HSC Public Health Agency

agenda

106th Meeting of the Public Health Agency Board

Thursday 18 October 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 20 September 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/01/10/18**	Mr Cummings

committee updates

8 2.00	Update from Governance and Audit Committee (to include minutes of previous meeting)	**PHA/02/10/18**	Mr Drew

items for approval

9 2.10	PHA Mid-Year Assurance Statement	**PHA/03/10/18**	Chief Executive

items for noting

10 2.20	Quality Improvement Plan Report	**PHA/04/10/18**	Mrs Hinds
11 2.40	Progress Update on Making Life Better, Community Planning and Programme for Government	**PHA/05/10/18**	Mr McClean

closing items

12 2.55	Any Other Business	Chair
13 3.00	Details of next meeting: *Thursday 15 November 2018 at 1:30pm* *Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast*	

HSC Public Health Agency

minutes

105th Meeting of the Public Health Agency Board

Thursday 20 September 2018 at 1.30pm

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

Present

Mr Andrew Dougal	-	Chair
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
Ms Deepa Mann-Kler	-	Non-Executive Director
Professor Nichola Rooney	-	Non-Executive Director
Mr Joseph Stewart	-	Non-Executive Director

In Attendance

Mr Paul Cummings	-	Director of Finance, HSCB
Ms Marie Roulston	-	Director of Social Care and Children, HSCB
Mr Robert Graham	-	Secretariat

Apologies

Mrs Valerie Watts	-	Interim Chief Executive
Mr John-Patrick Clayton	-	Non-Executive Director
Mr Leslie Drew	-	Non-Executive Director
Alderman Paul Porter	-	Non-Executive Director
Mrs Joanne McKissick	-	External Relations Manager, PCC

84/18 **Item 1 – Welcome and Apologies**

84/18.1 The Chair welcomed everyone to the meeting. Apologies were noted from Mrs Valerie Watts, Mr John-Patrick Clayton, Mr Leslie Drew, Alderman Paul Porter and Mrs Joanne McKissick.

85/18 **Item 2 - Declaration of Interests**

85/18.1 The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.

86/18 **Item 3 – Minutes of previous meeting held on 16 August 2018**

86/18.1 The minutes of the previous meeting, held on 16 August 2018, were approved as an accurate record of that meeting, subject to the following amendments:

86/18.2 The last section of paragraph 74/18.2 which reads, “Dr Mairs said that it would be beneficial to develop multi-disciplinary teams, but that the real issue is that there are no local multi-disciplinary training programmes available, but that this is being addressed.” should read, ““Dr Mairs said that public health consultant posts were open to both medical and non-medical public health specialists, but that the real issue is the lack of a local multi-disciplinary public health training programmes. Work is on-going with DoH to address this issue.”

86/18.3 Paragraph 76/18.9 which reads, “Mr Stewart complimented officers on their work in scaling down the funding into projects of a meaningful size.” should read, “Mr Stewart complimented officers in scaling the procurement requirements to match the scale of the project”.

87/18 Item 4 – Matters Arising

77/18.6 Campaigns

87/18.1 Mr McClean advised that the list of proposed campaigns forwarded to DoH in July would be distributed to members.

88/18 Item 5 – Chair’s Business

88/18.1 The Chair expressed his congratulations to the Interim Chief Executive, Acting Director of Public Health, HSCB Director of Finance and HSCB Director of Commissioning for their professionalism during their appearance in front of the Northern Ireland Affairs Committee.

88/18.2 The Chair advised that he had attended the Public Health England (PHE) conference and from speaking to representatives from PHE, there was agreement that there is a need to examine the implications of not running media campaigns, and he cited the example of smoking rates. Mr McClean agreed and advised that PHA would note a decrease in the uptake of smoking quit kits during periods when there is no public information campaign.

89/18 Item 6 – Chief Executive’s Business

89/18.1 In the absence of the Interim Chief Executive, Mr McClean updated members on four areas.

89/18.2 Mr McClean advised that the Transformation work relating to HSC structures is continuing and he referenced the correspondence from the Permanent Secretary which outlined the new arrangements for the management of the Performance Management and Service Improvement directorate in HSCB.

89/18.3 Mr McClean informed members that PHA has received correspondence concerning the retention of documents relating to the UK-wide Infected Blood Enquiry. He noted that the information sought relates largely to

legacy documents and may not be in the possession of PHA, however PHA will undertake the necessary due diligence searches in this matter when further contact is had by the Inquiry.

89/18.4 Mr McClean advised members that the Belfast Healthy Cities conference is taking place from 1st to 4th October. He explained that Belfast Healthy Cities is co-funded by PHA and Belfast City Council and he highlighted some of the site visits and side events that will be taking place as part of the programme.

89/18.5 Mr McClean told members that senior officers in HSCB and PHA had attended a two-day workshop on strategic emergency and crisis management. Mr Stewart said he was pleased that such a workshop had taken place given PHA's important role in this area.

90/18 Item 7 – Finance Report (PHA/01/09/18)

90/18.1 Mr Cummings advised that the Finance Report for the period up to 31 July showed a surplus of £717k, but that this was not an issue and is due to current spend falling behind planned expenditure. Mr Cummings explained that there is a slight overspend in some areas of Trust expenditure, but this is due to the process of realignment of budgets not having yet taken place.

90/18.2 In relation to the management and administration budget, Mr Cummings advised that the situation remains that there is a high level of vacant posts, therefore the £300k surplus is likely to continue. He said that the issue with regard to vacancies is not solely an issue for PHA and he highlighted the costs of bank and locum staff for the Health Service in general, but he clarified that bank and locum staff is not an issue for PHA.

90/18.3 Ms Mann-Kler asked if there is an action plan to fill vacant posts. Mr Cummings said that there is not a plan in the short term, but there is a workforce study being led by the Department of Health looking at the longer term. Dr Mairs explained that within public health, it can take up to five years for an individual to be trained. Mr McClean explained that in some instances, staff are promoted so there are backfill issues. He added that there are some roles within the PHA where staff can gain better remuneration outside the public sector.

90/18.4 Mr Stewart suggested that the Remuneration Committee of the PHA should be looking at succession planning. The Chair noted the point and agreed that a meeting of that Committee should be convened shortly.

90/18.5 Councillor Ashe noted that within goods and services, the current spend is ahead of profile and asked if this was an issue. Mr Cummings said that there was no issue and this is a timing matter.

90/18.6 The Chair asked at what stage PHA should consider utilising any surplus to fund a public information campaign. The Chair was conscious that

there were only six months remaining in the financial year and any campaign would require 3 to 6 months to initiate. Mr Cummings said that work could begin on a campaign at any time, subject to approval from the Department of Health. Mr McClean added that any potential campaign would take up to four months to develop so a decision to proceed would need to be made in the next 4/6 weeks.

90/18.7 Mr Cummings presented members with a list of the HSCB and PHA Transformation initiatives. The Chair queried whether it would have been beneficial to undertake a smaller list of larger programmes. Mr Cummings that almost 1200 staff are required to undertake all of this work.

90/18.8 Mr Stewart asked if there was any potential for the funding to be continued given that this funding had come from political lobbying. Mr Cummings said that this was unlikely without a further political intervention, but he agreed that it would be beneficial if the funding was recurrent and that this issue arose as part of the conversation at the Northern Ireland Affairs Committee hearing.

90/18.9 The Chair asked if only proposals that were time limited had been chosen. Mr Cummings said that it was felt that the funding could be used to maximise training, but some training can take more than two years. Mr Stewart commented that staff undertaking training would remove them from their daily work.

90/18.10 Mr Cummings advised members that Simon Christie, Assistant Director of Finance, HSCB was leaving to take up the post of Director of Finance in a local Council. Members passed on their congratulations to Mr Christie for his appointment to this role.

90/18.11 Members noted the Finance Report.

91/18 Item 8 – Draft Commissioning Plan (PHA/02/09/18)

Dr Miriam McCarthy and Mr Roger Kennedy joined the meeting for this item.

91/18.1 Dr McCarthy began by saying that following the Board workshop she had received correspondence from Mr Clayton expressing concerns about the draft Plan and that she, and Dr Mairs, had met with Mr Clayton to discuss this. She felt that the discussion had been useful and had allowed for an understanding of the process of putting together the Plan, the constraints in terms of timescales, how inequalities are dealt with as part of PHA's work in areas such as health improvement, and the approach taken in terms of the equality screening.

91/18.2 The Chair asked if there had been any major changes made to the Plan. Dr McCarthy said that since the workshop there had not been any major changes, and that the draft Plan had been approved by the HSCB Board

at its meeting last week. She said that the Plan is a joint Plan between HSCB and PHA and that this year there was a more joined up approach with a multi-disciplinary editorial team and that this approach had felt more cohesive.

91/18.3 The Chair asked about outcome measures. Dr McCarthy said that it would depend on the objective, and that it can be difficult to have objectives with actions that can be easily measured, but the aim is to have SMART objectives. For some of the longer term objectives, she said that there are different approaches to measuring success, e.g. statistical analysis. Dr Mairs said that looking at commissioning priorities and the evidence leads to the outcome, but there will be a stage when a determination must be made as to whether a particular objective is worthwhile. Mr Stewart said that there are so many objectives and asked how they can all be measured to determine if a difference is being made. He asked if short, medium and long term objectives are all looked at separately. Dr McCarthy responded by saying that there is a rigorous approach to performance management. She explained that there are ministerial targets within the Plan e.g. 12-hour waiting times, MRSA, where outcomes are measured, but there are other objectives which may be input-based, e.g. additional pathology staff. She said that there is not one single report that pulls all of these together.

91/18.4 Mr Stewart said that from an assurance point of view, he cannot understand how the objectives can be measured. Mr Cummings explained that it is the role of HSCB to undertake the measurement and that each month its Board would receive reports on progress. Mr Stewart asked if it the role of the PHA Board to approve the funding, but Mr Cummings said that it was in relation to the £100m PHA budget, not the Commissioning Plan budget. He added that the role of PHA Board vis-à-vis the Commissioning Plan is to determine if PHA's views have been incorporated into the Plan. Mr Stewart questioned if this meant that effectively the role of measurement has been delegated to another body. Mr McClean acknowledged that this process reflects the particular characteristics of the relationship between the two organisations, and how it is the role of HSCB to undertake performance management. He added that it is HSCB's role to propose a Plan and for PHA to be content that its views have been given due regard during the preparation of the Plan. Mr Stewart said that from consultation of the governing rules and procedures it was for the Agency Board to approve the plan.

91/18.5 Mr McClean asked Dr Mairs and Mrs Hinds if they were content that their views, and those of their staff, have been taken on board. Dr Mairs said that his staff would be intimately involved in the preparation of the Plan and may also lead on some of the work. Mrs Hinds said that it is a very inclusive process, and she felt this year, despite the financial challenges that the Commissioning Plan was a more rounded document.

91/18.6 Ms Mann-Kler raised how rural proofing had been taken into account. Dr McCarthy said that it had been dealt with at a high level and

acknowledged that individual aspects of the Plan may be rural proofed in more detail as that would be more meaningful. Mr Cummings added that the draft Plan is prepared in line with capitation, which takes into account health inequalities. Mr McClean said that the Trust Delivery Plans will also look at issues regarding rural proofing and inequalities.

91/18.7 The Chair asked if there is a link between the Commissioning Plan and the PHA's Corporate Strategy. Mr McClean said that PHA's annual Business Plan, which derives from the Corporate Plan, is based on priorities set by the Department and the Commissioning Plan is also developed in that way.

91/18.8 Professor Rooney asked about the recent correspondence from the Permanent Secretary and its impact on future arrangements. Mr Cummings said that this will mean that the Department of Health's senior team will also receive reports on performance.

91/18.9 Members approved the Commissioning Plan, with the exception of Mr Clayton who had advised in advance of the meeting that he was not content to approve the Plan primarily due to the lack of clarity with regards to the savings it requires Trusts to make of £44.7 million.

92/18 Item 9 – Director of Public Health Annual Report (PHA/03/09/18)

92/18.1 Dr Mairs presented his Director of Public Health Annual Report, which for this edition has the theme of early intervention. He said the Report looks at the full life course from pre- and post-pregnancy to interventions for older people. He went through the Report and highlighted examples of initiatives from each directorate within public health; health improvement, health protection, screening and research and development. He said that those who had contributed to the report came from a wide range of backgrounds: public health, health intelligence, nursing and social care.

92/18.2 The Chair was delighted to see that there was much to celebrate in this report. He said that thirty years ago Scotland and Northern Ireland were suffering the worst record of premature mortality from coronary heart disease, but now Northern Ireland has a much lower rate than Scotland and is on a par with Wales. He added that in the last 30 years Northern Ireland had enjoyed a reduction of 59% in premature deaths from coronary heart disease. This is no mean achievement.

92/18.3 Councillor Ashe welcomed the theme of early intervention, but he noted that waiting lists are getting longer which has an impact on people's mental and physical wellbeing. Mr McClean said that there is always a balance to be struck between demand and capacity, and you can put more and more money into services, but what PHA aims to do, through its work, is to delay the day when people may need access to these services by maintaining and improving their health and social wellbeing. He added that there is a workshop taking place with the Northern Trust to look at health inequalities and health needs and how the Trust might plan its work on a different, and in the longer term, more effective basis.

92/18.4 The Chair asked if any of the Transformation money is being used on waiting lists. Mr Cummings said that £30m has been allocated as part of a three-year plan, but £100m a year is required. Dr Mairs said that his Report does not look at waiting lists, but he advised that the Patient Client Council had published a report recently on waiting lists and the findings indicated that this is a public health issue given the emotional and physical impact of waiting for treatment.

92/18.5 Ms Mann-Kler asked about next steps and how the Report is circulated. She cited obesity as an area where more work needs to be done. She asked if the mental health first aid has been undertaken in schools. Dr Mairs confirmed that this had been done.

92/18.6 Dr Mairs said that the Report will be published and launched at a PHA event shortly. In terms of obesity, he advised that there is an Obesity Strategy which is taken forward by the Health Improvement directorate. He said that it is a multi-faceted strategy looking at physical activity as well as healthy eating and is done in partnership with local Councils. He suggested that the food sector should also be involved. Ms Mann-Kler noted that the figures are continuing to rise and questioned if PHA is confident in its approach to tackling this issue. Dr Mairs said that PHA is doing what it can to tackle the problem. Ms Roulston advised that there is work happening in schools with school nurses working with children. Mrs Hinds said that if more funding were available, she would like to see more school nurses. Mr McClean said that this area could be the subject of a workshop. He added that issues such are this are often more amenable to actions by Councils and the education sector, rather than PHA alone and that is why PHA has emphasised inter-agency working to activate and mobilise other sectors to effect behavioural change.

92/18.7 Ms Mann-Kler suggested that the message could be turned around with the emphasis on staying healthy, rather than becoming overweight. The Chair said that Public Health England has moved its focus to obesity in children. Councillor Ashe said that Councils would not have the experience or the resources for this type of work and would need assistance. The Chair said that in Coventry, improvements were able to be made as two of the Councillors took an interest in public health.

92/18.8 The Chair asked about anti-microbial resistance (AMR), and if there are enough GP champions advocating the need to reduce the number of prescriptions being issued. Dr Mairs said that there are some champions and that work is being done to impress on GPs the need to reduce the number of antibiotics being issued.

92/18.9 Members noted the Director of Public Health Annual Report.

93/18 **Item 10 – Management Statement / Financial Memorandum (PHA/04/09/18)**

93/18.1 Mr McClean advised members that the Management Statement and Financial Memorandum had been reviewed and revised in this format in line with a template stipulated by the Department of Finance.

93/18.2 Mr Stewart asked whether the revised version changed any of the powers of the Department vis-à-vis the PHA, but Mr McClean advised that this was not the case.

93/18.3 Members noted the Management Statement / Financial Memorandum.

94/18 **Item 11 – Review of PHA Procurement Planning Procedures (PHA/05/09/18)**

94/18.1 Mr McClean explained that PHA is required to have a Procurement Plan to assist with dealing with all of the contracts it holds with the community and voluntary sector. He said that the part of the procurement process that required the most work was perhaps not the procurement itself, but the preparatory work and that this was proving a challenge for PHA.

94/18.2 Mr McClean said that, as part of an exercise to look to see if this could be carried out in a more effective way, it would be useful to have the input of a Non-Executive Director on a short life working group. He asked that any member interested should advise the Chair.

94/18.3 Members noted the update on the review of PHA procurement planning procedures.

95/18 **Item 12 – Programme for Government Report Cards (PHA/06/09/18)**

Miss Julie Mawhinney joined the meeting for this item.

95/18.1 Mr McClean explained that PHA is required to produce these report cards based on an Outcomes Based Accountability (OBA) approach.

95/18.2 Miss Mawhinney advised that in the absence of an Assembly, an Outcomes Delivery Plan has been brought in to replace Programme for Government. She said that across the 12 outcomes, there are 3 that are relevant to PHA which have a total of 6 areas that PHA has to report on. She explained that these report cards have been issued to the Department of Health in draft and will, in time, be forwarded to The Executive Office for publication, possibly around mid-November.

95/18.3 The Chair noted that there has been a changeover of staff within the Department and asked if this has had an impact. Mr McClean said that changes have resulted in delays in timescales, but despite there being no Assembly, PHA has an opportunity to try to make the development of these reports an exercise that is as meaningful as possible, and to learn

for the future.

95/18.4 Mr Cummings said that while he appreciated the presentation of the information, he felt some of it could be misleading and confusing without a developed understanding of the context. Ms Mann-Kler agreed and asked who the audience is for this information. Miss Mawhinney said that ultimately the information is for the public. Mr McClean acknowledged the point, but said that in some cases PHA does not have a choice in terms of what information must be presented. Ms Mann-Kler said that there is valuable information on the report cards, and that this could be a model for reporting in the future.

95/18.5 Mr Stewart said that there is an issue for PHA in terms of being able to show its work in a format that can be understood and he suggested that these could be used as an adjunct to the Annual Report. Mr McClean agreed saying that this is the time for PHA to start thinking about the format of its Annual Report for this year, and how the Report could be made more user friendly and meaningful for the public. He added that there is some latitude for PHA in this regard and that the Report should be used as a marketing tool. Mr Stewart said that it was his reading of the legislation that the Agency was required to produce an annual report in a particular format. However this did not prevent the agency from presenting a summary document or leaflet for wider consumption in the same way which many other organisations currently do. The Chair reported that he had in the room a copy of the Annual Report of Public Health England for 2017/18 and it is in a format which would be somewhat more appealing to the public.

95/18.6 Members noted the Programme for Government report cards.

96/18 Item 13 – Any Other Business

96/18.1 Mr Stewart made reference to the information presented to Board members regarding programme expenditure at the end of the previous meeting, and asked when members could receive further information in terms of how contracts are managed, what assurances are received, escalation procedures and monitoring. Mr McClean said that this type of discussion would be more appropriate for a Board workshop and agreed to come back to members with a proposal regarding this.

97/18 Item 14 – Details of Next Meeting

Thursday 18 October 2018 at 1.30pm

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

Signed by Chair:

Date:

Public Health Agency

Finance Report

2018-19

Month 5 - August 2018

PHA Financial Report - Executive Summary

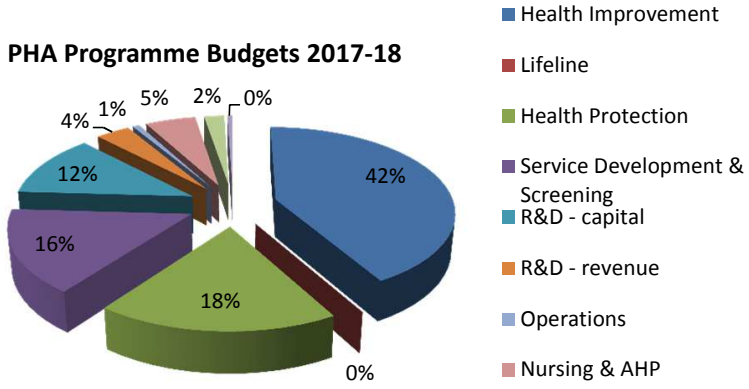
Year to Date Financial Position (page 2)

At the end of month 5 PHA is underspent against its profiled budget by approximately £1.3m. 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.

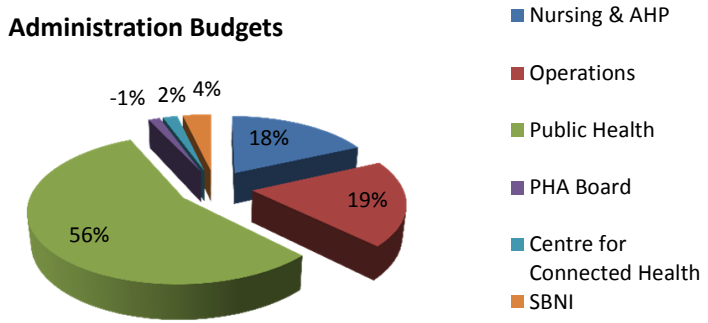


Administration Budgets (page 5)

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.

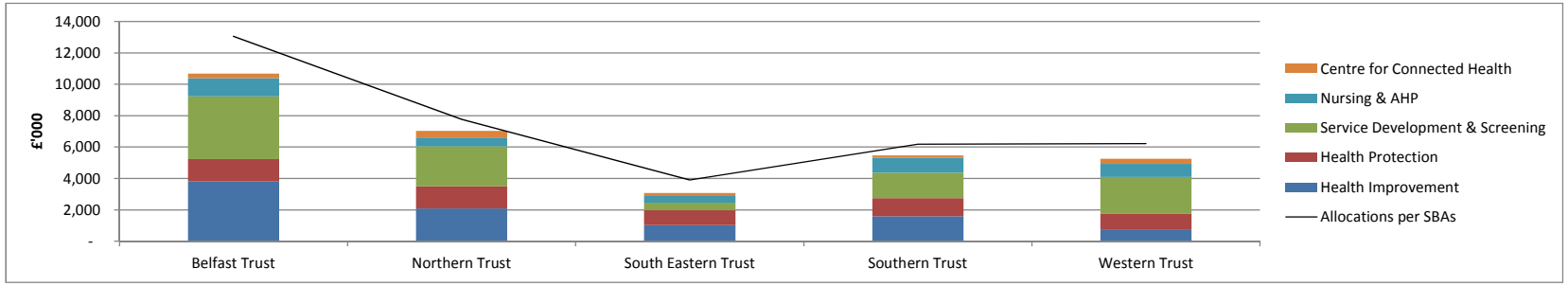
Public Health Agency
2018-19 Summary Position - August 2018

	Annual Budget					Year to Date				
	Programme		Ringfenced	Mgt & Admin	Total	Programme		Ringfenced	Mgt & Admin	Total
	Trust £'000	PHA Direct £'000	Trust & Direct £'000	£'000	£'000	Trust £'000	PHA Direct £'000	Trust & Direct £'000	£'000	£'000
Available Resources										
Departmental Revenue Allocation	31,551	43,885	8,610	18,657	**102,702**	11,843	11,772	1,390	7,749	**32,753**
Revenue Income from Other Sources	28	190		560	**778**	12	175	-	241	**428**
Total Available Resources	31,579	44,074	8,610	19,217	**103,480**	11,855	11,947	1,390	7,990	**33,182**
Expenditure										
Trusts	31,579	-	1,730	-	**33,309**	13,158	-	720	-	**13,879**
PHA Direct Programme *	-	44,674	6,880	-	**51,555**	-	9,838	547	-	**10,385**
PHA Administration	-	-		18,617	**18,617**	-	-		7,593	**7,593**
Total Proposed Budgets	31,579	44,674	8,610	18,617	**103,480**	13,158	9,838	1,268	7,593	**31,855**
Surplus/(Deficit) - Revenue	(0)	(600)	0	600	(0)	(1,303)	2,109	122	397	**1,326**
Cumulative variance (%)						***-10.99%***	***17.66%***	***8.79%***	***4.97%***	***4.00%***

The year to date financial position for the PHA shows an underspend against profiled budget of approximately £1.3m, mainly due to spend behind profile on PHA Direct Programme budgets (see page 4), and also a year to date underspend on Admininstration budgets (see page 5). It is currently anticipated that the PHA will achieve breakeven for the full year with underspends on Administration budgets being used to support a range of Programme priorities.

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

Programme Expenditure with Trusts



Core Funds 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	3,805	2,081	1,030	1,587	725	**9,229**	2,808	3,845	(1,037)
Health Protection	1,424	1,416	940	1,158	1,019	**5,957**	2,482	2,482	0
Service Development & Screening	4,004	2,554	477	1,613	2,349	**10,997**	4,515	4,582	(67)
Nursing & AHP	1,153	560	426	950	827	**3,915**	1,446	1,631	(185)
Centre for Connected Health	297	420	204	164	325	**1,410**	574	587	(14)
Other	24	13	11	12	11	**72**	30	30	0
Total current RRLs	**10,706**	**7,044**	**3,089**	**5,484**	**5,257**	**31,579**	**11,855**	**13,158**	**(1,303)**
Cumulative variance (%)									***-10.99%***

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

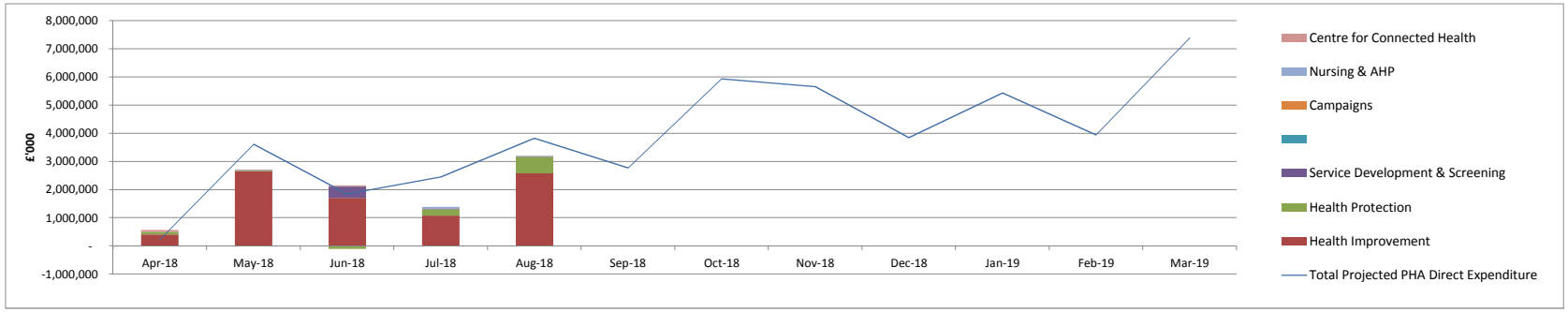
The year to date position shows an overspend against profile, but this is a timing issue only as funds initially held within non-Trust budgets have been issued to Trusts. (Budgets are realigned between Trust and PHA Direct periodically during the year, and this will be done in month 6.) The Programme position across both Trust and PHA Direct budgets is a £0.8m underspend, mainly due to expenditure behind profile in several areas within Public Health (see page 4). It is expected that these budgets will break even at the end of the year.

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

Ringfenced Funds	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 / £'000
C&S Transformation and EITP funds	**329**	**374**	**329**	**369**	**329**	**1,729**	**720**	**720**	**0**
									0.00%

Confidence & Supply Transformation funds and the Early Intervention Transformation Programme are ringfenced by DoH and must be reported separately from Core Funds.

PHA Direct Programme Expenditure



Core Funds	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	1,287	2,812	2,545	1,210	3,245	2,983	4,463	**28,185**	9,641	8,432	1,209	*12.5%*
Health Protection	56	347	93	78	446	888	2,960	1,818	1,023	1,001	709	1,149	**10,568**	1,020	834	186	*18.2%*
Service Development & Screening	18	140	524	74	74	528	89	108	449	74	141	832	**3,053**	830	633	197	*23.7%*
Research & Development - revenue	-	-	-	-	-	-	-	1,100	1,100	1,011	-	-	**3,211**	-	2	(2)	*0.0%*
Campaigns	9	9	9	9	9	9	9	9	9	9	9	93	**195**	46	3	43	*-100.0%*
Nursing & AHP	17	17	20	24	130	17	17	34	20	50	57	435	**837**	208	94	114	*54.7%*
Centre for Connected Health	40	40	40	40	40	40	40	40	40	40	40	40	**484**	202	92	109	*54.3%*
Other	-	-	-	-	-	-	-	-	-	-	-	380	**380**	0	(253)	253	*100.0%*
Total Projected PHA Direct Expenditure	**227**	**3,607**	**1,842**	**2,450**	**3,820**	**2,770**	**5,928**	**5,654**	**3,851**	**5,431**	**3,939**	**7,393**	**46,913**	**11,947**	**9,838**	**2,109**	
Cumulative variance (%)																***17.66%***	
Actual Expenditure	**570**	**2,784**	**2,007**	**1,380**	**3,097**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**9,838**				
Variance	**(343)**	**824**	**(165)**	**1,071**	**723**								**2,109**				

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

Expenditure is £2.1m behind profile for the year to date, however some of this funding has been allocated to Trusts and is shown on page 3. (Budgets are realigned between Trust and PHA Direct periodically during the year, and this will be done in month 6.) Programme spend as a whole (Trust and PHA Direct) is £0.8m behind profile at month 5, mainly due to delays on payments in several areas within Public Health. Budget managers will continue to review variances closely throughout the remainder of the year to ensure PHA meets its breakeven obligations.

Ringfenced Funds	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**	**104**	**249**	**265**	**100**	**166**	**231**	**5,095**	**6,880**	**670**	**547**	**122**
																18.25%
Actual Expenditure	**-**	**170**	**55**	**299**	**24**								**547**			
Variance	**-**	**(167)**	**(35)**	**202**	**122**								**122**			

Confidence & Supply Transformation funds and the Early Intervention Transformation Programme are ringfenced by DoH and must be reported separately from Core Funds. Some of this funding will transfer to Trusts when the appropriate business cases are approved.

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	3,469	2,605	10,826	173	319	484	**17,876**
Goods & Services	177	1,269	349	35	54	246	**2,130**
Savings target				(500)			**(500)**
Total Budget	**3,646**	**3,874**	**11,175**	**(292)**	**373**	**730**	**19,507**
Budget profiled to date							
Salaries	1,374	1,085	4,516	72	133	202	**7,381**
Goods & Services	68	487	130	(194)	31	87	**609**
Total	**1,441**	**1,572**	**4,646**	**(122)**	**164**	**289**	**7,990**
Actual expenditure to date							
Salaries	1,335	1,006	4,258	47	139	120	**6,904**
Goods & Services	73	410	127	5	9	64	**688**
Total	**1,408**	**1,416**	**4,385**	**52**	**148**	**184**	**7,593**
Surplus/(Deficit) to date							
Salaries	38	79	258	25	(6)	82	**476**
Goods & Services	(5)	78	3	(199)	21	23	**(79)**
Surplus/(Deficit)	**34**	**156**	**261**	**(174)**	**15**	**105**	**397**
Cumulative variance (%)	*2.34%*	*9.94%*	*5.62%*	*142.95%*	*9.37%*	*0.00%*	***4.97%***

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 £0.4m surplus which has been generated by a number of vacancies during the year. A surplus of approximately £0.6m is currently forecast for the full year, and Senior Management will develop a plan over the coming months to ensure this surplus is used to fund key Programme priorities and enable the PHA to meet its breakeven obligation for the financial year.

August 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	7,107	3,516	-	**10,623**	2,961	1,381	-	**4,343**
Expenditure								
Capital Expenditure - Trusts	7,107			**7,107**	2,961			**2,961**
Capital Expenditure - PHA Direct		3,516		**3,516**		546		**546**
	7,107	3,516	-	**10,623**	2,961	546	-	**3,507**
Surplus/(Deficit) - Capital	-	-	-	-	-	836	-	**836**
Cumulative variance (%)					*0.00%*	*60.48%*	*0.00%*	***19.24%***

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

PHA Prompt Payment

Prompt Payment Statistics

	August 2018 Value	August 2018 Volume	Cumulative position as at 31 August 2018 Value	Cumulative position as at 31 August 2018 Volume
Total bills paid (relating to Prompt Payment target)	£3,021,268	347	£15,546,988	2,197
Total bills paid on time (within 30 days or under other agreed terms)	£3,014,272	333	£15,389,530	2,083
Percentage of bills paid on time	**99.8%**	**96.0%**	**99.0%**	**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 93.0% by value for the year to date, which significantly exceeds the 10 day DoH target for 2018-19 of 60%.

HSC Public Health Agency

minutes

Governance and Audit Committee Meeting

Wednesday 6 June 2018 at 10.00am

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

Present

Mr Leslie Drew	-	Chair
Mr John Patrick Clayton	-	Non-Executive Director
Ms Deepa Mann-Kler	-	Non-Executive Director
Mr Joseph Stewart	-	Non-Executive Director

In Attendance

Mr Ed McClean	-	Interim Deputy Chief Executive / Director of Operations
Miss Rosemary Taylor	-	Assistant Director, Planning and Operational Services
Mr Simon Christie	-	Assistant Director of Finance, HSCB
Ms Jane Davidson	-	Head Accountant, HSCB
Mr David Charles	-	Internal Audit, BSO
Mr Brian Clerkin	-	ASM
Ms Anu Kane	-	Northern Ireland Audit Office
Mr Robert Graham	-	Secretariat

Apologies

Ms Una Turbitt	-	Assistant Director, Public Health Nursing
Mr Paul Cummings	-	Director of Finance, HSCB
Mrs Catherine McKeown	-	Internal Audit, BSO

		Action
28/18	**Item 1 – Welcome and Apologies**	
28/18.1	Mr Drew welcomed everyone to the meeting. He especially welcomed Mr John Patrick Clayton and Mr Joseph Stewart who were attending their first Governance and Audit Committee meeting.	
28/18.2	Apologies were noted from Ms Una Turbitt, Mr Paul Cummings and Mrs Catherine McKeown.	
29/18	**Item 2 - Declaration of Interests**	
29/18.1	Mr Drew asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.	

30/18	**Item 3 – Minutes of previous meeting held on 9 April 2018**
30/18.1	The minutes of the previous meeting, held on 9 April 2018 were **approved** as an accurate record of that meeting.
31/18	**Item 4 – Matters Arising**
	25/18.2 Emergency Planning
31/18.1	Miss Taylor advised that the 2017/18 Report on Emergency Preparedness would be brought to the next meeting of the Committee.
32/18	**Item 5 – Chair's Business**
32/18.1	The Chair advised that the two items listed under Chair's business would be picked up under other agenda items in today's meeting.
33/18	**Item 6 – Internal Audit**
	Shared Services Update [GAC/23/06/18]
33/18.1	Mr Charles explained that although Shared Services functions are provided by BSO, PHA is reliant on these functions and therefore receives a summary report of relevant internal audits. BSO is responsible for implementation of the recommendations. He advised that four reports had been completed and that one of these, relating to Payroll, had provided an unacceptable level of assurance. He said that one of the issues which led to this finding related to structures, staffing and resourcing. However, he advised that there is a Payroll Improvement Project under way. He advised that the second main issue related to the underpayment of superannuation, but that this did not have implications for PHA. He added that BSO had been levied with a fine due to delays in implementing the national living wage.
33/18.2	Mr Stewart asked if any underpayments in superannuation would be reflected in the accounts. Mr Christie confirmed that this would be the case.
33/18.3	Mr Clayton noted that there are a number of issues for BSO to take forward. Mr Charles acknowledged that a significant number of recommendations had been made, but that a number of implementation working groups have been established. He said that Internal Audit would be undertaking a follow up audit in September.
33/18.4	Mr Clayton asked what the main barriers would be to progress.

	Mr Charles advised that historically there have been staffing issues, but that these are slowly being resolved. He added that staff using the system need to have a certain level of competence. He added that staff are being recruited and that the follow up audit will determine what progress has been made. Mr Drew advised the new members of the Committee that the Governance and Audit Committee has been discussing this issue over a long period of time and had previously written to the BSO expressing its concerns.
33/18.5	Ms Mann-Kler said it was positive that 89% of previous recommendations across all audits have been fully implemented; however 65% of the recommendations within the Payroll audit have not been fully implemented. She asked whether the targets for implementation were too ambitious, and if improvements were anticipated for the next audit. Mr Charles said that he had no doubt that BSO was taking these audits seriously, and that there is a lot of work to be done, but that some of the recommendations will take time. Ms Mann-Kler asked if there are adequate resources. Mr Charles advised that one of the workstreams is about resources, but he added that BSO is receiving assistance from HSC Trusts.
33/18.6	Mr McClean asked whether the recommendations that have been implemented have had the desired effect. Mr Charles advised that sufficient action has been taken which has led to the overall level of assurance moving from unacceptable to limited.
33/18.7	Mr Christie said that, from a finance point of view, he was satisfied that BSO is giving this work sufficient priority. He added that while some of the issues are not as material for PHA as for other organisations, there have been some difficulties.
33/18.8	Mr Clayton asked about another pay award having to be implemented. Mr Drew said that if the previous 1% award had now been implemented he hoped that the system would be able to cope with another pay award. He added that although there are plans in place, the Committee would continue to monitor this closely.
33/18.9	Mr Charles advised that the audit of Accounts Payable had provided a satisfactory level of assurance, as had the audit on Shared Services Governance.
	HIA Annual Report [GAC/24/06/18]
33/18.10	Mr Charles moved onto the Head of Internal Audit Annual Report. He gave an overview of the KPIs, and advised

	members that during 2017/18, a total of five audits had been carried out. He went through each of the audits and the levels of assurance provided and highlighted the significant findings which had resulted in the limited assurances being provided within three of the audits.	
33/18.11	Mr Charles advised that the Department of Health requires Internal Audit to verify four of the Controls Assurance Standards, and that following verifications, Internal Audit endorsed PHA's self-assessment of substantive compliance against each of the four.	
33/18.12	Mr Charles advised that at the year end, PHA had fully implemented 73% of outstanding recommendations, with the remaining 27% partially implemented.	
33/18.13	Mr Charles informed the Committee that overall the Head of Internal Audit is providing a satisfactory assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.	
33/18.14	Mr Drew asked what was going replace Controls Assurance Standards. Miss Taylor said that she would bring a paper to the next meeting regarding this as there is a suite of different arrangements coming from different policy leads within the Department and that this is still being worked through. Mr Drew expressed concern that there will not be a consistent approach.	Miss Taylor
33/18.15	Mr Clayton asked about the issues pertaining to procurement of contracts within the community and voluntary sector. Mr Charles explained that PHA has a large number of contracts with a range of providers and although there is a procurement plan in place, there has been slippage against this plan and that there are issues around value for money and testing the market. Mr McClean advised that many of the contracts are long standing contracts, some of which will be ending in the next 12/24 months. He said that the EU procurement regulations demand that PHA produces a specification, undertakes market testing, awareness sessions and engagement with service users, and that the capacity is not there for this volume of work. He added that PHA needs to consider if it is undertaking this work in the most appropriate way.	
33/18.16	Mr Stewart said that, from a Board perspective, there is a risk of embarrassment, and that when deadlines slip it is more likely that mistakes will be made. He noted that only 6 procurement exercises have been completed in the last year, and that there are 170 outstanding. Mr McClean explained that	

	while the procurements range in size, the PHA would ensure that no shortcuts are taken.
33/18.17	Mr Drew advised that he has met with Mr McClean and appreciates that the issues mainly relate to capacity and skill set and that it would be useful to see a proposal on a way forward. He cited the example of the Lifeline contract and how well it was done. Mr McClean said that this particular procurement had taken required significant time and resources to complete.
33/18.18	Mr Clayton asked about the access to the information on the Child Health System. Mr McClean said that it is not a constraint on the PHA not having the access to the information from the other Trusts.
33/18.19	Mr Charles presented the update on the Internal Audit work plan for 2018/19 and said that following correspondence from the Permanent Secretary, Internal Audit was carrying out an audit of travel in all HSC organisations. He said that this audit should not have as much of an impact on PHA compared to other organisations. He noted that as a result of this additional audit the number of days for the financial audit would have to be reduced.
33/18.20	Members acknowledged the importance of the audit of travel given recent issues, but did not wish to see the number of days for the financial review greatly reduced.
34/18	**Item 7 – Finance** *Annual Report and Accounts incorporating Governance Statement and Letter of Representation*
34/18.1	Mr Christie presented the PHA Annual Report and Accounts for 2017/18 which he said were being recommended for approval by the Committee to go to the PHA Board. He advised that the accounts had been presented in draft form in May prior to the auditors undertaking their work, and that following the audit there are no changes to be made to the accounts.
34/18.2	Mr Christie took members through the Annual Report which he said was largely unchanged, but he advised that there had been some amendments made to the Governance Statement where a section on fraud has been included. He said that under the internal control divergences the section on Recruitment and Selection Shared Services has been moved to be a control issue which is no longer an issue. Mr Christie advised that a section on neurology will also be included, but that the wording for this has not yet been finalised.

34/18.3	Mr Christie gave an overview of the remuneration report saying that in the main PHA staff numbers had remained consistent. Moving onto the financial statements, he said that PHA had achieved a year-end break even position as the surplus of £140k was within the ±0.25% tolerance level.
34/18.4	Mr Christie finished by saying that subject to receipt of the auditors certificate, this report is ready for recommendation by the Committee to the Board.
34/18.5	Ms Mann-Kler said that the range of work undertaken by PHA, as outlined in the Report, is impressive. However, she noted that some areas of work could be emphasised in the next report.
34/18.6	Mr Clayton commended the work in respect of the financial outturn. With respect to the narrative, he asked when this had been submitted to the Department of Health. Miss Taylor explained that the draft Governance Statement had been submitted to the Department, and their comments have been incorporated. Mr Clayton suggested that next year there should be more narrative on health inequalities.
34/18.7	Mr Drew said that the Report is a useful reminder of the breath and scope of the work of the Agency, but wished it could be more succinct. Miss Taylor said that the format of the Report is largely set, but that it has been agreed that next year PHA will commence work on the Report earlier and look to see how it can be made more meaningful. Mr McClean added that there is a missed opportunity as this Report is a useful marketing tool. Ms Mann-Kler suggested putting messages out on social media once it has been published. Mr McClean confirmed that PHA would seek to do this.
34/18.8	Members **APPROVED** the Annual Report and Accounts and recommended that these be brought to the PHA Board on 11 June for approval.
35/18	**Item 8 – External Auditor's Report to those Charged with Governance**
35/18.1	Mr Clerkin presented the NIAO Report to those Charged with Governance and began by thanking staff for their co-operation in enabling the audit to be completed within the tight timescales. Overall, he advised that there was an unqualified audit opinion.
35/18.2	Mr Clerkin advised that there were no adjustments on the accounts and there were no Priority One recommendations, but there were three outstanding issues. He advised that there

	were no issues of significant risk highlighted before the audit commenced, but there were three areas of risk which were reviewed which related to BSTP, the ability to break even and the Lifeline contract.
35/18.3	Mr Clerkin gave an overview of the main audit findings and highlighted two of these as being of particular interest, namely the financial outlook and the closure of HSCB. He noted that the Department has provided a form of words for the Governance Statement regarding the financial outlook, and that there is reference to the closure of HSCB in the letter of representation.
35/18.4	In terms of the main audit findings, Mr Clerkin said that there were three which related to apprenticeship levy, IR35 and Direct Award Contracts. He said that the appendices to the report included the letter of representation and audit certificate.
35/18.5	Mr Drew asked about IR35. Ms Davidson advised that PHA is working through the HMRC toolkit. Mr Clerkin explained that the main change in the public sector is that HMRC has passed the responsibility from the individual to the public sector organisation. Mr Christie said that he did not think that there would be many cases that this would apply to in PHA.
35/18.6	Mr McClean picked up on the issue regarding Direct Award Contracts and said that for Etain, PHA used that organisation to ensure data protection for the transition of Lifeline records. Mr Christie added that while management would accept the recommendation, in both cases there were extenuating circumstances.
35/18.7	Mr Drew thanked Mr Christie and his team for their work in putting the accounts together and to Internal and External Audit for their work in completing the audits within a tighter timescale.
36/18	**Item 9 – Annual meeting with Auditors (External and Internal) without officers present**
	Officers left the meeting for this item.
37/18	**Item 10 – Corporate Governance**
	At this point Ms Davidson left the meeting.
	Corporate Risk Register (at 31 March 2018) [GAC/25/06/18]
37/18.1	Miss Taylor advised that, following the most recent review, there had been no risks added or removed from the Corporate

	Risk Register. She said that following a request by the Committee, the Register will be looked at in more detail at the Board workshop on 21 June.
37.18.2	Members **APPROVED** the Corporate Risk Register which will be brought to the PHA Board on 11 June.
	PHA Whistleblowing Policy [GAC/26/06/18]
37/18.3	Miss Taylor said that, as a result of an RQIA review on whistleblowing arrangements, it was recommended that a regional policy be developed and that following receipt of a model policy from the Department, the PHA has updated its policy. She added that PHA will liaise with HSCB with regard to training for senior managers and that staff will be made aware of this new policy through the Intranet and staff newsletter.
37/18.4	Ms Mann-Kler said that this policy is a much improved policy and should be used as a model for other policies. She asked about next steps. Miss Taylor said that there will be training commencing in June.
37/18.5	Mr Clerkin noted that the contact details for the Chair and the Non-Executive Director are internal numbers, and that staff may be reluctant to use internal numbers. Ms Mann-Kler said that it would not be appropriate for personal numbers to be given out.
37/18.6	Mr Clayton asked if the policy has been agreed with trade unions and Miss Taylor advised this would have been at a regional level. He also asked about grievances and bullying, but it was noted that these are covered under a separate policy.
37/18.7	Members **APPROVED** the Whistleblowing Policy which will be brought to the PHA Board on 11 June.
38/18	**Item 11 – Information Governance**
	Information Governance Action Plan [GAC/27/06/18]
38/18.1	Miss Taylor advised that the Information Governance Action Plans have been considered by the Information Governance Steering Group. She said that a lot of work has been carried out, but that some of the 2017/18 actions remained rated as "amber".
38/18.2	Miss Taylor advised that training is an ongoing issue, but that staff will continue to be encouraged to undertake their

	mandatory training. She added that the Information Asset Registers have now all been updated, and that although this took longer than intended, it is hoped that this process will being earlier in 2018/19.
38/18.3	Miss Taylor moved onto to the action plan for 2018/19, and said that this year's Plan incorporates the additional requirements under GDPR.
38/18.4	Members noted the Information Governance Action Plan.
	Information Governance Policies updated to reflect changes brought about by GDPR [GAC/28/06/18]
38/18.5	Miss Taylor advised that the Access to Information Policy, Data Breach Incident Response Policy and Data Protection Policy have all been revised in the light of GDPR. She highlighted some of the key changes, including the reduction in the deadline for responding to Subject Access Requests, and that organisations are no longer able to charge a fee for these.
38/18.6	Mr Drew acknowledged the amount of work required by organisations to implement GDPR. Ms Mann-Kler asked if there was a summary of the key points which could be made available for staff. Miss Taylor said that for the most part, the policies are not that different and that for staff the message remains the same in terms of protecting data and confidentiality. She advised that once the policies are approved by the Board there will be information placed onto the Intranet and staff newsletter about these. She added that Information Asset Owners and the Information Governance Steering Group will ensure that appropriate information is disseminated.
38/18.7	Mr Clayton noted that there is a lot of legal terminology within the Data Protection Policy, some of which is quite complex. He suggested that some of this terminology needed to be more clearly explained to readers within the body of the policy.
38/18.8	Members **APPROVED** the Information Governance policies which will be brought to the PHA Board on 11 June.
39/18	**Item 12 – Audit Committee Self-Assessment Checklist [GAC/29/06/18]**
39/18.1	Mr Drew said that members had had an opportunity to go through the checklist and that he was content with the responses made.
39/18.2	Members **APPROVED** the Audit Committee self-assessment

	checklist.
	At this point Miss Taylor left the meeting.
40/18	**Item 13 – SBNI Declaration of Assurance [GAC/30/06/18]**
40/18.1	Mr McClean explained that PHA acts as a corporate host for SBNI, a decision that was made by the Department of Health. As part of this arrangement, he said that SBNI is required to produce a Declaration of Assurance which states that it is complying with PHA policies. He advised that there is an MOU between SBNI, PHA and the Department of Health and that this is currently being reviewed, and that in the future there could be a greater role for PHA.
40/18.2	Ms Mann-Kler asked about the underspend and what happens to that funding. Mr Christie said that any underspend is returned to the Department of Health, and that in PHA's accounts SBNI funding and expenditure are recorded as being identical.
40/18.3	Mr Clayton asked about the corporate hosting arrangements and any expansion of those under the revised MOU. Mr McClean said that the biggest issue of concern for PHA would be that if, in the future, the social care function of HSCB moves into PHA, it would not be appropriate for PHA to have an arrangement with SBNI.
40/18.4	Members noted the SBNI Declaration of Assurance.
41/18	**Item 14 – Update on Use of Direct Award Contracts [GAC/31/06/18]**
41/18.1	Mr McClean advised that for 2017/18 a total of 17 Direct Award Contracts had been made, a reduction from 19 the previous year. He drew members attention to the list appended to the paper and said that for some of these, there have been previous agreements in place, for example with the Family Nurse Partnership programme, as this is a licensed programme.
41/18.2	Mr McClean explained that there is a process whereby all DACs come through PALS before the Chief Executive or Deputy Chief Executive approves and signs off, and that the Permanent Secretary and the Department of Health takes a great interest in this area.
41/18.3	Ms Mann-Kler asked why the Safetalk DAC is rated as "amber". Mr McClean said that this initiative had reached a stage where it was felt that a procurement exercise should be undertaken.

41/18.4	Mr Christie advised that the ratings on the DACs are provided by PALS, who have a compliance manager who reviews all DACs.
41/18.5	Members noted the update on Direct Award Contracts.
42/18	**Item 15 – Any Other Business** There was no other business.
43/18	**Item 16 – Date and Time of Next Meeting** *Thursday 4 October 2018 at 10am* *Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast.* Signed by Chair: **Leslie Drew** Date: 4 October 2018

HSC Public Health Agency

board paper

PHA Mid-Year Assurance Statement

date	18 October 2018	**item**	9	**reference**	PHA/03/10/18
presented by	Mrs Valerie Watts, Interim Chief Executive				
action required	For approval				

Summary

All arm's length bodies are required to submit a Mid-year Assurance Statement to the Department.

The attached Mid-year Assurance Statement was considered by the Governance and Audit Committee at its meeting of 4 October 2018. The final statement will be sent once approved by the PHA Board.

Equality Impact Assessment

Not applicable.

Recommendation

The Board is asked to **APPROVE** the Mid-Year Assurance Statement.

DoH ARM'S LENGTH BODY: MID-YEAR ASSURANCE STATEMENT

This statement concerns the condition of the system of internal governance in the Public Health Agency as at 30 September 2018

The scope of my responsibilities as Accounting Officer for the Public Health Agency, the overall assurance and accountability arrangements surrounding my Accounting Officer role, the organisation's business planning and risk management, and governance framework, remain as set out in the Governance Statement which I signed on *11* June *2018*. The purpose of this mid-year assurance statement is to attest to the continuing effectiveness of the system of internal governance. In accordance with Departmental guidance, I do this under the following headings.

1. Governance Framework

The Governance framework as described in the most recent Governance Statement continues in operation. The Governance and Audit Committee and Remuneration Committee have continued to meet and to discharge their assigned business. Minutes of their meetings, together with board meeting minutes containing the Committees' reports, are available for Departmental inspection to further attest to this.

2. Assurance Framework

An Assurance Framework, which operates to maintain, and help provide reasonable assurance of the effectiveness of controls, has been approved and is reviewed by the board. Minutes of board meetings are available to further attest to this.

3. Risk Register

I confirm that the Corporate Risk Register has been regularly reviewed by the board of the organisation and that risk management systems/processes are in place throughout the organisation. As part of the board-led system of risk management, the Register is presented to the Governance and Audit Committee for discussion and approval and all significant risks are reported to the Board – most recently on 11 June 2018.

In addition I confirm that Information Risk continues to be managed and controlled as part of this process.

4. Performance against Business Plan Objectives/Targets

I confirm satisfactory progress towards the achievement of the objectives and targets set out in the organisation's business plan as approved by the Department.

5. Finance

I confirm that proper financial controls are in place to enable me to ensure value for money, propriety, legality and regularity of expenditure and contracts under my control, manage my organisation's budget, protect any financial assets under my care and achieve maximum utilisation of my budget to support the achievement of financial targets.

I confirm compliance with the principles set out in MPMNI and the Financial Memoranda which includes:

- safeguarding funds and ensuring that they are applied only to the purposes for which they were voted;
- seeking Departmental approval for any expenditure outside the delegated limits in accordance with Departmental guidance;
- preparation of business cases for all expenditure proposals in line with the Northern Ireland Guide Expenditure Appraisal and Evaluation (NIGEAE) and Departmental guidance and ensuring that the organisation's procurement, projects and processes are systematically evaluated and assessed;
- accounting accurately for the organisation's financial position and transactions;
- securing goods and services through competitive means unless there are convincing reasons to the contrary; and
- procurement activity should be carried out by means of a Service Level Agreement with a recognised and approved Centre of Procurement Expertise (CoPE)

6. Information Governance - General Data Protect Regulation (GDPR) & Data Protection Act (DPA) 2018

I can confirm that my organisation has taken appropriate steps and is carrying out the necessary actions to ensure compliance with GDPR and DPA 2018.

7. External Audit Reports

I confirm implementation of the external auditor's accepted recommendations. There were two priority 2 and one priority 3 recommendations made by the external auditor in the 2017/18 Report to Those Charged with Governance. Two of these recommendations have been fully implemented with the third one in relation to IR35 being an ongoing process.

8. Internal Audit

I confirm implementation of the accepted recommendations made by internal audit

Internal Audit carried out a full review of the recommendations from the 2017/18 internal audits and provided a detailed progress report to the Governance and Audit Committee on 4 October 2018. A copy of this report is available if required. Of the 46 recommendations identified, 70% have been fully implemented and 30% partially implemented. Action is currently being taken to ensure the remaining recommendations are being fully implemented.

Three reports have been finalised for 2018/19:

Title	**Level of Assurance**
Personal and Public Involvement	Satisfactory
Compliance with DoH Permanent Secretary's Instructions regarding Travel	Satisfactory
Management of Vaccination Programmes	Satisfactory
Risk Management	Satisfactory

9. RQIA and Other Reports

I confirm implementation of the accepted recommendations made by RQIA.

The HSCB/PHA has a system in place via the Safety and Quality Alerts Team (SQAT) to provide the appropriate assurance mechanism that all HSCB/PHA actions contained within RQIA reports are implemented.

This system of assurance takes the form of a 6 monthly report which details the progress on implementation of RQIA recommendations. The most recent report, for the period ending 30 June 2018 was considered by the Agency Management Team on 18 September 2018.

10. NAO Audit Committee Checklist

I confirm completion of the NAO Audit Committee Checklist and that action plans will be implemented to address any issues. I also confirm that any relevant issues will be reported to the Department.

11. Board Governance Self Assessment Tool

I confirm completion of the Board Governance Self Assessment Tool and that action plans will be implemented to address any issues. I also confirm that any relevant issues will be reported to the Department.

12. Internal Control Divergences

I confirm that my organisation meets, and has in place controls to enable it to meet, the requirements of all extant statutory obligations, that it complies with all standards, policies and strategies set by the Department; the conditions and requirements set out in the MSFM, other Departmental guidance and guidelines and all applicable guidance set by other parts of government. Any significant control divergences are reported below.

Business Services Transformation Project/Shared Services (Payroll)

The audit assignment carried out during 2016/17 for Payroll Shared Services resulted in an unacceptable level of assurance being received from the Internal Auditor. While the issues raised in this audit report had limited impact on the PHA, it was of some concern that progress on issues identified in prior years had not been made. As a result of the 2016/17 Payroll audit, an action plan was developed by BSO to attempt to address the control and system stability issues identified. Internal Audit has provided limited assurance for the 2017/18 audit of Payroll Shared Services. A number of key functions have not yet stabilised and significant control issues remain, including the resolution of known system issues.

Quality, Quantity and Financial Controls

While acknowledging the difficulties in commissioning and supporting services provided to the population of Northern Ireland in an environment where demand for these services continues to increase and the budget available for commissioning them remains constrained, the actions taken by the PHA during 2017/18 enabled it to maintain the integrity of existing services commissioned and to ensure that additional priorities were implemented and progressed, within budget.

The Northern Ireland Assembly was dissolved from 26 January 2017 with an election taking place on 2 March 2017, on which date Ministers ceased to hold office. An Executive was not formed following the 2 March 2017 election. As a consequence, the Northern Ireland Budget Act 2017 was progressed through Westminster, receiving Royal Assent on 16 November 2017, followed by the Northern Ireland Budget (Anticipation and Adjustments) Act 2018 which received Royal Assent on 28 March 2018. The authorisations, appropriations and limits in these Acts provide the authority for the 2017/18 financial year and a vote on account for the early months of the 2018/19 financial year as if they were Acts of the Northern Ireland Assembly.

Across the HSC sector it is expected that the significant financial challenges faced will intensify and extensive budget planning work to support the 2018/19 financial plan is ongoing between the PHA and Department of Health (DoH). However, as with other financial years the PHA remains committed to achieving financial break-even, and will continue to take appropriate actions and manage its budget to ensure the most effective service provision possible within budget constraints.

Management of Contracts with the Community and Voluntary Sector

The 2017/18 Internal Audit report on the management of health and social wellbeing improvement contracts provided satisfactory assurance on the system of internal controls over PHA's management of health and social wellbeing contracts, reflecting the significant work that has been undertaken by the PHA. Service level Agreements are in place, appropriate monitoring arrangements have been developed, payments are only released on approval of previous progress returns and a procurement plan is in place, with action being taken against it during the year.

However, while Internal Audit acknowledged the improving position, a priority one finding remains in respect of the procurement of services. Although the PHA is continuing to implement the procurement plan, progress is slow due to a number of factors, including staff capacity and waiting for the new DoH Protect Life Strategy to enable mental health tenders to be progressed. That said, progress was made during 2017/18, with a number of contracts awarded. The PHA is also continuing to take forward preparatory work linked to suicide prevention and 'use of place' contracts, as well as a number of smaller contract areas.

The PHA's Procurement Plan is a live document, and is continually revised to ensure that all contracts are included and the timelines set are achievable given the significant resources required to manage each tender. Progress against the Procurement Plan is monitored by the PHA Board. A process has also been initiated to review the PHA Procurement Plan, and in particular pre-procurement

planning, to identify any changes that could improve how future procurements are planned and managed.

PHA also continues to work closely with BSO Procurement and Logistics Services (PALS) and Directorate of Legal Services (DLS) to develop appropriate social care procurement processes and documentation. This work is overseen by the PHA Procurement Board.

The PHA will continue to work closely with colleagues in HSCB, BSO, the HSC Trusts and the DoH, to develop and put in place appropriate and proportionate regional processes that meet the new procurement regulations.

Reduction in the PHA Management and Administration Budget

The 2015/16 management and administration allocation for the PHA was reduced by 15% (£2.8m). In order to meet this significant budget reduction, the PHA introduced a number of controls reducing goods and services expenditure, along with vacancy controls. However in order to achieve the savings required on a recurring basis it was necessary to avail of the Voluntary Exit Scheme (VES). This has resulted in a loss of knowledge and experience as well as reduced capacity.

In 2016/17 there was a further reduction of 10% (£1.6m) from the management and administration budget, followed by another reduction of 0.6% (£100k) in 2017/18.

While the PHA has taken measures to ensure that core and essential work is maintained, pressures are evident, especially as PHA responds to new and changing demands and needs.

The opening budget allocation for 2018/19 has been received and includes a further reduction of £500k in the management and administration budget. This is likely to have a negative impact on the work of the PHA. The PHA will continue to work closely with the DoH.

Campaigns Budget

One of the PHA core functions as set out in the Health and Social Care (Reform) Act (Northern Ireland) 2009 is “health promotion, including in particular enabling people in Northern Ireland to increase control over and improve their health and social wellbeing” (section 13 (2) (a)). In undertaking this function, the PHA may “provide information, advice and assistance” (section 13 (4) (f)). The running of evidence based social marketing campaigns has been a core element of how the PHA carries out this function. Since its establishment in 2009 the PHA has led on the development and commissioning of many campaigns aimed at informing the public about key health and wellbeing issues and providing the information and ‘nudge’ to take action to improve their health and wellbeing, for example mental health, obesity and tobacco control campaigns.

However as part of the 2017/18 budget reductions, the PHA campaigns budget of £1.195m was removed. While this reduction was non-recurring, it did have a significant impact on the PHA ability to raise public awareness on key health and wellbeing issues.

While the scale was much reduced in 2017/18, PHA did however, take all possible steps to raise public awareness, including running a Dementia campaign (funded through Atlantic Philanthropies), and obtaining approval to launch the Breastfeeding campaign (*#Not Sorry Mums*) in January 2018, given that the majority of planning and development work had already been completed in 2016/17. Key messages were also disseminated via other available communication channels, including PR, social media, and digital platforms.

There is a considerable lead in time to plan and develop campaigns prior to their launch and the financial constraints in 2017/18 have therefore also impacted on the ability of the PHA to begin to plan and develop campaigns that could run in 2018/19. The opening budget allocation for 2018/19 has now been received and includes a reduction of £1m from the campaigns budget.

No campaigns budget for a second year, or indeed a significantly reduced campaigns budget in 2018/19 will make it increasingly difficult to raise public awareness, and enable behavioural change on key health and wellbeing issues. The PHA will however look to other lower-cost and lower impact means of messaging during 2018/19 and will continue to seek to further develop a range of key partnerships that can help to disseminate priority public health communications.

EU Exit

The Public Health Agency is actively scoping the potential impact of a 'no deal' outcome from the UK-EU negotiations on the services it provides, in line with the information provided by the Department. The process will continue to be refined as more clarity emerges on the detail of the final agreement.

Neurology Call Back

Due to concerns raised in relation to the practice of a consultant neurologist at the Belfast Trust, including work he undertook on behalf of other Trusts and in relation to his private practice, the HSCB and PHA have, at the direction of the DoH, established a Regional Coordination Group (which includes representatives from each of the five Trusts and relevant independent sector providers) to co-ordinate the work necessary to complete a call-back review of those patients who remained under active review of the consultant. The PHA is working closely with the HSCB, the Trusts and independent providers to ensuring that a consistent approach is taken both during the patient review and reporting of outcomes to enable patients to be assessed and receive appropriate treatment and care where it is required.

The DoH has established an independent inquiry panel to examine how concerns about the clinician were communicated and responded to. The DoH has also directed RQIA to undertake an expert review of the records of deceased patients of the clinician who have died over the past ten years, and to include patients who died before this if there is a concern.

Furthermore, the DoH has requested the RQIA to undertake a review of the governance of outpatient services in the Belfast Trust with a particular focus on neurology services.

The initial phase of the call-back exercise was completed at the end of July 2018. Following their initial review, those patients who required further investigation will be reviewed before the end of October 2018, along with a small number of patients who require an initial review (at their own request or because they DNA'd prior to July). The Regional Coordination Group is working closely with the DoH to determine the best approach with regard to patients who had been discharged by the consultant. The Governance Review and Independent Inquiry are not planned to commence fully until the call back exercise is completed in order to avoid diverting resources away from ensuring the needs of patients are addressed.

13. <u>Mid-year assurance report from Chief Internal Auditor</u>

I confirm that I have referred to the Mid-Year Assurance report from the Chief Internal Auditor, which details the organisation's implementation of accepted audit recommendations.

Signed *Date*

CHIEF EXECUTIVE & ACCOUNTING OFFICER

HSC Public Health Agency

board paper

Quality Improvement Plan Report

date	18 October 2018	**item**	10	**reference**	PHA/04/10/18

presented by Mrs Mary Hinds, Director of Nursing, Midwifery and AHPs

action required For noting

Summary

HSC Trusts are required to submit to PHA, an annual Quality Improvement Plan which includes the indicators identified in the HSCB/PHA Commissioning Plan and locally identified quality improvement initiatives. This data is reviewed and analysed by the PHA/HSCB and used to inform this report. The data relating to each indicator is accompanied by commentary to allow explanation of variation in compliance or outcome and any actions taken in response. Findings are used to prioritise the PHA Safety and Quality Work plan to support on-going quality improvement initiatives. This report covers a two year period from 1st April 2016 to 31st March 2018.

The key areas covered in this report are:

- Prevention of Pressure Ulcers
- Reduction of Harm from Falls
- Compliance with accurately completed National Early Warning Scores (NEWS) charts
- Mixed Gender Accommodation

Although these initiatives were implemented across Northern Ireland trusts, current systems used locally, regionally and nationally to monitor the QIPs lack standardisation. This has led to concerns about variation locally and regionally and subsequent inconsistency in reporting.

Whilst there has been significant work from all organisations involved to reach the point we are at now, we recognise the 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.

Please note there was a marked increase in avoidable pressure ulcers in the NHSCT. The NHSCT has been supported by the PHA in relation to working towards improvement. They have undertaken an in-depth validation exercise to review the

reporting and analysis of grade 3 and 4 pressure ulcers. They are currently undertaking an improvement project in conjunction with the PHA and have produced an action plan to have a targeted reduction in hospital acquired avoidable pressure ulcers. They are focusing on the pressure ulcer risk assessment, the plan of care to promote pressure ulcer prevention and on learning from hospital acquired and avoidable pressure ulcers.

Equality Impact Assessment

Not applicable.

Recommendation

The PHA board is asked to **NOTE** the Quality Improvement Plan Report.

Quality Improvement Plan Report

April 2016 – March 2018

Final Report

Produced by HSCB Information, PMSID in conjunction with the QSE Team (PHA)

Contents

Introduction

Quality is at the heart of our services and the Public Health Agency (PHA) is committed to driving improvement in safety, outcomes, access, efficiency and patient satisfaction. Providing quality services is a collective endeavour, requiring shared effort and collaboration between Health and Social Care Board (HSCB) / PHA, Trusts and individuals at every level of the health and social care system.

The HSC framework requires HSCB/PHA to gain assurance on progress with regional safety and quality priorities via Quality Improvement Plans (QIPS). The Commissioning Plan is a response to the Commissioning Plan Direction[1], and identifies the key strategic priorities whilst outlining the safety and quality indicators which must be included in Quality Improvement Plans developed by Trusts.

The HSCB and PHA recognise that for the quality of the care and services to be of the highest level, the culture of the organisation must be open, honest, transparent and above all patient and client focused. The Quality 2020 Strategy[2] aims to protect and improve the quality of health and social care in Northern Ireland. In line with this strategy, we are committed to measuring improvements; and in doing so, ensuring that lessons from the information are learned, areas of high performance are duplicated and areas of lower performance are supported to improve.

The purpose of this document is to provide measurement on the regional priority areas to improve outcomes for patients and service users and review the process through which this will be achieved. The information contained within this report has been supplied by HSC Trusts via a quarterly collection of data on the Public Health Agency (PHA) SharePoint site. Occupied bed days data has been provided by Department of Health (DOH) and are subject to validation.

Information supplied by Trusts is correct at time of print of this report, however it is subject to change as recording practices and audit findings are reviewed through individual trust processes. This report addresses the quality indicators outlined in the commission plan directions 2016/17 and 2017/18.

The key areas covered are:

1 Prevention of Pressure Ulcers
2 Reduction of Harm from Falls
3 Compliance with accurately completed National Early Warning Scores (NEWS) charts
4 Mixed Gender Accommodation

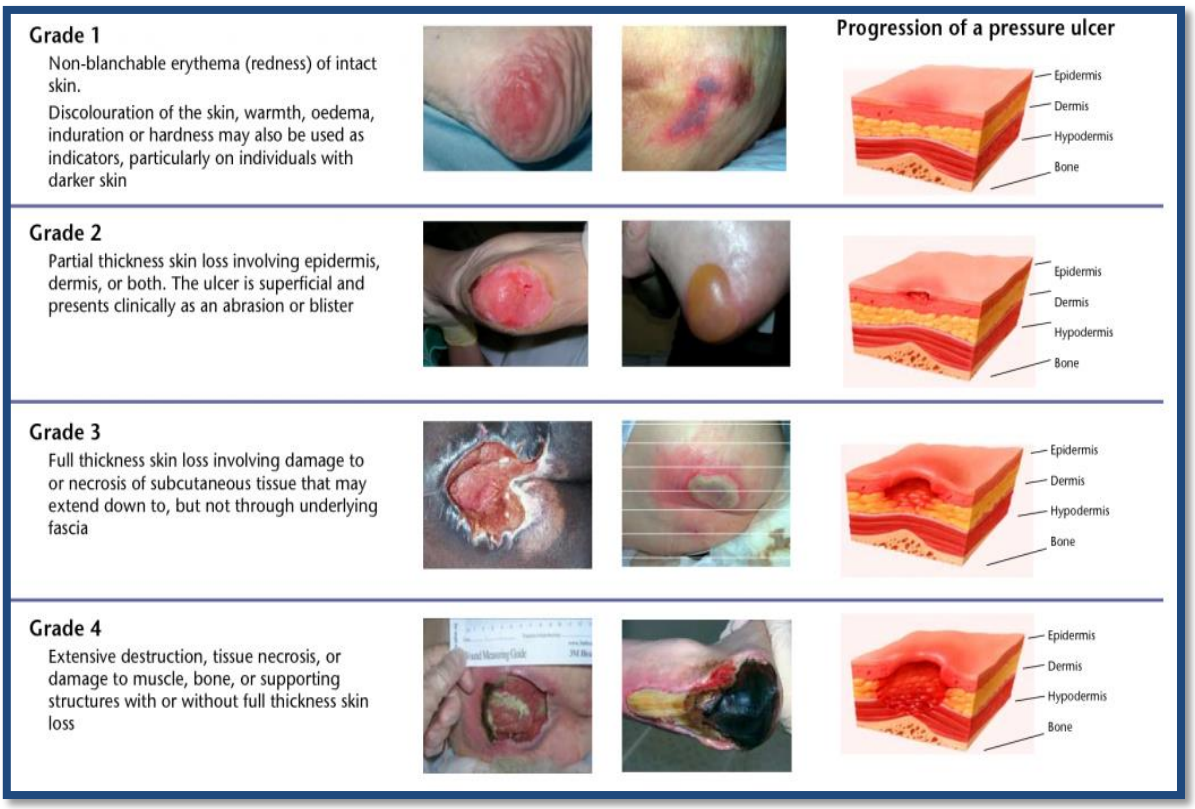
[1] The Health and Social Care Commissioning Plan Direction (Northern Ireland) 2015
[2] Q2020 – A 10 Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland, November 2011

1.0 Pressure Ulcer

1.1 What is a pressure ulcer?

A pressure ulcer is an area of localised damage to the skin and underlying tissue caused by pressure, shear, friction or a combination of these (EPUAP 2014)[3]. They are most likely to occur when a hard bony area covered by a thin layer of tissue is in contact with a hard surface, such as a bed, trolley, theatre table, wheelchair etc.

The body can withstand high interface pressures for a very short period of time. It is when the pressure is not regularly relieved that damage occurs and a pressure ulcer develops. Elderly patients, those with a long term medical illness / disease / condition are particularly vulnerable because their skin usually becomes thinner and more fragile with age. Pressure ulcers can develop in a matter of hours. There are four recognised grades of pressure ulcers in the EPUAP 2014 wound classification (see diagram below).



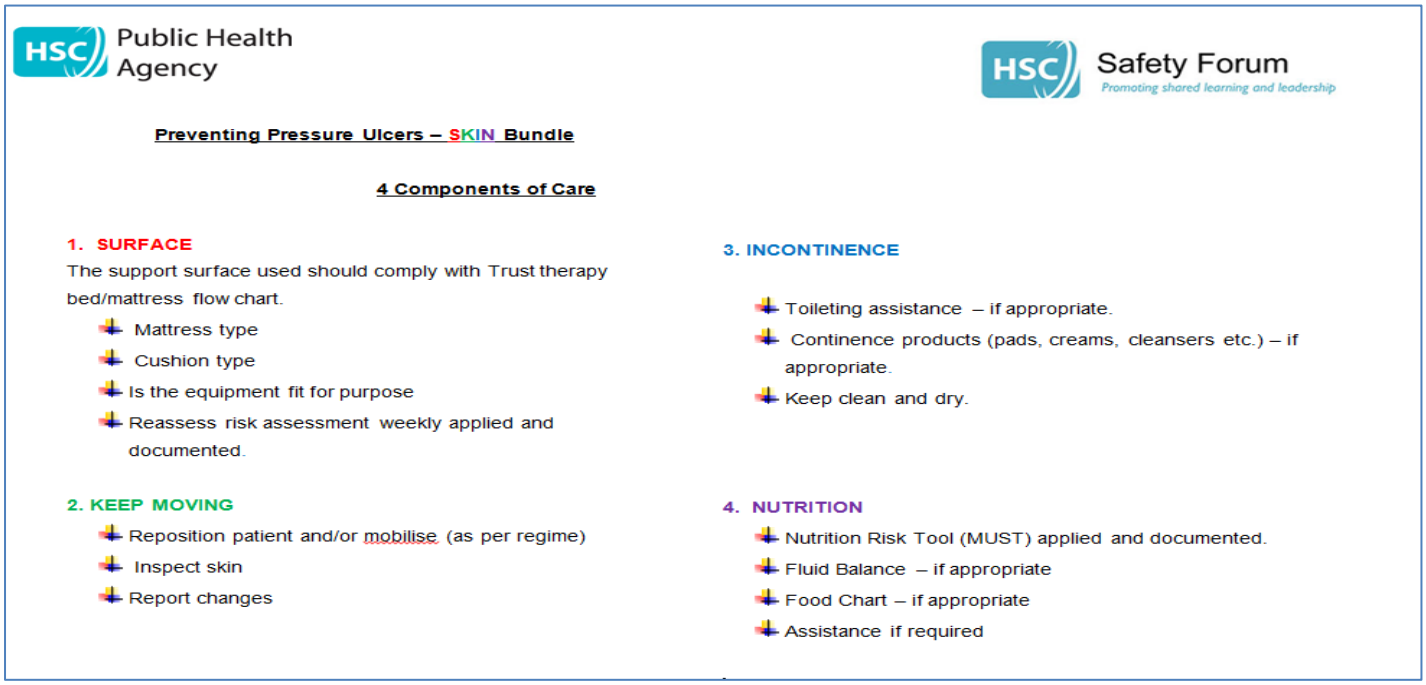
[3] Prevention and Treatment of Pressure Ulcers: Quick Reference Guide National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance (2014)

Whilst some pressures ulcers are unavoidable, many are avoidable see definitions below.

Avoidable	Unavoidable
Avoidable means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following: • evaluate the person's clinical condition and pressure ulcer risk factors • plan and implement interventions that are consistent with the persons' needs and goals, and recognised standards of practice • monitor and evaluate the impact of the interventions or revise the interventions as appropriate	**Unavoidable' means that the person receiving care developed a pressure ulcer even though the provider of the care had evaluated the person's clinical condition and pressure ulcer risk factors using the following:** • planned and implemented interventions that are consistent with the persons needs and goals and recognised standards of practice • monitored and evaluated the impact of the interventions and revised the approaches as appropriate • or the individual refused to adhere to prevention strategies in spite of education of the consequences of non-adherence

The SKIN Bundle (see diagram below) is an evidence based collection of interventions proven to prevent pressure ulcers developed in 2004 at St Vincent's Medical Centre[4], in Florida, US.

SKIN is an acronym that prompts nurses to remember four key elements of good skin care: **S**urface selection, **K**eep moving, **I**ncontinence management, and **N**utrition.



[4] Joint Commission Journal on quality and Safety, (September 2006) Volume 32 Number 9

NICE Clinical Guideline 179[5] recommends that pressure ulcers of grade 2 and above are reported locally as incidents. This ensures that information is gathered about the circumstances of the pressure ulcer and helps prevent future incidents.

The higher the grade of pressure ulcer, the more severe the injury to the skin and underlying tissue. Grade 3 or 4 pressure ulcers can develop quickly, for example, in susceptible people, a full-thickness pressure ulcer can sometimes develop in just one or two hours. However, in some cases, the damage will only become apparent a few days after the injury has occurred.

The PHA supports HSC Trusts through the Regional Pressure Ulcer Prevention Group to implement SKIN in all hospitals in Northern Ireland. This Group provides advice, support and shares regional learning across Northern Ireland. It focuses on strategies for pressure prevention and management across the Health and Social Care Trusts.

1.2 Commissioning Plan Target

The 2016/17[6] & 2017/18[7] Commissioning Plan pressure ulcer related associated quality and performance indicator reads as:

"*The number of incidents of hospital-acquired pressure ulcers (grade 3 & 4) in all adult inpatient wards, and the number of those that were avoidable. Trusts will monitor and provide reports on bundle compliance and the rate of pressure ulcers per 1,000 bed days.*"

Trusts are committed to ensuring pressure ulcer prevention is a priority. As part of their QIPs, pressure ulcer incidence is monitored and information submitted to HSCB and PHA on a quarterly basis.

The table below provides an overview of the number of adult inpatient areas for each Trust where quality improvement for pressure ulcers has been implemented.

Total number of acute adult in-patient wards*					
	BHSCT	**NHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**
Totals 16/17	70	31	31	26	31
Total 17/18	68	31	30	26	36

*when measuring the spread of quality improvement bundles the total number of adult inpatient wards may vary slightly within each Trust for a variety of reasons including; the appropriateness of the bundle within the particular area, the opening / closure of wards and/or re-categorisation of wards. It should be noted that the WHSCT has increased the number of acute adult in-patient wards to include their PCOP mental health inpatient wards from April 2017

[5] National Institute for Healthcare Excellence Guidelines - Pressure ulcers: prevention and management of pressure ulcers [CG179] 2014
[6] HSCB/PHA Commissioning Plan 2016/7
[7] Draft HSCB/PHA Commissioning Plan 2017/8

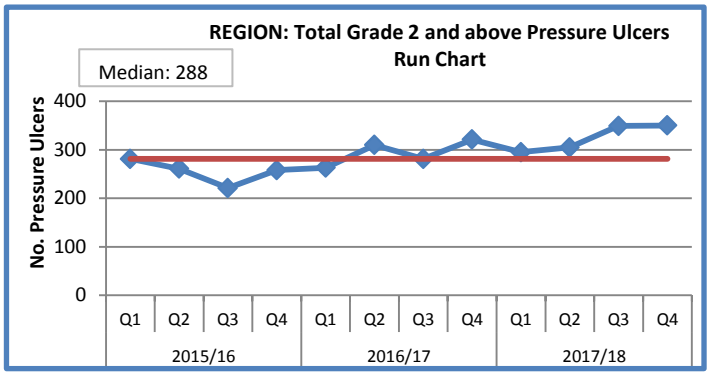
The key areas that are monitored include the number and rate of pressure ulcers by grade and the compliance with the SKIN bundle

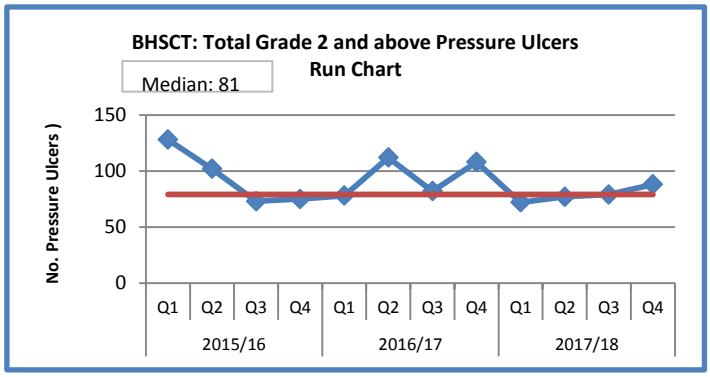
A basic principle of quality measurement is: If it can't be measured, it can't be improved. Therefore, pressure ulcer performance must be counted and tracked as one component of a quality improvement program. By tracking performance of the SKIN bundle, this will give an indication whether care is improving, staying the same, or worsening in response to efforts to change practice. Moreover, continued monitoring will be key to understanding where you are starting and to sustaining your improvement gains.

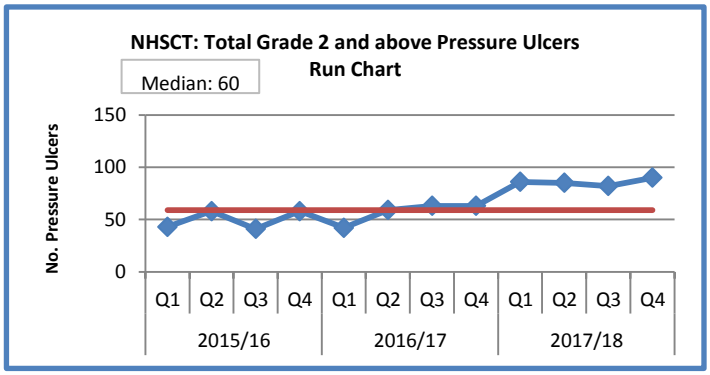
Pressure ulcer rates are the most direct measure of how well progress is being achieved in preventing pressure ulcers. If the rate is low or improving, then you are likely to be doing a good job in preventing pressure ulcers. Conversely, if the pressure ulcer rate is high or increasing, then there might be areas in which care can be improved.

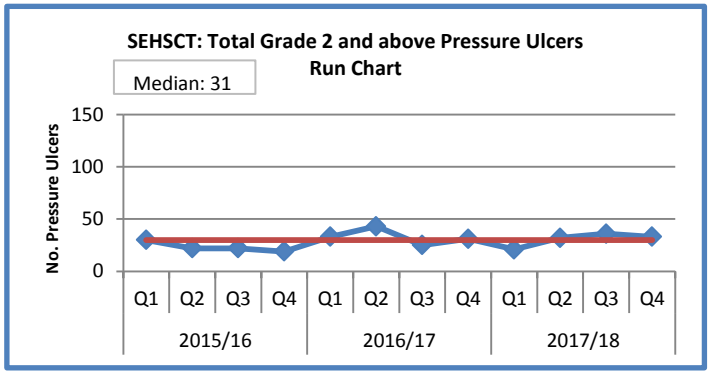
1.3 Numbers and rates of pressure ulcers

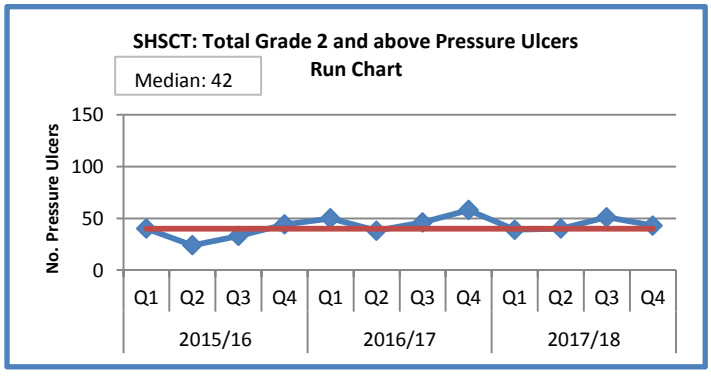
The following graphs show from April 2015 –March 2018 **regional numbers** of pressure ulcers grade 2 and above.

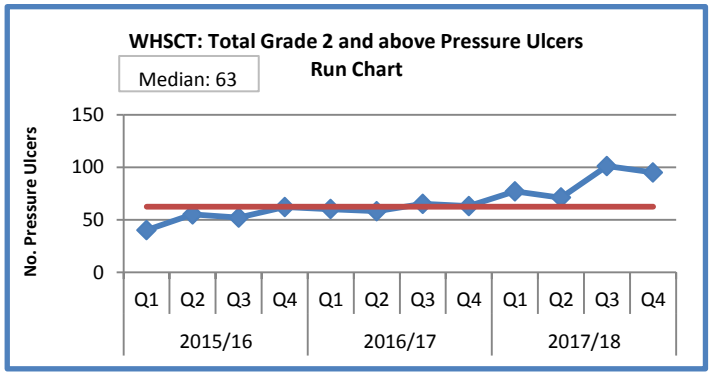




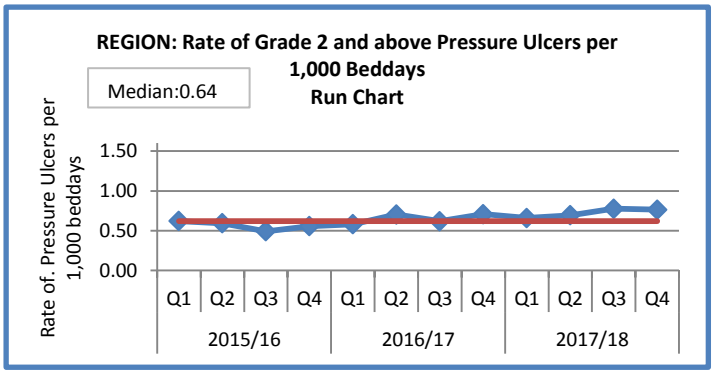


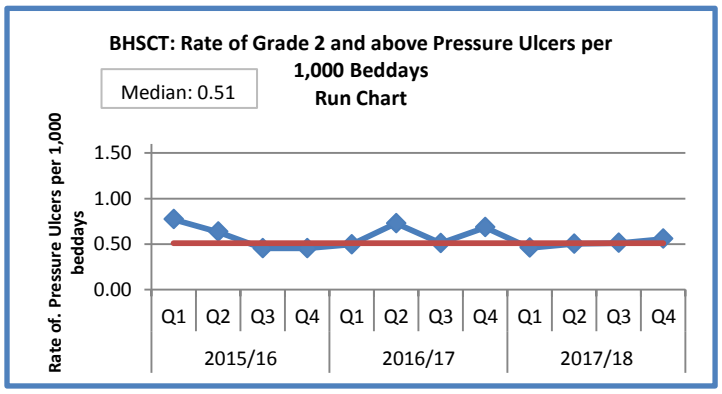


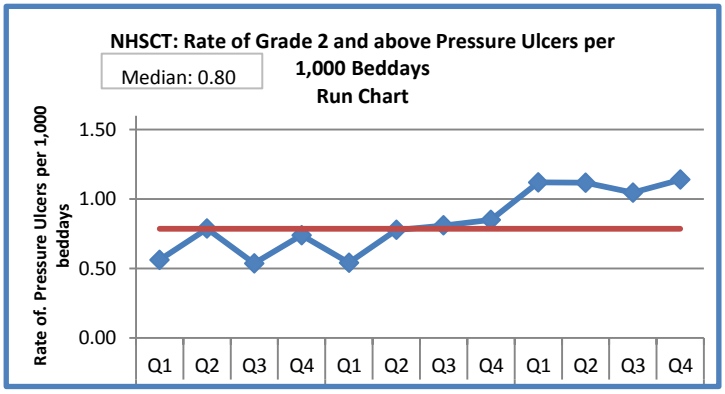


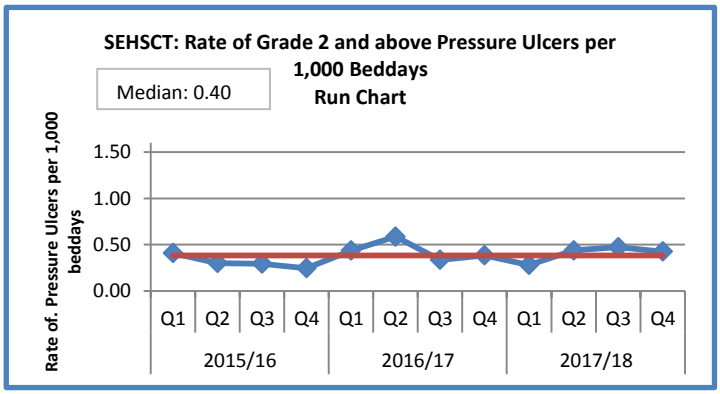


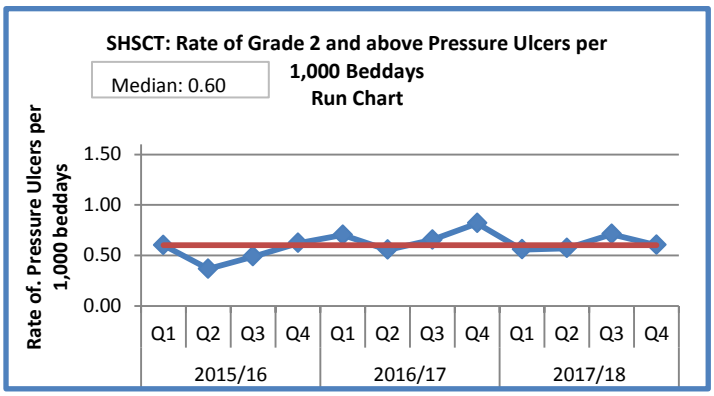
The following graphs show from April 2015 –March 2018 regional **rates** of pressure ulcers grade 2 and above.

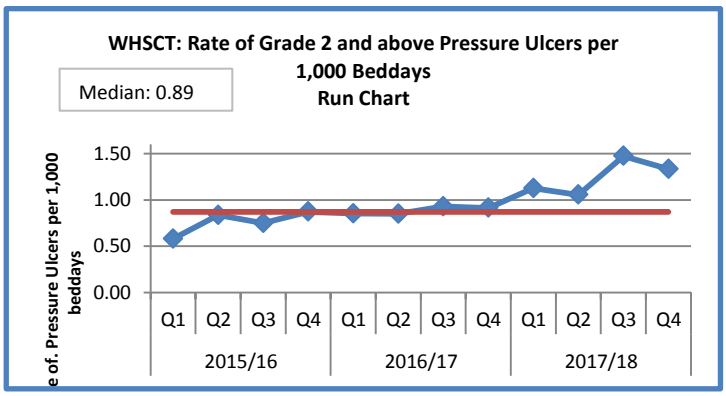












1.4 Analysis of Numbers and rates of pressure ulcers

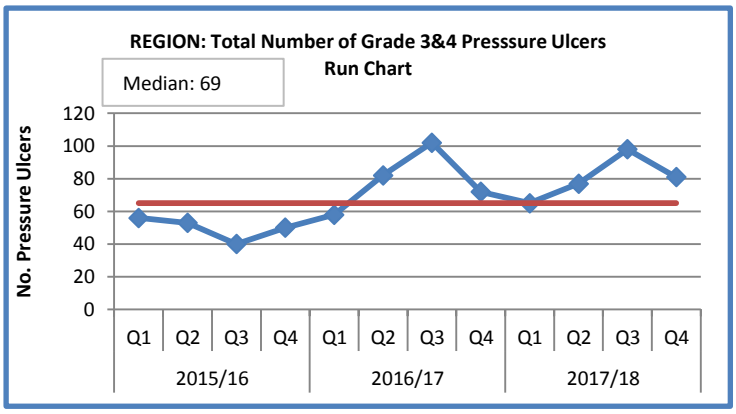
Regionally, there has been an increase in the number and rates of grade 2 and above pressure ulcers, particularly in Q3 & Q4 17/18. At local Trust level, this increase is most evident in NHSCT and WHSCT.

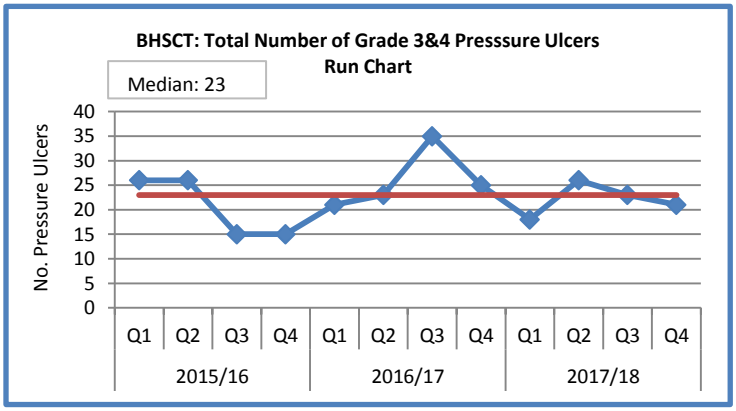
The WHSCT has increased the number of acute adult in-patient wards to include their Programme of Care for Older People (PCOP) mental health inpatient wards since April 2017; this has resulted in an increased number of reported pressure ulcers.

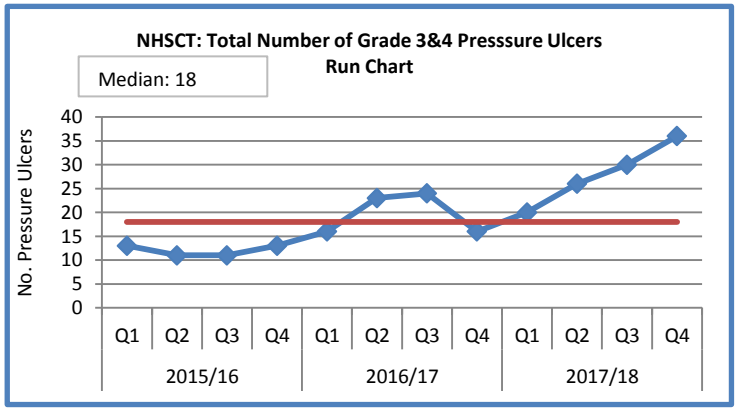
The NHSCT are currently undertaking a Trust wide focused pressure ulcer improvement project to facilitate learning from the numbers and rates of reported pressure ulcers. Further information is provided in the Grade 3 & 4 avoidable section. There were no notable trends or patterns in the other three trusts.

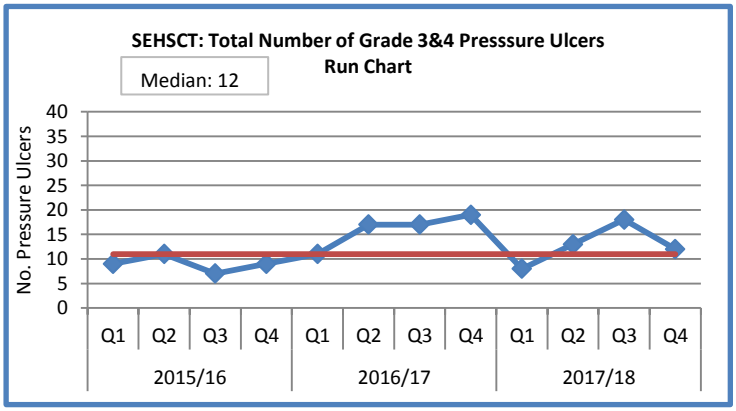
1.5 Grade 3 & 4 pressure ulcers

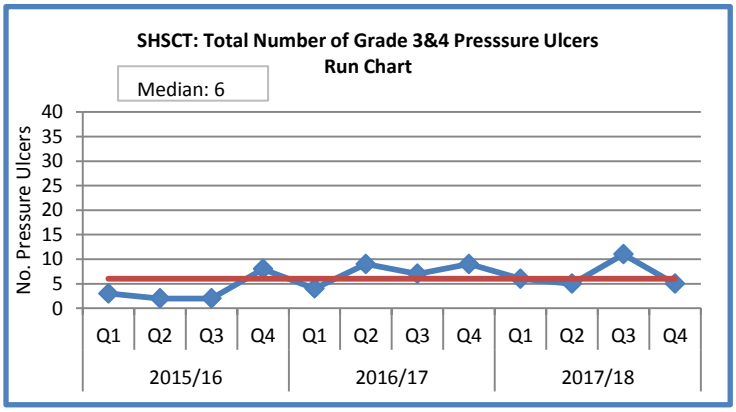
The following graphs below show the **total number of grade 3&4 pressure ulcers** that were recorded each quarter by Trusts April 15 – March 2018.

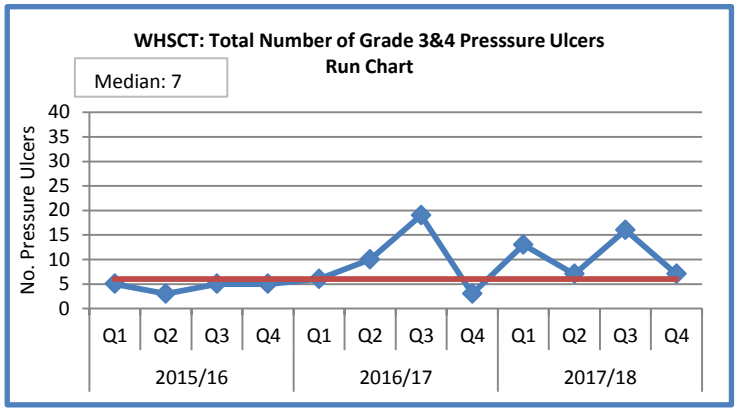




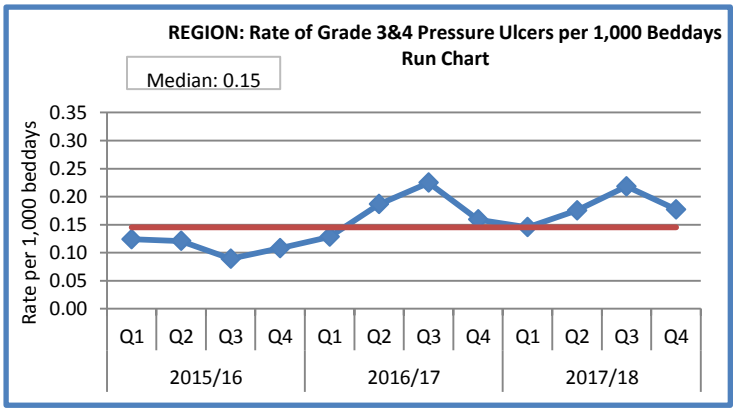


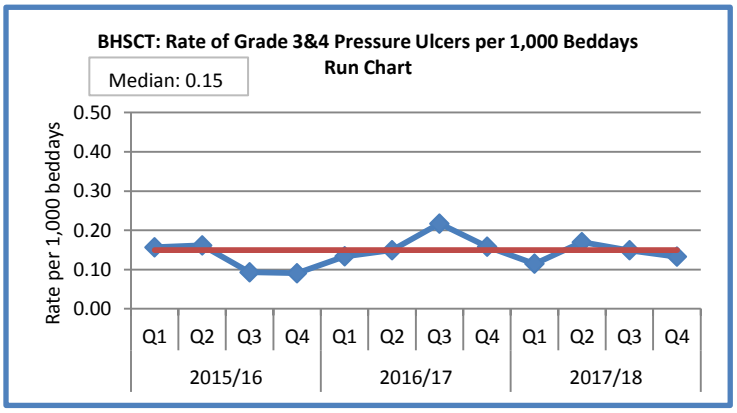


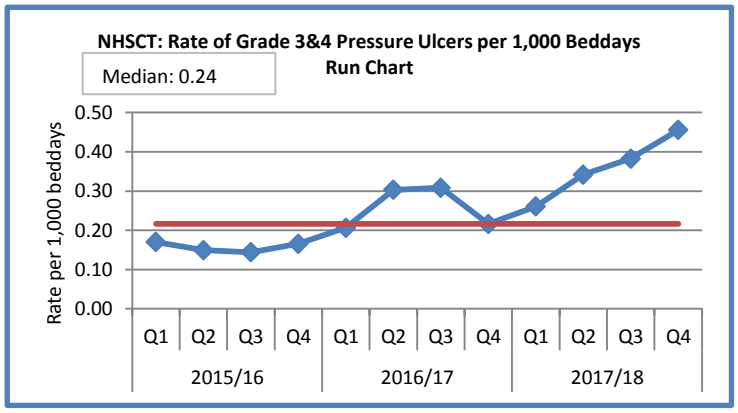


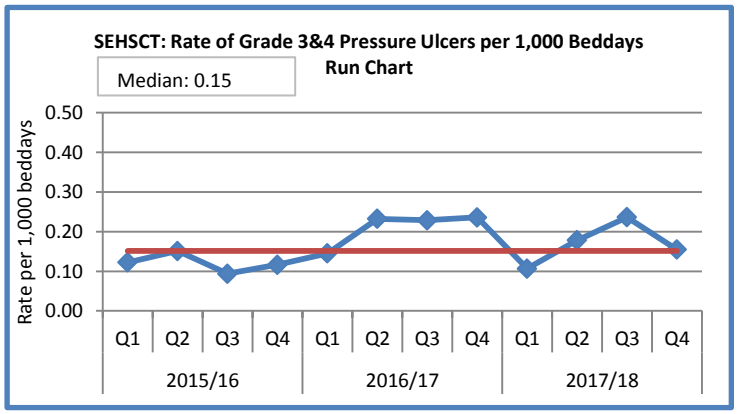


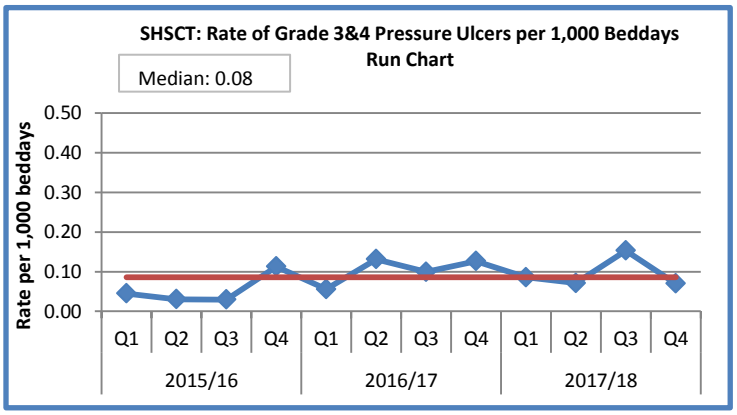
The following graphs below show the **rate of grade 3 & 4 pressure ulcers per 1,000 bed days** that were recorded each quarter by Trusts April15 – March 2018

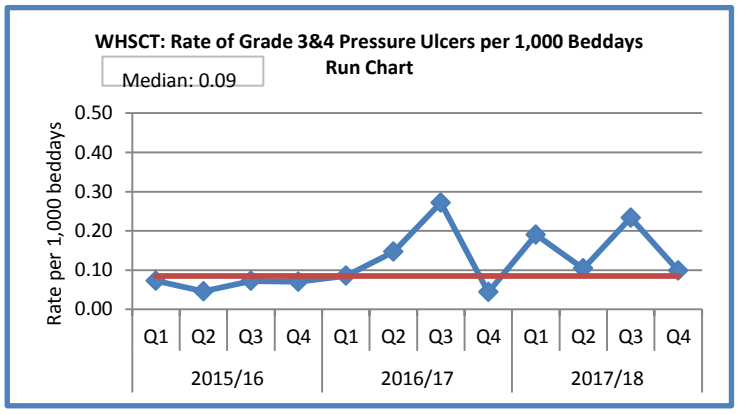












The following table shows the total number of grade 3&4 pressure ulcers recorded each quarter by each Trust April 2015 to March 2018

Year	*Qtr*	*BHSCT*	*NHSCT*	*SEHSCT*	*SHSCT*	*WHSCT*	*REGION*
2015/16	Q1	26	13	9	3	5	**56**
	Q2	26	11	11	2	3	**53**
	Q3	15	11	7	2	5	**40**
	Q4	15	13	9	8	5	**50**
2015/16 Total		**82**	**48**	**36**	**15**	**18**	**199**
2016/17	Q1	21	16	11	4	6	**58**
	Q2	23	23	17	9	10	**82**
	Q3	35	24	17	7	19	**102**
	Q4	25	16	19	9	3	**72**
2016/17 Total		**104**	**79**	**64**	**29**	**38**	**314**
2017/18	Q1	18	20	8	6	13	**65**
	Q2	26	26	13	5	7	**77**
	Q3	23	30	18	10	16	**97**
	Q4	21	36	12	5	7	**81**
2017/18 Total		**88**	**112**	**51**	**26**	**43**	**320**

The following table shows the rates of grade 3&4 pressure ulcers recorded each quarter by each Trust April 2015 to March 2018

Year	*Qtr*	*BHSCT*	*NHSCT*	*SEHSCT*	*SHSCT*	*WHSCT*	*REGION*
2015/16	Q1	0.16	0.17	0.12	0.05	0.07	**0.12**
	Q2	0.16	0.15	0.15	0.03	0.05	**0.12**
	Q3	0.09	0.14	0.09	0.03	0.07	**0.09**
	Q4	0.09	0.17	0.12	0.11	0.07	**0.11**
2016/17	Q1	0.13	0.21	0.15	0.06	0.09	**0.13**
	Q2	0.15	0.30	0.23	0.13	0.15	**0.19**
	Q3	0.22	0.31	0.23	0.10	0.27	**0.22**
	Q4	0.16	0.22	0.24	0.13	0.04	**0.16**
2017/18	Q1	0.11	0.26	0.11	0.09	0.19	**0.15**
	Q2	0.17	0.34	0.18	0.07	0.10	**0.17**
	Q3	0.15	0.38	0.24	0.14	0.23	**0.22**
	Q4	0.13	0.46	0.15	0.07	0.10	**0.18**

1.6 Analysis of Grade 3 & 4 pressure ulcers

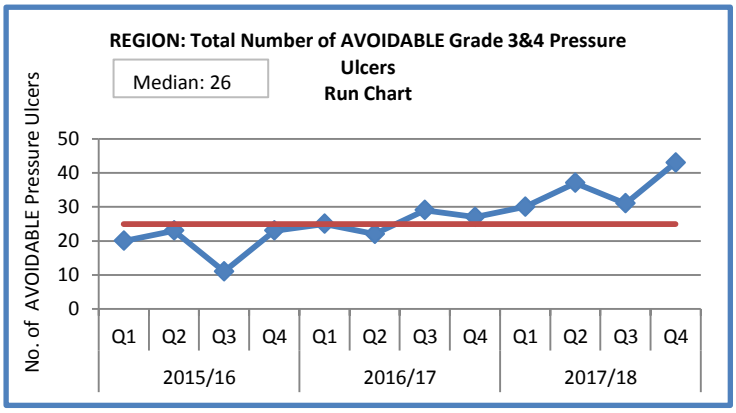
The numbers and rates of grade 3 and 4 pressure ulcers reflects a regional increase and all Trusts, from quarter 2 there has been a slight increase in these numbers which has impacted on the increase on the rate shown. The overall rate increase attributed to all Trusts may reflect the complex issues across each trust. Regional data is not used to compare outcomes between Trusts, in recognition that staff may report pressure ulcers in a different way, patients within Trusts may be more or less vulnerable to developing pressure ulcers for example, each hospital may have younger or older patient populations, who are more or less mobile, have increased length of stays or are undergoing treatments for different conditions.

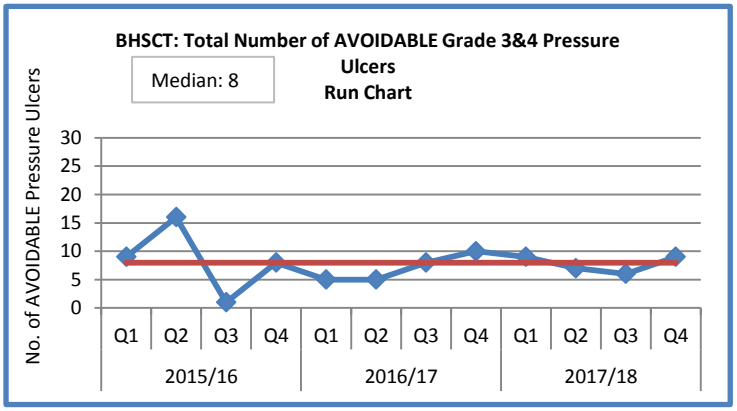
1.7 Prevention of avoidable grade 3 & 4 pressure ulcers

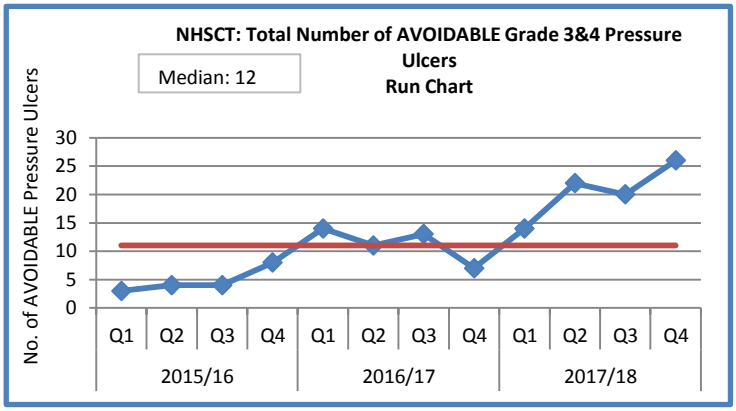
At the Regional Pressure Ulcer Prevention Group, Trusts agreed to focus on prevention of avoidable grade 3 & 4 pressure ulcers, as these create deeper cavity wounds which can result in more pain and suffering to patients. 'Avoidable' means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following:

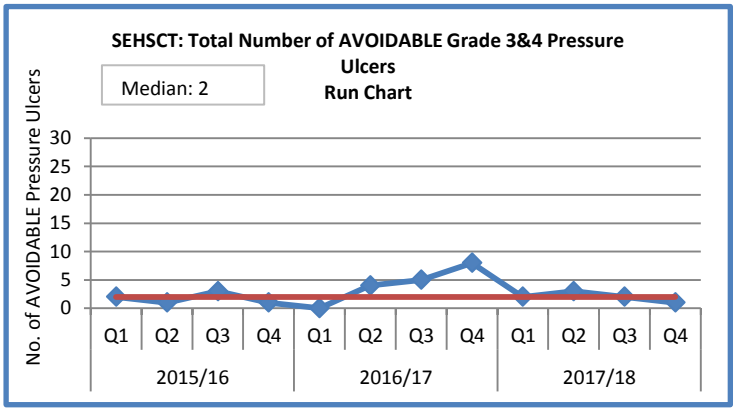
- evaluate the person's clinical condition and pressure ulcer risk factors
- plan and implement interventions that are consistent with the person's needs and goals, and recognised standards of practice
- monitor and evaluate the impact of the interventions
- Revise the interventions as appropriate
- Or demonstrate evidence of the same

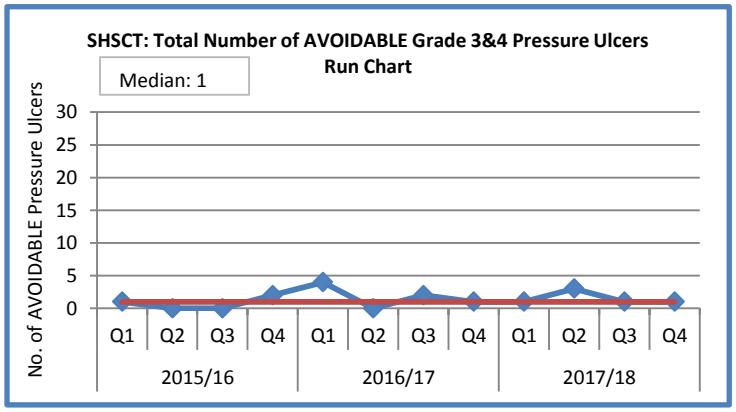
The following graphs below shows the **number** of **avoidable** grade 3 & 4 pressure ulcers that were recorded each quarter by Trusts from April 2015 – March 2018

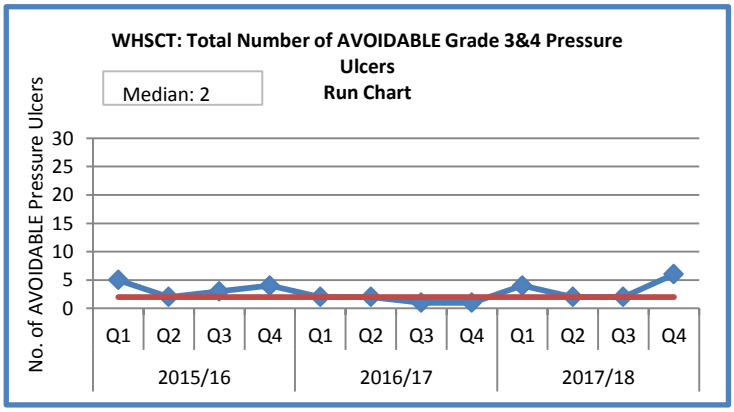




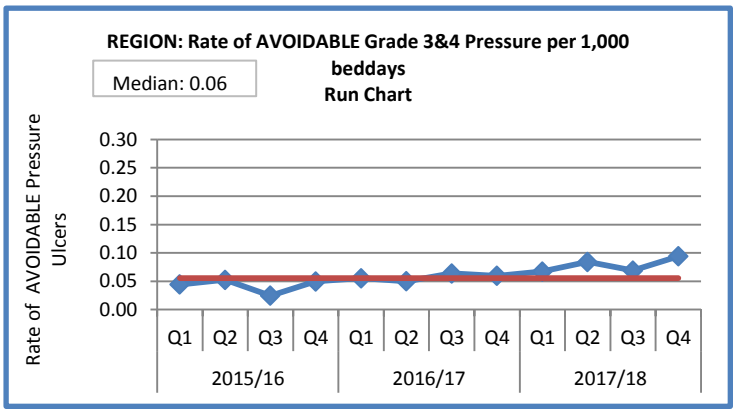


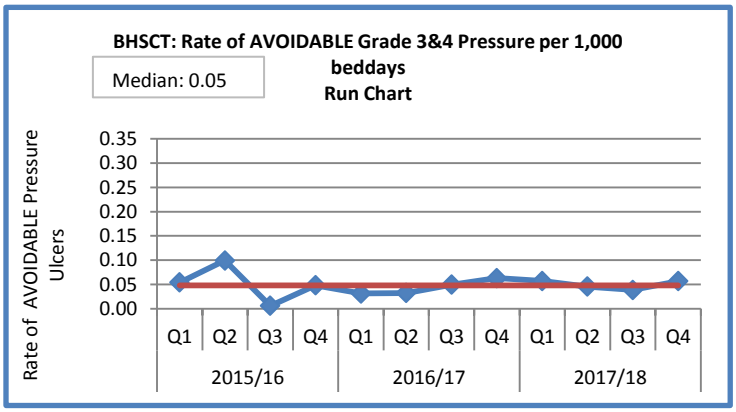


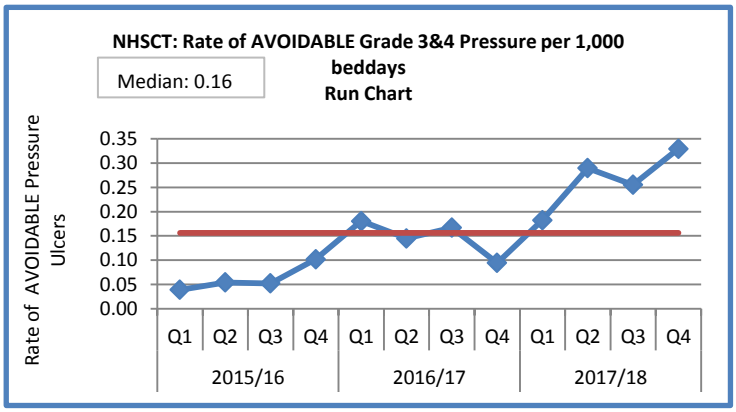


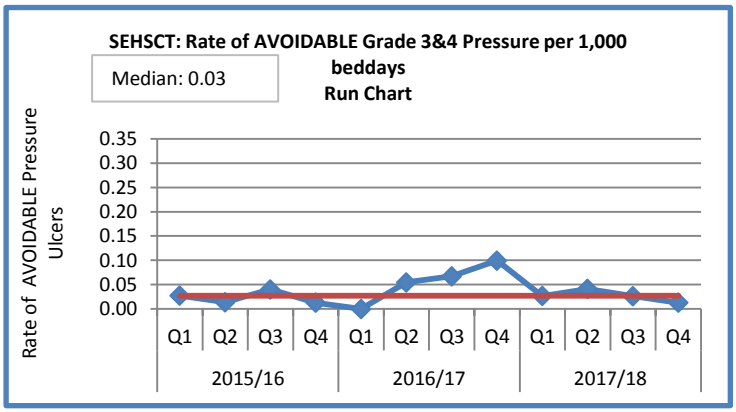


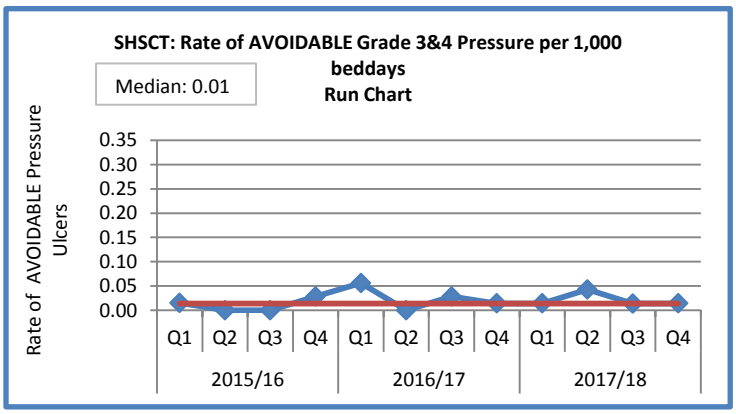
The following graphs below shows the **rate per 1,000 bed days** of **avoidable** grade 3 & 4 pressure ulcers that were recorded each quarter by Trusts between April 15– March 2018:

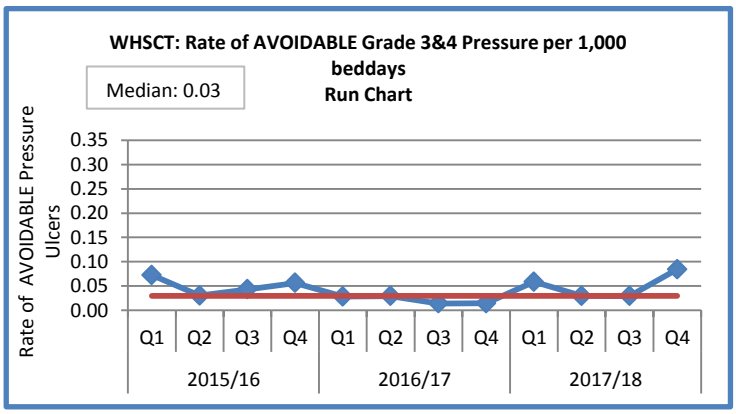












The following table shows the total number of avoidable grade 3&4 pressure ulcers recorded each quarter by each Trust April 2015 to March 2018

Year	*Qtr*	*BHSCT*	*NHSCT*	*SEHSCT*	*SHSCT*	*WHSCT*	*REGION*
2015/16	Q1	9	3	2	1	5	**20**
	Q2	16	4	1	0	2	**23**
	Q3	1	4	3	0	3	**11**
	Q4	8	8	1	2	4	**23**
2015/16 Total		**34**	**19**	**7**	**3**	**14**	**77**
2016/17	Q1	5	14	0	4	2	**25**
	Q2	5	11	4	0	2	**22**
	Q3	8	13	5	2	1	**29**
	Q4	10	7	8	1	1	**27**
2016/17 Total		**28**	**45**	**17**	**7**	**6**	**103**
2017/18	Q1	9	14	2	1	4	**30**
	Q2	7	22	3	3	2	**37**
	Q3	6	20	2	1	2	**31**
	Q4	9	26	1	1	6	**43**
2017/18 Total		**31**	**82**	**8**	**6**	**14**	**141**

The following table shows the rate per 1000 beddays of avoidable grade 3&4 pressure ulcers recorded each quarter by each Trust April 2015 to March 2018

Year	*Qtr*	*BHSCT*	*NHSCT*	*SEHSCT*	*SHSCT*	*WHSCT*	*REGION*
2015/16	Q1	0.05	0.04	0.03	0.02	0.07	**0.04**
	Q2	0.1	0.05	0.01	0	0.03	**0.05**
	Q3	0.01	0.05	0.04	0	0.04	**0.02**
	Q4	0.05	0.10	0.01	0.03	0.06	**0.05**
2016/17	Q1	0.03	0.18	0	0.06	0.03	**0.06**
	Q2	0.03	0.15	0.05	0	0.03	**0.05**
	Q3	0.05	0.17	0.07	0.03	0.01	**0.06**
	Q4	0.06	0.09	0.1	0.01	0.01	**0.06**
2017/18	Q1	0.06	0.18	0.03	0.01	0.06	**0.07**
	Q2	0.05	0.29	0.04	0.04	0.03	**0.08**
	Q3	0.04	0.26	0.03	0.01	0.03	**0.07**
	Q4	0.06	0.33	0.01	0.01	0.08	**0.09**

1.8 Analysis of avoidable grade 3 & 4 pressure ulcers

Regionally a variation in the rate of avoidable grade 3 and 4 pressure ulcers is noted with a range between Trusts of 0.01 to 0.33.

While this data cannot be used to compare performance between Trusts as staff may report pressure ulcers in a different way, it can be used by Trusts to assess their own individual improvement.

The data indicates:

- There was a marked increase in avoidable grade 3 & 4 pressure ulcers within the NHSCT. This is subject to further review and investigation by the Trust
- The data for 2017/18 for the NHSCT shows a continued increase in grade 3 & 4 pressure ulcers
- The Data for other Trusts shows no notable pattern or trend.

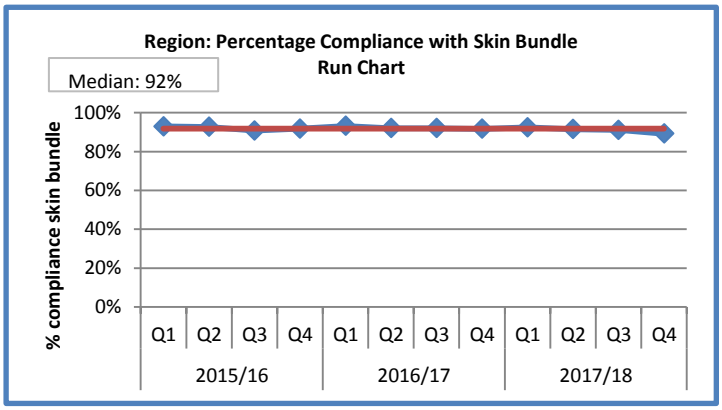
1.9 Action

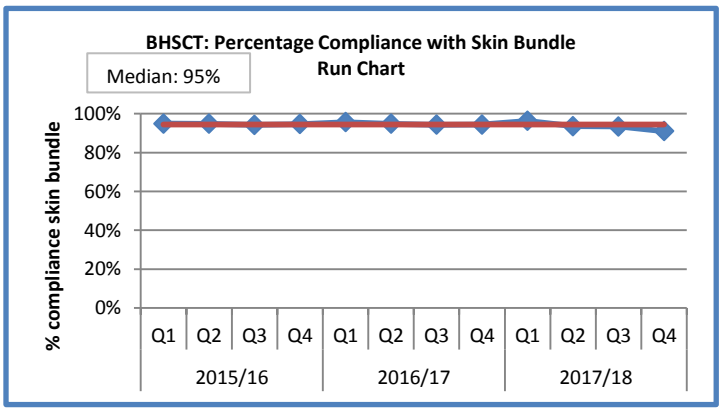
All trusts continue to promote the evidence based actions to prevent pressure ulcers. Given the persistent increase in NHSCT pressure ulcer rate, the Trust is taking forward the following actions:

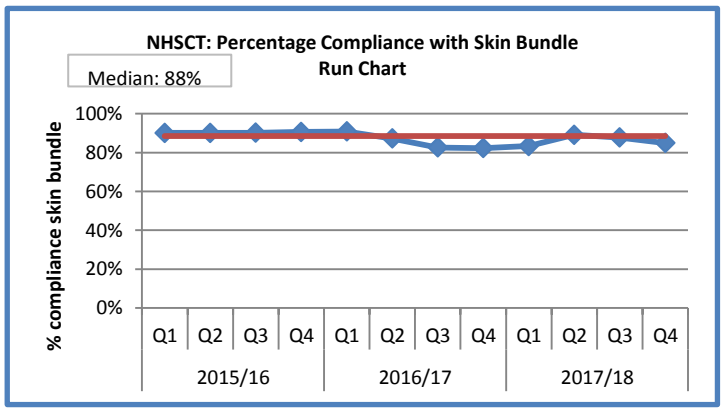
- The NHSCT has completed an in depth validation exercise to review the reporting and analysis of grade 3 and 4 pressure ulcers
- The Trust has commenced a local improvement project with an associated action plan related to a targeted reduction in hospital acquired avoidable pressure ulcers. Particular attention has been paid to pressure ulcer risk assessment, the plan of care to promote pressure ulcer prevention, learning from hospital acquired and avoidable pressure ulcers and education and training of staff.

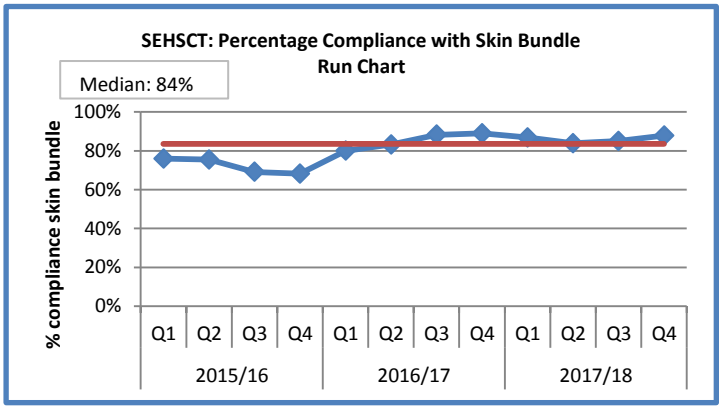
1.10 Compliance with SKIN bundle

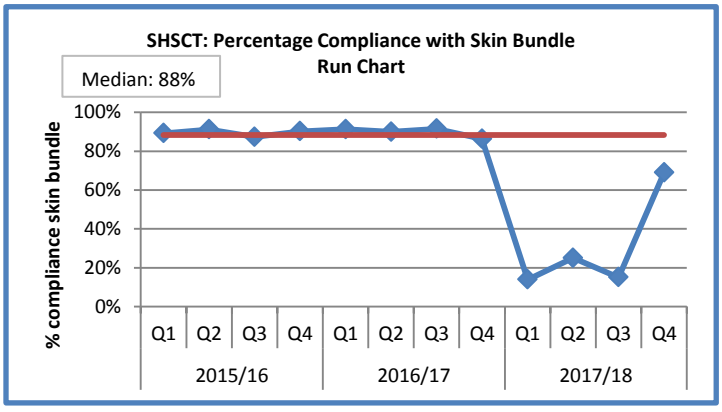
The following graphs show the percentage compliance with the Skin Bundle by Trust for each of the quarters (from April 2015 to March 2018):

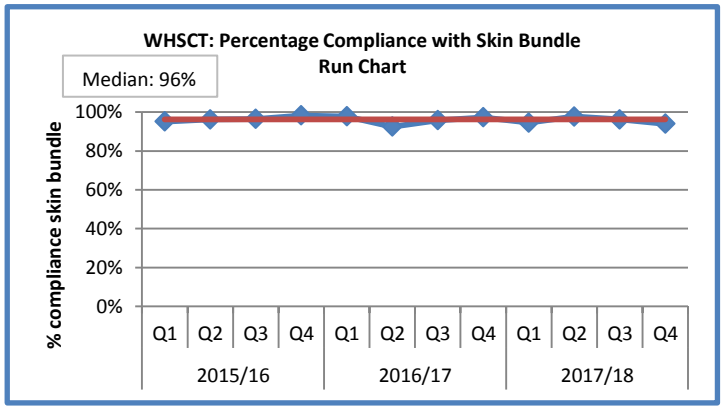




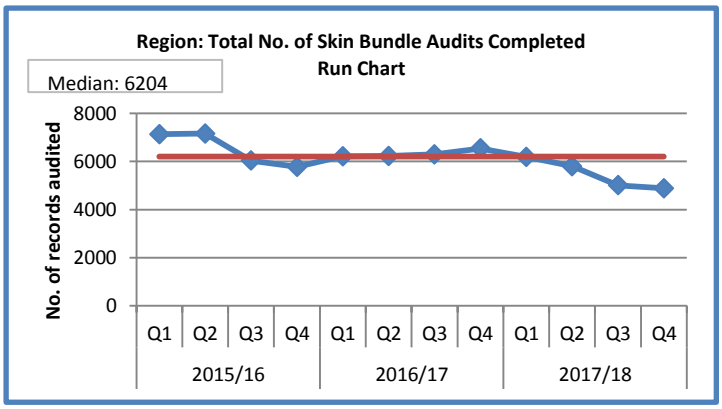


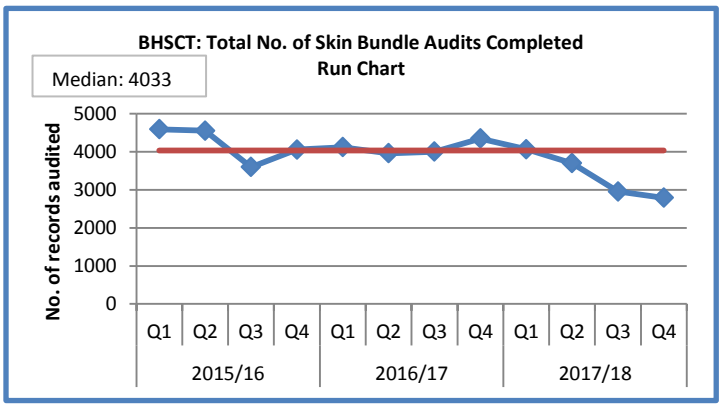


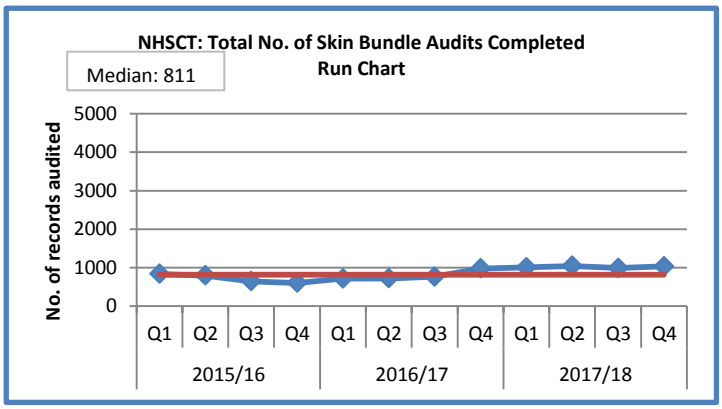


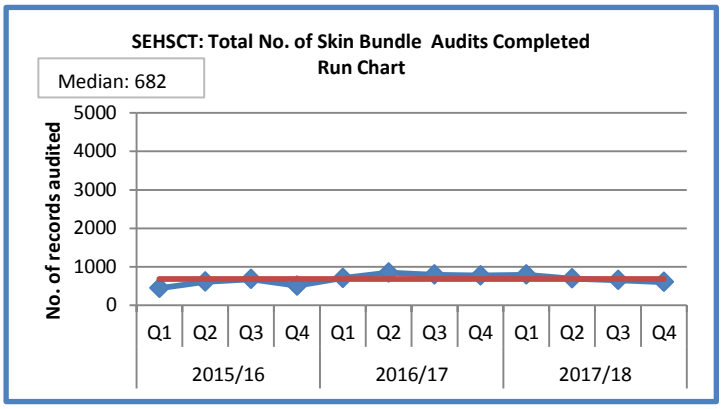


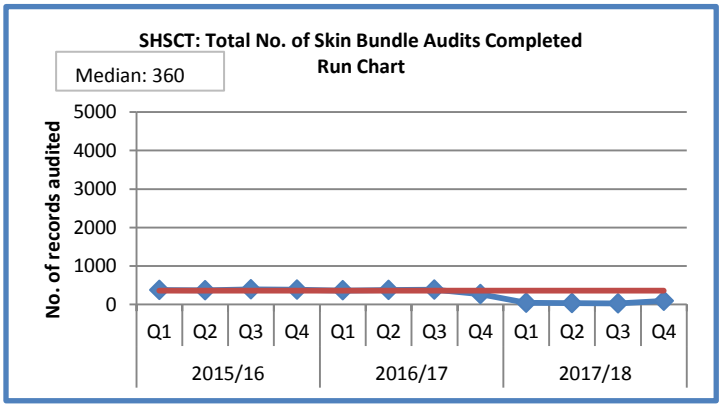
The following graphs show the number of audits carried out with the Skin Bundle by Trust for each of the quarters (from April 2015 to March 2018):

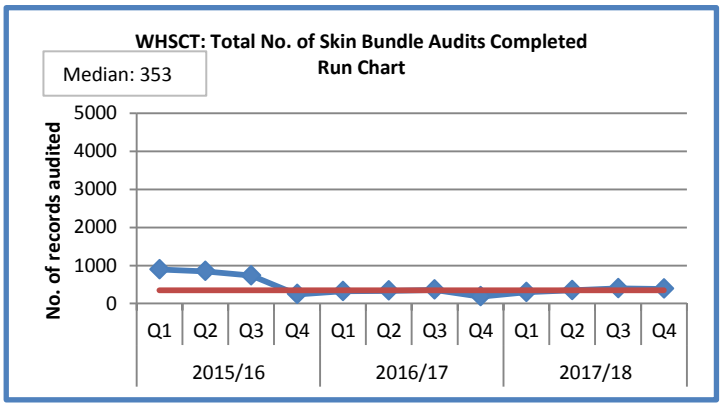












The following tables show the percentage compliance with the Skin Bundle and the number of audits carried out with the Skin Bundle by Trust for each of the quarters (from April 2015 to March 2018

% Compliance Skin Bundle 15/16

Trust	Skin Bundle % Compliance 2015/16					Audits carried out Skin Bundle 2015/16				
	Q1	Q2	Q3	Q4	15/16 Total	Q1	Q2	Q3	Q4	15/16 Total
BHSCT	95%	95%	94%	95%	**95%**	4593	4556	3600	4059	**16808**
NHSCT	90%	90%	90%	91%	**90%**	833	789	643	599	**2864**
SEHSCT	76%	75%	69%	68%	**72%**	441	608	674	503	**2226**
SHSCT	89%	91%	87%	90%	**89%**	372	363	387	378	**1500**
WHSCT	95%	96%	96%	98%	**96%**	895	847	735	240	**2717**
REGION	**93%**	**93%**	**91%**	**92%**	**92%**	**7134**	**7163**	**6039**	**5779**	**26115**

Skin Bundle Numbers Audited 15/16

% Compliance Skin Bundle 16/17

Trust	Skin Bundle % Compliance 2016/17					Audits carried out Skin Bundle 2016/17				
	Q1	Q2	Q3	Q4	16/17 Total	Q1	Q2	Q3	Q4	16/17 Total
BHSCT	96%	95%	94%	94%	**95%**	4123	3961	4006	4349	**16439**
NHSCT	91%	87%	83%	82%	**85%**	710	716	761	973	**3160**
SEHSCT	80%	83%	88%	89%	**85%**	705	847	790	771	**3113**
SHSCT	91%	90%	92%	86%	**90%**	356	370	379	264	**1369**
WHSCT	98%	93%	96%	97%	**96%**	320	336	360	184	**1200**
REGION	**93%**	**92%**	**92%**	**92%**	**92%**	**6214**	**6230**	**6296**	**6541**	**25281**

Skin Bundle Numbers Audited 16/17

% Compliance Skin Bundle 17/18

Trust	Skin Bundle % Compliance 2017/18					Audits carried out Skin Bundle 2017/18				
	Q1	Q2	Q3	Q4	17/18 Total	Q1	Q2	Q3	Q4	17/18 Total
BHSCT	96%	94%	93%	91%	**94%**	4068	3702	2957	2791	**13518**
NHSCT	83%	89%	88%	85%	**86%**	1004	1041	988	1027	**4060**
SEHSCT	87%	84%	85%	88%	**86%**	789	689	648	598	**2724**
SHSCT	14%	25%	15%	69%	**44%**	36	28	20	87	**171**
WHSCT	95%	98%	96%	94%	**96%**	296	345	396	383	**1420**
REGION	**92%**	**92%**	**91%**	**89%**	**91%**	**6193**	**5805**	**5009**	**4886**	**21893**

Skin Bundle Numbers Audited 17/18

1.11 Analysis of SKIN bundle compliance

The region as a whole has continued to maintain an average % compliance of Skin Bundle throughout the 2016/17 year of at least 92 and % compliance of Skin Bundle throughout the 2017/18 year of at least 89. From April 2017 the SHSCT has moved to Independent Auditing and are using a new database to collect data. They have had a significant dip in compliance with the SKIN bundle audit findings since commencing the independent audits cycle and have reported that they are experiencing issues with data input/extraction; therefore the use of the data should be guarded. They are also reintroducing "self-auditing" to run alongside the new audit process in Q3 to drive improvement between audit cycles. There are individual ward areas that are at 1000 plus pressure ulcer free days, in these areas there has been a reduction in audits.

1.12 Sharing of Regional Learning and Actions

Alongside providing ongoing support to the HSC Trusts through the Regional pressure Ulcer Group a number of specific actions in response to the analysis of the data has commenced to include:

- Undertake an improvement project in relation to measurement, display and interpretation of improvement data.
- Review of current operational definitions, including current application.
- Review process for root cause analysis and process for obtaining bed day figures which reflect exactly the wards & clinical areas within which pressure ulcer data is collated and submitted to PHA ;
- Development of a schedule for validation of data.
- Development of a regional education E-learning tool for pressure ulcer prevention.
- Work with Trusts to ensure local and regional learning is identified and shared.
- Work with service users and staff in relation to the development, assessment and analysis of the QIP process.
- Development of a regional guidance on safeguarding.

2.0 Regional Falls Prevention

2.1 The significance of a fall

Falls are a common cause of injury. Anyone can have a fall, but older people are more vulnerable and likely to fall, especially if they have a long-term health condition. Falls are a common, but often overlooked, cause of injury. Around one in three adults over 65 who live at home will have at least one fall a year, and about half of these will have more frequent falls.

Frequently the cause of a fall is related to:

- footwear
- lighting
- activity
- medication
- eyesight

Most falls do not result in serious injury. The human cost of a fall includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than £2.3 billion per year[8]. Therefore falling has an impact on quality of life, health and healthcare costs.

Fall prevention involves managing a patient‘s underlying fall risk factors (e.g., problems with walking and transfers, medication side effects, confusion, frequent toileting needs) and optimising the hospital‘s physical design and environment. A number of practices have been shown to reduce the occurrence of falls.

Falls are among the top five most frequent adverse incidents reported within Health and Social Care (HSC) Trusts. Falls can be categorised depending on harm caused. Regionally the PHA, HSCB, DoH and HSC Trusts had agreed definitions for moderate to severe harm and these were used up until 31st March 2017 (see table below)

[8] Falls in Older People: assessing risk and prevention Clinical Guidelines {CG161} Published date: June 2013

Definitions of moderate to severe in the context of slips and falls[9]		
Moderate harm	**Severe harm**	**Death**
Harm requiring hospital treatment or a prolonged length of stay but from which a full recovery is expected (e.g. fractured clavicle, laceration requiring suturing).	Harm causing permanent disability (e.g. brain injury, hip fractures *where the patient is unlikely to regain their former level of independence*).	Where death is directly attributable to the fall

The Business Services Organisation (BSO) internal audit carried out an audit of learning from serious adverse incidents (SAIs) and from falls across HSC organisations. This audit found that these definitions were not consistent with the Trusts' classifications of falls and recommended that the current definitions should be brought into line with the regional incident grading matrix[10] (appendix 2). There was regional agreement that this should commence from April 2017. Following review moderate to severe harm equated with the moderate major and catastrophic definitions and therefore there were no significant differences.

HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

2.2 Commissioning Plan Target

The 2016/17 & 2017/18 Commissioning Plan requirement states:

- Trusts will continue to improve compliance with Part B of the 'Fallsafe' Bundle.
- Trusts will spread the regionally agreed elements of Part A of the 'Fallsafe' bundle and demonstrate an increase each quarter in the % of adult inpatient ward/areas in which 'Fallsafe' bundle has been implemented.

[9] www.npsa.nhs.uk
[10] HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)

- Trusts will monitor and provide reports on bundle compliance, the number of incidents of falls, those which cause moderate or major/catastrophic harm and the rate per 1,000 bed days."

Falls incidents are monitored and information submitted to the HSCT and PHA on a quarterly basis.

During 2016/17 and 2017/18 the PHA worked closely with HSCB and HSC Trusts to implement and spread the Royal College of Physicians 'Fallsafe' bundle, an evidence based collection of interventions proven to reduce falls; in inpatient settings.

The Falls Bundle contains a number of regionally agreed elements, which are evidenced to reduce falls, outlined below, which Trusts measure compliance against and report to the PHA and HSCB on a quarterly basis.

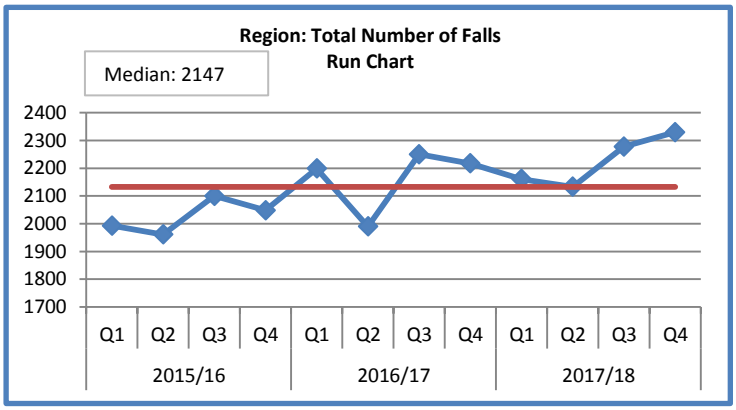
Part A Element	Part B Elements
• Asked about history of falls in past 12 months • Asked about fear of falls • Urinalysis performed • Call bell in sight and reach • Safe footwear on feet • Personal items within reach • No slips or trips hazards within reachNo slips or trips hazards	• Cognitive Screening • Lying & Standing Blood Pressure record • Full Medication review requested • Bedrails risk assessment

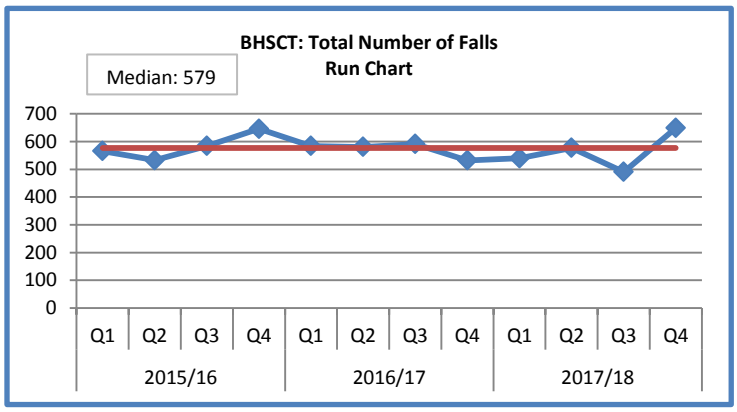
A core function of the Public Health Agency (PHA) is to provide leadership and support to health and social care providers in improving the quality of services delivered to service users. A Regional In-Patient Falls Group, led by the PHA, has been established to provide multidisciplinary advice and support across the HSC in preventing harm to patients who fall whilst in hospital and share regional learning across Northern Ireland. It focuses on sustainable strategies for falls prevention and management across Trusts.

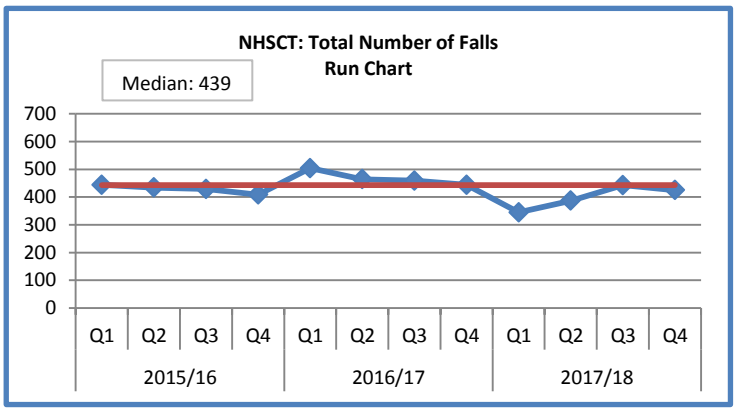
HSC Trusts routinely report to the PHA/HSCB and Department of Health (DoH), the number of falls incidents classified as causing moderate to major/catastrophic harm.

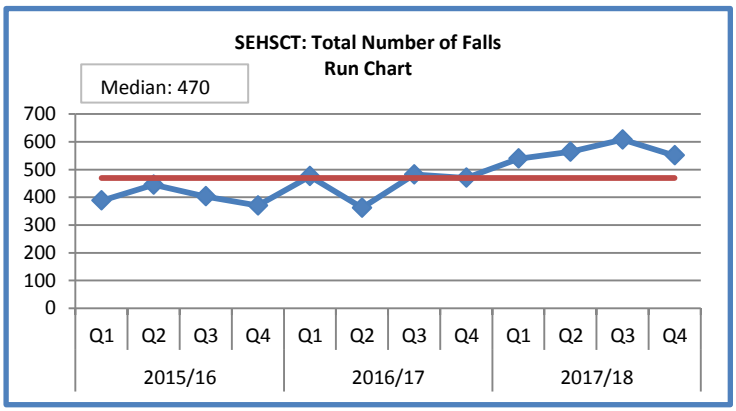
2.3 Regional numbers and rates for falls

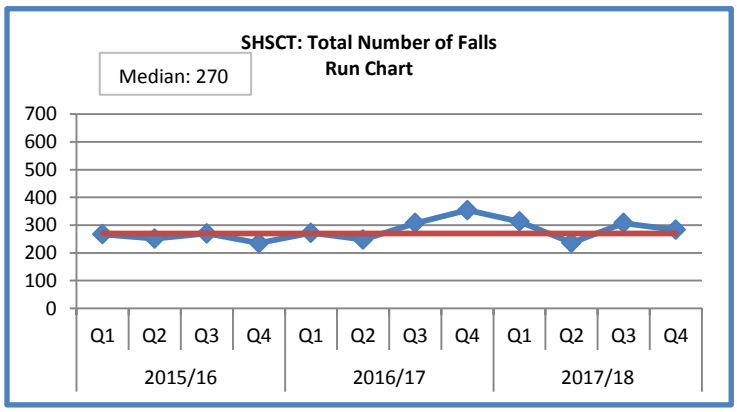
The following graphs from April 2015 –March 2018 show the total number of falls recorded per quarter across each HSC Trust.

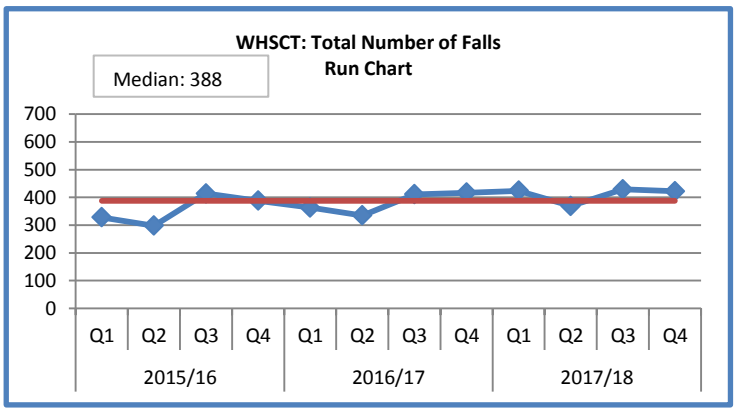




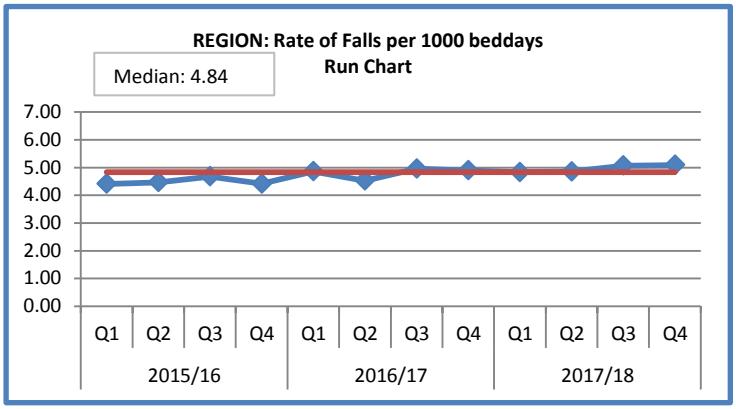


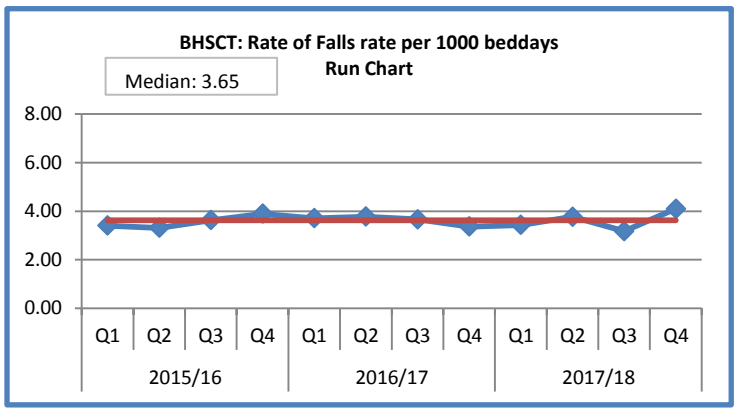


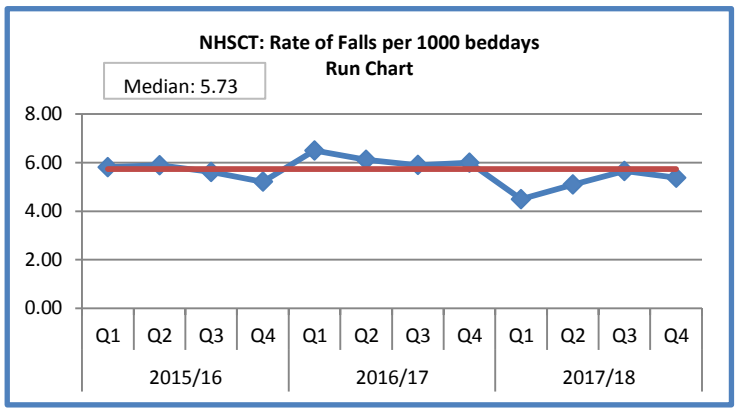


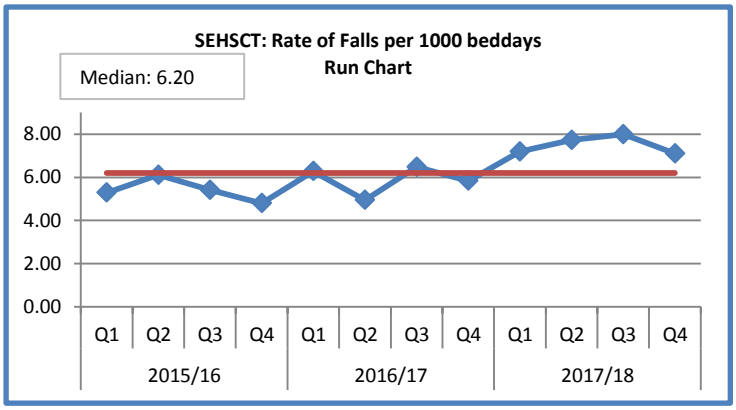


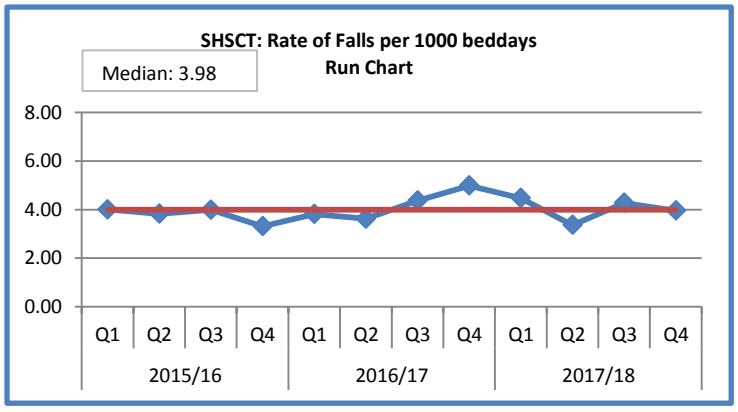
The following graphs from April 2015 –March 2018 show the rate of falls recorded per quarter per 1000 bed days across each HSC Trust

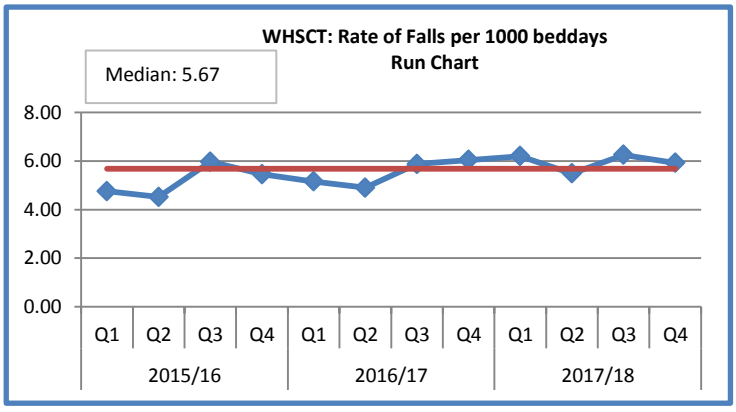












2.4 Analysis for regional numbers and rates for falls

Regionally, there has been an increase in the number and rates of the total number of falls noted. At local Trust level, this increase is most evident in SEHSCT.

There were no notable trends or patterns in the other trusts.

The following table shows the total number of falls recorded since 2013/14 by Trust:

Year	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Region
2013/14	2702	2081	1993	1116	1555	**9447**
2014/15	2790	1925	2163	1226	1458	**9562**
2015/16	2329	1716	1606	1023	1428	**8102**
2016/17	2288	1871	1790	1181	1526	**8656**
2017/18	2257	1600	2262	1139	1644	**8902**

The number of areas where the Falls Bundle has been spread by each Trust at the end of March 2018 is as follows:

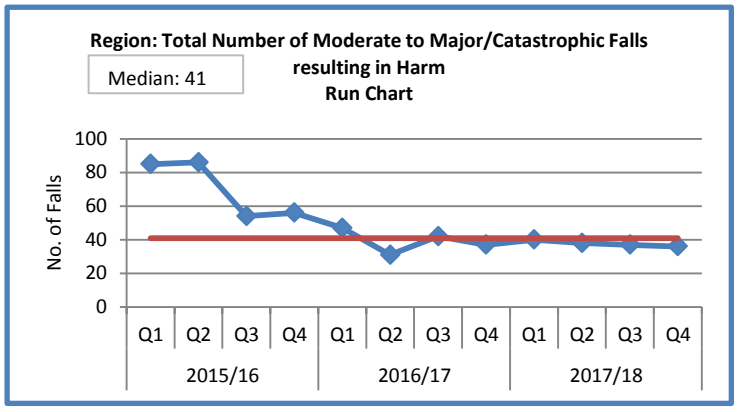
Total number of acute adult in-patient wards*					
	BHSCT	**NHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**
Totals 16/17	70	31	31	26	31
Total 17/18	68	31	30	26	36

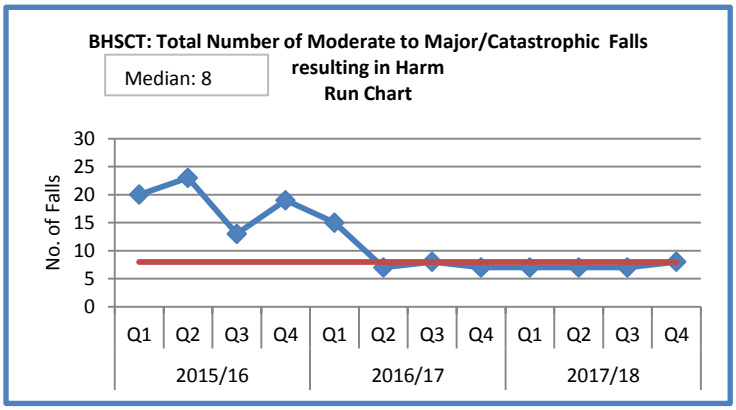
This equates to 100% total within the adult inpatients areas wards for each Trust.

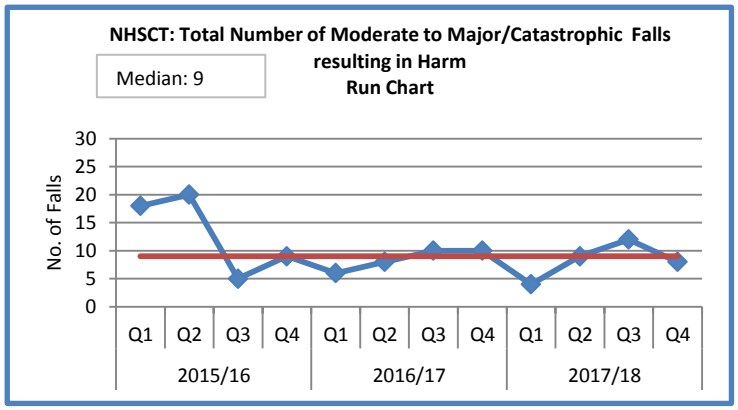
*when measuring the spread of quality improvement bundles the total number of adult inpatient wards may vary slightly within each Trust for a variety of reasons including; the appropriateness of the bundle within the particular area, the opening / closure of wards and/or re-categorisation of wards.

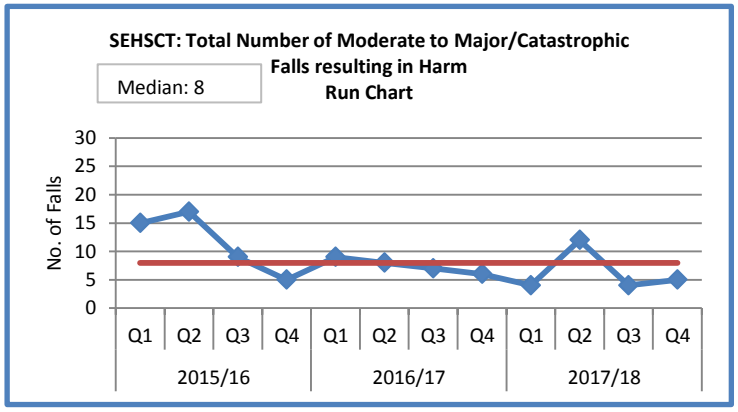
2.5 Total number and rates for falls resulting in moderate to major/catastrophic harm

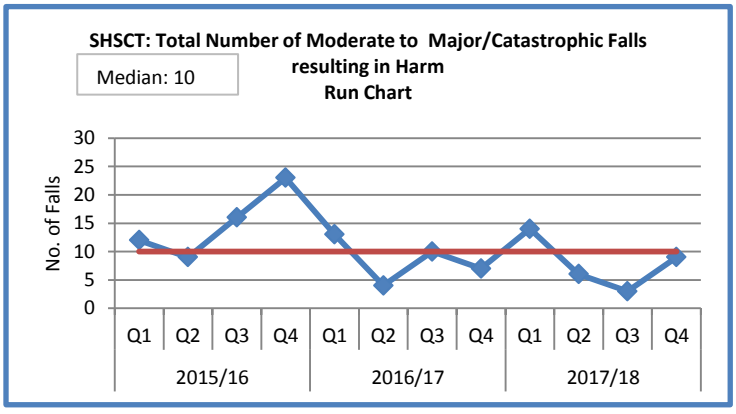
The following graphs show the total number of falls per 1,000 occupied bed days (from April 2015 to March 2018) which resulted in harm of a moderate/major/catastrophic nature.

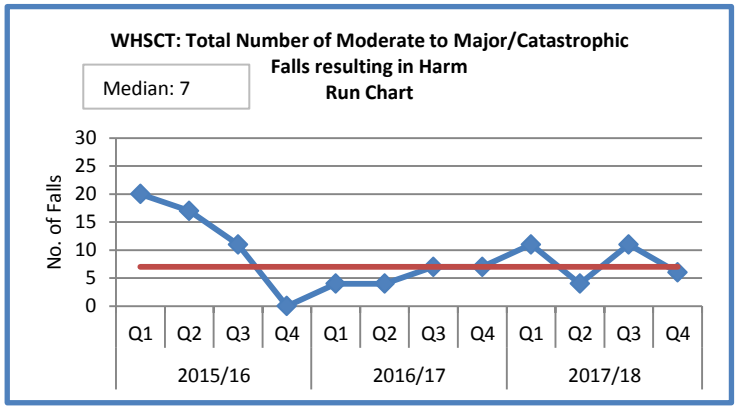




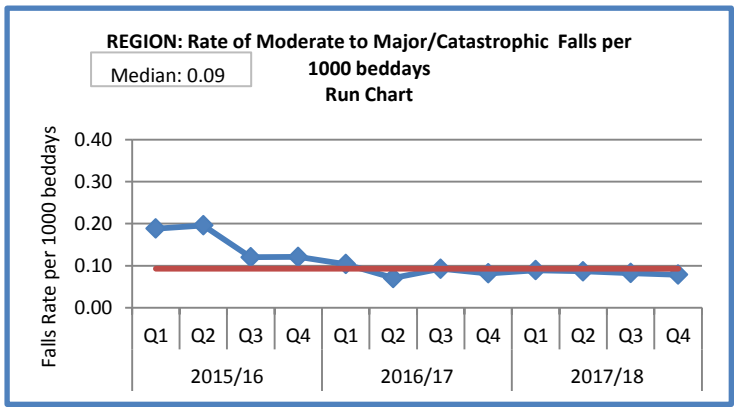


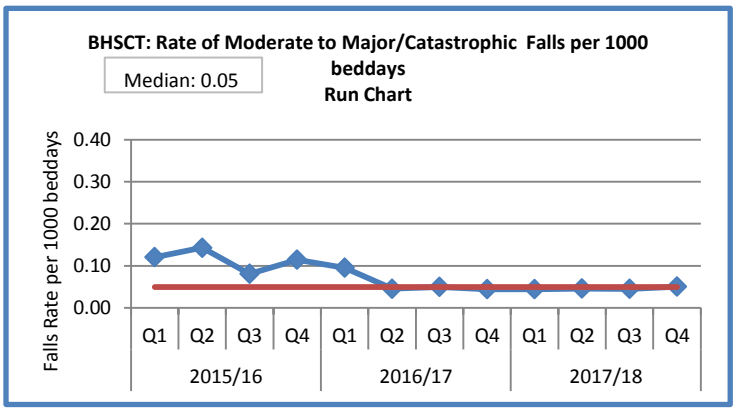


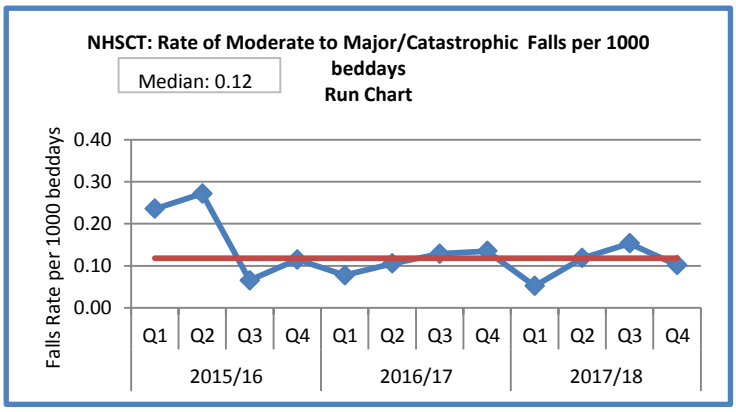


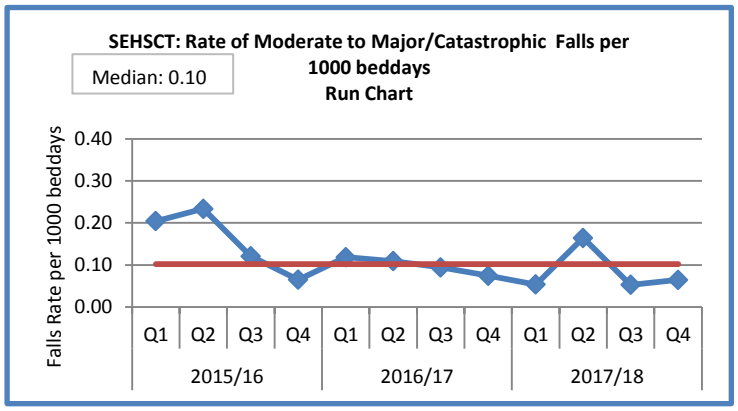


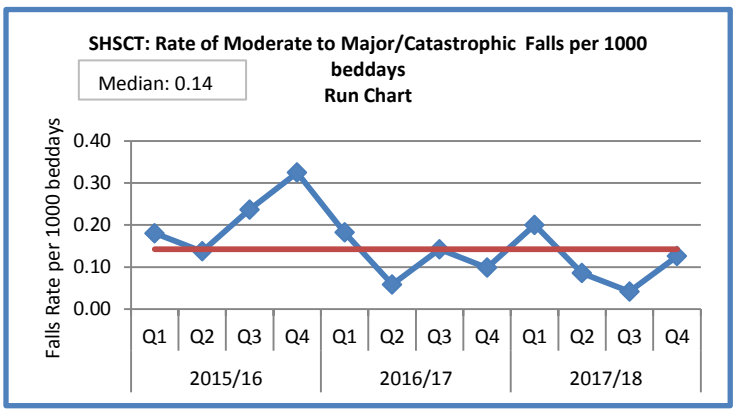
The following graphs show the total rate of falls per 1,000 occupied bed days (from April 2015 to March 2018) which resulted in harm of a moderate/major/catastrophic nature.

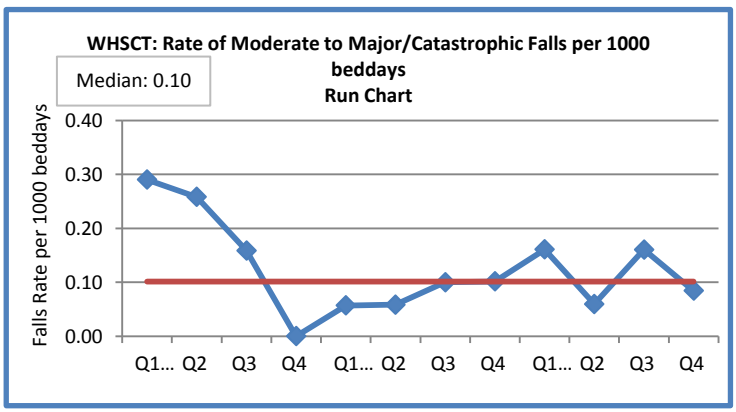












The following table shows the total number of falls resulting in moderate to major/catastrophic harm recorded from April 2016 to March 2018 by Trust:

Year	Qtr	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	REGION
2016/17	Q1	15	6	9	13	4	**47**
	Q2	7	8	8	4	4	**31**
	Q3	8	10	7	10	7	**42**
	Q4	7	10	6	7	7	**37**
2016/17 total		**37**	**34**	**30**	**34**	**22**	**157**
2017/18 Total	Q1	7	4	4	14	11	**40**
	Q2	7	9	12	6	4	**38**
	Q3	7	12	4	3	11	37
	Q4	8	8	5	9	6	36
2017/18 total		**29**	**33**	**25**	**32**	**32**	**151**

The following table shows the rates of falls resulting in moderate to major/catastrophic harm recorded from April 2016 to March 2018 by Trust:

Year	Qtr	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	REGION
2016/17	Q1	0.10	0.08	0.12	0.18	0.06	**0.10**
	Q2	0.05	0.11	0.11	0.06	0.06	**0.07**
	Q3	0.05	0.13	0.09	0.14	0.10	**0.09**
	Q4	0.04	0.14	0.07	0.10	0.10	**0.08**
2016/17		**0.10**	**0.09**	**0.08**	**0.09**	**0.07**	**0.09**
2017/18	Q1	0.04	0.05	0.05	0.2	0.16	**0.09**
	Q2	0.05	0.12	0.16	0.09	0.06	**0.09**
	Q3	0.05	0.15	0.05	0.04	0.16	**0.08**
	Q4	0.05	0.10	0.06	0.13	0.08	**0.08**
2017/18		0.05	0.11	0.08	0.11	0.12	**0.08**

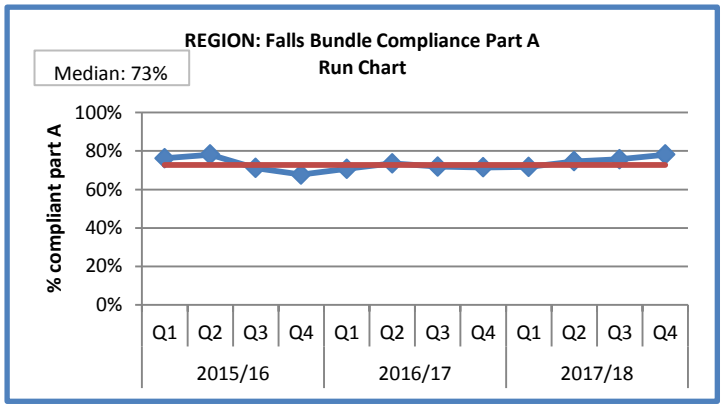
2.6 Analysis of number and rates of falls which resulted in a moderate/major/catastrophic nature

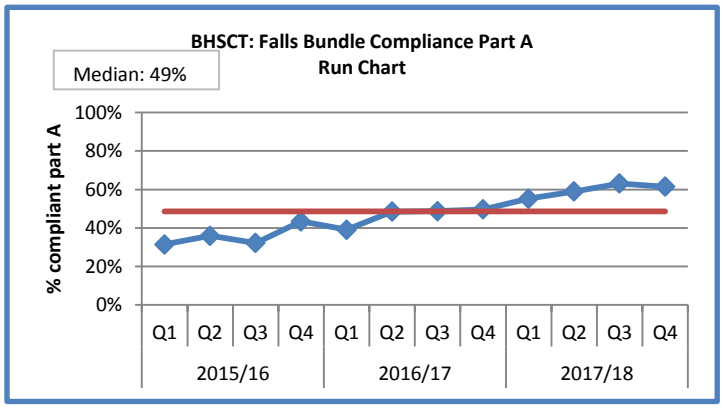
Regionally, the 2016/18 annual Trust range of falls resulting in moderate to major/catastrophic harm reported was between 0.08 to 0.11 per 1000 bed days. Regionally, there has been a reduction in falls rates over the past 2 years. BHSCT has also shown a reduction in falls resulting from Q2 in moderate/major/catastrophic in 2016/17 up to now. All other Trusts have shown a downward pattern with aspects in variation in their reporting.

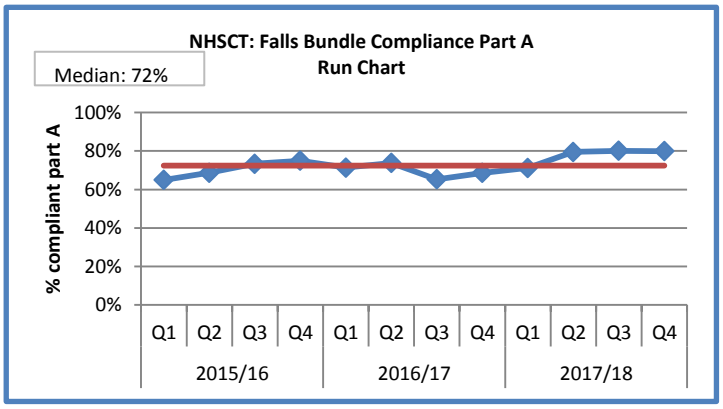
It should be noted that this initiative uses incident rates to compare improvement over time, but not for the purpose of comparison between Trusts as it is recognised that differences in the ways that organisations collect data and the patients that they care for, and the services they provide, all mean that direct comparisons are not possible.

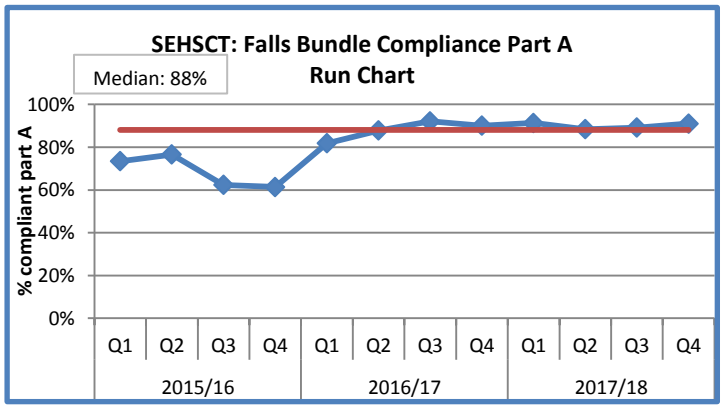
2.7 Compliance with falls bundle

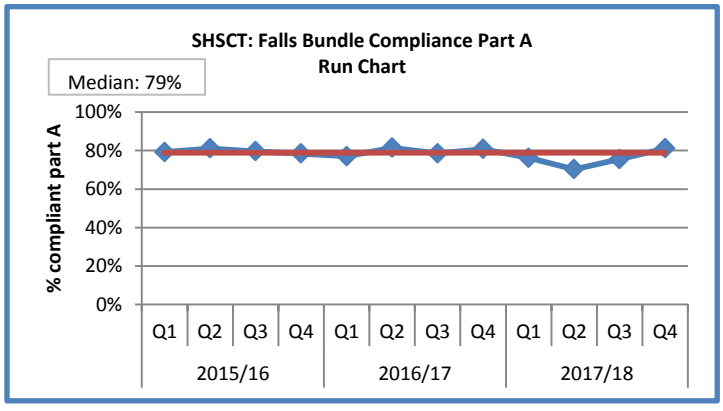
The following graphs show the percentage compliance with the Falls Bundle (Part A) by Trust for each of the quarters from April 2015 to March 2018:

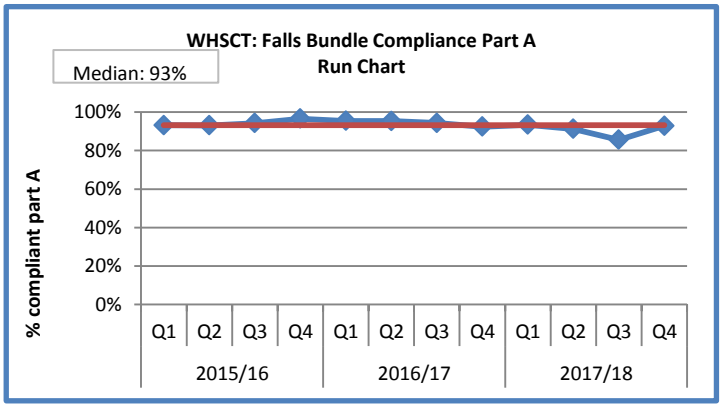




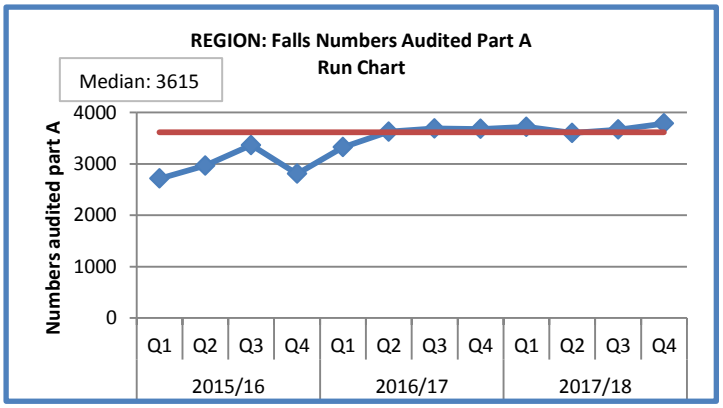


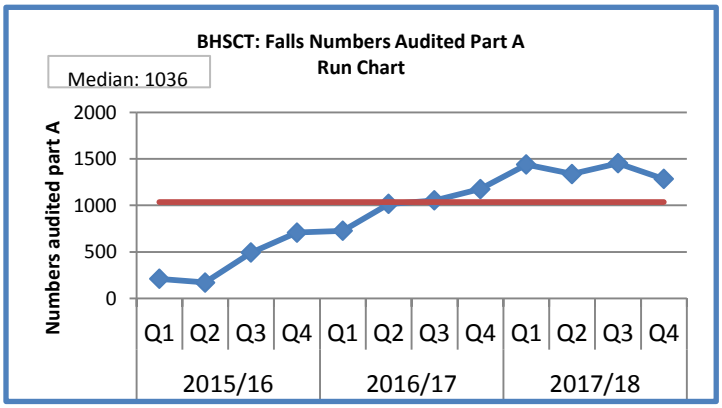


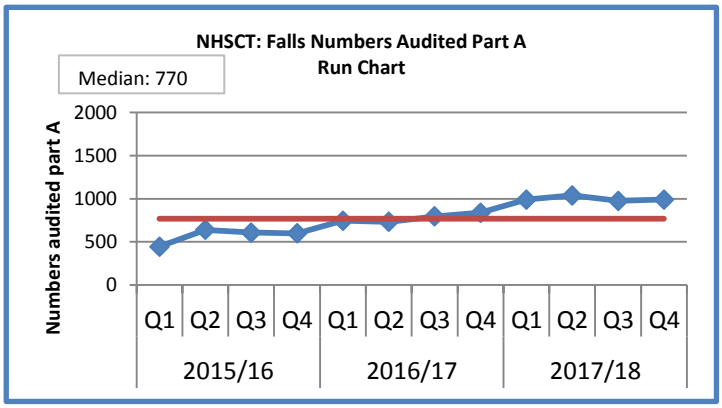


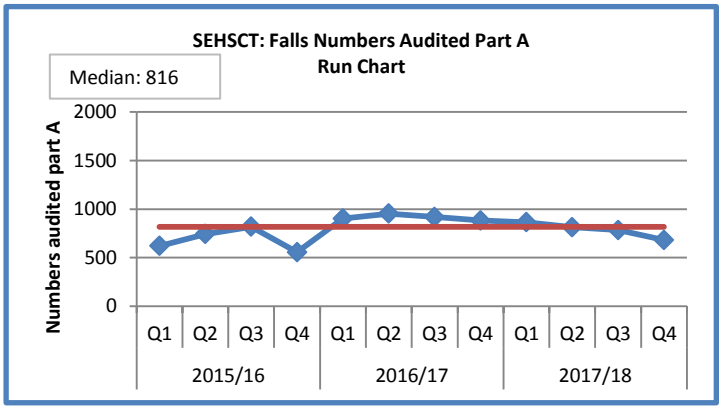


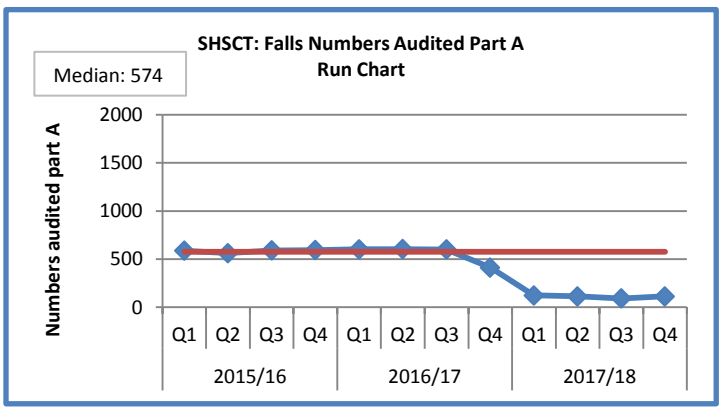
The following graphs show the numbers audited in compliance with the Falls Bundle (Part A) by Trust for each of the quarters from April 2015 to March 2018:

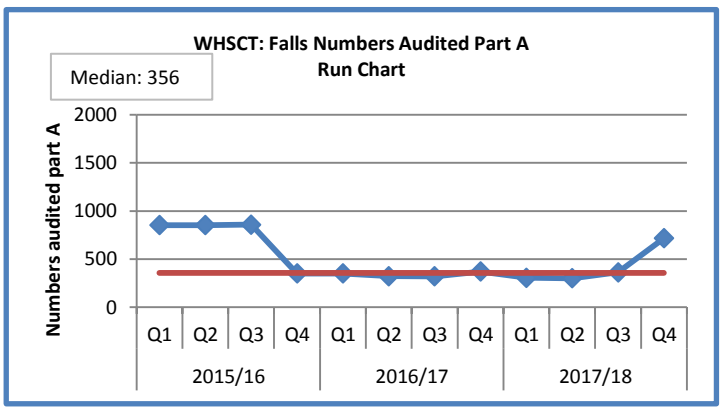












2.8 Analysis of compliance with falls bundles part A

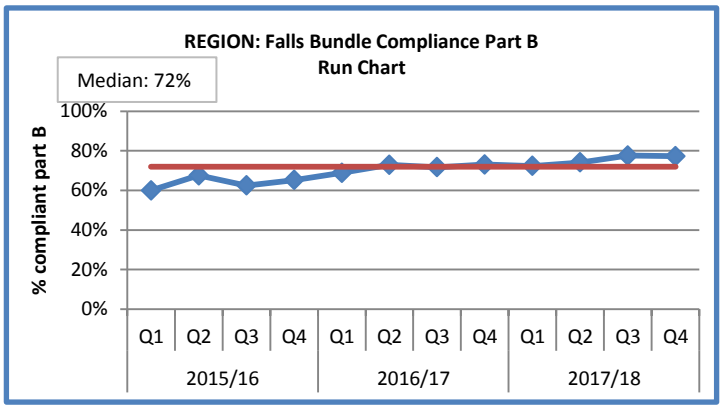
The region as a whole has continued to improve % compliance for Part A of the Falls bundle from 71 to 78 throughout 2016/17 & 2017/18. BHSCT has improved steadily and is now at 60% compliance for part A. A number of falls awareness events for staff working directly with patients are planned over the next year to educate staff on the importance of bundle compliance. The NHSCT has also increased compliance from 71 to 80% throughout 2016/17 and 2017/18. The trust has a programme of short “Falls Fast Facts” sessions based upon independent validation of the falls safe bundle (for part A and B). From April 2017 the SHSCT has moved to Independent Auditing and are using a new database to collect data. They have had a significant dip with the number of audits completed, since commencing these independent audits and have reported that they are experiencing issues with data input/extraction, therefore the use of the data should be guarded. They are also reintroducing "self-auditing" to run alongside the new audit process in Q3 to drive improvement between audit cycles. There are individual ward areas that are at 1000 plus pressure ulcer free days, in these areas there has been a reduction in audits.

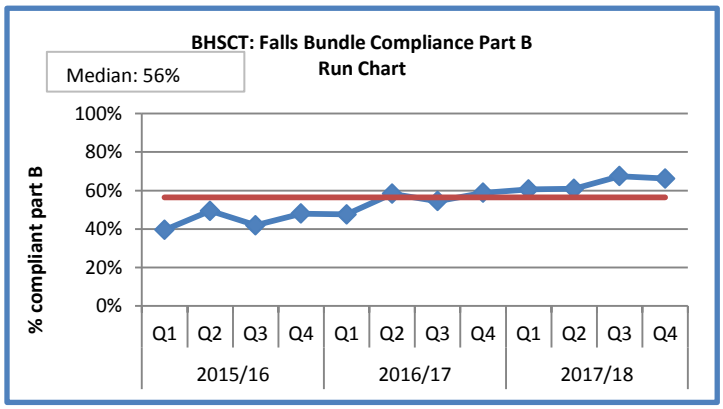
The following tables show more detail with the number of audits carried out in each Trust during each of the four quarters in 2016/17 and 2017/18 with Regional compliance of the Falls Bundle Part A:

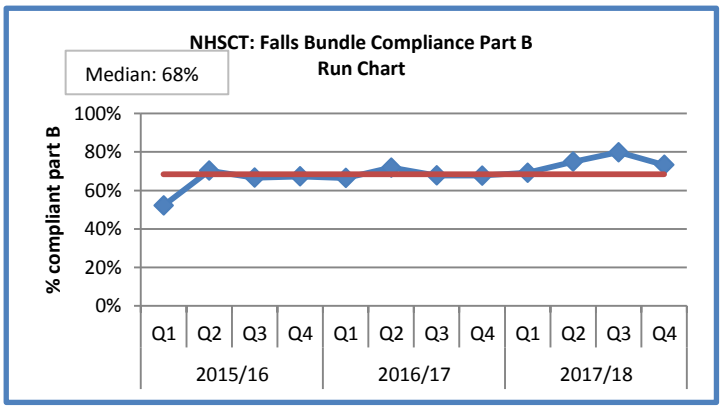
Trust	Part A % Compliance 2016/17					Audits carried out Part A 2016/17				
	Q1	Q2	Q3	Q4	16/17 Total	Q1	Q2	Q3	Q4	16/17 Total
BHSCT	39%	48%	49%	50%	**47%**	727	1017	1055	1177	**3976**
NHSCT	71%	74%	65%	69%	**70%**	745	733	795	839	**3112**
SEHSCT	82%	88%	92%	90%	**88%**	903	953	919	882	**3657**
SHSCT	77%	81%	79%	81%	**79%**	601	603	600	412	**2216**
WHSCT	95%	95%	94%	92%	**94%**	350	322	319	370	**1361**
REGION	**71%**	**74%**	**72%**	**71%**	**72%**	**3326**	**3628**	**3688**	**3680**	**14322**

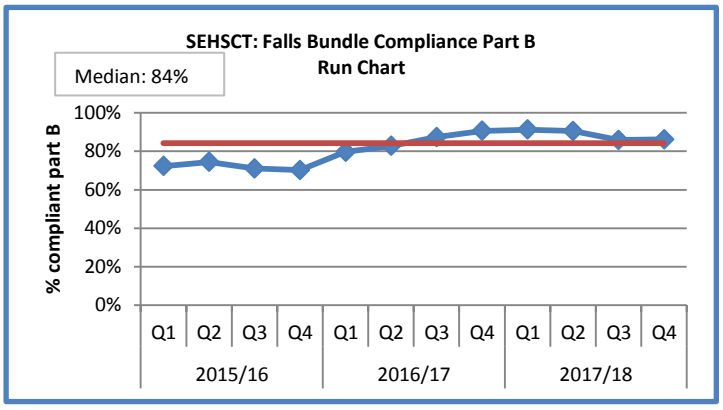
Trust	Part A % Compliance 2017/18					Audits carried out Part A 2017/18				
	Q1	Q2	Q3	Q4	17/18 Total	Q1	Q2	Q3	Q4	17/18 Total
BHSCT	55%	59%	63%	61%	**59.7%**	1440	1339	1455	1286	**5520**
NHSCT	71%	79%	80%	80%	**77.7%**	991	1039	976	991	**3997**
SEHSCT	91%	88%	89%	91%	**90%**	864	813	784	682	**3143**
SHSCT	76%	70%	76%	81%	**75.8%**	122	111	90	111	**434**
WHSCT	93%	91%	86%	93%	**90.8%**	305	299	362	716	**1682**
REGION	**72%**	**75%**	**76%**	**78%**	**75%**	**3722**	**3601**	**3667**	**3786**	**14776**

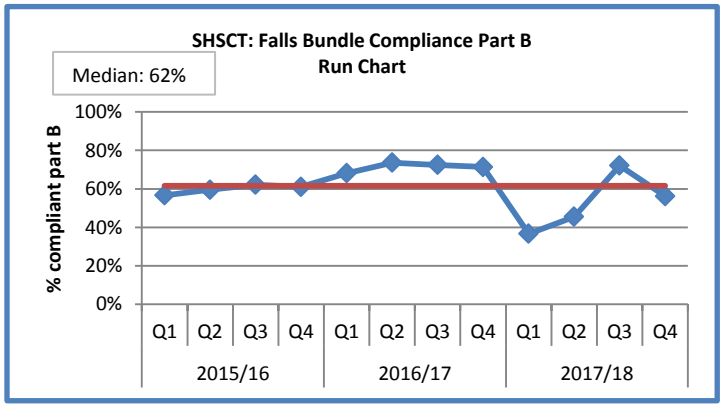
In relation to Part B of the Falls Bundle, the following graphs show the percentage compliance with the Falls Bundle (Part B) by Trust from April 2015 to March 2018.

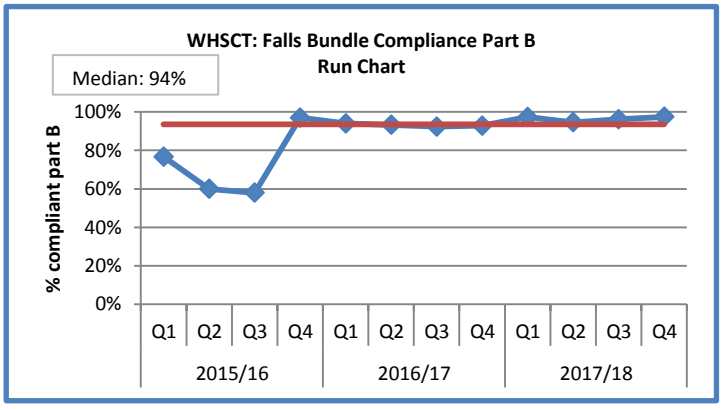




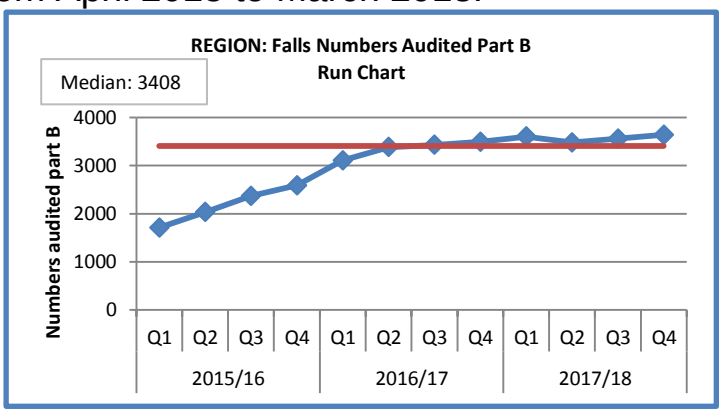


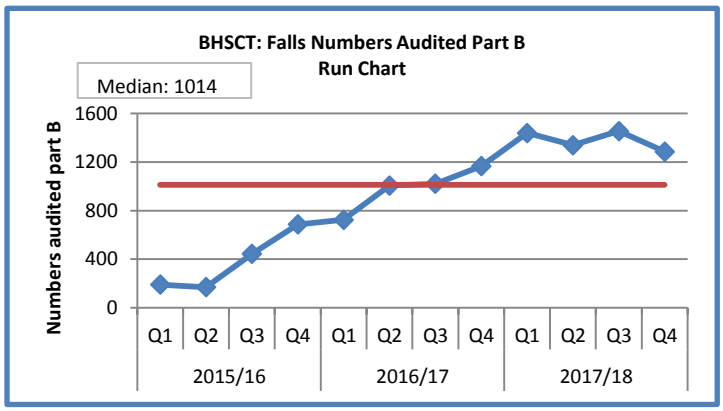


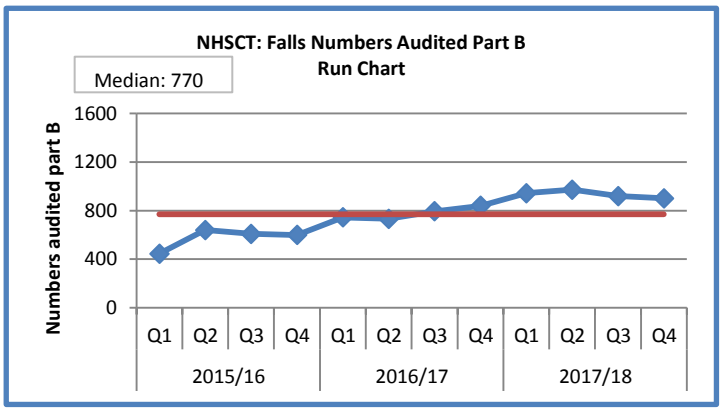


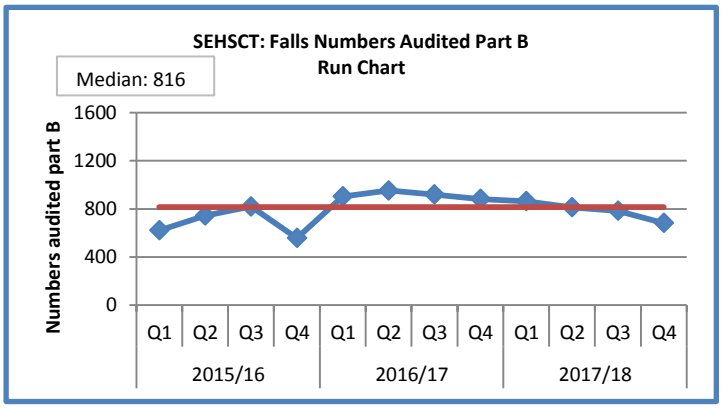


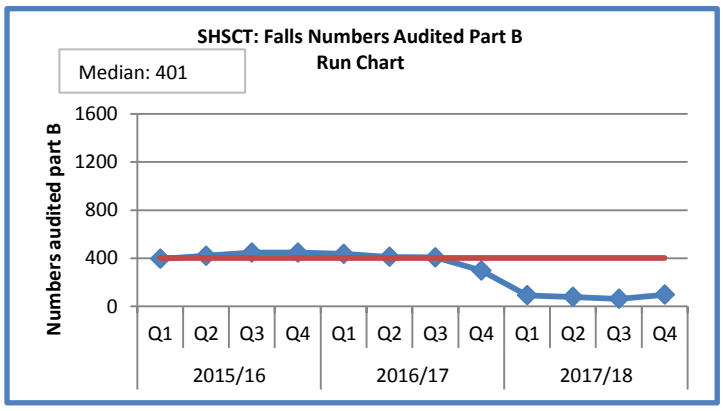
The following graphs show the total number of audits completed for Falls Bundle (Part B) by Trust from April 2015 to March 2018.

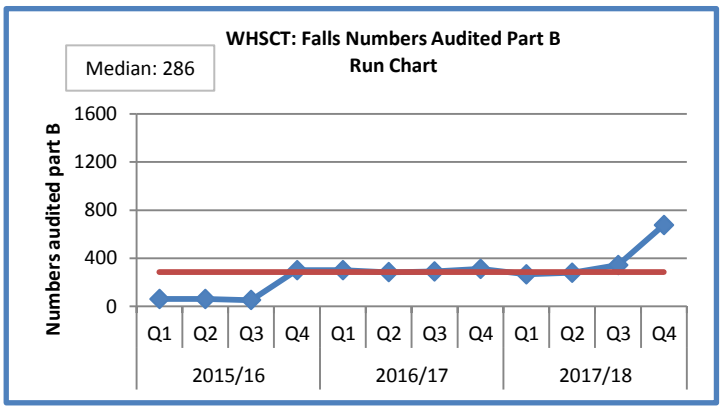












2.9 Analysis of compliance with falls bundles part B

All Trusts have shown progress in percentage compliance with Part B of the Falls Bundle in from Q1 in 2016/17 to the end of 2017/18. It should be noted that the WHSCT had a significant rise in progress with part B of the bundle for the final quarter of 2015/16 and continued this throughout 2016/18. There has been an increased focus on training within the WHSCT in conjunction with Clinical Education Centre and they have increased their audit numbers from Q4 in 2015/16 onwards.

The following table shows more detail with the number of audits carried out in each Trust from April 2016 to March 2018 with Regional compliance of the Falls Bundle Part B:

Trust	Part B % Compliance 2016/17					Audits carried out Part B 2016/17				
	Q1	Q2	Q3	Q4	16/17 Total	Q1	Q2	Q3	Q4	16/17 Total
BHSCT	48%	58%	54%	59%	**55%**	725	1007	1021	1167	**3920**
NHSCT	66%	72%	68%	68%	**68%**	745	733	795	839	**3112**
SEHSCT	80%	83%	87%	91%	**85%**	903	953	919	882	**3657**
SHSCT	68%	74%	72%	71%	**71%**	436	410	407	297	**1550**
WHSCT	94%	93%	92%	93%	**93%**	300	282	289	310	**1181**
REGION	**69%**	**73%**	**72%**	**73%**	**72%**	**3109**	**3385**	**3431**	**3495**	**13420**

Trust	Part B % Compliance 2017/18					Audits carried out Part B 2017/18				
	Q1	Q2	Q3	Q4	17/18 Total	Q1	Q2	Q3	Q4	17/18 Total
BHSCT	61%	61%	67%	66%	**63.8%**	1440	1339	1455	1286	**5520**
NHSCT	69%	75%	80%	73%	**74.3%**	944	973	920	901	**3738**
SEHSCT	91%	91%	86%	86%	**88.5%**	864	813	784	682	**3143**
SHSCT	37%	45%	72%	56%	**52.6%**	90	77	61	96	**324**
WHSCT	97%	95%	96%	97%	**96.4%**	265	279	342	676	**1562**
REGION	**72%**	**74%**	**78%**	**77%**	**75.3%**	**3603**	**3481**	**3562**	**3641**	**14287**

All Trusts have achieved 100% spread in each quarter from April 2016 to March 2018 for both Part and Part B of the Fallsafe bundle.

2.10 Sharing of Regional Learning

The Regional Falls Group meet on a quarterly basis this group is led by the PHA and membership comprises a multidisciplinary team across the 5 HSC trusts. At

each meeting progress is monitored, support and advice is given and regional learning is shared in relation to the prevention and management of falls.

The PHA/HSCB are currently working with Trusts to evaluate current processes and plan for improve in the following area:

- Risk identification
- Risk assessment
- Reliable implementation of Part A & Part B of the Falls bundle
- Identification and grading of moderate to major/catastrophic falls
- Education – we are working with the Clinical Education Centre (CEC) to develop a Falls Prevention programme, to ensure it is suitable for regional delivery and have a programme plan for roll out.

2.11 Thematic Review of falls reported as serious adverse incidents (SAIs)

A thematic review of all falls reported as serious adverse incidents (SAIs) over a six month period was carried out in 2015/16; this provided a detailed analysis, identifying themes and causative factors. As a result a different approach relating to the post falls review of these incidents was adopted.

Trusts will manage falls resulting in moderate to severe injury as adverse incidents and undertake a post falls review internally; ensuring front line multidisciplinary staff are involved in this review, unless there are particular issues or identified learning that need to be investigated through the SAI process.

All falls resulting in moderate to severe harm are reviewed locally by Trusts as near to the incident happening as possible; and on a quarterly basis are reported to the Regional In-Patient Falls Group to identify learning, themes and trends. The Regional In-Patient Falls Group are working towards adopting a regional approach to the management of patient falls across Trusts in N.I. It will work towards the standardisation of a regional post falls review documentation and post falls assessment tool for use in all settings in line with best practice. This approach will be evaluated to include the period from 1st April 2016 to the 31st March 2018, to assess its effectiveness.

The identified themes will be highlighted to inform the quality improvement work in falls prevention through the Regional Falls Group. Elements within the ‘Fallsafe’ bundle link directly with the themes arising from the thematic review and confirm the opportunity to use this to address the factors contributing to harm.

3.0 NEWS (National Early Warning Scores)

NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

Since its initial launch in 2012, NEWS has seen widespread uptake across the NHS. At present all Trusts are using NEWS. Through standardisation of NEWS we can reduce the number of patients whose conditions deteriorate whilst in hospital, and potentially save lives.

As part of its leadership role, the HSC Safety Forum has led the regional implementation of the National early warning score (NEWS), including appropriate escalation arrangements to improve care of the deteriorating patient, in all HSCTs. This tool helps professional staff identify early deterioration in a patient's condition. Abnormal scores prompt specific actions and/or referral to greater expertise. Part of this work involved facilitating HSCTs to clearly define their expectations regarding intervention when NEWS is abnormal.

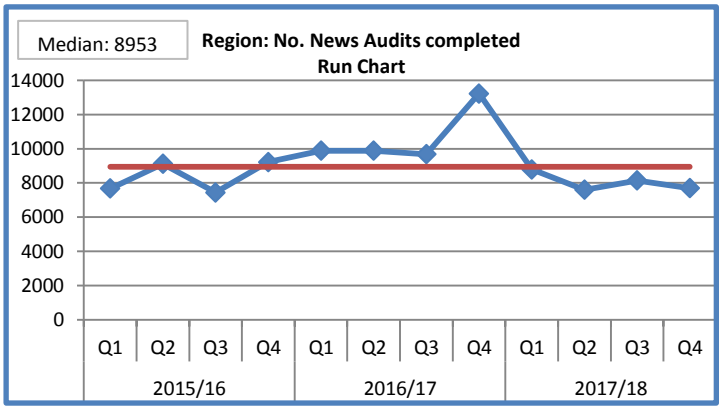
In December 2017, an updated version of NEWS, NEWS2 was published. From April 2018 the Safety Forum/PHA will work with trusts on the following:

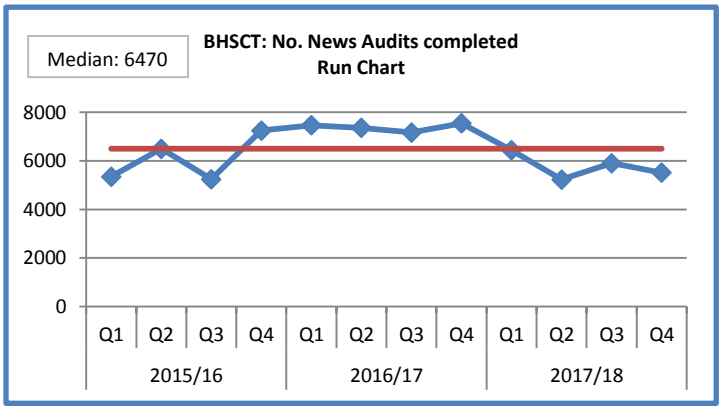
- Effective arrangements should be in place to implement and measure National Early Warning Scores (NEWS) to identify early deterioration and prompt specific action.
- The PHA will work with Trusts to develop arrangements to implement NEWS2
- Throughout 18/19 the clinical conditions of all patients must be regularly and appropriately monitored in line with the NEWS KPI audit guidance and timely action taken to respond to any signs of deterioration.

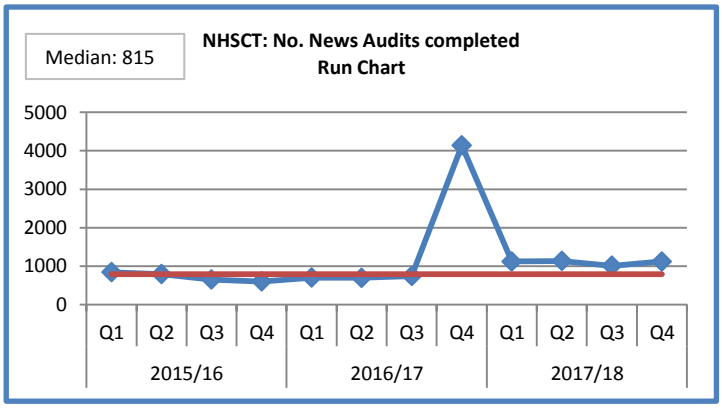
3.1 Commissioning Plan Target

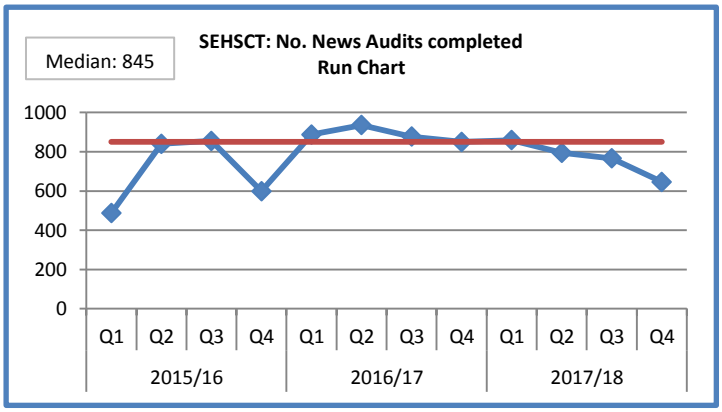
The 2016/17 & 2017/18 Commissioning Plan requirement states: "% compliance with accurately completed NEWS charts".

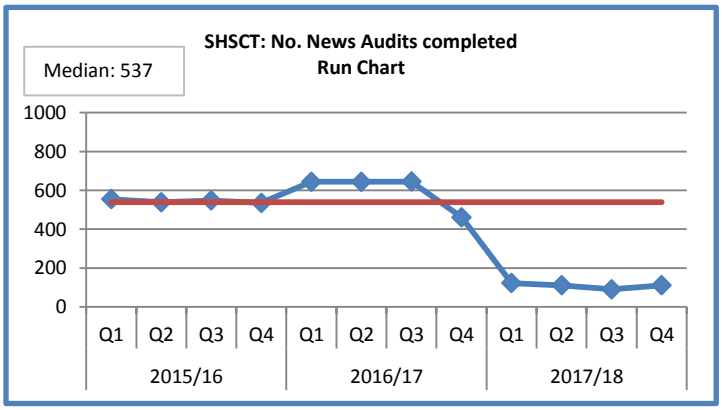
The following graphs show the total number of audits of NEWS completed by Trust for each of the quarters from April 2015 to March 2018

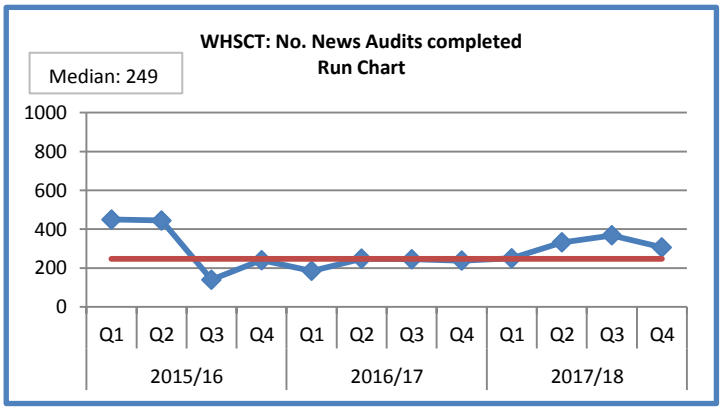




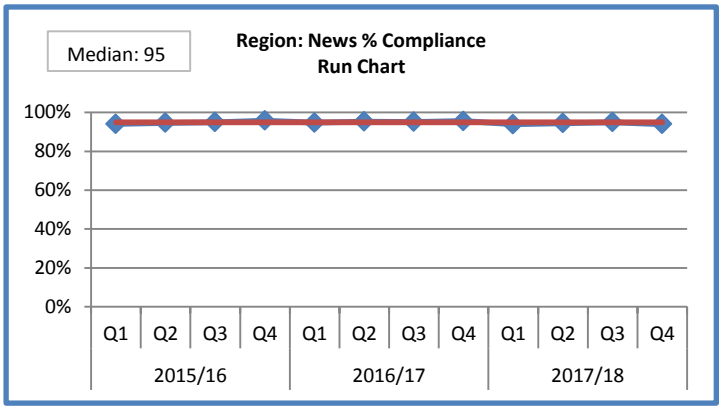


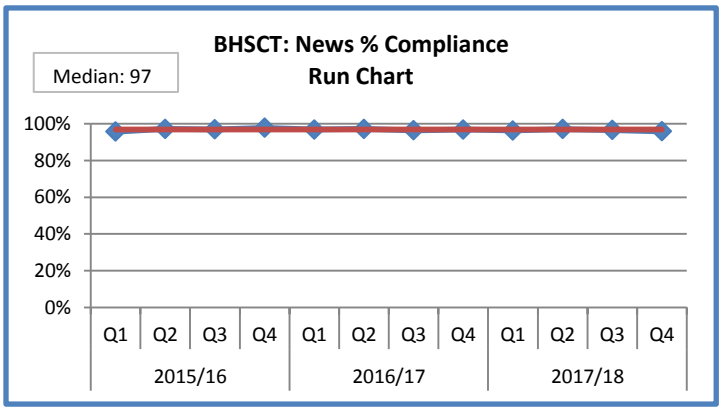


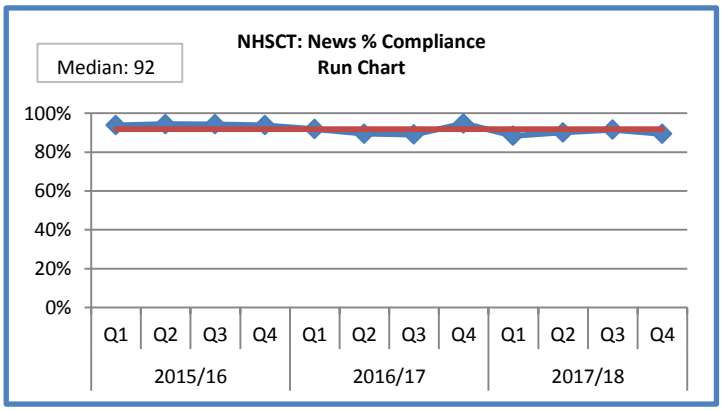


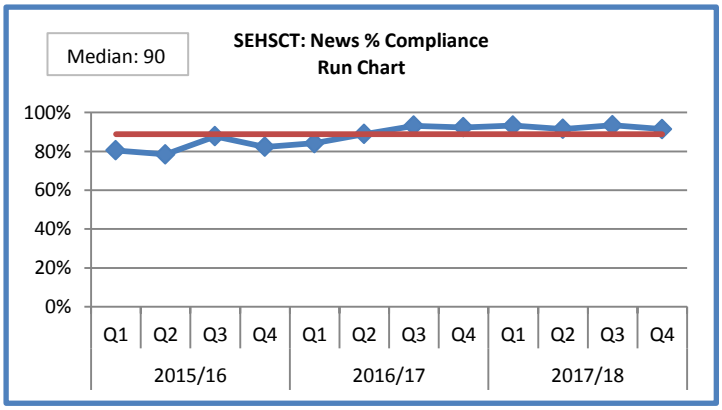


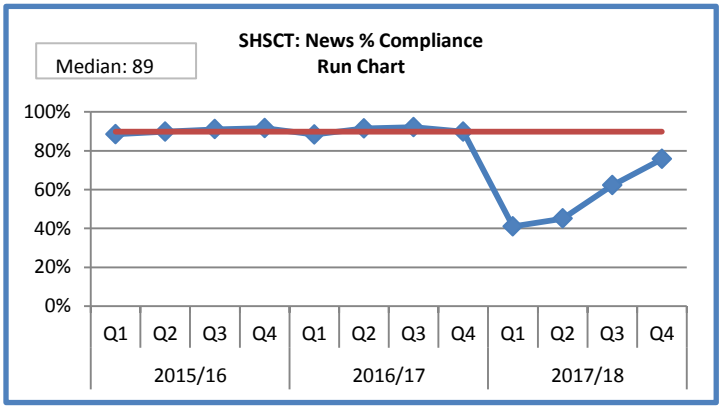
The following graphs show the percentage compliance of NEWS by Trust for each of the quarters from April 2015 to March 2018:

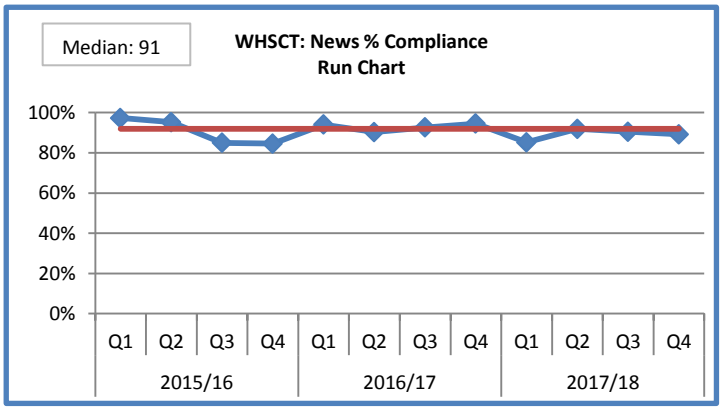












The following tables show more detail with the number of audits carried out in each Trust from April 2016 to March 2018 with regional compliance of the NEWS audit

Trust	Compliance with NEWS bundle 2016/17				Number of NEWS audits 2016/17			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
BHSCT	97%	97%	96%	97%	7468	7360	7171	7546
NHSCT	92%	89%	89%	95%	699	694	741	4138
SEHSCT	84%	89%	93%	92%	888	936	877	850
SHSCT	88%	91%	92%	90%	644	644	645	461
WHSCT	94%	90%	93%	95%	185	248	245	238
REGION	**95%**	**95%**	**95%**	**96%**	**9884**	**9882**	**9679**	**13233**

Trust	Compliance with NEWS bundle 2017/18				Number of NEWS audits 2017/18			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
BHSCT	96%	97%	97%	96%	6439	5234	5908	5515
NHSCT	88%	89%	91%	89%	1121	1133	1009	1119
SEHSCT	93%	92%	93%	91%	859	795	766	646
SHSCT	41%	45%	62%	76%	122	111	90	111
WHSCT	85%	92%	90%	89%	250	332	368	306
REGION	**94%**	**94%**	**95%**	**94%**	**8791**	**7605**	**8141**	**7697**

3.2 Analysis of compliance with NEWS bundle

The region as a whole has continued to maintain an average % compliance of NEWS throughout the 2016/17/18 years of 94-96. From April 2017 the SHSCT has moved to Independent Auditing and are using a new database to collect data. They have had a significant dip in compliance with the NEWS audit since commencing these independent audits and have reported that they are experiencing issues with data input/extraction; therefore the use of the data should be guarded. They are also reintroducing "self-auditing" to run alongside the new audit process in Q3 to drive improvement between audit cycles.

It should be noted that using the Regional Audit Tool and guidance notes developed by the Regional Early Warning Scores (EWS) Working Group. An audit has been undertaken annually by each Trust since 2014 (in the period Jan-March) with the aim of measuring the use of NEWS and associated care escalation protocols. The 2017 figures from the N.I. Safety Forum relating to the overall compliance with NEWS charts shows a regional average compliance rate of 80% with a range of 66-93% across Trusts, this relates to a point prevalence survey being undertaken in

February 2017. The spread of NEWS bundle for each Trust from the start of 2016/17 was 100% during each quarter.

4.0 Mixed Gender Accommodation

Within the Health and Social Care services we are committed to the delivery of person centred care: where all patients/clients/service users are treated with dignity, respect, privacy and sensitivity irrespective of their age, ethnic origin, religious belief, race, gender, sexuality or disability.

International and National evidence has suggested that the provision of single gender accommodation has been identified by patients and relatives/carers as having significant impact on maintaining privacy and dignity whilst in hospital.

Current HSC estates and increasing service demands may present challenges to HSC Trusts in their endeavour to eliminate MGA such as the layout of wards, patient numbers and flow.

All HSC new builds which involve general ward accommodation or a major refurbishment in NI will be planned on the basis of 100% single room accommodation.

There are areas of exception where it is recognised that it is not always possible to segregate male and female patients. A minority of patients may have a clinical condition which requires immediate access to potentially life-saving treatments which can only be delivered within critical care environments. At these points in a patients journey, access to and treatment within appropriate locations is paramount. In these situations mixing of male and female patients may be justified. These include highly specialised departments, such as Intensive Care Units, Emergency departments, Medical Assessment, Coronary Care Units etc. In addition there are areas where patients need specialist nursing and medical skills; therefore it is appropriate their care and treatment is provided in the same ward from a single team.

Where it is not possible to provided single gender bays/rooms the aim at all times is to promote the safety, dignity and privacy of patients and to assess and mange risks associated with MGA.

4.1 Commissioning Plan Target

The 2017/18 Commissioning Plan requirement states:

"By March 2018, all patients in adult inpatient areas should be cared for in same gender accommodation, except in cases when that would not be appropriate for reasons of clinical need including timely access to treatment".

The table below shows the wards/areas monitored within each Trust of mixed gender accommodation from 1st April 2017 to 31st March 2018.

2017/18 Feedback - 1st April 2017 – 31st March 2018				
Trust	**Areas monitored using regional template**			
BHSCT	RVH Ward 4A	RVH Ward 4B	RVH Ward 4C	RVH Ward 4D
NHSCT	A3 Antrim	C3 Antrim	Rehab Causeway	
SHSCT	All	All	All	All
SEHSCT	Ward 13 UHD	Ward 1A LVH	Ward 1 DH	
WHSCT	Orthopaedics	General Medicine	Specialist Medicine	

The table below shows the feedback from monitoring occurrences of mixed gender accommodation from 1st April 2017 to 31st March 2018.

Trust	Number of Breaches in the identified wards/areas				Number of breaches which were not justified			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
BHSCT	0	0	0	180	0	0	0	Not identified
NHSCT	126	101	86	99	0	50**	41**	17***
SEHSCT	Not monitored	32	67	18	Not monitored	0	0	0
SHSCT	0	0	0	0	0	0	0	0*
WHSCT	0	0	0	2	0	0	0	2**
REGION	**126**	**133**	**153**	**299**	**0**	**50**	**41**	

*** SHSCT: During the peak flu season during January & February the acute directorate agreed to infection prevention and control request to cohort male and female patients who were positive for flu in mixed gender bays within one ward.**

****Code D - Placed a patient in mixed-gender accommodation because of predictable fluctuations in activity or seasonal pressures recorded f**

*****Code E - Placed a patient in mixed-gender accommodation because of a predictable non-clinical incident.**

4.2 Analysis of Feedback for Mixed Gender Accommodation

All HSC Trusts have confirmed that there are processes in place to monitor occurrences of Mixed Gender Accommodation; however there are variations in reporting and recording across the Trusts.

During 2017/18 it was noted that while each Trust had a process to record breaches of MGA, agree operational definitions and develop a regional monitoring template for reporting occurrences from 1st April 2017. It was agreed regionally to test and evaluate the revised monitoring process on a small scale with a small number of wards per hospital sites in the first instance (1st April 2017 to 31st March 2018)

The BHSCT are currently working on developing a more effective way to monitor and record occurrences of mixed gender accommodation. Previously BHSCT monitored wards across the trust on a regular basis providing a heat map type report. This however did not record every occurrence as required. The change in the method of recording has accounted for the increased number of occurrences; further to this, it has to be noted that the 180 times accounts for the number of times each day across the four wards that there was mixed gender accommodation.

A regional priority for 18/19 will be to undertake an improvement project in relation to Mixed Gender Accommodation to improve on the following areas:

- A thematic review of Mixed Gender accommodation
- Measurement, display and interpretation of improvement data;
- Consistent application of operational definitions
- Development of targeted root cause analysis
- Ensure local and regional learning is identified and shared

In addition through 2018/19 the PHA will work with Trusts to measure and report compliance with the DoH policy for mixed gender accommodation in 100% of relevant inpatient areas.

5.0 Conclusion

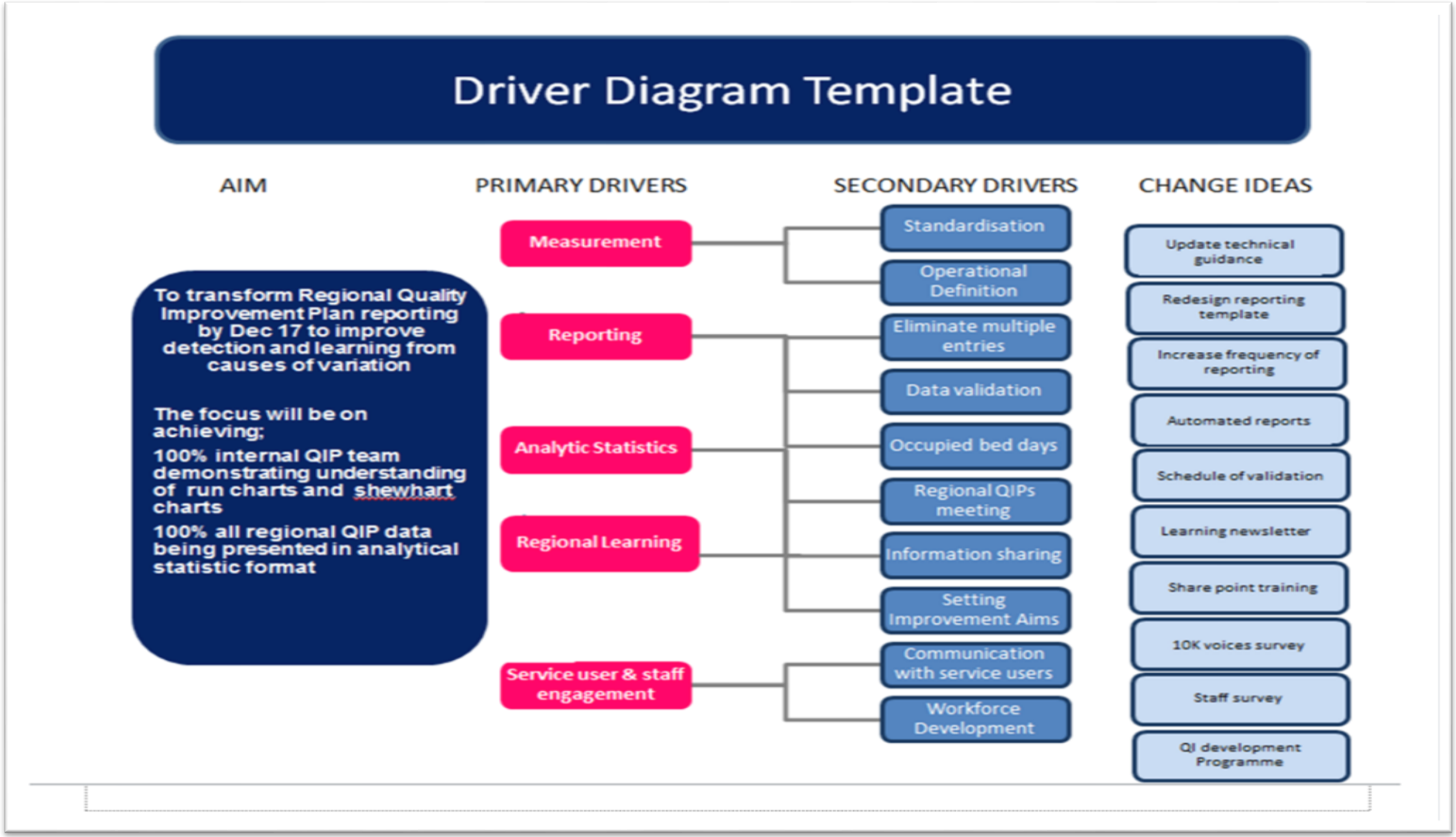
It is recognised that collecting and understanding data on the causes of harm is a key principle of quality improvement approaches in healthcare. Accurate measurement must accompany a quality improvement method to make changes and improve outcomes for service users and patients.

Although these initiatives were implemented across Northern Ireland trusts, current systems used locally, regionally and nationally to monitor the QIPs lack standardisation. This has led to concerns about variation locally and regionally and subsequent inconsistency in reporting.

Whilst there has been significant work from all organisations involved to reach the point we are at now, we recognise the 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 outlined within this document 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.

Appendix 1


Driver Diagram Template
AIM
PRIMARY DRIVERS
SECONDARY DRIVERS
CHANGE IDEAS
To transform Regional Quality Improvement Plan reporting by Dec 17 to improve detection and learning from causes of variation
The focus will be on achieving;
100% internal QIP team demonstrating understanding of run charts and shewhart charts
100% all regional QIP data being presented in analytical statistic format
Measurement
Reporting
Analytic Statistics
Regional Learning
Service user & staff engagement
Standardisation
Operational Definition
Eliminate multiple entries
Data validation
Occupied bed days
Regional QIPs meeting
Information sharing
Setting Improvement Aims
Communication with service users
Workforce Development
Update technical guidance
Redesign reporting template
Increase frequency of reporting
Automated reports
Schedule of validation
Learning newsletter
Share point training
10K voices survey
Staff survey
QI development Programme

Appendix 2

HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency (How often might it/does it happen?)**	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

HSC Public Health Agency

board paper

Progress Update on Making Life Better, Community Planning and Programme for Government

date 18 October 2018 **item** 11 **reference** PHA/05/10/18

presented by Mr Edmond McClean, Interim Deputy Chief Executive

action required For noting

Summary

The following paper provides an update on PfG, Community Planning and Making Life Better and the links between these key strategic areas as of October 2018.

Key points to note are:

- Strong and clear alignment between MLB, PfG and Community Planning
- PHA led structures to facilitate joint working and collaboration across HSC
- MLB focussed actions emerging from Community Planning action plans
- Clear direction of travel for the refreshed MLB regional structures and the focus on networking, learning and upscaling of good practice
- Completion and submission of final PfG report Cards
- Further links are also being developed with the transformation agenda under Delivering Together

Equality Impact Assessment

Not applicable.

Recommendation

The PHA board is asked to **NOTE** the update on Making Life Better, Community Planning and Programme for Government.

Progress Update on MLB, Community Planning and PfG Oct 2018

The following paper provides an update on PfG, Community Planning and Making Life Better and the links between as of October 2018.

PfG

Further to last month's update on PfG and the current reporting processes, the report cards were amended and submitted to DoH for TEO publication under the Outcomes Delivery Plan 2018/19 (ODP18/19) Mid-Year monitoring. Work continues to progress all areas outlined in the ODP18/19 and draft PfG Delivery Plans. Regular meetings with DoH Senior Responsible Owners for PfG also continue three times a year for reporting and to ensure continued strategic alignment with MLB. The final versions are available on request.

Community Planning

All eleven councils and community planning partnerships are currently working to finalise and agree their actions plans and the HSC Family has worked to ensure the alignment of health and wellbeing community planning actions with the strategic direction of Making Life Better and PfG and through the following agreed HSC areas of focus:

- Improvements to the early years of life
- Increased opportunities for physical activity
- Improved mental health and wellbeing
- Older people will maintain healthy, active lives; and promotion of age friendly communities

These four areas have not only provided a consistent regional direction in line with existing strategies but have also allowed for local flexibility in developing and agreeing locally appropriate actions and initiatives within each council area and their population. HSC, led by PHA, has also worked to ensure that the actions agreed to and delivered by HSC through community planning are part of the implementation of MLB. Some examples of local actions include:

- Take 5 - Antrim and Newtownabbey and Mid and East Antrim Councils have agreed to implement the Take 5 approach to mental health and wellbeing across a range of settings
- Age Friendly - Lisburn and Castlereagh and Ards and North Down Councils have jointly agreed to work towards WHO Age Friendly Cities and Communities accreditation
- Physical Activity - Councils within the SHSCT Area (Newry, Mourne and Down; Armagh, Banbridge and Craigavon, Mid Ulster) have agreed a strategic approach to physical activity and are working to develop a shared action plan

The PHA established and led HSC Community Planning Forum continues to meet twice a year to facilitate and encourage alignment and collective action for HSC organisations involved in community planning. A time-bound subgroup of the Forum, also led by PHA, is considering the HSC's approach to OBA monitoring and input to the monitoring of community planning action plans to ensure consistency and comparability across the HSC, especially for those initiatives taken forward across a number of council areas. This continued connectivity and strategic alignment are essential as Community Planning progresses and to strengthen this further, formal links are now being made with the HSC MLB Partnership.

Links have also been made with Sharon Gallagher, Director of Transformation, DoH in preparation for a presentation and discussion with the Permanent Secretaries Group (PSG) and SOLACE on 12th October exploring the links between Community Planning, Delivering Together and Making Life Better.

MLB

A key responsibility of Making Life Better is to facilitate a cross-sectoral, multi-agency, collaborative approach to improving the health and wellbeing of our people and communities and to reduce health inequalities. Cognisant of this, Making Life Better implementation has taken three main approaches –alignment, action and structure.

MLB Alignment

In order to strengthen partnership and collaboration in addressing the social determinants of health, implementation has focussed considerably on building relationships, developing collaboration and ensuring alignment across a number of strategic developments. Emerging priorities for Making Life Better have been reflected and reiterated in the draft delivery plans for PfG and actions being agreed within Community Planning are in line with the four key areas of focus (outlined above).

It should also be noted that key links exist between Delivering Together, Making Life Better and Community Planning and these are also being explored. The Healthy Places Programme outlined within the ODP18/19 is a key example of this, as is the Community Development Strategy written by Mary Black under the Delivering Together Community Development Work stream.

MLB Action

MLB implementation is seen in the everyday work of the Public Health Agency and its key priorities but a number of areas of work have emerged that require a specific focus.
The ODP18/19 reflects a number of these key areas reporting on work around Giving Every Child the Best Start in Life (FNP, low birth weight babies); Empowering Healthy Living (Thrombolysis for Ischaemic Stroke; Smoke-Free Sites; and the Self

Harm Intervention Programme) and; Creating the Conditions and Empowering Communities (Healthy Places Programme).

The draft PfG delivery plans, while not published, also detail key areas of work progressing under Making Life Better including the Healthier Workplaces Programme. This is a key area of focus for HSC and work continues through the PHA led HSC Healthier Workplaces Network to develop a consistent approach to improve staff health and wellbeing through an HSC Healthier Workplaces Programme looking at online tools, the ageing workforce, measurement of staff health and wellbeing and the potential for a workplace health charter. Other areas of work aligned to both PfG and MLB are also progressing around:

- Active travel with Schools;
- Work with Museums and Libraries to utilise local venues for engagement events, meetings and discussions with local communities on local health and well-being issues
- Making Every Contact Count - an approach that utilises day to day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing

As noted earlier, Community Planning, is a key area and the actions beginning to emerge are MLB focussed. HSC, led by PHA, has worked to ensure that work agreed to and delivered by HSC through community planning is part of the implementation of MLB.

PHA is also working with NHSCT to consider population planning, its function and potential impact for improving population health and wellbeing and reducing inequalities.

MLB Structure

The Making Life Better regional implementation arrangements have been under review and consideration with regard to how Making Life Better could build on recent developments and facilitate renewed momentum for improving health and reducing health inequalities. A new network style approach to regional implementation with an HSC focussed group was agreed by the MLB All Departments Officials Group (ADOG) and the Transformation Implementation Group (TIG) in November 2017.

Following approval, PHA began to develop the model and implement this approach, beginning with the establishment of the MLB HSC Partnership in April 2018. Membership comprises Chief Executives and Directors from across HSC organisations and the focus is on embedding MLB through a coordinated approach. The Partnership will report through to ADOG as required. PHA is represented at ADOG by our Chief Executive, Deputy Chief Executive and Director of Operations and the Assistant Director for Health and Social Wellbeing Improvement.

Acknowledging that for a network approach to be effective it must be driven and designed by partners and theirs needs, PHA began a period of engagement with key partners to consider how best to take forward the network style part of the new model. The main event of this engagement was a Stakeholder Workshop held in June with representation from across the public and community and voluntary sector. The full report of the workshop is available on request.

The workshop identified that stakeholders did not want to create a ‘hard shell’ network or partnership structure that would duplicate existing structures, rather to focus on an approach that will add value. It was felt that enhanced opportunities for networking held more potential and that MLB should build on what exists to add value and impact through a connected whole system approach that helps us to share learning, to inform each other’s efforts, to showcase, expand and spread good practice across the region in line with the needs of local communities.

The agreed approach then to the new arrangements will not utilise a hard shell approach but will provide different levels of engagement and involvement for interested stakeholders with opportunities for members to meet, network, collaborate and share their experiences and learning both virtually and in person. This will require regular information sharing through robust communication mechanisms such as newsletters or online forums as well as appropriate networking opportunities and through regular seminars or learning events and an annual conference for example.

ADOG approved this approach in August 2018 and work is now underway to develop a plan and exemplars of this approach in practice as well as a proposed launch of new structures in early 2019.