face to face appointment or a telephone consultation. The nurse will explain the significance of having an AAA and offer lifestyle advice (including advice on smoking cessation) and advice on blood pressure control (if relevant) to help decrease the risk of the aneurysm growing. The man will also be asked to attend his GP to have measurements taken for his height, weight and blood pressure and to discuss the need for any medication.

Referral and Treatment

The Northern Ireland AAA Screening Programme refers all men with a large aneurysm to the vascular service within the Belfast Health and Social Care Trust. Vascular units are required to meet national standards set by the Vascular Society of Great Britain and Ireland (VSGBI)[2]. The regional vascular service in the Royal Victoria Hospital within the Belfast Trust meets these standards.

[2] https://www.vascularsociety.org.uk/_userfiles/pages/files/Document%20Library/VSGBI-AAA-QIF-2011-v4.pdf

All men referred to the vascular service are required to be seen by a consultant vascular surgeon within two weeks of the scan when the large AAA was detected. During this period, the man will have a CT scan to confirm the size of the aneurysm and get more detailed imaging to help decide the best option for treatment. All men diagnosed with a large AAA are discussed at a weekly vascular multidisciplinary team meeting (MDT) and also undergo vascular pre-assessment by a specialist nurse and vascular anaesthetist. The vascular consultant will then discuss treatment options at outpatient review. The two main treatment options are open surgery or endovascular (EVAR) surgery. Open surgery requires a longer hospital stay and initial recovery period. Endovascular treatment, with a stent graft, allows for quicker recovery but has a longer follow-up period with X-ray surveillance. The decision regarding the choice of operation depends on many factors and is discussed in detail by the vascular team. The nominated consultant will then discuss the appropriate options with the man to enable him to make an informed choice. For some men further investigation and optimisation of underlying medical issues may be required prior to treatment of their AAA.

End Point of Screening Programme for Men

As outlined within Public Health England guidance[3], active inclusion in the screening programme ends when:

- the scan is found to be within normal limits
- an AAA reaches 5.5cm diameter on ultrasound and the man has been referred to the vascular unit
- the director of the local screening programme or the GP decides referral for treatment should be considered based on other factors (for example, symptoms or co-morbidities)
- after three consecutive scans showing an aortic diameter less than 3cm on ultrasound where the initial scan was 3cm or greater
- after 15 scans at one-year intervals the AAA remains below 4.5cm
- if the man declines to be in the screening programme, fails to attend consecutive appointments as per local policy, moves out of the area and becomes the responsibility of another screening programme (if one exists) or dies

[3] https://www.gov.uk/government/publications/aaa-screening-standard-operating-procedures

Section 5:

Programme Performance

The current population of Northern Ireland is just over 1.86 million. Within this, the number of men aged 65 and over in 2016 was 133,381 of which 8,961 were men aged 65[4].

During its fifth year, the Northern Ireland AAA Screening Programme invited all men who turned 65 between 1 April 2016 and 31 March 2017 for screening.

This section of the report focuses on the performance of the programme. Data included covers the 2016-17 cohort, the self-referrals and others offered screening through the programme as at end of March 2017[5]. All data outlined within this report have been provided by the Belfast Trust programme team and quality assured by the Public Health Agency.

Eligible Cohort

The table below outlines the number of men who were eligible to be offered AAA screening by the programme from the 2016-17 cohort.

Table 1: 2016-17 AAA Screening cohort

Category / Men:	Number:
Identified Screening cohort for 2016-17 (all men who had their 65th birthday during the year 1 April 2016 – 31 March 2017)	**9,192**
Cohort not eligible for screening (these men were not eligible for screening as they either (a) died before being offered an appointment; (b) were no longer registered with a GP; (c) had previously had surgery for an AAA; or (d) had previous imaging to confirm they did not have an AAA)	**231**
Eligible screening cohort 2016-17	**8,961**

Self-referrals

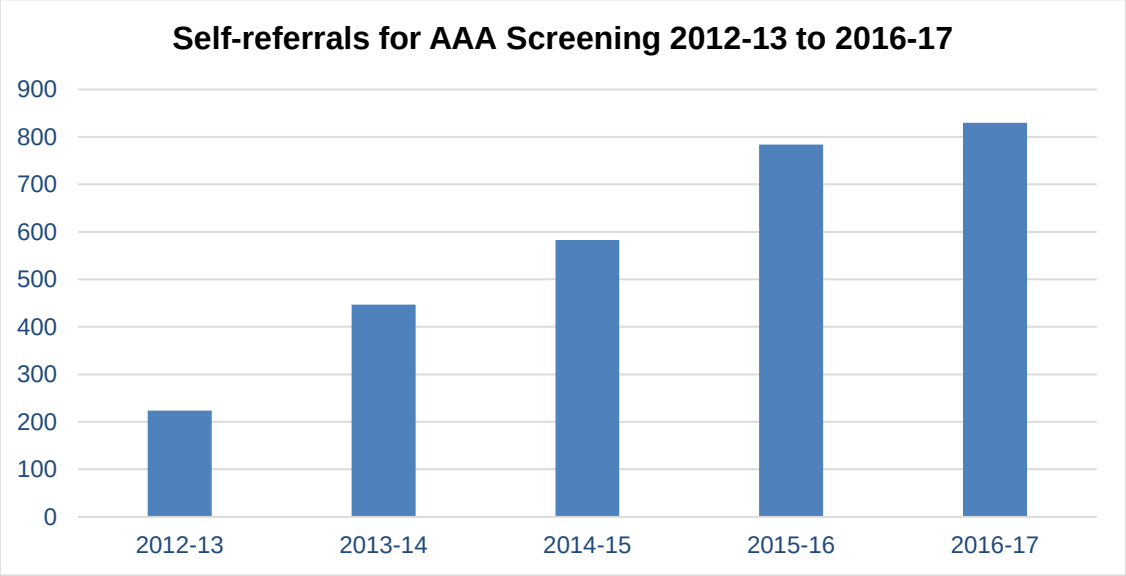
Men over 65 who have never been screened can self-refer to the programme and request a screening appointment. During 2016-17, 830 men self-referred. The

[4] www.NISRA.gov.uk

[5] Data for the 2016-17 cohort are as at 30/06/2017 to allow time for screening episodes to be completed; data for self-referrals and men on surveillance is as at 31/03/2017

figure below shows the increasing number of self-referrals the programme has had since it started.

Figure 1: Self-referrals for AAA Screening 2012-13 to 2016-17



Screening and Uptake

All men who turned 65 between 1 April 2016 and 31 March 2017, and who were registered with a GP in Northern Ireland, were sent at least one screening appointment by the end of March 2017. All men who did not attend their first appointment were offered a further appointment by the end of June 2017. Table 2 below shows the number of men actually screened during the year

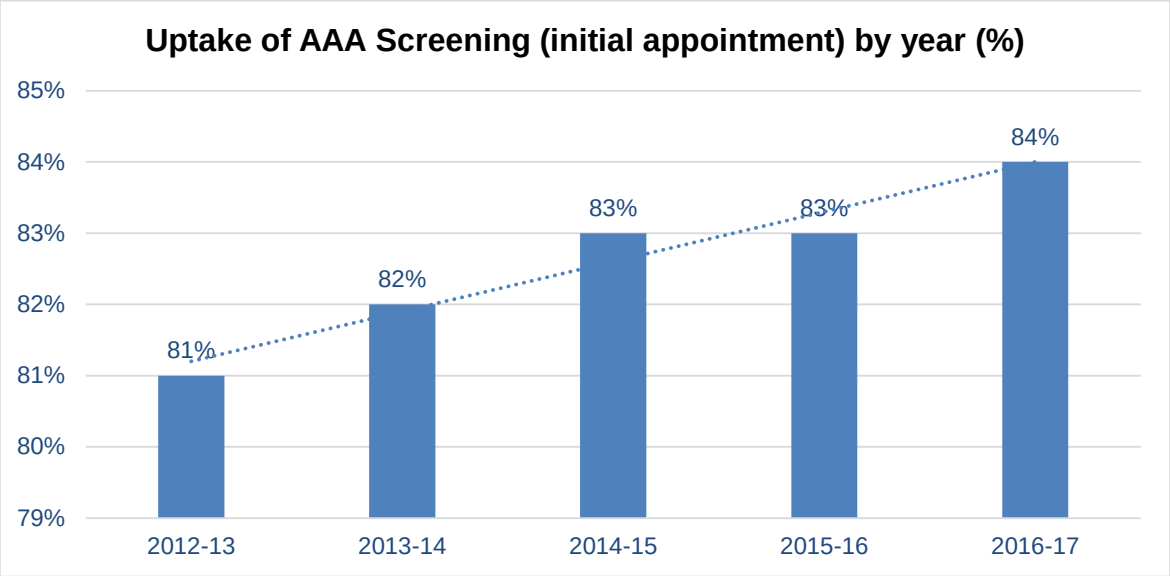
Table 2: Number of men screened in 2016-17 and uptake rate

			TOTAL[6]
2016-17 eligible men and self-referrals aged 65 and over			**9,791**
Those screened:			
Total men 65 and over screened for the first time	**2016-17 cohort**	**7,528**	8,358
	Self-referrals	**830**	
Uptake of initial screening (calculated using 2016-17 cohort only)			84%

Uptake for 2016-17 was 84%, the highest since the programme started. Figure 2 below shows the uptake rates by screening year.

[6] A detailed breakdown of some data is not provided to ensure no patient is identifiable

Figure 2: Uptake of AAA Screening for initial appointment by year



The table below outlines the number of men screened by Trust areas across NI. Please note that for this purpose a Trust is allocated based on the postcode of a man's GP rather than the man's postcode.

Table 3: Uptake rates for AAA Screening by Trust for 2016-17

TRUST	Eligible Men Invited	Number Screened	Uptake
Belfast	1,849	1,471	**80%**
Northern	2,211	1,887	**85%**
South Eastern	1,714	1,504	**88%**
Southern	1,660	1,386	**84%**
Western	1,515	1,280	**85%**
TOTAL	**8,949**	**7,528**	**84%**

AAAs Detected and Prevalence

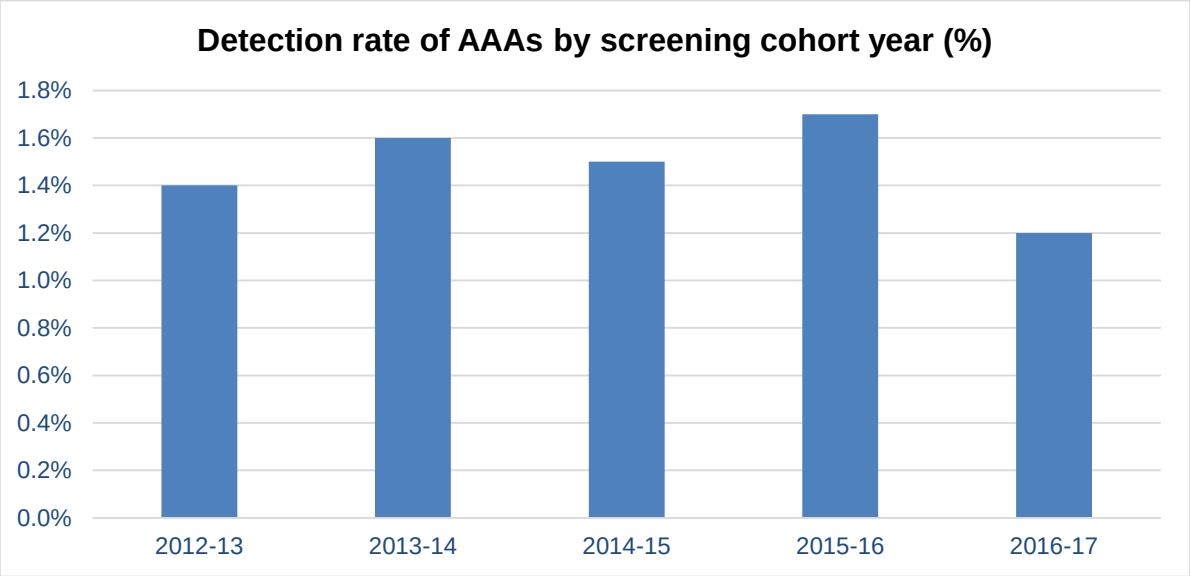
Table 4 below outlines the number of AAAs detected during the 2016-17 screening year, broken down by cohort men and self-referrals. It also notes the number of overall referrals for large AAAs to the Vascular Unit within the Belfast Trust and the prevalence rate.

Table 4: Number of AAAs detected by the Screening Programme 2016-17

Detected AAAs:			
AAAs newly detected by the programme	2016-17 cohort	94	107
	Self-referrals	13	
Referrals to the Vascular Unit			24
Prevalence (calculated using 2016-17 cohort only)			1.2%

Figure 3 below outlines the AAA detection rate for the programme, broken down by year. The prevalence of AAA (aortas measuring 3.0cm in diameter or wider) was 1.2% compared to 4.7% reported in the 20-year-old randomised trial, probably reflecting the reduction in smoking rates and the increase in use of statins during that time. AAA screening should remain cost effective unless the prevalence of AAA in 65-year-old men falls below 0.35%.[7]

Figure 3: Detection rate of AAAs by screening cohort year



Surgery by Type

The vascular team within the Belfast Trust performed surgery on 23 men referred by the programme during 2016-17. Of these, 52% had an elective open repair of their abdominal aortic aneurysm, compared to 48% having endovascular surgery.

[7] **Impact of the first 5 years of a national abdominal aortic aneurysm screening programme** Jacomelli J, Summers L, Stevenson A, Lees T, Earnshaw JJ Br J Surg. 2016 Aug

Performance against key Pathway Standards for 2016-17

The table below compares the programme's overall performance against key national pathway standards for 2016-17.

Table 5: Performance against key Pathway Standards for 2016-17

	Programme Performance	Pathway Standard - Acceptable	Pathway Standard - Achievable
Uptake for initial screening	84%	**≥ 75%**	≥ 85%
Uptake for surveillance	98%	**≥ 90%**	**≥ 95%**
Definitive outcome of scan (screening encounters where aorta could not be visualised)	1.2%	**≤3%**	≤1%
Timely referral (men with AAA ≥ 5.5cm referred within one working day)	100%	**≥ 95%**	**100%**
Timely intervention (men with aorta ≥ 5.5cm seen by a vascular specialist within two weeks)	96%	**≥ 90%**	**≥ 95%**
Timely treatment (men with AAA ≥ 5.5cm deemed fit for intervention and not declining, operated on by a vascular specialist within eight weeks)	83%	**≥ 60%**	**≥ 80%**
30 day mortality (following elective surgery on screen-detected AAAs)	0%	n/a	n/a

Along with the above national pathway standards, the NI programme has adopted an additional standard outlined below in relation to AAAs measuring over 7cm.

Timely treatment (men with AAA >7cm deemed fit for intervention and not declining, operated on by a vascular specialist within four weeks)	100%

Section 6:

Health Inequalities

Population screening programmes need high levels of participation to achieve their desired public health impact. Informed personal choice is central to the screening strategy and the decision to have a screening test or not is for the individual involved. However, many people chose not to take a decision about screening, are not aware of the offer or do not attend their appointment or complete the self-test.

Health inequalities are systematic, avoidable and unjust differences in health and wellbeing between different groups of people. The Marmot Review Fair Society, Healthy Lives (2010) highlighted the social gradient of health inequalities, i.e. the more disadvantaged the person's social position, the worse their health.

Studies on inequalities in AAA screening have found a number of factors:

- the Multicentre Aneurysm Screening Study (MASS) found that higher age and social deprivation are associated with poorer screening attendance and having an AAA[8]
- a Scottish analysis found that both urban residence and social deprivation were associated with lower uptake among men invited for AAA screening[9]

The table and chart below show the uptake rates for initial AAA Screening appointments in Northern Ireland (NI) broken down by areas of deprivation for the 2016-17 screening year. Please note data below was run from a live system on 31 May 2018 and therefore differs slightly to section 5, which is as at 30 June 2017.

Table 6: % men in NI who attended for screening[10] by deprivation 2016-17

Geography		No. eligible	No. screened	% screened (uptake)
NIMDM 2017 Quintile (SOA)	1 (most deprived)	1,552	1,213	78.16%
	2	1,829	1,542	84.31%
	3	1,858	1,613	86.81%
	4	1,876	1,657	88.33%
	5 (least deprived)	1,842	1,642	89.14%
	Unknown	7	7	100.00%
	Northern Ireland	**8,964**	**7,674**	**85.61%[11]**

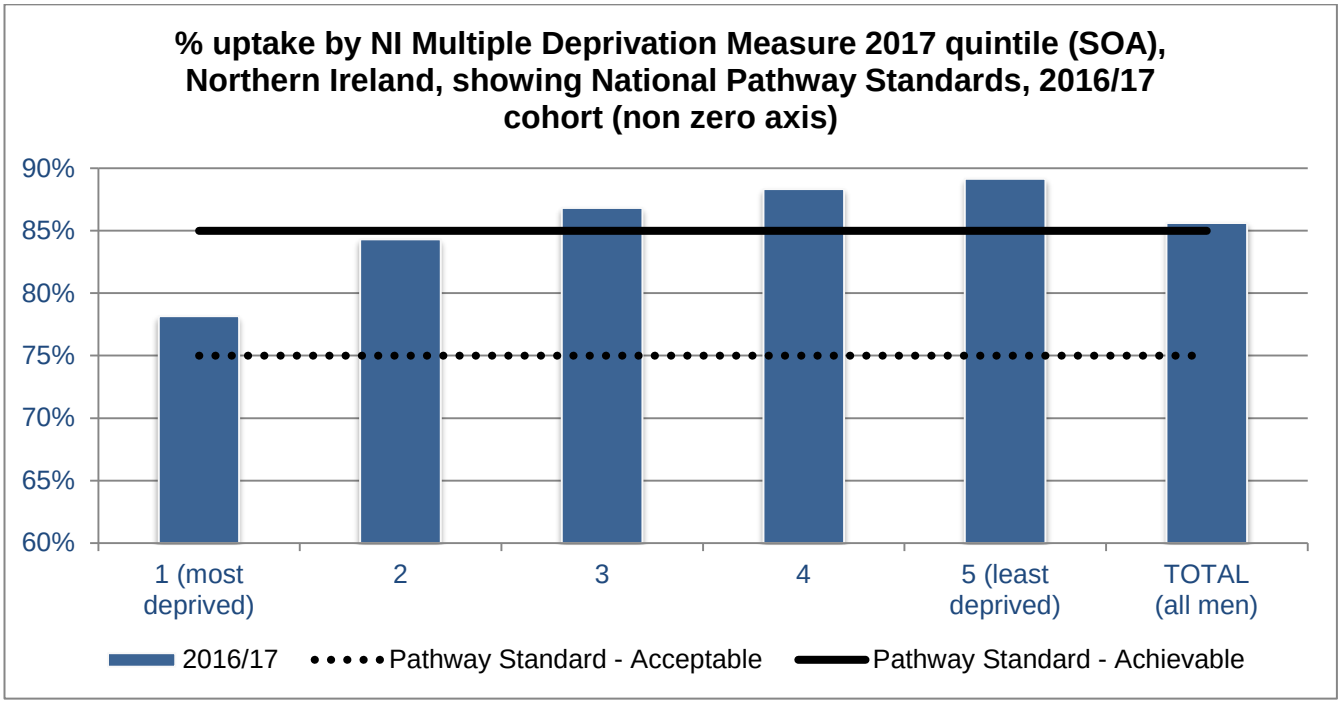
[8] http://journals.sagepub.com/doi/abs/10.1177/096914130301100112?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed&

[9] https://onlinelibrary.wiley.com/doi/pdf/10.1002/bjs.9803

[10] Data relates to 2016-17 cohort only and does not include self-referrals

[11] 2016-17 data was run from the live AAA IT system on 31 May 2018. Data shown is extracted from a live system and so differs slightly from other published data due to different run dates, i.e. year-end uptake for 2016-17 as at 30 June 2017 was 84%

Figure 4: % uptake by NI Multiple Deprivation Measure 2017 quintile (SOA), Northern Ireland, showing National Pathway Standards, 2016/17



Source: AAA Screening Programme, Public Health Agency and Belfast Health and Social Care Trust
Data refers to men invited in the year they turn 65 years of age; self-referrals are not included
National Pathway Standards: Acceptable uptake: ≥75%, Achievable uptake: ≥85%
Northern Ireland Statistics and Research Agency, NI Multiple Deprivation Measure 2017
https://www.nisra.gov.uk/statistics/deprivation/northern-ireland-multiple-deprivation-measure-2017-nimdm2017

There is a clear difference in screening uptake by deprivation quintile. Uptake in areas of Northern Ireland considered most deprived was 78% in 2016-17, rising to almost 89% in least deprived areas.

Notes:
Geographic data is based on the postcode of residence of the man invited / attending for screening. Previously published AAA data and other data in this annual report is analysed using the postcode of the GP Practice at which the man being screened is registered.

Deprivation data is based on the Northern Ireland Multiple Deprivation Measure 2017 at Super Output Area level
(NISRA) https://www.nisra.gov.uk/statistics/deprivation/northern-ireland-multiple-deprivation-measure-2017-nimdm2017

Section 7:

Personal and Public Involvement (PPI)

Personal and Public Involvement (PPI) is enabling the public to influence the planning, commissioning and delivery of health and social care (HSC) services. It includes actively engaging with communities, specifically those who use services such as screening.

The Public Health Agency is the lead organisation responsible for the implementation of PPI policy across all HSC organisations within Northern Ireland.

During 2016-17, the Northern Ireland AAA Screening Programme completed several PPI projects in collaboration with key stakeholders and service users. As well as the annual Service User Event, these included development of a wallet card for men screen-detected with an AAA and the production of an easy-read information leaflet. Further details on all these initiatives are outlined below.

Completed PPI Projects

- The **fifth service user event for men** screen-detected with an AAA and their wives/companions was held in April 2017. In order to ensure the programme continues to identify and meet the evolving needs of its eligible population, the 2017 Service User Event was extended to all men screen-detected with an AAA since the programme's inception in 2012. This was a development from previous events when only men who had been screened in the previous year's cohort were invited (and in line with service user suggestions at the 2016 event).

  The morning workshop was attended by a record number of individuals, with almost 100 participants. More than 70 of these were service users, including many who had taken part in events in previous years. The workshop was facilitated by staff from the PHA and Belfast HSC Trust. It included:
  - updates on programme activity and developments during 2016-17
  - two group discussions
  - lifestyle advice from the Vascular Nurse Specialists (in keeping with requests at the 2016 event)
  - a question and answer session with the programme leads

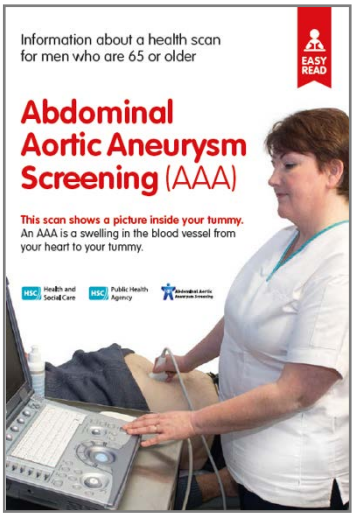
  Attendees also learned that their request for a wallet card had been actioned. The Programme was further delighted to welcome the Chair of

the Public Health Agency, Mr Andrew Dougal, who took part in group discussions and the closing feedback session.

The Chair of the PHA Board, Mr Andrew Dougal, with attendees at the 2017 Service User Event in Belfast

- In response to service users' needs, the programme began issuing **Alert Cards** in early 2017 for men under surveillance (following detection of a small or medium AAA after their initial scan). The card (pictured below) is business card-sized with one side containing information on the size of a man's AAA and how frequently he attends for surveillance; the other carries programme contact details. Men are encouraged to carry these cards and present them to an HSC professional when attending hospital or medical appointments.

- The programme aims to ensure screening is equally available to all men who are eligible. To facilitate this, **easy read versions of the general information leaflet are now available**, in PDF and hard copy formats. These provide information in a format that is suitable for individuals who may have learning disabilities or find reading and writing difficult. The programme is indebted to the wide range of service users within the learning-disabled community, HSC professionals and other key stakeholders who contributed to the project.



- Local newspapers featured an article on **Mr Brian Topping and his wife Naomi** after Brian was screen-detected with a large AAA. Following successful surgery Brian is now fully recovered and enjoying a normal, active life once again. A video, produced with the kind co-operation of Brian and Naomi, recounts Brian's experience of being diagnosed with an aneurysm over 5.5 cm. It is available on the AAA Screening Programme website at **www.aaascreening.info**.

Naomi and Brian Topping with Gill Swain (right), Vascular Nurse Specialist, at the 2015 Service User Event

- Communication colleagues at the PHA, who were instrumental in the production of the new video, also took the opportunity of promoting Brian and Naomi's story via social media. Messaging around Brian's story and the video was published on Facebook, reaching 7,305 people, with 2,700 views of the video. The post got 27 likes and 27 shares. Our thanks to Gary McKeown, Communications Manager, and his colleagues for their help and input.

Section 8:

Role of Primary Care

Primary Care teams are integral to the successful delivery of the NI AAA Screening Programme.

During 2016-17, further editions of the newsletter, 'The AAA Team', were produced. This newsletter, aimed at healthcare professionals, is an important vehicle for the programme to continually engage with primary care teams.

Since the programme began in 2012, the considerable contribution and partnership working with primary care team has been invaluable, particularly in the areas outlined below.

Supporting men with a screen-detected AAA

When an aneurysm is detected, the programme informs the man's GP practice by telephone on the same day. This is followed up in writing.

GPs are then asked to arrange to take measurements for height, weight, BMI and blood pressure, and consider commencing the man on anti-platelet and statin therapy (unless contra-indicated).

For men with a large AAA, GPs are also asked to make a standard referral to the vascular team for further intervention / treatment and to arrange an urgent blood test (U&E).

GPs are the key providers of aftercare for men who have undergone surgical repair.

Providing information to facilitate screening appointments for eligible men

The programme continually liaises with primary care on a range of issues such as:

- Ensuring patient records are accurate – information is downloaded into the programme's IT system on eligible men registered with GPs; programme staff liaise with practices about any discrepancies

- Seeking information about particular needs of men invited for screening, e.g. a physical or sensory disability, limited mobility or a learning disability

– this helps facilitate the screening appointment and allows appropriate arrangements to be made, e.g. extra time for the appointment if required

- Organising an appropriate interpreter or signer when required to facilitate an appointment

Promoting screening

People often rely on the advice of primary care teams when making health decisions. It is therefore important that these teams are well informed about the programme and can discuss the benefits and harms of AAA screening to enable eligible men to make an informed choice.

GPs are notified when a man does not attend his screening appointment. Some GP practices, upon being informed of non-attendance, will either talk to the men opportunistically about screening or proactively contact men to specifically encourage attendance.

Primary care teams have continued to actively promote the programme during 2016-17 to those over 65 and eligible to self-refer. Approximately 35% of all men who self-referred to the programme in 2016-17 did so after being advised of the programme by their GP / pharmacist, or after seeing a poster in the practice waiting area. In particular, GPs have recommended screening to eligible men who have a strong family history of AAAs.

Following the review of the programme's information materials, new packs for healthcare professionals were distributed to all GP practices and pharmacies across NI. Over the course of the next few months, the number of self-referrals increased. Men frequently reported that they had picked up a leaflet in their local pharmacy or their GP surgery or their GP had recommended screening.

Section 9:

Programme Promotion

Evidence of the successful promotion of the programme in 2016-17 is demonstrated by the 830 men who self-referred for AAA screening.

The whole programme team continues to look for opportunities and be involved in a range of activities to raise awareness of AAA screening. A number of highlights are noted below.

Newington Day Centre – clinic

As part of Men's Health week in June 2016, the programme ran a clinic in Newington Day Centre. This non-clinical setting encouraged men who regularly attended the Day Centre to consider screening, men who may not otherwise have been screened. The programme scanned a total of 17 men on the day with a number of others making appointments to be screened at a later date in another venue.

Providing outreach clinics in partnership with Health Promotion teams and the Healthy Living Alliance

During 2016-17, links continued with Health Promotion teams across Trusts and the Healthy Living Alliance. (The Healthy Living Alliance provides services and support to communities experiencing disadvantage and health inequalities, using a neighbourhood-based, community-led approach.) This partnership enabled the programme to run seven clinics identified by the Healthy Living Alliance across NI. Over 100 men were screened across these clinics, men who may not otherwise have been aware of AAA screening.

The clinics provided an opportunity to raise the profile of AAA screening among the local community. It also consolidated links to the voluntary sector and community staff who work in the area and who are keen to continue to work to promote screening locally.

Maximising promotional opportunities at existing screening locations

On an ongoing basis, screening technicians ensure promotional materials are available at all 23 venues across NI where they run clinics. They ensure all the venues are well stocked with posters, promotional packs and leaflets. They also continue to engage with staff in the venues and nearby GP surgeries, dental practices and pharmacies to make sure they were aware of the work of the programme.

Promotion at other healthcare venues and events

As part of the Trust's 'Safetember' event in September, programme staff set up promotional stands in the foyers of four hospital sites within the Trust – Royal Victoria Hospital, Belfast City Hospital, the Mater Hospital and Musgrave Park Hospital. To reach as many eligible men as possible, stands were planned at times when foyers were expected to be busiest, either during visiting times or when outpatient clinics were running.

Men's Sheds

Partnerships have continued to be developed between AAA screening and a number of Men's Sheds across the country.

Men's Sheds originated in Australia to help improve the health and wellbeing of all males. Typically, a Shed is a larger version of what a man might have in his back garden – a place where he feels at home, pursuing practical interests on his own terms. The men share tools and resources to work on projects they've chosen at their own pace in a safe, friendly and inclusive venue. Many Sheds also welcome information sharing initiatives on a wide range of topics including healthcare. Some Sheds target older men to reduce the potential risks of social exclusion and any reduced access to healthcare they might encounter with aging.

During 2016-17, staff attended a number of Men's Sheds local meetings to talk about the programme to members; in addition, promotional materials were sent to further Sheds for inclusion in their local newsletters.

Other promotional activities

The team was also involved in a range of other events such as:

- Working with groups in local areas to submit promotional articles to local press, e.g. the Ulster Gazette, the Newry Reporter
- Attending events at local libraries to promote the programme
- Attending a range of events within local areas, e.g. vintage rally in Greencastle
- Attending events such as those for International Men's Day, Men's Health Fayres and Older People's events

Section 10:

Governance and Accountability

The Public Health Agency

The Public Health Agency has a number of key functions in relation to screening programmes including:

- Leading on the implementation of screening policy, including the introduction of new screening programmes and any changes required to existing screening programmes

- Ensuring the delivery of high quality, safe, effective and equitable screening programmes for people in Northern Ireland

- Supporting continuous quality improvement through programme monitoring and evaluation, and adverse incident investigation and management

The Agency takes lead responsibility for external quality assurance (QA) of the programme. This involves the establishment of a robust QA structure and function, to ensure it meets the responsibilities outlined above.

To help fulfil its core quality assurance function, the PHA has ensured:

- A formalised process is in place for the timely appointment/re-appointment of a clinical lead and an imaging lead

- The establishment of an AAA Screening Co-ordinating Group. This is chaired by the Public Health lead for AAA screening, including PHA staff, patient representatives and all relevant members of the Belfast Health and Social Care Trust NI AAA Screening Programme team

- Regular monitoring of QA data is undertaken

- Appropriate fail-safe mechanisms are in place to ensure screening is offered to all eligible men and that those men requiring surveillance and referral are followed up in a timely and appropriate way

- There is an agreed programme of equipment monitoring

- A programme of formal, external quality assurance visits will be

established in collaboration with the English NHS AAA Screening Programme

Appendix 4 details the PHA's governance and accountability reporting arrangements.

The Belfast Health and Social Care Trust

The Belfast Health and Social Care Trust is responsible for the operational management and delivery of the NI Abdominal Aortic Aneurysm Screening Programme.

The Trust ensures all eligible men are invited to attend for screening in their 65th year. It ensures they are provided with appropriate information, support and advice, particularly those men who have an AAA detected through the programme.

Staff who have responsibility for the operation of the programme are employed by the Trust and carry out all of the scans, including rescans and surveillance scans.

The surveillance programme for men identified with a small or medium AAA is provided by the Trust as part of the NI AAA Screening Programme. Those men who are identified with a large AAA are referred to the vascular surgery team at the Royal Victoria Hospital within the Belfast Trust to discuss potential treatment options.

The Trust also has responsibility for:

- Setting operational policy for the programme
- Liaising with GPs regarding secondary care, particularly when a man is detected as having an aneurysm
- Local (internal) quality assurance of the entire screening process
- Ensuring appropriate failsafe systems are in place
- Providing reports on the performance of the programme and data for quality assurance purposes
- Engaging with stakeholders regarding development of the programme
- Organising and taking part in promotional activities for the programme

Appendix 5 details the Belfast Trust's governance and accountability reporting arrangements.

Audit and Research

Both organisations take joint responsibility for developing and facilitating audit and research activities related to the programme. In 2016-17, a number of research projects were undertaken including the following project outlined below.

AAA Screening in NI increases prescribing of preventative cardiovascular medication for men diagnosed with a small or medium AAA (*G Armstrong, A Maguire, D Bradley, A Mairs, D O'Reilly, F Kee)*

Dr Armstrong's co-authored study considered the impact of AAA Screening, and the intervention of primary care, on the use of medications to reduce cardiovascular risk.

Background
The study was premised on evidence that men diagnosed with abdominal aortic aneurysms are at significant risk of cardiovascular events such as stroke and ischaemic heart disease. Research in England and Wales also suggested that this risk is not addressed sufficiently. The AAA Screening Programme in Northern Ireland has diagnosed hundreds of men with small-medium aneurysms. The aim of this project was to determine if men within the surveillance arm of the NI AAA Screening Programme were being prescribed medications to reduce their risk of cardiovascular events.

Methods
Datasets were linked from the NI AAA Screening Programme (NIAAASP) and the Enhanced Prescribing Database. All men were included who were invited for AAA screening between 2012 and 2014 (n=24,278). Prescription of medications to reduce cardiovascular risk before and after screening was compared, including: anti-platelets, statins and anti-hypertensives. Statistical analysis was performed to determine the likelihood of prescription of these medications for the men.

Results
Diagnosis with a small or medium aneurysm increased statin prescribing by 26% and anti-platelet prescribing by 50%. This relationship was even stronger in men who were not on any medications prior to screening. There was no significant change in prescription of cardiovascular medications for men who did not attend screening or for men with no aneurysm.

Conclusion
Attending the NIAAASP increases the likelihood that men diagnosed with small to medium AAAs are commenced on cardiovascular risk-reducing medication. AAA screening may therefore provide an opportunity to address cardiovascular risk factors for a high-risk group.

Dr Gillian Armstrong presented this work at the **NHS England AAA Screening Programme's Audit and Research Day in February 2017 in Leicester**.

Section 11:

Future Developments

The NI AAA Screening Programme (NIAAASP) remains committed to continued development of the programme, building on achievements to date and continuing to improve the AAA screening experience for service users.

Whilst continuing to deliver on the core objectives of the programme as outlined in Section 3 of this report, during 2017-18 the programme will:

- Endeavour to secure a date for an External Quality Assurance (EQA) visit from Public Health England and English NHS AAA Screening Programme colleagues. This is in line with the rollout of the NIAAASP's EQA function and structure.

- Produce an AAA screening video detailing what happens when men attend for an initial scan, including information on how to access screening for minority groups (for example physically and learning disabled men).

- Identify and address inequalities in the AAA Screening Programme through awareness-raising sessions amongst relevant voluntary groups and participation in the development of a UK Health Inequalities Toolkit.

- Work in partnership with appropriate prison healthcare providers to facilitate screening clinics for eligible men.

- Consider any further opportunities to raise general awareness of the programme and encourage further self-referrals, e.g. through promotional opportunities and continued engagement with Men's Sheds, etc.

- Continue engagement with GPs and other primary care teams to raise awareness of the programme and continue to promote the self-referral pathway, e.g. by attending flu clinics.

- As appropriate, identify additional appropriate venues to enable AAA screening to be provided within local areas.

- Undertake the required procurement process to source funding for and purchase six new portable ultrasound machines for the programme.

- Undertake a review of the letters used by the programme and update as appropriate.

Appendices

1 NI AAA Screening Programme Staff

2 Map of Screening Locations

3 The Screening Pathway

4 Governance and Accountability Structure: Public Health Agency

5 Governance and Accountability Structure: Belfast Health and Social Care Trust

Appendix 1 – NI AAA Screening Programme Staff

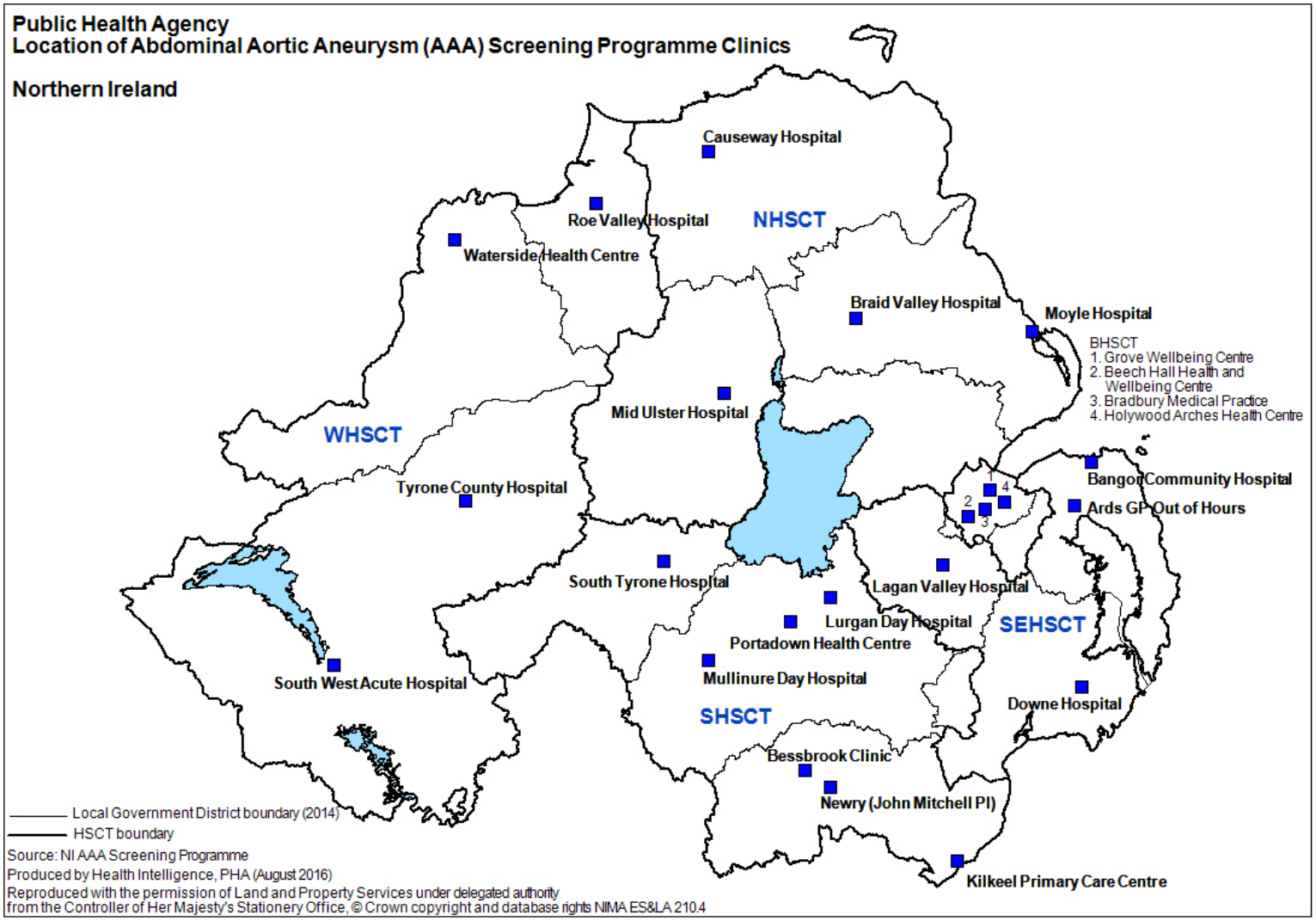
Belfast Health and Social Care Trust

Paul Blair	Clinical Lead
Janet Callaghan	Clinical Co-ordinator
Lisa Campbell	Administrative Assistant
Ciara Conway	Screening Technician
Sarah Davidson (until June 2016)	Administrative Assistant
Trez Dennison	Vascular Nurse Specialist
Elaine Donnelly	Screening Technician
Sarah-Louise Dornan (from May 2016)	Deputy Programme Manager
Peter Ellis	Imaging Lead
Paul Fusco (from October 2016)	Administrative Assistant
Deborah Galloway	Screening Technician
Paul Goodyear (from August 2016)	Screening Technician
Paula Heaney	Screening Technician
Deirdre Kearns	Lead Screening Sonographer
Pauline McMahon	Screening Technician
Karen McClenaghan	Specialist Surgery Services Manager
Kathy McGuigan	Vascular Nurse Specialist
Gillian Newell	Screening Technician
Diane Stewart	Programme Manager
Gill Swain	Vascular Nurse Specialist

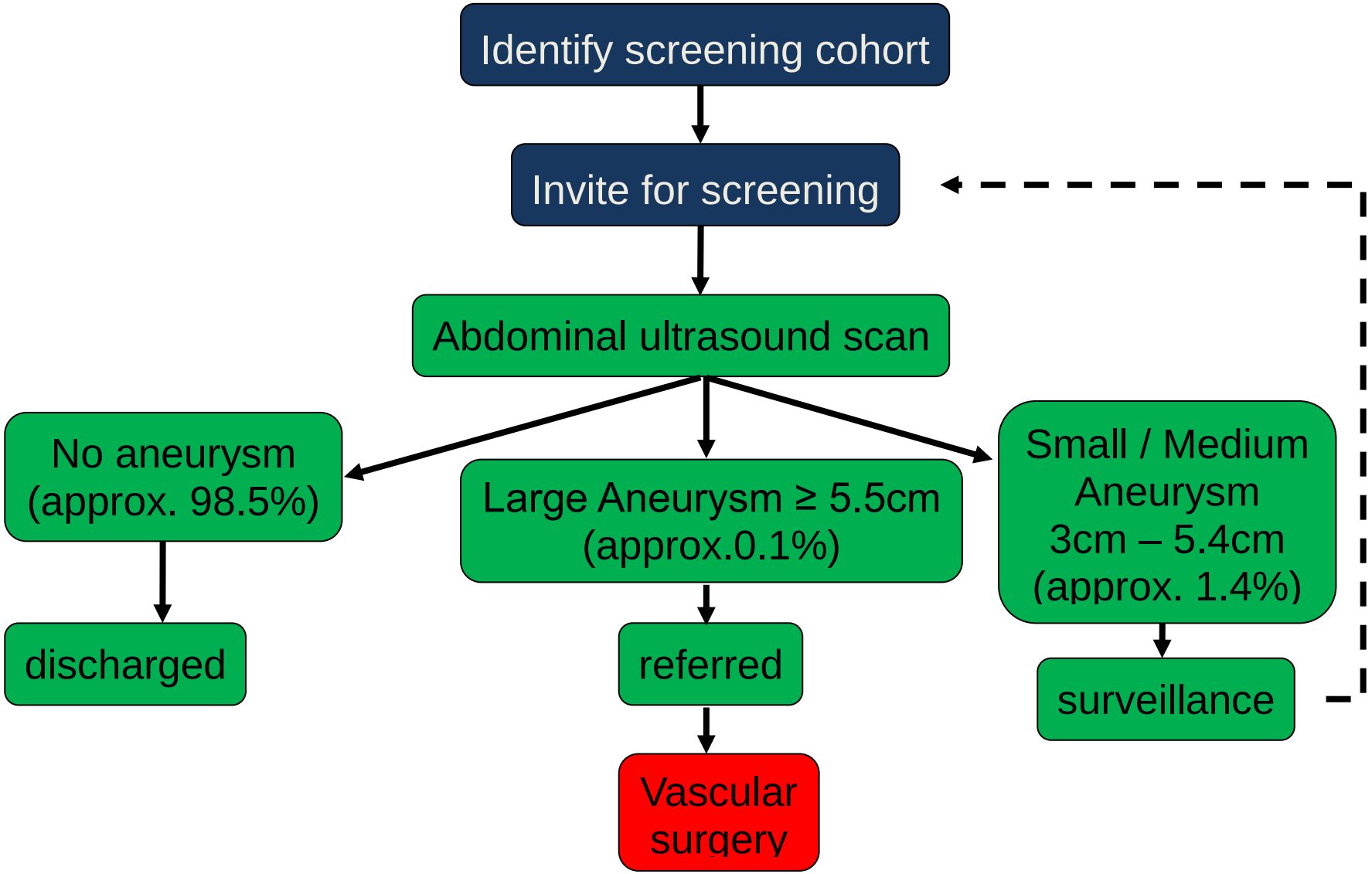
The Public Health Agency

Adrian Mairs (until September 2016)	Public Health Lead
Stephen Bergin (from October 2016)	Public Health Lead
Jacqueline McDevitt	QA and Commissioning Support Mgr
Sonya Myladoor (from November 2016)	Administrative Support

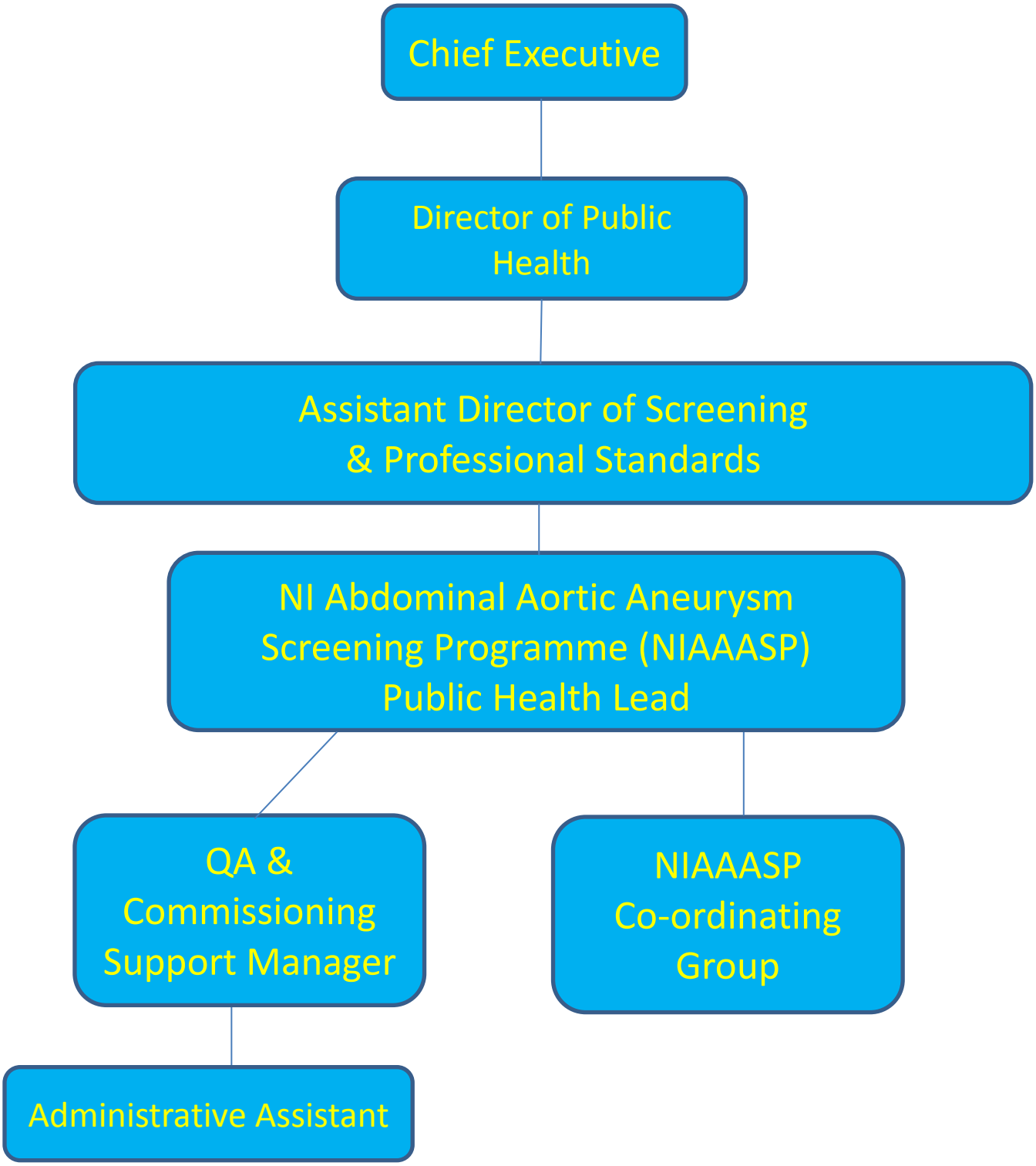
Appendix 2 – Map of Screening Locations



Appendix 3 – The Screening Pathway

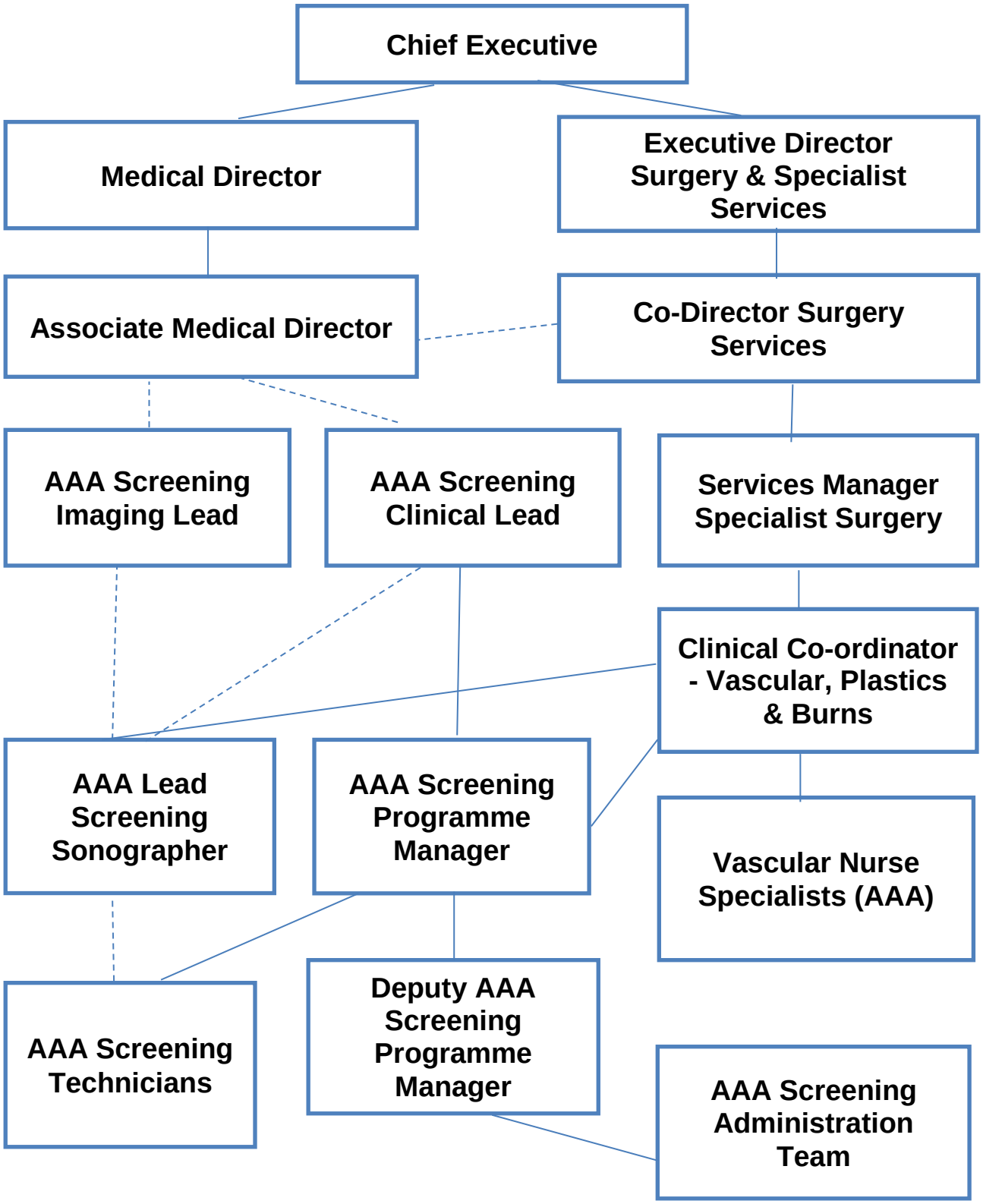


Appendix 4 – Governance and Accountability Structure: Public Health Agency



Appendix 5 – Governance and Accountability Structure: Belfast Health and Social Care Trust

Organisational chart as at March 2017



If you are interested in finding out more about being screened please contact the Screening Programme Office on 02890 631828.

HSC Public Health Agency

board paper

Annual Immunisation Report for Northern Ireland 2017/18

date	15 November 2018	**item**	10	**reference**	PHA/04/11/18

presented by Dr Adrian Mairs, Acting Director of Public Health

action required For noting

Summary

This is the third annual immunisation report for Northern Ireland for the year 2017-18, collated by the Immunisation Team of the Health Protection Directorate.

The report includes vaccine coverage for all universal and targeted childhood and adult programmes delivered in Northern Ireland. Coverage is provided at different time points in the year depending on the programme.

This year, PHA vaccination programmes were audited by Internal Audit and reported an overall satisfactory level of assurance. A minor recommendation was to present the annual report on a timelier basis (last year February 2018). We therefore present this year's report in early November - the earliest date possible following collection of data from vaccine programmes delivered in schools. Targets for the immunisation programmes are also included in PHA business plans.

The year 2017-18 has again been a successful one for the childhood and adult immunisation programmes. Uptake of immunisations for children under 5 years of age continues to be amongst the highest in the UK although work continues to ensure that this high level is maintained.

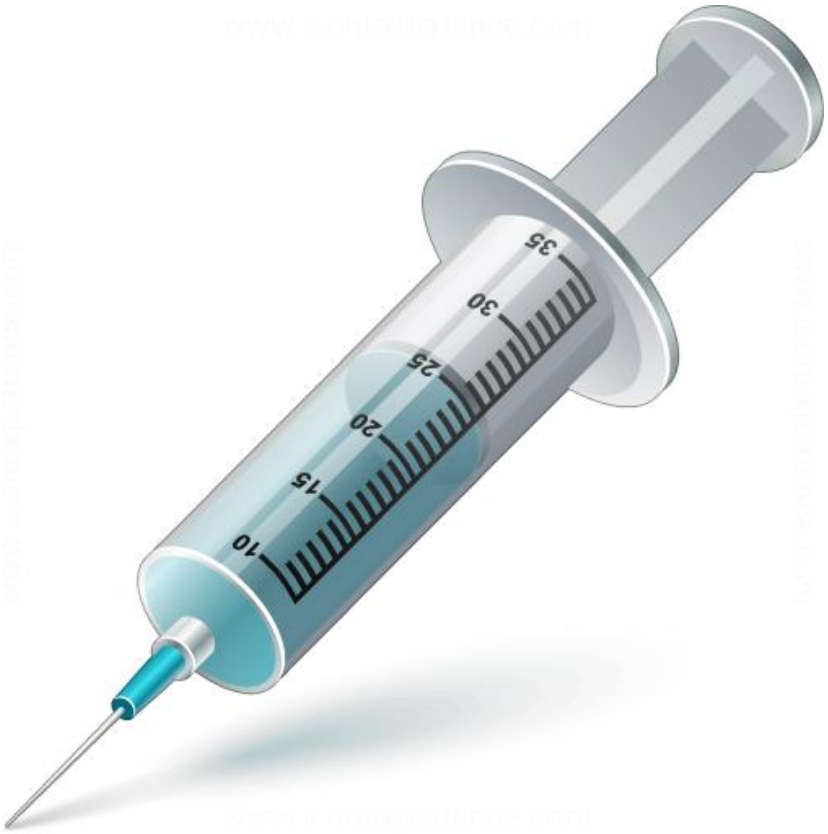
Equality Impact Assessment

Not applicable.

Recommendation

The Board is asked to **NOTE** the Annual Immunisation Report for 2017/18.

Annual Immunisation Report for Northern Ireland 2017-18



HSC Public Health Agency

Acknowledgements

The Public Health Agency immunisation team would like to thank everyone who works so hard across Northern Ireland to ensure that the population is protected against vaccine preventable diseases by maintaining high vaccine coverage. This includes health visitors, school health teams, GPs, practice nurses, treatment room nurses, midwives, paediatricians, genitourinary medicine (GUM) staff, Trust occupational health staff, Northern Ireland Child Health teams and the PHA communications team.

We are grateful to all those who contributed to the uptake data in this report including Northern Ireland Child Health System teams, school health teams and surveillance colleagues Joy Murphy, Ruth Campbell, Monica Sloan, Lewis Shilliday and Mark O'Doherty.

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Summary

Immunisation Programmes

- For the year 2017-18 uptake of three doses of DTaP/IPV/Hib vaccine by 12 months of age was 96.2% in Northern Ireland, which is a slight decrease from the previous year, but still above the 95% target level
- Uptake of one dose of MMR vaccine by 2 years of age was 94.4%. This is a 0.5% decrease from last year and just below the 95% target level
- Uptake of two doses of MMR by 5 years of age was 92.4%, a 0.4% decrease on the level last year, but still the highest uptake in the UK
- By the end of school year 10, 84.7% of girls had completed a course of HPV vaccine, a decrease from 89.6% in 2016-17
- By the end of school year 12 in 2018, 94.4% of young people had received two doses of MMR vaccine, 80.0% had received a booster of Td/IPV vaccine and 85.3% had received the new meningococcal ACWY vaccine
- Uptake of pertussis vaccine in pregnancy was 69.3% in Northern Ireland for the first year (September 2017 to August 2018) using data from the Northern Ireland Maternity Administration System (NIMATS)
- For the year 2017-18, 51.5% of 70 year olds received the shingles vaccine and 48.2% of 78 year olds. This is a slight increase to the previous year but still lower than when the first programme commenced. Uptake of those still eligible to receive the vaccine in subsequent years has increased over time
- Uptake for the first 15 months (October 2016 – December 2017) of the HPV vaccine programme for men who have sex with men (MSM) under 46 years of

age was 73.3% for one dose, 50.2% for two doses and 24.5% for three doses (completed course)

- In September 2017 a new combined vaccine containing protection against hepatitis B was added to the primary immunisation schedule for babies at 2, 3 and 4 months of age

Priorities for Improvement

- PHA will continue to work with GP, health visitor and Child Health Information System colleagues to gain a greater understanding of the decreases in pre-school immunisation uptake across Northern Ireland and work together to improve coverage, particularly in the Belfast area
- PHA will work with school health and communications colleagues to improve the uptake of HPV vaccine for 2018-19
- PHA will develop the Northern Ireland Measles and Rubella Elimination Action Plan in partnership with relevant colleagues
- PHA will develop new monitoring reports to outline shingles coverage for each annual routine cohort since the programme commenced
- PHA will work with maternity colleagues to improve the awareness and understanding of vaccinations given in pregnancy

Introduction

According to the *WHO Global Vaccine Action Plan 2011-2020*, "Overwhelming evidence demonstrates the benefits of immunisation as one of the most successful and cost-effective health interventions known."[1] Their vision for the Decade of Vaccines (2011–2020) is of a world in which all individuals and communities enjoy lives free from vaccine preventable diseases.

Immunisation policy for Northern Ireland is set by the Department of Health, on advice from the independent Joint Committee for Vaccines and Immunisation (JCVI). This committee regularly reviews the epidemiology of vaccine preventable diseases (VPDs) in the UK and makes recommendations on the introduction of new programmes in response to changes in disease incidence and the likely cost-effectiveness of vaccination programmes. The UK has a very comprehensive vaccine programme, free at the point of delivery for those eligible by virtue of age or risk group status.

Northern Ireland has implemented all JCVI recommendations and has some of the highest immunisation uptakes worldwide. This has undoubtedly contributed to a reduction in the burden of communicable diseases in Northern Ireland.

Though vaccine coverage is high overall, health inequalities mean that some groups of people and some areas in Northern Ireland are less likely than others to be vaccinated. The PHA immunisation team is committed to working towards the WHO vision where individuals and communities enjoy lives free from VPDs by maintaining and improving uptake rates of all immunisations.

The 2017-18 Northern Ireland Vaccination Report includes information on the vaccine coverage in each of the programmes. Coverage data in each section is provided at different time points in the year depending on the programme:

- Coverage for the childhood immunisations up to the age of 5 are presented for the financial year April 2017 – March 2018, in line with national COVER statistic reporting

- Coverage for immunisations provided in schools are presented for the school year September 2017 – August 2018 in line with delivery of school programmes
- Coverage for shingles and pneumococcal polysaccharide vaccine (PPV) is presented from September 2017 - August 2018, in line with delivery of the programme alongside the seasonal influenza vaccine programme
- Coverage for the pertussis vaccine in pregnancy is presented from September 2017 to August 2018 for this year, in line with introduction of new data extracted from the Northern Ireland Maternity Administrative System (NIMATS system introduced 7 August 2017). Future years will presented by financial/calendar years

Information on the epidemiology of VPDs is now included in a separate report to enable more timely reporting, released annually in the spring. Information on influenza immunisations has been published elsewhere, in the Surveillance of Influenza in Northern Ireland 2016-17 report[2].

The Routine Childhood Immunisation Schedule in Northern Ireland from October 2017

When to immunise	Diseases vaccine protects against	How it is given
2 months old	Diphtheria, tetanus, pertussis (whooping cough), polio, Hib and hepatitis B	One injection
	Pneumococcal infection	One injection
	Rotavirus	Orally
	Meningococcal B infection	One injection
3 months old	Diphtheria, tetanus, pertussis, polio, Hib and Hepatitis B	One injection
	Rotavirus	Orally
4 months old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B	One injection
	Pneumococcal infection	One injection
	Meningococcal B infection	One injection
Just after the first birthday	Measles, mumps and rubella	One injection
	Pneumococcal infection	One injection
	Hib and meningococcal C infection	One injection
	Meningococcal B infection	One injection
Every year from 2 years old up to P7	Influenza	Nasal spray or injection
3 years and 4 months old	Diphtheria, tetanus, pertussis and polio	One injection
	Measles, mumps and rubella	One injection
Girls 12 to 13 years old	Cervical cancer caused by human papillomavirus types 16 and 18 and genital warts caused by types 6 and 11	Two or three injections over six months
14 to 18 years old	Tetanus, diphtheria and polio	One injection
	Meningococcal ACWY	One injection

Targeted Childhood Immunisations

When to immunise	Diseases vaccine protects against	Vaccine given
At birth, 1 month old and 12 months old	Hepatitis B	Hepatitis B vaccine
At birth	Tuberculosis	BCG
Six months up to two years	Influenza	Inactivated flu vaccine
11 to less than 18 years	Influenza	Flu nasal spray or inactivated flu vaccine

(For children assessed as being at risk of these conditions)

Routine Immunisation Schedule for Adults

When to immunise	Diseases vaccine protects against	Vaccine given
Age 65 years	Pneumococcal Disease	PPV-23
Annually from age 65 years	Influenza	Inactivated flu vaccine
Age 70 years	Shingles	Zostavax ®

Targeted Adult Immunisations

Who to immunise	Diseases vaccine protects against	Vaccine given
Risk groups described in annual CMO letter	Influenza	Inactivated flu vaccine
Risk groups described in Green Book	Pneumococcal Disease	PPV-23
Pregnant women from 16th gestational week	Pertussis (Whooping Cough) in newborn	Boostrix-IPV ®

Men who have sex with men, aged ≤45 years who attend GUM clinics	Anal, throat and penile cancer caused by human papillomavirus types 16 and 18 and genital warts caused by types 6 and 11	Gardasil ®
All adults born since 1970 with no history of two doses of MMR vaccine	Measles, mumps and rubella	MMR vaccine
Catch-up cohorts published annually	Shingles	Zostavax ®

Uptake and Coverage in Childhood Immunisation Programmes

Immunisations up to 12 months of age

The routine immunisation schedule for babies at 2, 3, and 4 months is detailed on page 8. In October 2017 a change was made to add protection against hepatitis B to the routine schedule with the combined 6 in 1 vaccine. Uptake data for this new antigen at the age of 12 months will be available next year. The uptake of primary immunisations in Northern Ireland is consistently equal to or higher than other areas of the UK. However, there is variation of uptake by local commissioning group (LCG) area, with uptake now 2-3% lower in Belfast than other areas (Table 1).

Table 1. Completed primary immunisations by 12 months of age, 2017-18, Northern Ireland and UK

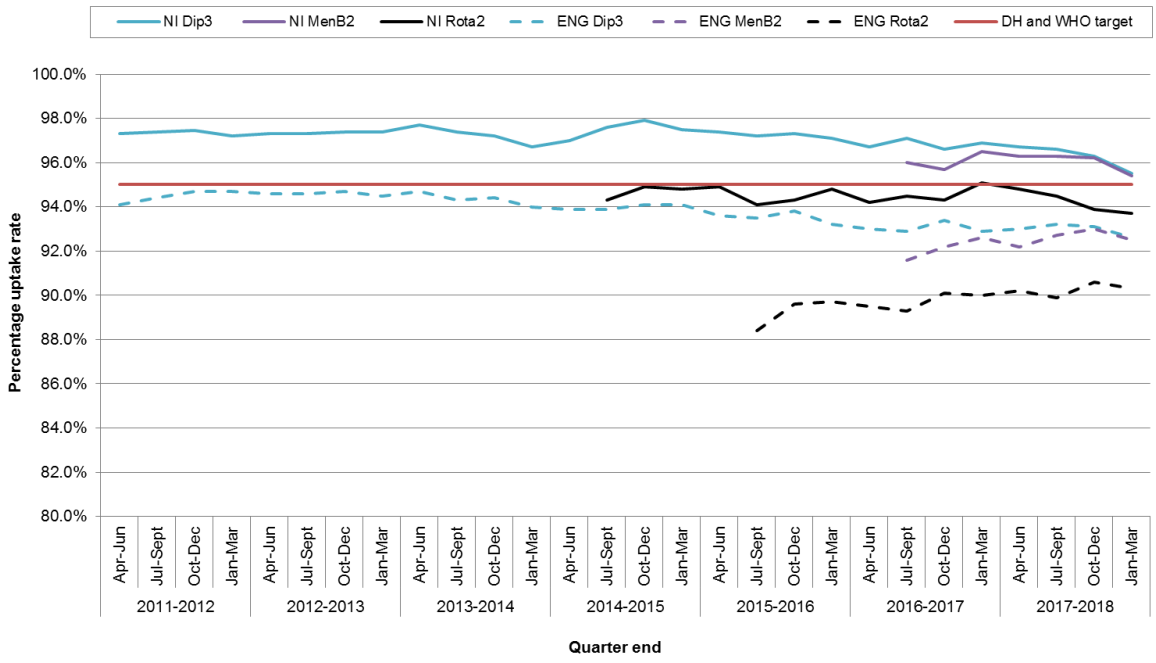
Area	% vaccinated at 12 months			
	DTaP/IPV/Hib3	PCV2	Rota2	MenB2
Belfast	93.4%	93.8%	92.4%	93.1%
South Eastern	96.2%	96.4%	94.4%	96.0%
Northern	96.8%	97.0%	95.0%	96.4%
Southern	97.0%	97.3%	94.7%	96.6%
Western	97.3%	97.5%	93.6%	96.9%
NI Total	**96.2%**	**96.4%**	**94.1%**	**95.8%**
England	**93.1%**	**93.3%**	**90.1%**	**92.5%**
Scotland	**96.5%**	**96.8%**	**93.4%**	**95.9%**
Wales	**95.9%**	**95.9%**	**93.8%**	**95.3%**
UK	**93.6%**	**93.8%**	**90.6%**	**92.9%**

Source: Quarterly COVER returns (Northern Ireland Child Health System and PHE)

A slight but concerning decrease in uptake can be noted over the past 18 months, which is mirrored in England.

PHA are working with colleagues in Northern Ireland as well as the rest of the UK to identify the reasons for this decrease and to work to improve uptake again.

Figure 1. Diphtheria, Meningococcal B and Rotavirus vaccination uptake rates at 12 months of age, April 2011 – March 2018, Northern Ireland and England



Source: Quarterly COVER returns (Northern Ireland Child Health System and PHE)

Immunisations up to 24 months of age

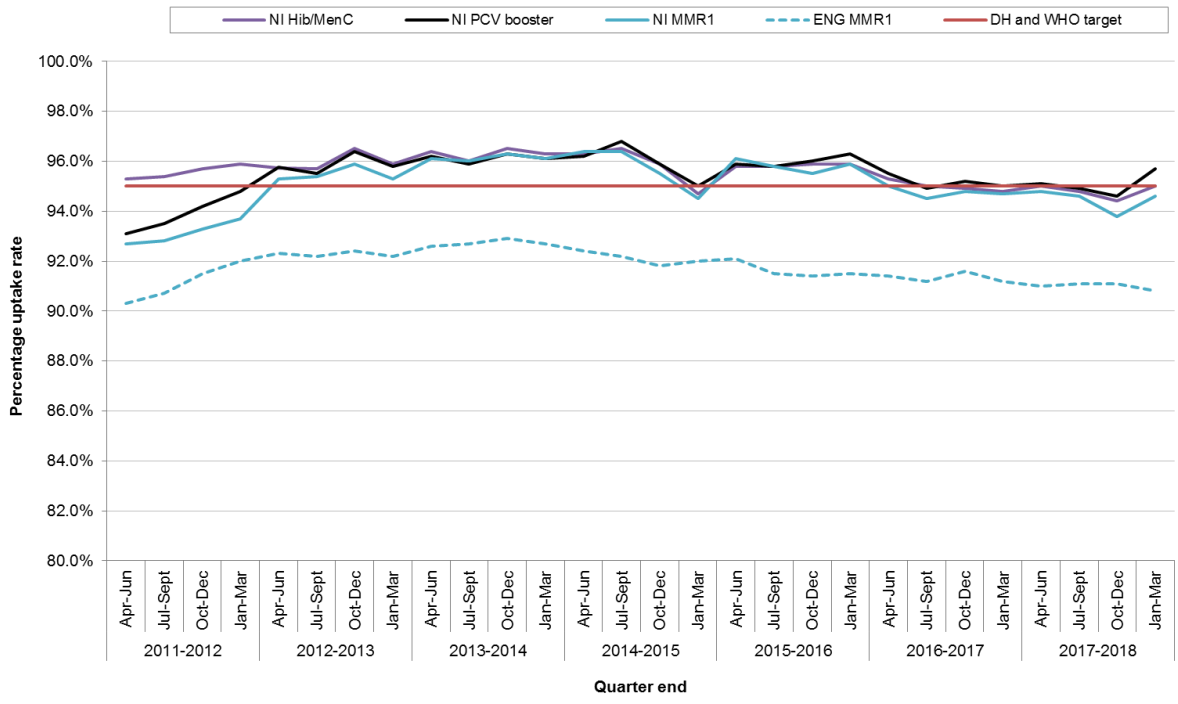
Uptake rates of all immunisations given just after the first birthday and measured at 24 months for 2017-18 (Table 2) are just below the 95% target, but they are still similar to or higher than the uptake across the other parts of the UK. This fall is mainly due to the fact that the uptake of vaccines at 24 months in the Belfast LCG area is only 90%, approximately 4% lower than the other areas.

Table 2. Completed primary immunisations by 24 months of age, 2017-18, Northern Ireland and UK

Area	% vaccinated at 24 months			
	DTaP/IPV/Hib3	PCV Booster	Hib/MenC	MMR1
Belfast	95.7%	90.8%	90.4%	90.8%
South Eastern	97.8%	95.3%	94.8%	94.9%
Northern	98.7%	95.8%	95.8%	95.1%
Southern	98.0%	94.9%	95.2%	95.1%
Western	98.3%	96.5%	96.4%	95.6%
NI Total	**97.8%**	**94.7%**	**94.6%**	**94.4%**
England	**95.10%**	**91.00%**	**91.20%**	**91.20%**
Scotland	**97.60%**	**94.80%**	**94.90%**	**94.60%**
Wales	**96.60%**	**95.20%**	**94.50%**	**94.70%**
UK	**95.40%**	**91.60%**	**91.70%**	**91.70%**

Source: Quarterly COVER returns (Northern Ireland Child Health System and PHE)

Figure 2. Haemophilus Influenzae type B/Meningococcal group C, Pneumococcal and MMR1 vaccination uptake rates at 24 months of age, April 2011 – March 2018, Northern Ireland and England



Source: Quarterly COVER returns (Northern Ireland Child Health System and PHE)

Quarterly uptake figures show that after slow decrease in uptake over about 18 months, the last quarter of 2017-18 shows an increase again and this will continue to be monitored. The quarterly data also show the first uptake figures for the booster dose of the new Meningococcal B vaccine. It is encouraging to note this is above 95% and in line with uptake of the other vaccines given just after the first birthday, showing that this vaccine is acceptable to parents.

Immunisations up to five years of age

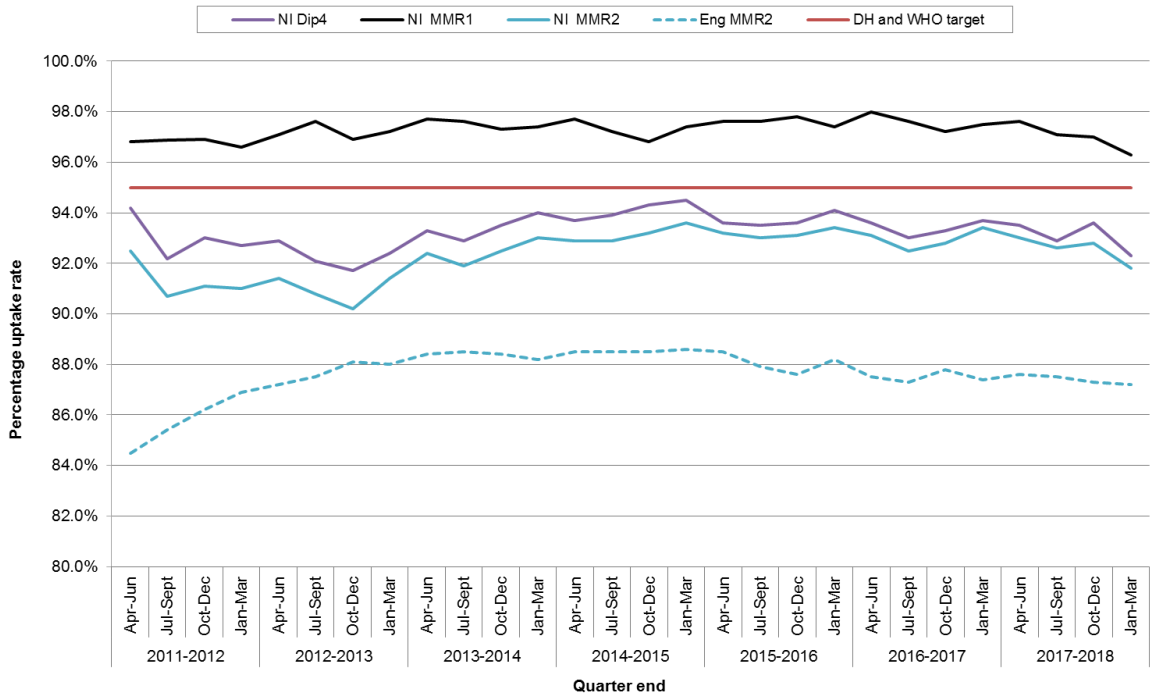
Children are offered “pre-school booster” immunisations from the age of 3 years and 4 months, providing a fourth dose booster of protection against diphtheria, tetanus, polio and pertussis (DTaP/IPV) and a second dose of MMR vaccine. Uptake of these immunisations measured at 5 years show that this is below 95% for 2017-18, and slightly below last year’s figures of 92.8% for second MMR and 93.3% for DTaP/IPV. Although uptake of one MMR in the Belfast area is over the 95% target by 5 years of age, the uptake of the booster doses are around 6% lower than the other areas. Uptake of MMR2 in Belfast is below the 95% target needed to ensure that the spread of measles outbreaks can be contained through herd immunity, making improving MMR2 uptake an important goal. With this in mind, PHA has worked with Belfast GP’s in 2018 to try to improve uptake of MMR in children of school age and the success of this approach will be evaluated and reported on next year.

Table 3. Completed primary immunisations and boosters by 5 years of age, 2017-18, Northern Ireland and UK

Area	% vaccinated at 5 years			
	DTaP/IPV/Hib3	MMR1	MMR2	DTaP/IPV booster
Belfast	96.3%	95.4%	87.3%	87.6%
South Eastern	97.6%	96.8%	93.0%	93.4%
Northern	97.8%	96.7%	93.7%	94.6%
Southern	97.2%	97.0%	93.3%	93.6%
Western	98.1%	98.3%	94.2%	94.9%
NI Total	**97.4%**	**96.8%**	**92.4%**	**92.9%**
England	**95.6%**	**94.9%**	**87.2%**	**85.6%**
Scotland	**98.0%**	**96.9%**	**92.1%**	**92.7%**
Wales	**93.5%**	**96.5%**	**89.5%**	**92.3%**
UK	**95.7%**	**95.2%**	**87.8%**	**86.6%**

Source: Quarterly COVER returns (Northern Ireland Child Health System and PHE)

Figure 3. Diphtheria and MMR vaccination uptake rates at 5 years of age, April 2011 – March 2018, Northern Ireland and England



Source: Quarterly COVER returns (Northern Ireland Child Health System and PHE)

As with uptake at one year, there has been a slow but steady decline in uptake at 5 years on the quarterly data. PHA are investigating the reasons for the decreasing uptake.

Work to improve uptake of pre-school immunisations

PHA again worked with Health and Social Care Board (HSCB) and Child Health System (CHS) colleagues to produce data for each GP practice on their uptake of pre-school immunisations. This was sent to all practices along with a sheet explaining how practices can work with the CHS to ensure that all eligible children are called in a timely way for the immunisations that they are due.

Further work is ongoing to work with particular practices where specific issues have been identified.

In 2018 PHA also looked at the MMR uptake of children from the ages of 4 years to those entering year 10 at school. It was noted that uptake was lower in the Belfast area than the rest of the province. PHA then worked with HSCB to provide some funding to Belfast practices to check the records of children thought not to be fully immunised with two doses of MMR. Child health records were updated if the information was incorrect and those who were under immunised were called for MMR vaccine. The success of this approach will be evaluated later in 2018.

During summer 2017 a small outbreak of measles occurred in unvaccinated adults and children in the Belfast area from a likely source of an imported Roma-Romania case that had travelled from Europe during the incubation period (described in VPD surveillance report). Following this, PHA worked with communications colleagues to provide information to the public on the importance of receiving two doses of the MMR vaccine before travel. PHA also commissioned a professional marketing company to carry out focus groups with Roma-Romanian communities living in the Belfast area to better understand the community's understanding, attitudes and factors influencing vaccinations. Findings showed a general acceptance of vaccinations but highlighted communication issues and access as barriers to receiving vaccines. The PHA has started working on promotional video resources to promote MMR vaccine.

Teenage Immunisations

Human Papilloma Virus (HPV)

In 2008, the Human Papilloma Virus (HPV) vaccine was introduced for girls aged 12-13 years old, with a catch-up campaign for girls up to 18 years old. The HPV vaccine offers protection against types 16 and 18 of the virus which together cause up to 70% of cervical cancers, as well as protection against types 6 and 11 of the virus which cause genital warts. The programme is delivered routinely in schools with vaccines given in year 9 and then opportunities provided in school to catch-up on missing doses in year 10.

The uptake of a completed course by the end of year 9 has fallen since a maximum in 2012, but due to further clinics being offered in year 10, nearly 85% of girls had completed the course by the end of year 10 in June 2018. This is higher than the uptake reported for the same age in England for 2016-17 of 83% (2017-18 data not yet available for England), (Table 4, Figure 4).

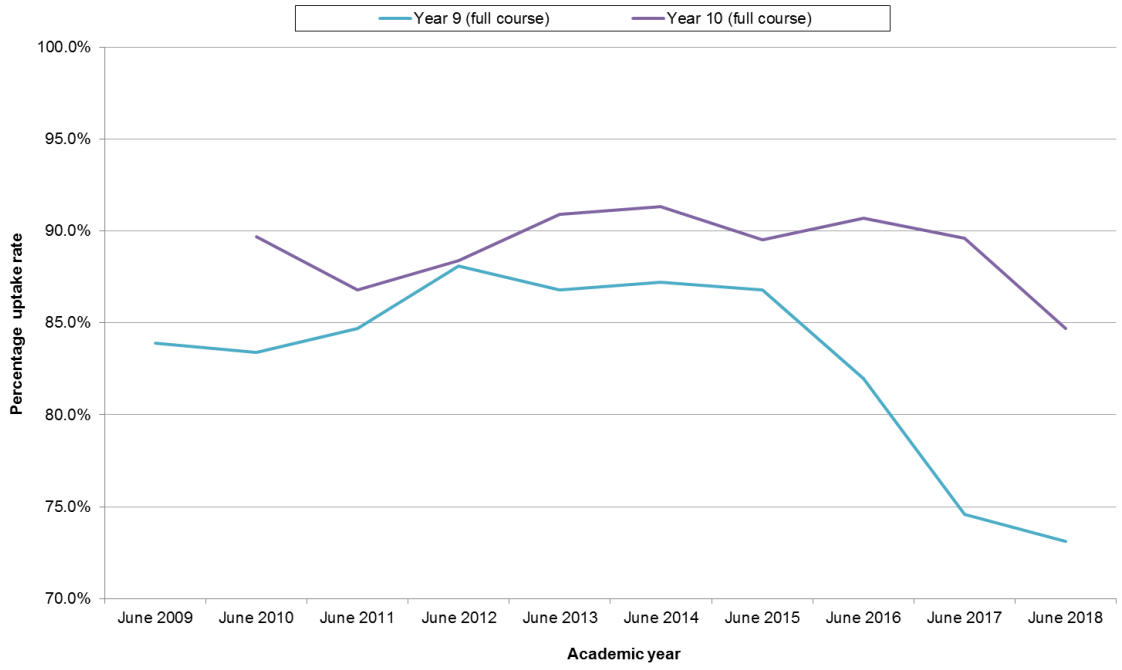
We are pleased to note that the fall in uptake for completed course in year 9 is much less than in the previous two years and is levelling off. Due to the catch-up opportunities in year 10, about 10% of girls who did not complete the course in year 9 in 2016-17 had done so in 2017-18 when they were in year 10. PHA are continuing to work with communications colleagues and school health teams to promote the vaccine and to encourage parents to take up the offer of HPV vaccine in year 9 rather than waiting until year 10. Girls who have not completed the course of vaccines can request this from their GP up to the age of 18 years.

Table 4. HPV vaccination uptake rates, year 9 and 10 girls completing full course, 2009-18, Northern Ireland

	Year 9 (full course)	Year 10 (full course)
June 2009	83.9%	
June 2010	83.4%	89.7%
June 2011	84.7%	86.8%
June 2012	88.1%	88.4%
June 2013	86.8%	90.9%
June 2014	87.2%	91.3%
June 2015	86.8%	89.5%
June 2016	82.0%	90.7%
June 2017	74.6%	89.6%
June 2018	73.1%	84.7%

Source: Northern Ireland Child Health System

Figure 4. HPV vaccination uptake rates, year 9 and 10 girls completing full course, 2009-18, Northern Ireland



Source: Northern Ireland Child Health System

Diphtheria, Tetanus and Polio booster

In year 11, school health teams offer a booster vaccine to all young people against diphtheria, tetanus and polio (Td/IPV), commonly known as the "school leaver booster". For most young people this will be the fifth and final dose that they require. At this visit, school health also offer MMR to any children who have not yet received two doses to ensure that they complete the recommended course. There is a further opportunity to receive the Td/IPV and MMR vaccines in year 12 for those who have not yet completed the course. Eighty percent of pupils had received the completed course of diphtheria, tetanus and polio containing vaccines by the end of year 12 in 2017-18, a decrease of 5% from last year (Table 5). Pupils who have not received this vaccine from school health can request it from their GP.

It is very encouraging to note that even though the level of two doses of MMR is below the 95% target level at five years of age, by the end of year 12 the population coverage for two doses of MMR has increased to 94.4%.

Table 5. Annual school leaver booster vaccine coverage, 2017-18, Northern Ireland

Area	Year 11 % vaccinated	Year 12 % vaccinated
Belfast	73.6%	77.0%
South Eastern	70.5%	76.3%
Northern	75.5%	83.1%
Southern	76.3%	82.1%
Western	68.3%	80.3%
NI Total	**73.3%**	**80.0%**

Source: Northern Ireland Child Health System

Table 6. Annual MMR2 vaccine coverage, 2017-18, Northern Ireland

Area	Year 12 % vaccinated
Belfast	93.3%
South Eastern	93.2%
Northern	95.2%
Southern	94.9%
Western	95.1%
NI Total	**94.4%**

Source: Northern Ireland Child Health System

Meningococcal ACWY vaccine

The meningococcal ACWY (Men ACWY) vaccine programme was introduced in August 2015 in response to an outbreak of meningococcal group W disease across the UK. Teenagers aged 14-18 years and university "freshers" were chosen as the target group for immunisation. For operational reasons the programme was introduced in a phased way. Although the catch-up has now finished, young people in the eligible age range but have not yet been immunised can request this from their GP up to the age of 25 years.

The Men ACWY vaccine is now provided routinely to young people in schools in year 11 with the school leaver booster and MMR, with an opportunity to catch up in year 12. By the end of year 12 in 2017-18, 85.3% of young people were immunised with the Men ACWY vaccine, which is a slight decrease of 1.2% from the previous year.

Table 7. Coverage of Men ACWY for year 11 and 12, September 2018, Northern Ireland

Area	Year 11 (DOB 02/07/02 - 01/07/03) % vaccinated	Year 12 (DOB 02/07/01 - 01/07/02) % vaccinated
Belfast	80.0%	85.8%
South Eastern	74.0%	81.3%
Northern	78.3%	87.6%
Southern	79.4%	87.1%
Western	69.9%	83.0%
NI Total	**76.8%**	**85.3%**

Source: Northern Ireland Child Health System and HSCB

Uptake and Coverage in Targeted Childhood Immunisation Programmes

Hepatitis B vaccine to babies born to hepatitis B positive mothers

Hepatitis B is a virus that mainly affects the liver and is transmitted by blood and bodily fluids. From August 2017, hepatitis B vaccine has been added to the universal primary immunisation schedule at 2, 3 and 4 months of age.

A selective hepatitis B immunisation programme is also delivered to protect those thought to be at high risk of contracting the infection. One group offered the hepatitis B vaccine are babies born to hepatitis B positive mothers. This is because hepatitis B can pass from mother to baby during pregnancy, birth or early life and without intervention about 90% will develop chronic hepatitis B infection which can lead to liver cirrhosis and liver cancer.

All pregnant women in Northern Ireland are offered testing for hepatitis B as part of their antenatal care and if found to be hepatitis B positive, their babies are offered post exposure hepatitis B immunisation to prevent mother to child transmission at or around the time of birth. Babies born before August 2017 receive the Hepatitis B vaccine at birth, 1, 2 and 12 months of age. Babies born after August 2017 now receive the combined 6 in 1 vaccine* at 2, 3, and 4 months and extra doses at birth, 1 and 12 months.

The number of babies born to hepatitis B positive women is small in Northern Ireland. During the financial year 2017-18 there were 25 babies born with an annual mean of 35 (25-46) babies since 2009-18.

In line with monitoring of all routine childhood immunisations, uptake of three doses of hepatitis B antigen is measured at 12 months and four doses at 24 months (Table 8). In 2017-18 100% babies born to hepatitis B positive mothers received three doses of vaccine by 12 months and 87.10% received four doses by 24 months. Due

* routine immunisation schedule for babies detailed on page 8

to the small birth cohort the number of babies that did not receive four doses by 24 months is very small (<5), this is attributed to families moving out of Northern Ireland.

Table 8: Hepatitis B vaccine uptake rates at 12 and 24 months of age, 2009-18, Northern Ireland

	Vaccination uptake @ 12 months (3 HepB doses)	Vaccination uptake @ 24 months (4 HepB doses)
2009-10	**82.76%**	**72.34%**
2010-11	**83.78%**	**65.52%**
2011-12	**93.18%**	**75.68%**
2012-13	**100.00%**	**81.82%**
2013-14	**100.00%**	**87.88%**
2014-15	**100.00%**	**93.94%**
2015-16	**95.65%**	**86.49%**
2016-17	**93.55%**	**89.13%**
2017-18	**100.00%**	**87.10%**

Uptake and Coverage in Routine Adult Immunisation Programmes

Shingles vaccine

The shingles vaccine programme for older adults was introduced in September 2013 following recommendation by JCVI in 2010 and a Northern Ireland policy outlined in HSS(MD) 27/2013.[3,4]

A single shingles vaccine is routinely offered to people aged 70 years on 1 September each year. Catch-up cohorts are also offered the vaccine so that all people in their 70s when the programme started on 1 September 2013 receive it over time (Table 9). Individuals who were previously eligible but did not take up the vaccine can still get vaccinated until they are aged 80 years on 1 September of the current catch-up programme year.

Table 9. Eligible cohorts for the Shingles vaccine (age on 1 September of each year)

Time Period	Routine Cohort	Catch-up Cohort	Still Eligible
1 Sept 2013-31 Aug 2014	70 years	79 years	NA
1 Sept 2014-31 Aug 2015	70 years	78 and 79 years	71 years
1 Sept 2015-31 Aug 2016	70 years	78 years	71, 72 and 79 years
1 Sept 2016-31 Aug 2017	70 years	78 years	71, 72, 73 and 79 years
1 Sept 2017-31 Aug 2018	70 years	78 years	71, 72, 73, 74, 79 years

Source: Apollo® Information System

Uptake of shingles vaccine is obtained using the Apollo® information system to count the number of vaccinated people and the eligible population recorded in primary care information systems. The reporting year for shingles is taken from 1 September to 31 October the following year. Data is extracted at the same time every year (1 October) to enable annual comparisons.

Since the programme began shingles vaccine uptake in the two main cohorts has been 50%-57%, with 70 year olds consistently 1-2% higher than 78 year olds (Table 10). Over time there has been a fall in uptake, in line with elsewhere in the UK, although reassuring an increasing proportion of those still eligible are receiving it in subsequent years. In 2017-18, uptake for 70 and 78 year olds improved compared to the previous year, at 51.5% and 48.2% respectively, but still in line with an overall decline since the programme began.

New presentations of data is currently in development which will report coverage of the yearly cohorts. This will be available next year.

Table 10. Estimated Shingles vaccine uptake, 2013-14 to 2017-18, Northern Ireland

Time period (1 Sept – 31 Aug)	**Age on 1 September (years)**						
	70	71	72	73	74	**78**	79
2013 -14	**52.5%**						49.7%
2014-15	**56.8%**	4.8%				**54.4%**	54.4%
2015- 16	**52.2%**	5.6%				**50.3%**	6.6%
2016- 17	**46.0%**	5.5%	3.1%	Not available		**45.4%**	6.0%
2017- 18	**51.5%**	7.9%	4.2%	2.5%	2.3%	**48.2%**	7.4%

Source: Apollo® Information System

Pneumococcal Polysaccharide Vaccine (PPV)

At present there is a long-term supply issue with Pneumococcal Polysaccharide Vaccine (PPV) with the vaccine only available intermittently. Correspondence from the Department of Health, outlined in HSS (MD) 23/2017, has been published to manage vaccination of priority patients in light of the shortage, based on Public Health England (PHE) temporary guidance. Uptake and coverage figures for the older adult programme will therefore not be published in this year's report.

In August 2003, the pneumococcal polysaccharide vaccine (PPV) programme for older adults was introduced. In the first year, it was offered to people over aged 80 years and in April 2004, was extended to include people over 75 years of age. Since April 2004, those over 65 years have been eligible for PPV vaccine. It is also offered to those aged 2 years to under 65 years with clinical risk factors.

The PPV vaccine contains purified polysaccharide from 23 capsular pneumococcal types (PPV23). Most healthy adults develop a good antibody response to a single dose. Children younger than two years do not and so the pneumococcal conjugate vaccine (PCV13) is used in the childhood immunisation programme.

Uptake and Coverage in Targeted Adult Immunisation Programmes

Pertussis (whooping cough) vaccine in pregnant women

In October 2012 the pertussis vaccine in pregnancy programme commenced as an emergency response to a national outbreak and was offered between 28 and 32 weeks gestation. Since then the programme has continued with Boostrix-IPV® (which contains diphtheria, tetanus, acellular pertussis and inactivated polio antigens – DTaP/IPV). Since May 2016 it has been offered from 16 weeks of gestation until delivery.

Since August 2017, uptake of pertussis vaccine in pregnancy is monitored from data extracted from the Northern Ireland Maternity Administrative System (NIMATS), a regional electronic information system that records maternal and neonatal information at the time of delivery. This data enables more accurate measurement of uptake because all pregnant women that deliver after 24 weeks gestation (live and stillbirths) are counted and completion of fields is mandatory.

Uptake for the year from September 2017 to August 2018 was 69.3% in Northern Ireland with variation seen across the Local Commissioning Group (LCG) areas.

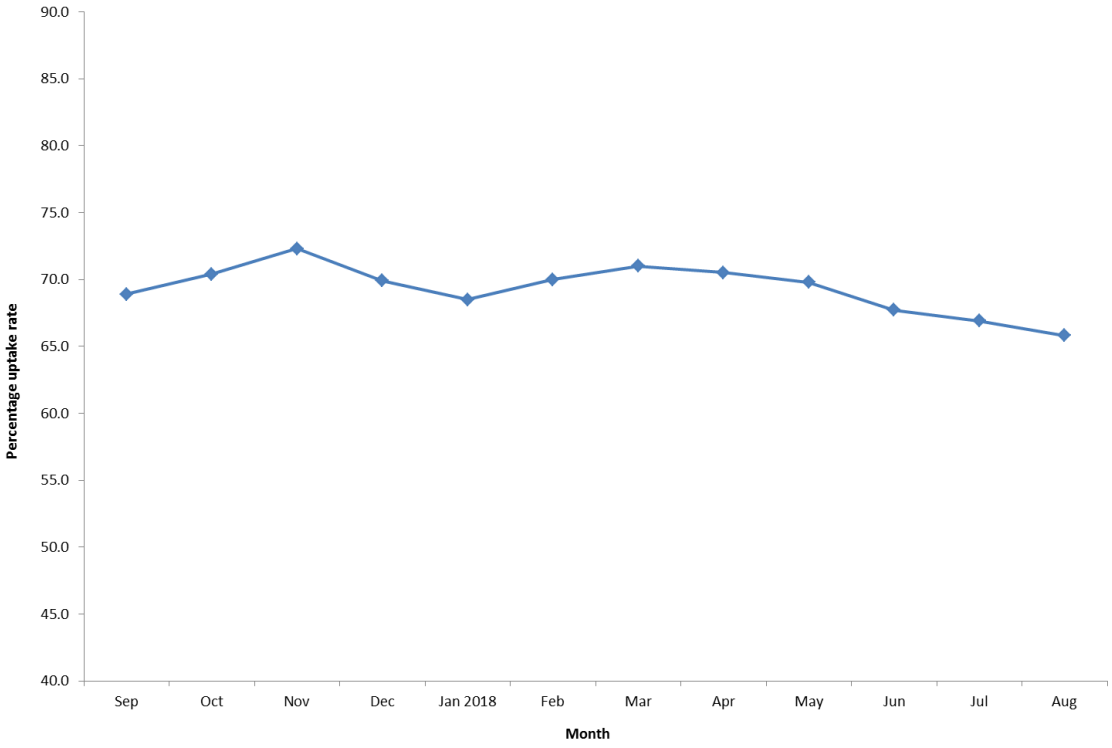
Table 11. Pertussis vaccination coverage (%) in pregnant women, September 2017 – August 2018, Northern Ireland

Area	% pregnant women vaccinated DTaP/IPV
Belfast	68.8
South Eastern	77.4
Northern	67.0
Southern	66.5
Western	68.2
NI Total	**69.3**

Source: NIMATS

Monthly uptake, now available, shows seasonal fluctuation of uptake with highest uptake during the winter months tailing off during spring and summer. This is a similar pattern to that seen in England and coincides with the delivery of the seasonal influenza vaccination programme, which also targets pregnant women. PHA will continue to monitor this pattern in future years.

Figure 5: Monthly pertussis vaccination coverage (%) in pregnant women, September 2017 – August 2018, Northern Ireland



Source: NIMATS

HPV vaccine in MSM aged up to 46 years who attend GUM clinics

In 2008 the girls' HPV vaccine programme was introduced across the UK. Studies have shown that, in addition to directly protecting females, the vaccine induces herd protection, which provides protection to boys when there is high vaccine coverage in girls. However, while the girls' programme confers indirect protection to heterosexual males, MSM receive little benefit from it. Evidence suggests that 80-85% of anal cancers, 36% of oropharyngeal and 50% of penile cancer are linked to HPV infection. In November 2015, the JCVI advised a targeted HPV vaccination programme with a course of three doses for MSM aged up to and including 45 years who attend GUM clinics.[5]

In October 2016, the HPV vaccine programme for MSM was offered across Northern Ireland. Three doses are offered preferably within one year, but is still clinically acceptable up to two years. Anonymised data is extracted from the GUM clinic Genito-Urinary Medical Clinic Activity Dataset (GUMCAD) to estimate the number of vaccines delivered and number of MSM up to 46 years attending a clinic.

Uptake for the first 15 months of the programme from 1 October 2016 to 31 December 2017 shows that 73.3% of MSM up to 46 years of age had one dose of HPV vaccine, 50.2% two doses and 24.5% had completed the schedule.

Work to improve uptake in adult immunisation programmes

During 2017-18, a study was carried out for the dissertation of Queens University Belfast, Masters in Public Health (MPH) with NIMATS level data to assess variation in pertussis containing vaccine and seasonal influenza vaccine coverage in pregnant women. The findings showed that for both vaccines, uptake was lower in some ethnic minority and migrant groups, younger mothers, those unemployed, those with an unplanned pregnancy, single mothers and women who smoked during pregnancy. In addition, PHA carried out a pilot with maternity colleagues in one LCG area where midwives offered and administered the seasonal influenza vaccine during November 2017 to May 2018. The success of this pilot will be evaluated later in 2018. Findings from both will be used during 2018-19 to consider interventions to improve uptake in pregnancy and support GP practices and maternity units in delivery of the programme.

Another study was also carried out for a dissertation of the MPH which looked at GUMCAD level data to assess variation in HPV vaccine coverage in MSM. This found that the clients' age and sexual identity contributed to variation in vaccination uptake. Coverage was lower in those that identified as bisexual men compared to homosexual men. Men over 41 years were less likely to receive vaccination compared to those under 21 years. These findings will be shared with GUM colleagues to enable them to target these groups.

Northern Ireland Measles and Rubella Elimination commitments

The United Kingdom, along with all Member States of the World Health Organisation (WHO) European Region, have signed up to a longstanding commitment to eliminate measles and rubella. Public Health England collates required information on behalf of the devolved administrations for submission to the UK national verification committee (NVC) and the WHO Regional Verification Commission for Measles and Rubella Elimination (RVC) for evaluation on an annual basis.

During 2018-19 the PHA will be developing the Northern Ireland Measles and Rubella elimination action plan to outline the local situation and set out local actions to deliver on our commitment to maintaining and achieving elimination.

Conclusions

The year 2017-18 has again been a successful one for the childhood and adult immunisation programmes.

Uptake of immunisations for children under 5 years of age continues to be amongst the highest in the UK although work continues to ensure that this high level is maintained. There was a continued decrease in the uptake of HPV vaccine for girls in year 9 in 2017-18 but most girls who had not been vaccinated in year 9 2016-17 received this in year 10.

Better data for pertussis vaccine in pregnancy, available from NIMATS, has enabled us to report more accurate uptake of 69.3% in Northern Ireland for one year. NIMATS data has also enabled PHA to obtain more detailed information on uptake, by LCG and by other demographic indicators. PHA will now look at more targeted ways to improve uptake with maternity colleagues. The HPV vaccine programme for MSM has been successfully rolled out across Northern Ireland and continues to show good uptake for the first 15 months. There remains an overall decline of shingles uptake since the programme started in 2013 but less of a drop in 2017-18 compared to 2016-17. This year, PHA is developing a new monitoring report to determine coverage of shingles for each annual cohort.

Recommendations

- PHA will continue to work with GP, health visitor and Child Health System colleagues to gain a greater understanding of the decrease in pre-school immunisation uptake across Northern Ireland and work together to improve coverage, particularly in the Belfast area
- PHA will develop the Northern Ireland Measles and Rubella Elimination Action Plan in partnership with relevant colleagues
- PHA will work with school health and communications colleagues to improve the uptake of HPV vaccine for 2018-19
- PHA will develop new monitoring reports to outline shingles coverage for each routine cohort since the programme commenced
- PHA will work with Maternity colleagues to improve the awareness and understanding of vaccinations given in pregnancy

Sources of further information

The most useful resource for health professionals is the on-line version of The Green Book, which contains the most up-to-date information on immunisation.

Name	Link
Immunisation against Infectious Diseases ("The Green Book")	https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book
Public Health Agency Immunisation page	http://pha.site/immunisationvaccine-preventable-diseases
Public Health England Immunisation page	https://www.gov.uk/government/collections/immunisation
Chief Medical Officer (CMO) letters (Northern Ireland):	https://www.health-ni.gov.uk/publications/letters-and-urgent-communications-2017
Country Specific Vaccine schedules	http://apps.who.int/immunization_monitoring/globalsummary/schedules
Vaccination of individuals with uncertain or incomplete immunisation status	https://www.gov.uk/government/publications/vaccination-of-individuals-with-uncertain-or-incomplete-immunisation-status
Public Health Agency Publications	http://www.publichealth.hscni.net/publications

Glossary of Terms

Antigen: A substance that when introduced into the body stimulates the production of an antibody.

Apollo®: Software used to extract data from primary care systems

BCG: (Bacillus Calmette-Guerin) is a vaccine primarily used to provide protection against Tuberculosis (TB)

Booster Vaccine: This is an additional dose of vaccine given following an earlier dose / course of vaccines which is referred to as primary vaccines. The purpose of a booster dose is to increase / "boost" immunity.

Vaccine Cohort: Group of people who are eligible for a vaccine programme based on age or other risk factors for developing a vaccine preventable disease.

COVER: (Cover of Vaccination Evaluated Early) is a quarterly data collection used to evaluate childhood immunisation coverage across the UK.

Diphtheria: is an infectious disease caused by the bacterium *Corynebacterium diphtheriae.* It primarily infects the throat and upper airways.

DTaP/IPV/Hib Vaccine: This vaccine offers protection against diphtheria, tetanus, pertussis, polio and *haemophilus influenza type b.* It is commonly referred to as the "five in one".

DTaP/IPV/Hib/Hep B: This vaccine offers protection against diphtheria, tetanus, pertussis, polio, *haemophilus influenza type b* and hepatitis B. It is commonly referred to as the "six in one" or "hexa" vaccine.

Epidemiology: The study of the distribution and determinants of health-related states / events (including disease) and the application of this study to the control of diseases / other health problems.

Hepatitis B: is a viral infection that attacks the liver and can cause chronic disease.

Hepatitis B positive: is a term used to describe someone who has hepatitis B infection and the diagnosis is based on the detection of hepatitis B surface antigen from a blood sample.

Hib: Haemophilus influenza type b is the second most common cause of bacterial pneumonia.

HPV Vaccine: is a vaccine that offers protection against certain types of Human Papilloma Virus.

Human Papilloma Virus (HPV): is a viral infection that is mainly transmitted via sexual contact. HPV-related disease includes genital warts, cervical and ano-genital cancers.

Immunisation: is a process whereby a person is made immune / resistant to an infectious disease, typically by administration of a vaccine.

Inactivated Vaccine: is a vaccine that is made from microorganisms (bacteria, viruses, other) that have been killed through physical / chemical processes. These killed organisms cannot cause disease.

Incidence: is the number of individual who develop a specific disease / experience a health-related event during a particular time period.

LCG: Local commissioning groups

Measles: is a vaccine preventable disease. Measles is a serious respiratory disease that causes a rash and fever and can cause significant morbidity and mortality.

Men ACWY Vaccine: Inactivated vaccine that offers protection against invasive meningococcal disease caused by *Neisseria meningitidis* groups A, C, W & Y.

Meningococcal Group B Vaccine: Inactivated vaccine that offers protection against invasive meningococcal disease caused by *Neisseria meningitidis* group B.

Meningococcal Group C Vaccine: Inactivated vaccine that offers protection against invasive meningococcal disease caused by *Neisseria meningitidis* group C.

MMR Vaccine: Combined vaccine used to offer protection against measles, mumps and rubella. MMR is a live vaccine i.e. contains attenuated / weakened organisms.

MSM: Men who have sex with men.

Pertussis: is a highly contagious disease of the respiratory tract caused by *Bordetella pertussis*. The disease caused by this bacterium is commonly referred to as “whooping cough”.

PHE: (Public Health England) is an executive agency of the Department of Health in England.

Pneumococcal Disease: is caused by a bacterium known as *Streptococcus pneumoniae*. Pneumococcal disease can range from upper respiratory tract infections to pneumonia, septicaemia and meningitis.

Polio: is a highly infectious disease caused by a virus. It invades the nervous system and can cause total paralysis in hours.

Rotavirus: is a virus that can cause severe diarrhoea and vomiting, especially in babies and young children.

Rubella: (German Measles) is a viral disease that causes a fever and a rash. It can cause defects in pregnant women who develop the infection.

Serogroup: A group of bacteria containing a common antigen / a group of viral species that are antigenically closely related.

Shingles: is caused by *varicella zoster virus* (VZV), the same virus that causes chickenpox.

Tetanus: is an infection caused by a bacteria called *Clostridium tetani*. The bacteria produce a toxin that causes painful muscle contractions.

Tuberculosis: (TB) is caused by the bacterium *Mycobacteria tuberculosis*. It usually causes infection of the lungs but can cause infection in other parts of the body too. If not treated properly TB can be fatal.

References

1 World Health Organization. Global Vaccine Action Plan 2011-2020. 2013. http://www.who.int/immunization/global_vaccine_action_plan/GVAP_doc_2011_2020/en/

2 Public Health Agency. Surveillance of Influenza in Northern Ireland 2016-2017. http://www.publichealth.hscni.net/publications/surveillance-influenza-northern-ireland-2016-17

3 Joint Committee on Vaccination and Immunisation. Statement on varicella and herpes zoster vaccines. 2010. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@ab/documents/digitalasset/dh_133599.pdf

4 McBride M. Introduction of shingles vaccine for people aged 70 years (routine cohort) and 79 years (catch-up cohort). 2013. https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-md-27-2013.pdf

5 Joint Committee on Vaccination and Immunisation. Statement on HPV vaccination of men who have sex with men. 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/477954/JCVI_HPV.pdf

HSC Public Health Agency

board paper

Annual Business Plan Mid-Year Monitoring Report

date	18 October 2018	**item**	11	**reference**	PHA/05/11/18

presented by Mr Edmond McClean, Interim Deputy Chief Executive

action required For noting

Summary

The attached paper provides the mid-year progress report, including RAG status, on the actions set out in the PHA Annual Business Plan 2018/19.

Of the 75 actions:

- One action has been categorised as red (significantly behind target/will not be completed)
- 6 actions have been categorised as amber (will be completed, but with slight delay)
- 68 actions have been categorised as green (on target to be achieved/already completed).

Equality Impact Assessment

Not applicable.

Recommendation

The PHA board is asked to **NOTE** the Annual Business Plan mid-year monitoring report.

PERFORMANCE MANAGEMENT REPORT

Monitoring of Targets Identified in

The Annual Business Plan 2018 – 2019

As at 30 September 2018

This report provides a mid-year update on achievement of the actions identified in the PHA Annual Business Plan 2018-19.

The updates on progress toward achievement of the actions were provided by the Lead Officers responsible for each action.

There are a total of 75 actions in the Annual Business Plan. Each action has been given a RAG status as follows:

	On target to be achieved or already completed		Will be completed, but with slight delay
	Significantly behind target/will not be completed		

Of these 75 actions 68 have been rated green, 6 as amber and 1 as red.

Outcome	Red	Amber	Green	Total
1) All children and young people have the best start in life	0	2	8	**10**
2) All older adults are enabled to live healthier and more fulfilling lives	0	1	8	**9**
3) All individuals and communities are equipped and enabled to live long healthy lives	0	1	20	**21**
4) All health and wellbeing services should be safe and high quality	1	2	22	**25**
5) Our organisation works effectively	0	0	10	**10**
Total	**1**	**6**	**68**	**75**

The progress summary for each of the actions is provided in the following pages.

Actions with a red RAG status.

3. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
	Continue to take forward the implementation plan for the Respiratory Service Framework.	Resources have yet to be identified for specialist hospital and community respiratory services. Respiratory services are included in the elective care commissioning process and business cases are being finalised for this.			(Dr Harper) Continue service reviews/ audits and seek to implement recommendations through Respiratory Forum and HSCB commissioning processes; continue to seek HSCB support to increase service development capacity.

Actions with an amber RAG status

1. All children and young people have the best start in life					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
4	Expand the Newborn Blood Spot Screening Programme to cover additional inborn errors of metabolism, in compliance with ministerial policy statement and advice of the UK National Screening Committee.	Process to enable procurement of Tandem mass spectrometer and recruit staff to support enhanced laboratory on call service has commenced. However there have been delays in finalising procurement specification. Funding allocated in June 2018, not yet released.			(Dr Harper) New Public Health Consultant lead for the programme in post from mid Sept 2018 Formal implementation project structures and project plan/timescales to be agreed and established
5	Continue to implement the Healthy Child Healthy Future programme	The workforce issues within Health Visiting workforce have impacted the fidelity of the programme delivery. Variation in the programme delivery needs to be reduced. The Key Performance Indicators for the uptake of the HCHF have improved slightly in the last quarter.			(M Hinds) The additional resources secured for MDTs will improve the workforce in two areas and will improve delivery of the programme.

2. All older adults are enabled to live healthier and more fulfilling lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
4	PHA, in conjunction with the HSCB and other external stakeholders will cost and pilot a new dementia memory assessment pathway.	Costings are still being finalised across the region before going to DoH for formal approval. ICP discussions have started around the memory pathway.			(M Hinds) Further engagement required with Clinicians to discuss specific aspects of the pathway

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
21	Deliver new communication programmes supporting public health messaging around suicide prevention, mental health promotion, smoking cessation and cancer awareness.	Planning and delivery of new public information campaigns has been paused due to DoH withdrawal of funding in-year. This has impacted the plans around mental health promotion, smoking cessation and cancer awareness. Responsibility for promotion of the Lifeline service has transferred successfully to the PHA and a new communications plan is currently being implemented.			(E McClean) The PHA has developed a range of communication programmes using alternative communications channels including PR, Social media and digital development. Examples include new promotional materials for smoking cessation services, PR / social media led campaigns on cancer awareness (Breast / Cervical) and refreshing of advertising collateral for suicide prevention.

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
10	Work with HSCB to finalise a Cancer Services Indicator Framework and to publish achievement against key indicators on a rolling basis (Staff and financial resources dependent).	Cancer Service Indicators framework (CSIF) was submitted to the Department on 26 September 2017.			(Dr Harper) Awaiting further guidance from DoH.
14	Continue to work with colleagues in the DoH, HSCB, HSCTs, voluntary agencies and patients to support Scheduled Care Reform.	PHA provides advice and support to the reform of scheduled care. With current staffing levels not all areas of scheduled care have input from PHA.			(Dr Harper) Prioritise area of work that require PHA input.

Actions with a green RAG status.

1. All children and young people have the best start in life					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
1	Implement the Breastfeeding strategy through the Breastfeeding Strategy Implementation Steering Group (BSISG) and Action Plan.	Mid-term strategy review completed and published online.			(Dr Harper)
2	Lead implementation and evaluation of Early Intervention Transformation Programme work streams 1 and 2.	EITP Work Stream 1 • 350 participants have completed Solihull 2 day Foundation course for midwives as of June 2018. • As of June 2018 4,200 first time mothers have participated in Group Based Antenatal Care & Education programmes; 2,520 mothers have completed the programme. • All pre-school education settings have been allocated a named Health Visitor. • The 3+ Review will be offered to 60% (100% in NHSCT) children attending DE funded pre-school education in 2018/19 academic year (increase from 50% in 2017/18) • Evaluation study of Getting Ready for Baby and Getting Ready for Toddler ongoing. QUB due to report end of 2019.			(Dr Harper and M Hinds)

1. All children and young people have the best start in life					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		EITP Work Stream 2: • Early Intervention Support Service has supported 2,125 families from August 2015 – June 2018 - 92% of cumulative target, and anticipated EISS will meet 95% of contract targets by September 2018. • Successful proposal to Transformation Fund to maintain 5 existing EISS until end March 2019. • QUB research evaluation report workshop planned October 2018 to consider findings & refine the EISS model. Snapshot assessment of EITP programme (both work streams) being undertaken by Deloitte October 2018. Stakeholder engagement ongoing to consider funding streams to sustain EISS post March 2020 and sustainability of the 3+ Review and Getting Ready for Baby.			

1. All children and young people have the best start in life				
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep / Mar	**Mitigating actions where performance is Amber / Red**
3	Implement the Infant Mental Health Action Plan	PHA continues to facilitate and lead the regional Infant Mental Health Implementation Group. Key Actions to date include: • Solihull Workforce Guide – plan due October 2018 • IMH Competency/Curricular Framework to inform critical development period of 0-3's • IMH e-bulletin: issued April 2018 • Launch and dissemination of PHA/NSPCC 'The Case for Infant Mental Health in NI' Policy and Evidence Report – April 2018. • Successful proposal to Transformation Fund for £500k to develop a Child Psychotherapy service team within Belfast Trust to support families with 0-3's in need of early intervention • Between April – June 2018 14 staff from various settings across 3 Trust localities trained to access Video Interactive Guidance (NICE recommended method of improving attachment relationship between parent and young child (0-5). All parents supported reported improved capacity to recognise and respond to needs of their babies. • From September 2018, 9 staff from CAMHS, Surestarts and Health Visiting enabled to access M9 Infant Mental Health Diploma. All report having increased knowledge and skills in work with under 3's.		(Dr Harper)

1. All children and young people have the best start in life					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
6	Enhance multi-disciplinary working within neonatal wards across each Trust area by embedding AHP support (dietetics, OT, physio, SLT)	Full roll out of AHP support across each Trust neonatal wards with evidence of greater multi-disciplinary working from 2 recent professional and parent/carer surveys			(M Hinds)
7	Roll out of the Regional Support for Education (RISE) model across the region	RISE is operational across all Trust areas and delivering the agreed regional principles. Additional investment has been secured to enhance the teams to meet increasing demands			(M Hinds)
8	Maintain and improve vaccination programmes for children and young people by working with HSC organisations, and delivering a PPI study to better understand barriers to vaccinate hard to reach communities such as the Roma	On- going work with HSCB on improvement of uptake in practices. Working with communications on a video to promote vaccines in Roma community.			(Dr Harper)
9	Achieve uptake targets for seasonal influenza vaccinations for children aged 2-4 years and the primary school programme set by DOH.	Flu vaccine season starts on 1st October. All preparation work carried out as planned.			(Dr Harper)

1. All children and young people have the best start in life					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
10	Develop and promote a range of communications aimed at helping parents and carers recognise and manage issues relating to the health and wellbeing of children and young people.	Good progress has been made to date on a range of communications including PR, Social media and publications. Birth to 5 and the Pregnancy book are currently at pre-production stage and a new communication programme on safe sleeping advice is under development.			(E McClean)

2. All older adults are enabled to live healthier and more fulfilling lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
1	Lead, in conjunction with other PHA/HSCB departments and external stakeholders, on creating a public health vision for frailty using an outcomes based approach. A frailty model will be tested that will include: • Falls • Continence • Mild Cognitive Impairment • Social Isolation	Substantial progress has been made which includes: • Establishment of a PHA/HSCB Strategic Frailty Oversight Group • Regional Frailty Network – first meeting planned for December 2018 • Pilot sites across the region testing different frailty models • Age NI report on 'Rethinking Frailty' completed with 700 service users participating • Links have been established across England, Wales, Scotland and Southern Ireland as well as with the EU Frailty Project ADVANTAGE with a view to creating an environment of shared learning and support.			(M Hinds)

2. All older adults are enabled to live healthier and more fulfilling lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
2	Establish a regional Age Friendly Network and implement, with partners, the WHO Age Friendly Communities model in local government districts in co-operation with DFC 'Active Ageing Strategy'	The NI Age Friendly Network has been established following 2 consultation events, organised by PHA, DFC and Age NI to agree aims and objectives. Each council has been asked to nominate 2 representatives. The first meeting will take place October/November 2018. • 10 of the 11 councils have identified high level actions in their Community Plan to improve the environment or services for older people. • 10 of the 11 council areas have Age Sector Networks supported by Age NI which bring together older people's groups to strengthen the regional voice of older people and support them to influence important decisions on local policy and services.			(Dr Harper)

2. All older adults are enabled to live healthier and more fulfilling lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
3	Develop and implement a regional arts programme to enhance the wellbeing and quality of life of older people across Northern Ireland through their active engagement and increasing access to participation in high quality arts activities	PHA in partnership with Arts Council NI and the Baring Foundation, provide a regional small grants programme to support local community/agency partnership responses to create arts and health opportunities for older people. A total of 19 groups were awarded funding in this round. The priority areas were NRAs, isolation and loneliness, older men and carers. PHA partners with Arts Care on the delivery of an annual Arts and Health festival engaging approximately 3000 participants. Currently participants are being matched with artists and the delivery will roll out between now and March 2019. Two artist induction days have been completed. Specific training this year led by Lead OT in SHSCT focused on conditions such as Parkinson's disease, dementia and depression. Training in safeguarding, monitoring and evaluation has also been provided.			(Dr Harper)

2. All older adults are enabled to live healthier and more fulfilling lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
5	Influence future practice and policy in the care of older people, through the launch of reports and leaflets from commissioned research in dementia and through follow-up knowledge exchange processes with key stakeholders.	A further 2 reports from the dementia programme, on the use of a healthcare passport and the development of facilitated reminiscence app, have been launched on our website with findings also being presented at local and national conferences. People with dementia and their carers have been actively involved as research partners, in the design of these research projects and testing the app. A seminar has also been held with approximately 50 key stakeholders to take forward the findings of the passport study through the development of further research proposals. A play to present the findings from the reminiscence study is in the process of being commissioned and produced.			(Dr Harper)
6	Lead work with the HSCB and Trusts to start delivering Phase Two of the Dementia EHealth and Data Analytics Pathfinder Programme for Northern Ireland including the implementation of a PatientPortal for Dementia Patients.	This Programme aims to build eHealth & data analytics capacity and capability with an initial focus on dementia, through the following work streams: **Development of a patient portal** to be branded ***"My Care Record"***. Testing of this portal is scheduled for early October and recruitment of Dementia patients and carers is underway.			(E Ritson)

2. All older adults are enabled to live healthier and more fulfilling lives

	Action from Business Plan:	Progress	Achievability (RAG) Sep	Achievability (RAG) Mar	Mitigating actions where performance is Amber / Red
		It is intended that use of this portal will be extended across a range of conditions. **Analytics Capability -** A GP Intelligence Platform (GPIP) is being developed to routinely capture data from GPs with the potential to link data at patient/client level with data from other hospital and community information systems, creating virtual population registries. An analytics team is being recruited to develop and utilise the platform. **Dementia data analytics research -** QUB have been commissioned to undertake work across 14 areas of research A Dementia Analytics Research User Group (DARUG), including commissioners, providers, data experts and service users, has been formed to tie together work on research, data analytics and to commission dementia data projects. The first tranche of project awards were made in September with a second call for submissions to be opened in December. **Key Information Summary (KIS) -** funding to incentivise GPs to complete KIS for dementia patients which are then flagged on the NI Electronic Care Record system. 141/152 practices have signed up to participate in phase			

2. All older adults are enabled to live healthier and more fulfilling lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		one. Phase two planned for December. **Training -** funding for multi-disciplinary dementia training through the Extension for Community Healthcare Outcomes (ECHO) initiative. **App development -** developing a framework for the development, commissioning & utilisation of apps. User engagement in relation to the use of dementia-specific apps is underway.			
7	Prepare for introduction of FIT testing within Bowel Cancer Screening Programme	A CAG has been established to commence the procurement process for the laboratory equipment and consumables required for the introduction of FIT. A site visit to the bowel screening programme in Scotland, which has already introduced FIT, has been arranged for November 2018. Awaiting policy and financial decision from the DoH.			(Dr Harper)
8	Continue with the vaccination programmes to protect the health of older adults such as flu and shingles.	Flu vaccine season starts on the 1st October 2018 with shingles vaccine delivered alongside flu vaccine. All preparation work carried out as planned.			(Dr Harper)

2. All older adults are enabled to live healthier and more fulfilling lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
9	Seek opportunities to develop and utilise innovative practices/technologies to improve health and wellbeing, working collaboratively with HSCNI and other stakeholders, including • leading NI input to EIP AHA; • targeting of EU and other sources of funding • working with Fermanagh & Omagh District Council on the EC funded PLACE-EE project to develop and implement locally derived sustainable solutions to encourage internet use and person-centred e-health amongst older people in rural communities.	Providing NI input to WE4AHA work on development of Blueprint for engagement on "Widening the support for large scale uptake of Digital Innovation for Active and Healthy Ageing" Successful EU bid for project VIGOUR on Integrated Care for both HSCB and PHA under 3rd Health Programme funding Progressing on the development of an educational toolkit to facilitate Intergenerational working between Older People and Young People through the use of Digital tools			(E Ritson)

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
1	Continue to work with local government on the implementation of community planning	PHA continues to work with all 11 councils and their community planning partnerships. The 4 areas agreed for HSC focus in community planning (mental health and wellbeing, physical activity, early years and later years/age friendly) are clearly reflected across all 11 community plans and action plans are now being agreed developed. Action plans are currently being developed and agreed. While these reflect HSC agreed focus and strategic direction, they vary in detail and approach, reflecting local needs. PHA continues to lead the HSC Community Planning Forum, including representation from all HSC Trusts and the HSCB. The Forum facilitates collective action across all the organisations and encourages alignment with MLB and PFG.			(E McClean)

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
2	Lead and coordinate regional implementation of the Making Life Better Public Health Framework	The regional implementation arrangements for MLB have been reviewed and refreshed to reflect the changes to ADOG and the development of the draft PFG Framework as well as community planning and its processes. The creation of the MLB HSC Partnership allows senior members of HSC to oversee the implementation of MLB and ensure a consistent approach is adopted across the HSC. Alignment with transformational work relating to Delivering Together on issues such as community development, healthy places and workplace health is also a key part of discussions. At a local level MLB has been embedded in the 11 council led Community Plans, cutting across the core themes of health and social wellbeing, regeneration and environmental sustainability. HSC actions within community planning are focussed on MLB. In terms of the delivery of projects a broad range of almost 120 initiatives are currently being delivered under the MLB banner, valued at £3.6m regionally. These range from partnerships with local government and other statutory partners to collaboration with a range of voluntary and community based organisations targeting interventions to stimulate sustainable improvements in health and wellbeing.			(Dr Harper)

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
3	Develop and implement the actions flowing from the Transformation work stream on the expansion of community development approaches.	• The first meeting of the Implementation and Innovation Board was held on 5 September 2018 with senior level engagement across HSC, Government Departments, Community and Voluntary sector network organisations; • Terms of Reference were agreed and the process of appointing a Co-Chair of the Board from the Community and voluntary sector has commenced; • An appointment to the role of Project Officer was made on 5 September 2018; and • A business case has been prepared for the tender process to deliver against the objectives of the Community Development Work Stream.			(Dr Harper)
4	Lead and implement programmes which tackle poverty (including fuel, food and financial poverty) and maximise access to benefits, grants and a range of social inclusion services for vulnerable groups.	While work continues across the following 3 key areas, stats on achievement will not be available until later in the year. • **Tackling fuel poverty** for vulnerable target groups including the implementation of the regional PHA Keep Warm Pack Scheme (7,000 packs will be distributed) and a range of locality based work relating to energy efficiency and fuel poverty support. • **Addressing food poverty** through support for the regional Fareshare food redistribution model as well as locality work to improve access to healthier affordable choices for those most at risk through			(Dr Harper)

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		building community capacity, skills and knowledge. At least 70 Community Food Members registered and receiving food on a weekly basis (to benefit at least 5,900 individuals/quarter). Food redistributed to provide at least 388,500 meals according to FSA guidelines. Maintain and train a pool of 25 volunteers for the Community Food Network. • **Improving incomes and benefit maximisation** for vulnerable clients through the provision of targeted benefit entitlement advice for those with underlying health needs. Approximately 1,603 vulnerable clients will be supported through the Northern and Southern locality 'Advice 4 Health' projects resulting in over £944k income/benefit maximisation. Through the BHSCT Mental Debt Advice Service 1,000 clients will receive advice and helpl to maximise their income/benefits with a minimum of £225,000 annualised realised for these clients.			

3. All individuals and communities are equipped and enabled to live long healthy lives				
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep / Mar	**Mitigating actions where performance is Amber / Red**
5	Implement the multi-agency obesity prevention action plan	PHA has continued to Implement 'A Fitter Future for All', monitoring its progress through the Regional Obesity Prevention Implementation Group. It is working with DoH to agree the next set of short term outcomes for the final phase of AFFA from 2019-2022. A wide range of programmes focusing on healthier eating, weight management and physical activity are being delivered. Of particular note in past six months: • Weigh to a Healthy Pregnancy has been expanded to include women with a BMI over 38 (previously over 40. • PHA is leading the development and procurement of an early years obesity prevention programme, which will be available in 2019-2020. This programme will be available in Sure Starts and in client's own home on referral from a Health Visitor. • A regionally consistent Physical Activity Referral Scheme has been agreed, with phased implementation about to commence. • The evaluation of the Choose to Lose pilot has been completed, which will inform future development of adult weight management initiatives. • A programme manager has been recruited to drive the implementation of the Minimum Nutritional Standards for staff and visitors in HSC facilities.		(Dr Harper)

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
6	Continue to consolidate the drug and alcohol services tendered and commissioned under the New Strategic Direction on Alcohol and Drugs (NSDAD) 2011-17 and the PHA/HSCB Drug and Alcohol Commissioning framework 2013-16 including revising the framework to inform future service design and procurement.	The procured Drug and Alcohol services continue to operate well and meet KPIs. Drugs and Alcohol staff within PHA are progressing the revision of the Commissioning framework 2013-16. Planning for a formal consultation process is underway, with stakeholder mapping having been completed and appropriate methods of communication with identified stakeholder groups agreed.			(Dr Harper)
7	Establish a minimum of 3 additional Community Pharmacy Needle and Syringe Exchange Scheme sites across NI in relation to identified need.	Work is ongoing to establish additional Community Pharmacy Needle and Syringe Exchange Scheme sites. The PHA is aware of need across NI with regard to this, but current focus is on increasing provision in Belfast due to the identified increase in need that area. One new community pharmacy site has been agreed in Belfast and another possible site has been identified which may prove suitable subject to a successful community engagement process.			(Dr Harper)
8	Commission and monitor uptake of stop smoking services in line with KPIs, in particular with young people, pregnant smokers and disadvantaged adults.	Stop Smoking Services continue to be commissioned across Northern Ireland with particular emphasis on pregnant smokers and their partners, disadvantaged smokers and young people. The prevalence of smoking remains at an all-time low level of 20%-22%			(Dr Harper)

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		Work has been undertaken to rebrand stop smoking services as uptake of these services has declined (similar pattern across the rest of the UK) over the past few years.			
9	Lead and implement a range of programmes to promote mental and emotional wellbeing and prevent suicide.	£8.7 million of services are been implemented annually in relation to promoting mental and emotional wellbeing and suicide prevention. These services are with community voluntary and statutory service providers including, for example: • Lifeline Service • Training **-** Suicide awareness & intervention skills; primary care depression awareness • Self-harm Registry and Self Harm Intervention Project • Emergency community response plans **f**or identifying & early response to emerging clusters of suicide • Community Capacity Building, programmes, services and small grants support; mental health promotion, therapeutic intervention • Bereavement support & guidance including the Regional Bereaved by suicide development Project. Other work includes support for farming communities, young people and the arts, stress control, work with sporting bodies, churches, prisons, LGBT communities/families, green gym/horticultural therapy.			(Dr Harper)

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
10	Lead on the strategic planning and commissioning of prison healthcare for Northern Ireland and co-ordinate the implementation of the joint health care and criminal justice strategy action plan which incorporates prioritising the transformation of health care services in police custody.	The Regional Commissioning/Planning Programme for Prison Healthcare and Associated Services Team for prison healthcare continues to meet monthly. A '10 point plan', which sets out key deliverables across 10 thematic services, has been included in the 2018/19 commissioning plan. This approach has been endorsed by DoH. A number of deliverables will be progressed through 7 transformation projects. The Task and Finish group (which reports directly to the permanent secretaries for Health and Justice) has progressed a significant work-plan to agree a service model and specification for a nurse led pathfinder in Musgrave custody suite. This pathfinder is now in place and operationally managed by BHSCT. The pathfinder is funded through transformation funding. A number of improvement projects are also being progressed by PHA in respect of workforce development, PPI, staff training and IT solutions for healthcare in criminal justice. A systematic review of SAIs in prisons is underway with PHA/RQIA.			(M Hinds)

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
11	Monitor, co-ordinate and promote the work of recovery colleges in NI, increase opportunities for co-production, and pilot Wellbeing and Recovery Star mental health teams and recovery colleges.	Transformation funding has been secured to enhance sustainability of Recovery Colleges and Evaluation of Recovery Colleges. Work has begun on Phase One of the evaluation which will be taken forward by PHA Health Intelligence. Pilot of Recovery and Wellbeing Outcome Star ongoing within Adult Mental Health services. Training delivered to staff in four Trusts and training planned with remaining Trust in November 2018 to pilot Drugs and Alcohol Star.			(M Hinds)
12	Develop healthier workplaces in the HSC and other sectors	PHA workplace health service is delivered across all 5 Trust areas by 3 providers with KPI's monitored and met. HSC Healthier workplaces network has secured transformation funding equivalent to 6 x Band 7 wte in each Trust and jointly for PHA/HSCB/BSO. IPT's have been approved to progress enhancement of existing workplace health and well-being programmes in HSC, through appointment of staff and delivery of psychological support.			(Dr Harper)

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
13	Award over €7m funding to support ten cross-border healthcare intervention trials in Northern Ireland and Republic of Ireland through the Cross-border Healthcare Intervention Trials in Ireland Network (CHITIN INTERREG VA) programme. Complete selection and initiation of 10 healthcare intervention trials under the CHITIN programme	HSC R&D's CHITIN programme, which received €8.8m (including 15% contribution from the DoH NI and ROI) from the EU's INTERREG VA Programme and on which the PHA is the lead partner, was officially launched in September 2018. €6,931,327 of this funding was awarded by the HSC R&D Division (to QUB, UU, BHSCT, NUIG and RCSI) in July to support 11 cross-border healthcare intervention trials. Three QUB led trials started in September with a focus on: Anticipatory Care Planning to reduce functional decline in older people; appropriate polypharmacy for older patients with multi-morbidity; and a habit-based intervention for overweight or obese pregnant women.			(Dr Harper)

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
14	Provide strategic leadership and co-ordinate the Regional Learning Disability Health Care and Improvement Steering group on behalf of PHA and HSCB	A workshop was held in October to review the work of the Regional Learning Disability Health Care and Improvement Steering Group and the three sub-groups to establish a work-plan for the next three to five years. Feedback from participants at the workshop will help inform the work-plan and structures for implementation of a revised Action Plan and contribute to new regional model of service for Learning Disabilities.			(M Hinds)
15	Lead the implementation of the Regional Palliative Care work plan	The early identification prototype commenced in June 2018 in 46 GP urban and rural practices across the region (initial target 14 practices in phase 1). A regional Advanced Care Planning (ACP) level 2 programme has been developed and has been delivered to Trusts between April-September 2018. £702k has been secured from transformation funding for the palliative care programme which will be used to implement the agreed work plan and work streams. Early identification Phase 2 and ACP training and raising awareness events will be two of the projects planned for 2019.			(M Hinds)

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
16	Lead on the development of the Promoting Good Nutrition (PGN) strategy implementation plan in the community	The PGN steering group through its sub groups have developed prevention messages and supporting materials. Screening and intervention pathways have been reviewed and updated. A workshop is currently being planned to bring together members from other projects or programmes which have malnutrition as a focus to share best practice and align work streams if appropriate.			(M Hinds)
17	Introduce surveillance clinics into the Diabetic Eye Screening Programme	IPT for introduction of surveillance clinics was approved by AMT in June 2018. Funding has been allocated to BHSCT for additional staffing, training and other recurrent costs. Recruitment processes are in progress and training for surveillance examinations has been carried out. As of end quarter one 2018/19 there are 1,515 patients on the digital surveillance pathway and 2,899 receiving Slit Lamp Biomicroscopy (Performance Report, Optomize).			(Dr Harper)
18	Prepare for introduction of primary screening with Human Papillomavirus Virus (HPV) testing within the Cervical Screening Programme.	While Initial scoping work has been completed and there are ongoing discussions with UK colleagues as to appropriate pathways and algorithms, a policy decision from the DoH is awaited.			(Dr Harper)

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
19	Continue working with interagency partners to improve health improvement, support and self-management services for people with long term conditions to include digital information resources for people with persistent pain.	MyNI social media campaign is concluded and PHA is exploring innovative routes for further development with its partners.			(Dr Harper)
20	Continue to lead the implementation and monitoring of eHealth and care Strategy under the objectives of • Supporting People • Using Information and Analytics • Fostering Innovation which will contribute to the development of a regional EHCR.	***Telehealth -*** The Inhealthcare system is being used by NHSCT and SHSCT for under-nutrition in care homes and work is ongoing to roll it out in WHSCT. Consideration is being given to a wider application across other conditions. Flo text messaging service roll-out has been delayed while work to resolve Information Governance issues is ongoing. ***Telecare -*** A discussion document on future of Telecare is under development. Development of proactive Telecare platform and local responder services being considered in context of availability of transformation funding. ***Citizen-facing VC -*** Project team and plan of work being established in context of availability of transformation funds ***HSC on-line -*** A-Z of health conditions publication schedule on target for completion by March 2019. PHA migration underway.			(E Ritson)

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		Further user testing scheduled for October 2018 in advance of formal launch early 2019. ***GP on-line -*** Merlock platform still to be tested to enable those practices that use this system to offer patient facing services. ***Directory of Services -*** SOC approved by steering group, June 2018. Wider HSC engagement planned and development of business case to follow. ***User feedback system -*** Business Case under development in context of transformation funding. ***Electronic assistive technology (EAT) -*** Development EAT being considered in context of availability of transformation funding. **eHealth & Care Blueprint -**CCHSC contributing to the development of blueprint for the delivery of the eHealth and Care Strategy and the formalisation of the portfolio.			

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
1	Continue to implement the PPI Strategy and deliver training on PPI in research for researchers and members of the public and facilitate opportunities for patients and public to be involved as partners and co-designers in the research process through the promotion of the PIER (Public Involvement enhancing Research) role.	A further training workshop for PIER members took place in June and a programme developed for 18/19 with 5 sessions planned. Six new members have been recruited to PIER. PIER members continue to be involved in a variety of activities as opportunities arise including research steering groups, funding panels, delivery of training for researchers, presentations at research launches (e.g. CHITIN). Twenty-four people attended a further Building Research Partnerships (BRP) course in April. PIER members are helping to ensure that PPI is implemented in all aspects of R&D's work and requests for their input from external bodies such as the universities demonstrate that their views and perspectives are being valued by other organisational partners e.g. the Health Research Board.			(Dr Harper)

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
2	Provide leadership, direction and guidance on involvement to the HSC including support for the Regional HSC PPI Forum and transformational work programmes.	The PHA have continued to provide leadership, direction and guidance on Involvement to the HSC, including: • Planning and supporting the Regional HSC PPI Forum meeting, the Regional HSC PPI Forum Strategic meeting and the Regional HSC PPI Service User and carer meetings. • The regional HSC PPI Action Plan has been finalised • PPI has been supported in a range of transformation projects including, Unscheduled Care, E-Health, Adult Social Care, Elective Care, Encompass, WHSCT LD, Recurrent Pregnancy loss, Dyspraxia, Dementia Patient Portal & App development and GP Information Platform.			(M Hinds)
3	Continue the work of the multiagency and multidisciplinary Regional Adult Dysphagia group, including work to improve awareness, identification and management of dysphagia	The regional group has an agreed work plan for 4 work-streams, awareness, identification, assessment & management and International Dysphagia Diet Standardisation Initiative (IDDSI). PHA has secured transformation funding to support a Dysphagia Champion for adult dysphagia and multidisciplinary dysphagia teams within HSC Trusts. PHA has supported the implementation of IDDSI regionally.			(M Hinds)

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
4	Identify opportunities to establish how the AHP workforce can support primary care transformation with an initial focus on first contact physiotherapy	Localities within Western and South Eastern Trusts identified as the early implementers of First Contact Physiotherapy. Further opportunities to establish how the AHP workforce can support primary care transformation are being explored			(M Hinds)
5	Lead and co-ordinate regional implementation of the District Nursing Framework and test new district nursing models of care, for a regional community nurse-led model of care prototype	The District Nursing framework was launched in early 2018 at a joint PHA/DoH conference. A District Nursing framework Implementation Group (chaired by Mary Hinds) and a number of subgroups have now been established. Two initial primary Care MDT sites have been identified and a neighbourhood District Nursing prototype will be tested in specific areas of each site. Business cases have been developed and a neighbourhood District Nursing subgroup established.			(M Hinds)

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
6	Implement the comprehensive patient and client experience programme, monitor the agreed key regional priorities for 2018/19 and continue to roll out 10,000 Voices in a range of areas e.g. Unscheduled Care and Discharge.	The PHA has worked collaboratively with the HSC Trusts in developing a comprehensive Patient and Client Experience programme for 2018/19 which uses a range of methodologies to gain the 'patient/client' experience of the health and social care, to drive quality improvements and enhance the patient and client experience. A number of key priorities have been identified. A range of 'Always Events' (those areas of care that are so important to patients and clients they should always happen), including noise at night, communication, family presence, mealtime matters and pain management, were piloted within each HSC Trust in 2017/18. Two always events in WHSCT and NHSCT have been prioritised for scale and spread in 2018/19.			(M Hinds)

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
7	Continue to gain assurance on progress with regional safety and quality priorities through Quality Improvement Plans and Key Performance Indicators; and provide advice and support to Trusts on the implementation of these key priorities.	The PHA continues to gain assurance on progress with regional safety and quality priorities through Quality Improvement Plans and Key Performance Indicators and provides advice and support to Trusts on the implementation of these key priorities. Whilst there has been significant work from all organisations to date, we need to continue to evaluate and refine this process to ensure better quality data and improved patient experience for the year ahead and into the future. The priorities for 2018/19 are designed to support a more consistent approach to the definition and measurement of pressure ulcers, falls, NEWS and MGA at both local and regional levels across all Trusts.			(M Hinds)
8	Provide a strategic role in the management of and learning from the SAI process, including leading the development of Learning Matters newsletter, development of thematic reviews and contributing to the SAI Biannual learning report.	One learning report has been developed and is due to be published October 2018. A thematic review commenced beginning September 2018 on mixed gender accommodation which is due to be completed March 2019. An SAI bi-annual learning report was published in June 2018.			(M Hinds)

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
9	Continue to oversee the implementation of the Q2020 Strategy including providing advice and support to the task streams and co-ordinate the development of the Annual Quality Report.	Regular meetings are held with the task leads and work is underway in relation to: • Continuing the development of Always Events within each HSC Trust with view to scaling regionally • Supporting multi-disciplinary faculty development in relation to human factors. • Developing an improvement project aimed at reducing surgical never events. • Implementing the learning identified from the task relating to strengthening our response to adverse incidents. • Continuing to promote training programmes aligned to the Attributes Framework and standardising HSC Trust level 2 and level 3 quality improvement programmes. • Supporting the development of a regional model for supporting staff involved in SAIs and other incidents, including the testing of Schwartz rounds and buddying model. The PHA have led the development of the annual quality report which is due for publication on World Quality Day (8th November 2018).			(M Hinds)

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
12	Support the implementation of the Northern Ireland Diabetes Strategic Framework through the regional diabetes network.	The PHA is leading on the introduction of a Diabetes Prevention program for N. Ireland. This is a behaviour change program to delay and /or prevent the onset of diabetes. The PHA is also supporting the implementation of the Diabetes Strategic framework to ensure the appropriate development of services to people with diagnosed diabetes.			(Dr Harper)
13	Support the stroke modernisation programme and the planned consultation on the organisation and delivery of stroke care.	The PHA is working collaboratively with the HSCB to finalise a Consultation document on modernisation of stroke services. The decision on timing of the consultation will be taken by the DoH.			(Dr Harper)

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
15	Raise awareness & knowledge about AMR, through: • Ensuring the timely availability of intelligence about antimicrobial use, antimicrobial resistance and healthcare-associated infections in secondary care by publishing regular reports, through an integrated dashboard and monitoring progress against targets set in the commissioning plan direction; and • Engaging the public and raising public awareness to help reduce inappropriate antibiotic use.	Significant progress has been made on the development of surveillance arrangements for antimicrobial use, antimicrobial resistance and healthcare-associated infections in secondary care. A dashboard is already developed and piloted across Trusts to share finding from AMU, GNB and HCAI surveillance system. Communication plan in place; activities for European Antibiotic Awareness Week (12 -18 Nov 2018) planned; messaging on social media in place; E Bug training to 200 teachers delivered – upcoming session for student teachers November 2018.			(Dr Harper)
16	Develop an operational plan for an Emergency Operation Centre (EOC) to support the management of an outbreak / major incident by PHA.	Complete and will be kept under review, to ensure that PHA can continue to meet its responsibility for co-ordinating a regional response to an outbreak/ major incident in adherence to the NI Infectious Diseases Outbreak plan and Joint Response Emergency Plan.			(Dr Harper)

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
17	Working in partnership with HSCB and HSCTs, continue to support and develop cancer services nursing, including: • Roll out of Clinical Nurse Specialist (CNS) workforce expansion plan across NI HSC Cancer Services; • Oversee the Acute Oncology Nursing Service (AONS); and • Develop a sustainable model for Non-Medical Prescribing (NMP)	Non-recurrent and recurrent funding for Phase 3 (2018/19) has been allocated to HSC Trusts. Due to Charitable partners having committed significant extra funding resource to bring forward some of the CNS posts from phases 3 and 4 within Trusts based on clinical need we are ahead of target with expected timeline for full implementation of workforce expansion. Acute Oncology nursing service continues to be monitored pending findings from recent AOS peer review. Non-medical prescribing model has been developed. Allocation has been issued to HSC Trusts moving towards implementation.			(M Hinds)
18	Deliver/Commission Flu Fighters to support the delivery of flu vaccine for HSCNI workers to achieve the 40% target.	The Flu vaccine season only starts on the 1st October 2018 which includes the HCW flu vaccine campaign. All plans are in place – Flu fighters have been commissioned for a second year and is progressing as expected.			(Dr Harper)
19	Lead on the development of methodology and models for the policy framework for Delivering Care Project NI for the nursing and midwifery workforce across NI.	The March 2018 returns report that permanent and temporary staff in post has increased to 4,470.58 WTE (current shortfall of 422.76 WTE against the target position of 4,893.34 WTE across 143 wards to achieve Phase 1 normative staffing).			(M Hinds)

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		Phased funding has now been implemented for the staffing models for Phase 2 Emergency Department; Phase 3 District Nursing; and Phase 4 Health Visiting. Phase 5 Mental Health, Phase 6 Neonatal, and Phase 8 Independent Sector are all underway. Phase 7 has progressed phased implementation via transformation funding with DoH support for 2 Federations. Phase 8 for the independent sector has been initiated and Trust workshops are planned.			

4. All health and wellbeing services should be safe and high quality				
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep / Mar	**Mitigating actions where performance is Amber / Red**
20	Implement the GP Nursing Framework, including addressing workforce capacity within primary care settings, through the development of ANP roles; rolling out regional education and training programmes, co-design with users, carers and communities.	The PHA have: • RCN have been commissioned to co-ordinate events for the regional GPN network. Four network events have taken place to date in 2018/19. • Delivering Care Phase 7 has been developed which identifies the need for additional general practice nurses and healthcare assistants to meet the increasing demand and pressures faced in general practice. 2 Federations have been identified to increase the numbers of GPNs incorporating skillmix and include an allocation for practices to undertake childhood immunisations • An additional 8 ANPs have taken up post across the GP Federations in 2018/19. • Ongoing discussions are being held with the primary care steering group, DoH and OU re the initiation of OU programmes for non-registered staff • The PHA has commissioned NIPEC to undertake the competency and career pathway for GPNs which is near completion. • A number of masterclasses and CPD events are planned.		(M Hinds)

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
21	Design and manage projects and programmes that directly impact on nursing workforce, recruitment and retention. Effective and methodical execution of nurse led initiatives including a public health focus. Plan and implement the Burdett grant across NI	Progress includes a training programme tailored to meet individual needs identified by ward staff including: Induction and preceptorship programmes tailored for older peoples specialty; Delivery of Action Learning sets by AGE NI Peer Facilitators with nominated staff from all wards; Use of Specialist Nurses to provide clinical updates to staff at ward levels; Non Clinical training- including Resilience & Assertiveness; Developing Motivation & Dynamic Leadership and Coaching for Improvement; Regional study days facilitated by the CEC on Mental Health Issues in Older people. Staff from RETAIN Wards have participated in recently commissioned awareness sessions on Frailty and Continence; Promotion and use of NIPEC Career Pathway; Health-promoting strategies for the ageing nursing workforce. End point data is currently being collected, and results from this will be presented at a celebratory event on 24th October 2018. Early indications confirm a significant improvement in the recruitment and retention of nursing staff within the majority of participating wards.			(M Hinds)

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
22	Support the DoH in undertaking a workforce analysis of the AHP professions to support the Delivering Together framework to determine the future capacity requirements of undergraduate and post graduate training numbers and the training and skills required to ensure that AHPs have the capacity and skills to support transformational reform	PHA AHP consultants have been leading workforce analysis work, on behalf of DoH, across all of the 12 AHP professions. Reviews are now drawing to a conclusion.			(M Hinds)
23	Scope the emerging issues related to the provision of high quality care in the nursing home sector.	A schedule of activity has been planned to enhance quality and safety for residents in care homes. This will include education and training, normative staffing and measuring the experience of care. A summary outline has been shared widely with care home providers and relevant stakeholders.			(M Hinds)
24	Facilitate regional learning and change within HSC as a result of The Inquiry into Hyponatraemia-related Deaths (January 2018)	Core funding has been reprioritised to recruit a temporary children's nurse in PHA.			(M Hinds)
25	Implement a range of actions through the HSC Safety Forum in support of HSC Trusts and other key stakeholders to improve the safety and quality of services delivered.	The Safety Forum is currently leading on a range of work in: • Sepsis • Maternity • Mental Health			(M Hinds)

4. All health and wellbeing services should be safe and high quality				
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep / Mar	**Mitigating actions where performance is Amber / Red**
		• Paediatrics • NIAS turnaround times • Regional EWS • Facilitating a 2nd QI ECHO programme. Begun in April with monthly ECHO sessions for teams in Trusts (13 teams involved). Final Sharing day in November 2018. • Hosts and facilitates Student Selected Component on Patient Safety (12 week course running from Feb 18 – May 18). • Hosted and facilitated annual Regional SAI event (7 June 2018) • Current organisation of the 4th Regional Annual Safety Forum Awards underway. First phase shortlisting complete (32 teams applied) and final interviews scheduled for December 2018 • Continues to co-ordinate the Health Foundation's Q Programme within NI (160 members in NI). The Safety Forum have organised a number of learning events: Two Data Masterclasses (October 2018), Coaching Workshop (November 2018) and Liberating Structures 2 day workshop (November 2018). Members have also been facilitated to attend a number of regional learning events.		

5. Our organisation works effectively

	Action from Business Plan:	Progress	Achievability (RAG) Sep	Achievability (RAG) Mar	Mitigating actions where performance is Amber / Red
1	Continue to take forward implementation of the PHA Procurement Plan	PHA continues to progress the Procurement Plan, as far as possible, within staffing resources available. Project teams have been established to complete tender processes in relation to Suicide Prevention services (60 contracts) and Healthier Places (62 contracts); both complex areas of work that require significant planning to progress. It is not anticipated that these tenders will be awarded before March 2020. Work is overseen by the PHA Procurement Board and a progress report was brought to PHA board, August 2018. A task and finish group is being established to review the procurement planning processes.			(E McClean)
2	Continue to facilitate and support embedding of OBA approach.	PHA continues to further develop business planning and corporate monitoring processes to reflect an OBA approach and place a focus on the impact PHA is having through its actions. Six report cards have been developed for publication under the Outcomes Delivery Plan 2018/19 (part of the draft PfG process led by TEO) and the learning from these will be used to further develop and embed an impact focussed approach.			(E McClean)

5. Our organisation works effectively

	Action from Business Plan:	Progress	Achievability (RAG) Sep	Mar	Mitigating actions where performance is Amber / Red
		PHA is also working with other HSC organisations to ensure a shared approach to incorporating OBA into Community Planning reports relating to health themes.			
3	Review and test the PHA Business Continuity Management Plan to ensure arrangements to maintain services to a pre-defined level through a business disruption.	Paper presented to AMT in August 2018 outlining approach for BCP test during 2018/19. Aim to undertake test during November/December 2018.			(E McClean)
4	Ensure appropriate Corporate and Information Governance arrangements are in place to underpin and support the Public Health Agency in undertaking its core business	Corporate and information governance arrangements continue to be maintained. A new Whistleblowing policy was approved June 2018 and awareness training provided for staff. Information governance policies and procedures have been updated to reflect GDPR and implementation will continue during 2018/19 as further guidance emerges. A paper outlining assurances in place following the cessation of Controls Assurance Standards has been prepared for GAC in October 2018.			(E McClean)
5	Support the Northern Ireland Public Health Research Network (NIPHRN) to identify opportunities for research in PHA priority areas through the organisation of a series of events on	The NIPHRN has recently been relocated, and as of September 2018 will be hosted in the School of Health Sciences at Ulster University. The NIPHRN will be hosting a seminar with the School of Health Sciences, Ulster University and			(Dr Harper)

5. Our organisation works effectively

	Action from Business Plan:	Progress	Achievability (RAG) Sep	Achievability (RAG) Mar	Mitigating actions where performance is Amber / Red
	key topic areas bringing a wide range of stakeholders together	the Institute of Public Health Ireland in December 2018 to discuss the new CMO physical activity guidelines. A network showcase event is currently in planning for Mar/Apr 2019 with guest speakers from the relevant research councils. One Research Development Group has been formed in the past 6 months.			
6	Action recommended changes arising from the 2017-18 Consultative Review of R&D funded infrastructure	Two initial actions from the review have been taken forward. A Change Manager took up post in May 2018 and has completed an options appraisal to scope change in ethics and governance management. A re-structuring proposal has been written for NICRN, moving from topic-based networks to a more generic approach covering all clinical specialities. All proposals for change relating to the review, have been created in full consultation with the research community including clinical & academic researchers, policy makers and commercial partners to ensure needs are met. While the impact of these changes is yet to be fully realised, initial implementation of UK-wide			(Dr Harper)

5. Our organisation works effectively

	Action from Business Plan:	Progress	Achievability (RAG) Sep	Achievability (RAG) Mar	Mitigating actions where performance is Amber / Red
		e-submission for R&D approval (which has been a key driver for other local changes) has already improved the experience of researchers and allowed more rapid processing of R&D approval applications.			
7	Design and deliver a new staff intranet to support communications within the PHA	Full redevelopment project of Connect with BSO underway. Initial template expected to be received by Nov 2018.			(E McClean)
8	Continue to embed PPI into the culture and practice of the organisation through the PPI internal leads group and the roll out of PPI training for PHA staff.	The PHA PPI team continue to work with the PHA internal leads group to embed PPI into the culture and practice of the organisation. The PPI monitoring recommendations have been endorsed by AMT and have been main streamed into the PHA PPI Action Plan. 139 staff have completed e-learning, 46 have completed face to face training to date. A 2018/19 PPI training plan has been agreed by the Internal leads group and Engage & Involve modules are being delivered in October and November 2018. Additional opportunities for training include commissioning of the 'Leading in Partnership' leadership programme. Further training is currently being planned.			(M Hinds)

5. Our organisation works effectively

	Action from Business Plan:	Progress	Achievability (RAG) Sep	Mar	Mitigating actions where performance is Amber / Red
9	Meet DoH financial, budget and reporting requirements	All deadlines in relation to Monthly monitoring to the DoH have been met and the year-end annual accounts completed.			(P Cummings)
10	Continue to support and develop staff during a period of organisational change, including relevant communication with staff	E-mail updates from the Chief Executive are provided to all PHA staff (most recently on 25 September 2018). Staff continue to have access to training and development opportunities through the HSC Leadership Centre.			(V Watts)