HSC Public Health Agency

agenda

Title of Meeting	113th Meeting of the Public Health Agency Board
Date	15 August 2019 at 1.30pm
Venue	Board Room, Tower Hill, Armagh

standing items

1 1.30	Welcome and apologies		Chair
2 1.30	Declaration of Interests		Chair
3 1.30	Minutes of Previous Meetings held on 11 June 2019 and 20 June 2019		Chair
4 1.30	Matters Arising		Chair
5 1.35	Chair's Business		Chair
6 1.40	Chief Executive's Business		Chief Executive
7 1.50	Finance Report	**PHA/01/08/19**	Mr Cummings

items for approval

8 2.00	Draft Annual Progress Report 2018-19 to the Equality Commission on Implementation of Section 75 and the Duties under the Disability Discrimination Order	**PHA/02/08/19**	Mr McClean
9 2.25	Draft Commissioning Plan 2019/20	**PHA/03/08/19**	Dr McCarthy
10 2.50	Consultation Report for Northern Ireland Diabetic Eye Screening	**PHA/04/08/19**	Dr Mairs
11 3.05	Northern Ireland Cervical Screening Programme – Annual Report for 2016/17	**PHA/05/08/19**	Dr Mairs
12 3.20	25 Years' Service Award Proposal	**PHA/06/08/19**	Mr McClean

closing items

13 Any other Business
3.25

14 Details of next meeting:

Thursday 19 September 2019 at 1.30pm

Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast, BT2 8BS

HSC Public Health Agency

minutes

Title of Meeting	Special Meeting of the Public Health Agency Board
Date	11 June 2019 at 2.15pm
Venue	Conference Rooms 3+4, 12/22 Linenhall Street, Belfast

Present

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

In Attendance

Mr Paul Cummings	-	Director of Finance, HSCB
Mr Robert Graham	-	Secretariat

Apologies

Mrs Mary Hinds	-	Director of Nursing and Allied Health Professionals
Professor Nichola Rooney	-	Non-Executive Director
Ms Marie Roulston	-	Director of Social Care and Children, HSCB
Mrs Joanne McKissick	-	External Relations Manager, PCC
Ms Nicola Woods	-	Boardroom Apprentice

1 Item 1 – Welcome and Apologies

1.1 The Chair welcomed everyone to the meeting. Apologies were noted from Mrs Mary Hinds, Professor Nichola Rooney, Ms Marie Roulston, Mrs Joanne McKissick and Ms Nicola Woods.

2 Item 2 – Declaration of Interests

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

3 **Item 3 – PHA Annual Report and Accounts 2018/19**

3.1 Mr Cummings advised that the Governance and Audit Committee had met on 5 June to consider the Annual Report and Accounts. He said that in order to comply with statutory requirements, the Chair and Chief Executive will today sign the letter of representation together with the Annual Report and Accounts once approved by the Board.

3.2 Mr Cummings said that the format of the Annual Report is largely dictated by the Department of Health. He said that PHA will seek to reduce the narrative in the Report next year, but he commended the addition of the section, "A Year in the Life Of".

3.3 Mr Cummings advised that the performance report and governance statement form the first half of the document and that the wording in these has been commented on by the Department of Health. He said that the accounts commence on page 82 and that the year-end position showed a surplus of £181k. He drew members' attention to PHA's prompt payment performance and advised that this was the first time an organisation had achieved the target of paying 95% of its invoices within 30 days. He also noted that PHA's capital expenditure for the year fell within the required limits.

3.4 Mr Drew said that Annual Report and Accounts had been presented to the Governance and Audit Committee. He noted that there had been work done to reduce duplication in the Report, but there remained further work to be done. He advised that the external auditors had commended the Report and that Internal Audit had also given the Committee the necessary assurances.

3.5 Mr Cummings advised that there were no Priority 1, 2 or 3 recommendations in the external audit. Mr Stewart commended this outcome. Mr Drew thanked Mr Cummings and his team for their work in producing the accounts, and this was endorsed by the Chair.

3.6 The Interim Chief Executive paid tribute to Mr Cummings and his team, and said she was pleased that this was a clean set of accounts.

3.7 The Board **APPROVED** the PHA Annual Report and Accounts.

4 **Item 4 – Any Other Business**

4.1 There was no other business.

5 **Item 5 – Details of Next Meeting**

Thursday 20 June 2019 at 1:30pm

Board Room, County Hall, 182 Galgorm Road, Ballymena

Signed by Chair:

Date:

HSC Public Health Agency

minutes

Title of Meeting	112th Meeting of the Public Health Agency Board
Date	20 June 2019 at 1.30pm
Venue	Board Room, County Hall, 182 Galgorm Road, Ballymena

Present

Mr Andrew Dougal	-	Chair
Mrs Valerie Watts	-	Interim Chief Executive
Mr Edmond McClean	-	Interim Deputy Chief Executive / Director of Operations
Ms Deirdre Webb	-	Regional Children's Services Nurse (*on behalf of Mrs Hinds*)
Alderman William Ashe	-	Non-Executive Director
Mr Leslie Drew	-	Non-Executive Director
Ms Deepa Mann-Kler	-	Non-Executive Director
Alderman Paul Porter	-	Non-Executive Director
Professor Nichola Rooney	-	Non-Executive Director

In Attendance

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

Apologies

Mrs Mary Hinds	-	Director of Nursing and Allied Health Professionals
Dr Adrian Mairs	-	Acting Director of Public Health Non-Executive
Mr John-Patrick Clayton	-	Director
Mr Joseph Stewart	-	Non-Executive Director
Mrs Joanne McKissick	-	External Relations Manager, PCC

44/19	**Item 1 – Welcome and Apologies**
44/19.1	The Chair welcomed everyone to the meeting. Apologies were noted from Mrs Mary Hinds, Dr Adrian Mairs, Mr John-Patrick Clayton, Mr Joseph Stewart and Mrs Joanne McKissick.
45/19	**Item 2 – Declaration of Interests**
45/19.1	The Chair asked if anyone had interests to declare relevant to any items

on the agenda. No interests were declared.

46/19 **Item 3 – Minutes of previous meeting held on 18 April 2019**

46/19.1 The minutes of the previous meeting, held on 18 April 2019, were approved as an accurate record of that meeting, subject to one amendment: Professor Rooney said that the word "psychology" should be replaced with "life sciences" in paragraph 35/19.10.

47/19 **Item 4 – Matters Arising**

47/19.1 There were no matters arising.

48/19 **Item 5 – Chair's Business**

48/19.1 The Chair advised that he had attended the UK Public Health Network meeting in Wales and was hugely impressed by the range of work being undertaken there. He said that the Welsh Assembly legislated for a Future Generations Act and this involved the appointment of a Commissioner for future generations and staff who were charged with analysing the policies, strategies and activities of public sector organisations with a view to assessing how these would impact on the lives of future generations. He noted that no similar position has been established in any country throughout the world. However, he said that it gives serious food for thought to ensure that the needs of future generations are taken into account in the formulation of strategy and policies.

48/19.2 The Chair said that he had attended the CONFED19 conference where as part of one of the main speeches, it was asserted that the Health Service requires increased funding each year of a rate of 3.3% above the rate of inflation.

49/19 **Item 6 – Chief Executive's Business**

49/19.1 The Interim Chief Executive advised that she, along with Dr Adrian Mairs, Dr Miriam McCarthy and Liz Fitzpatrick from HSCB attended to give evidence to the Independent Neurology Inquiry which is being chaired by Brett Lockhart QC. She said that, to date, 80 witnesses have been called to the Inquiry with a further 80 still to attend. She said that it is therefore expected that it will be up to a year before the Inquiry publishes its final Report.

49/19.2 The Interim Chief Executive said the session covered a range of issues including performance management of Trusts, prescribing, appraisals and governance.

49/19.3 The Interim Chief Executive advised that PHA has received approval from the Permanent Secretary to proceed with the recruitment of the Director of Nursing post following Mrs Hinds' decision to retire in

September 2019. She added that she has also received sign off from the Chief Medical Officer on the job description for the Director of Public Health role and is proceeding with the recruitment of this post.

49/19.4 The Interim Chief Executive informed members that a ground clearing Sponsorship Review Meeting with the Chief Medical Officer and other Department of Health officials had taken place on 12 June and that this meeting covered a range of issues including finance, governance and staffing. With regard to staffing, she said that PHA has produced a plan. Ms Mann-Kler asked what period this plan covered given that the issue of staffing is on PHA's Corporate Risk Register. The Interim Chief Executive said that the Plan is for both the short and long term, and she agreed to bring the Plan to the next PHA Board meeting. She noted that the PHA end-year Accountability Meeting with the Permanent Secretary is due to take place on 4 July.

49/19.5 The Interim Chief Executive reminded members that in the latter stages of 2018/19, the Department of Health had agreed that PHA could run a number of time limited public information campaigns targeted at key priority areas. She said that these included a new Anti-microbial resistance campaign developed by Public Health England (end of December to mid-February), a new smoking cessation campaign encouraging smokers to make a quit attempt by availing of the 500+ smoking cessation services available throughout Northern Ireland (11 March to 31 March); a rerun of the FAST campaign (February 2019) and a re-run of the Change your Mind campaign developed in partnership with Inspire (March 2019).

49/19.6 The Interim Chief Executive agreed to share with members an overview of the early findings of the post-campaign evaluations, but she confirmed that the campaigns have performed very strongly in relation to reach and awareness.

49/19.7 The Interim Chief Executive informed members that the PHA and HSCB have been involved in multi-disciplinary discussions over recent months regarding the planning for the 2019 Open Golf Championship which is being held at Royal Portrush from 14-21 July. She said that over 200,000 visitors are expected and that a leaflet has been produced to help give advice regarding entitlement to services, emergency treatment, the role of pharmacists, how to access GP services, GP Out-of-Hours arrangements and dental services.

49/19.8 The Interim Chief Executive told members about a new "Living Well Service" programme which is aimed at offering advice to pharmacy customers on public health issues. She said this was launched on 1 June by PHA, HSCB and Community Pharmacy NI. She explained that there will be targeted campaigns within pharmacies over the coming year focusing on care in the sun (currently underway), obesity prevention, Stay Well This Winter, antimicrobial resistance and mental health awareness. She added that a second element of the initiative will

focus on opportunistic interventions to help reduce risk factors which cause illness in Northern Ireland e.g. high blood pressure, tobacco use, harmful misuse of alcohol, unhealthy diet, sexual health and substance misuse.

49/19.9 Ms Mann-Kler asked if there will be an evaluation to see what impact this new programme has. Mr McClean said that an evaluation will be done three months after the completion of the programme, but he said that PHA is currently carrying out a telephone survey of a random sample of pharmacists to check if they are promoting the initiative.

50/19 Item 7 – Update from Governance and Audit Committee (PHA/01/06/19)

50/19.1 Mr Drew advised members that the minutes of the Governance and Audit Committee meeting of 17 April were available for members for noting. He said that he had given members an overview of the meeting of 5 June at the special Board meeting on 11 June when the Annual Report and Accounts were approved. He reiterated that the Committee had met with both internal and external auditors and that the auditors were content. He thanked Mr Cummings and his team for their work in producing the accounts.

50/19.2 The Chair asked if there had been any discussions about EU Exit at the Governance and Audit Committee. Mr Drew said this issue has arisen at recent meetings.

50/19.3 Members noted the update from the Chair of the Governance and Audit Committee.

51/19 Item 8 – PHA Draft Budget 2019/20 (PHA/02/06/19)

51/19.1 Mr Cummings presented the draft budget for PHA for 2019/20. He said that he was unable to present the budget before the financial year commenced as he did not have the allocation letter from the Department of Health. He pointed out that the budget would normally be accompanied by the Investment Plan, but that the Investment Plan has not yet been agreed because the PHA cannot finalise it until it receives a response from the Department on its savings proposals.

51/19.2 In summary, Mr Cummings said that PHA has an overall budget of £108m. In terms of how this is allocated, he began with an overview of Trust expenditure before moving onto programme expenditure, R&D capital expenditure and management and administration. He said that he had no concerns regarding how PHA will spend its funding, but he said that depending on the outcome of PHA's savings proposals, some decisions may have to be made regarding the Investment Plan.

51/19.3 Professor Rooney noted that the Belfast Trust receives almost 40% of PHA's Trust allocation. Mr Cummings advised that the Belfast Trust

	treats patients from outside its own Trust area. He noted that the issue of fair shares across all Trust populations is important and it may be timely to consider this further to ensure that there is no undue weighting towards Derry/Londonderry and Belfast.P important, and that there is no perfect formula and he agreed that PHA does need to reflect on whether it is content with the levels of funding it is spending outside of Belfast and Derry/Londonderry.
51/19.4	Alderman Porter suggested that the Belfast and Western Trust areas may receive the highest levels of funding as these are the areas where most community and voluntary sector organisations operate. He suggested that if the funding was skewed in favour of the other three Trusts, then the Belfast and Western Trusts would raise their concerns. Mr Cummings highlighted the example of the organisation which members had an opportunity to visit earlier that day, and how it raised its number of centres from 3 to 8, and these are not all in Belfast.
51/19.5	Professor Rooney suggested that PHA needs to look at how effectively it is utilising its funding in areas such as health improvement and health protection.
51/19.6	Members **APPROVED** the PHA budget for 2019/20.
52/19	**Item 9 – Corporate Risk Register (PHA/03/06/19)**
52/19.1	Mr McClean advised that the Corporate Risk Register for the period up to 31 March 2019 had been presented to the Governance and Audit Committee at its meeting on 5 June 2019. He said that the one new risk had been added since the previous review and this relates to emergency planning and the need to have an adequate mechanism in place to financially compensate staff who may have to work outside normal hours. However, he advised that HR is currently looking at a policy.
52/19.2	Mr McClean advised that two risks have been removed from the Corporate Risk Register, those relating to campaigns and Lifeline. He advised members that the Department had reinstated PHA's campaign budget for 2019/20.
52/19.3	Professor Rooney focused on the risk relating to staffing, and asked if this was wider than focusing on public health consultants. The Interim Chief Executive said that it covered staffing in general. Professor Rooney asked if PHA was at a tipping point. The Interim Chief Executive said that every day PHA can hire staff, but there are also staff leaving and she noted that there is a higher number of staff in higher age brackets. She said that PHA needs to ensure that it has the right people carrying out the right roles. Professor Rooney asked about PHA's turnover. Mr McClean said that this is approximately 15%.
52/19.4	The Chair noted the disparity in wages between Northern Ireland and other parts of the UK, particularly in senior roles. The Interim Chief

Executive said that in Northern Ireland there is a need to train staff, but also to retain them.

52/19.5 Ms Mann-Kler asked about PHA's workforce planning. The Interim Chief Executive said that PHA needs to be able to attract new staff, and provide good HR support. She said that at a recent TIG meeting, there was a presentation about how to attract new GPs with an option being to offer them a mix of experience of, for example, three days a week in general practice and two days carrying out a particular specialty.

52/19.6 Mr Drew said that PHA needs to become an attractive place to work. He noted that a recent survey showed that 60% of candidates are "lost" to organisations within five minutes of commencing the application form process. Professor Rooney said there are two issues, firstly identifying needs and having the right staff, and secondly, supporting and retaining those staff.

52/19.7 The Chair asked when the output of the last HSC staff survey will be available. Mr McClean anticipated that the overall results of this survey should be available in September. He said that one of the findings of the last survey is that staff who have a degree of autonomy in their roles are more content. The Interim Chief Executive said that she would be keen to speak to Professor Rooney about the concept of the "psychological contract".

52/19.8 Ms Woods said that for young people today, there is a thought that they will have to work until they are 70 before they can retire so they may consider a career change.

52/19.9 Ms Mann-Kler asked about staff engagement and if PHA has a staff wellbeing strategy. The Interim Chief Executive said that there are many things PHA does in terms of staff engagement. She said that staff appreciate you sitting down with them and asking them about what they are working on, and what is infuriating them. Ms Webb said that she felt that there is good collaborative working at the moment, but that there is frustration around the increased demands being placed on PHA by the Department of Health and the bureaucracy around Transformation funding. Alderman Porter said that staff like to be appreciated and thanked. Mr McClean said that Directors and Assistant Directors would acknowledge the work of their staff, and that there is a staff newsletter which highlights the good work of staff and acknowledges their contribution.

52/19.10 Members **APPROVED** the Corporate Risk Register.

53/19	**Item 10 – Breast Screening Programme Annual Report (PHA/04/06/19)**
	Dr Damien Bennett joined the meeting for this item.
53/19.1	Dr Bennett thanked members for the opportunity to present the Breast Screening Annual Report for 2016/17. He explained that PHA has a role in quality assuring the Breast Screening Programme and that the programme offers services to women aged between 50 and 70 on a 3-yearly basis. He said that the aim is to detect invasive breast cancers.
53/19.2	Dr Bennett said that the uptake for the programme in 2016/17 was 77% which compares favourably with the rate in England (71%). He advised that 5.7 per 1,000 women screened for the first time had an invasive cancer detected which fell to 5.1 per 1,000 women who were attending subsequent screening. Furthermore, he said 2.9 per 1,000 women under the age of 53 who were being screened for the first time had a small invasive cancer detected.
53/19.3	Dr Bennett said that 98.2% of women received an appointment for screening within 36 months of their previous screening, and that 98.8% of women received their results within 2 weeks.
53/19.4	The Chair asked why women under the age of 50 are not screened. Dr Bennett explained that while screening has benefits, it can also cause harm and there is a balance to be struck between screening people unnecessarily and considering that some cancers that are detected may not be invasive. He said that there is a trial ongoing in England where the age range has been widened to 47-73.
53/19.5	Professor Rooney asked about the consultation on the reconfiguration of breast screening services. Dr Bennett explains that relates to the breast assessment service, which receives approximately one-third of its clients from screening and the other two-thirds from GP referrals.
53/19.6	Ms Mann-Kler asked why it had taken so long to produce this report. Dr Bennett advised that he had only recently taken on a role within this particular programme, but he explained that the staff on the programme had been involved in dealing with the incident which had occurred in England. He anticipated that the report for 2017/18 would be finalised shortly. Ms Mann-Kler asked if PHA will look at the learning from the incident in England. Dr Bennett said that PHA is keeping an eye on the review in England.
53/19.7	Ms Mann-Kler asked about the 23% of women who do not attend for screening, and if PHA knows the profile of these women. Dr Bennett said that the biggest factor is that these women live in areas of deprivation. He added that there are also language issues, but he said that PHA is working with GP practices to talk to particular groups. Ms Mann-Kler suggested there should be a campaign. Mr McClean

explained that PHA's approach has been to target those areas and using people with local influence and knowledge to help improve uptake rates. The Chair put forward the view that there may be benefit particularly in deprived areas In asking the GP to sign the letter, since these individuals may have a heavy reliance on the GP at the medical centre. Alderman Porter disagreed with the Chair on the possibility of success of this approach.

53/19.8 Alderman Porter asked whether the information leaflets that are distributed by PHA explain false negatives. Dr Bennett said that the information being issued is more balanced and outlines the risks involved in screening.

53/19.9 Mr Drew thanked Dr Bennett for the report and asked whether the upward trend, in terms of attendance, is continuing. Dr Bennett said that PHA would receive quarterly statistics and that the uptake remains at around 75/76%. Mr Drew said that is important to acknowledge the work of the support staff.

53/19.10 Professor Rooney asked about more posters etc. being available giving advice. Dr Bennett said that there is information on "Be Cancer Aware" and that women should contact their GP if they have any concerns.

53/19.11 Ms Mann-Kler noted the high uptake in the Northern Trust area and asked if there was a reason for this. Dr Bennett advised that the Health Intelligence unit had carried out an analysis of uptake in different areas across the Trust, and while all Trusts are working hard to increase the uptake, it depends on the makeup of the population.

53/19.12 Ms Mann-Kler asked if men can get breast cancer. Dr Bennett confirmed that this was the case.

53/19.13 Members **APPROVED** the Breast Screening Programme Annual Report for 2016/17.

54/19 Item 11 – MOU between the Department of Health, PHA and SBNI (PHA/05/06/19)

Miss Rosemary Taylor joined the meeting for Items 11, 12 and 14.

54/19.1 Miss Taylor advised that when the Safeguarding Board for Northern Ireland (SBNI) was first established in 2011 it was agreed that PHA would act as a corporate host, but that PHA would not be responsible for the organisation's performance against its statutory functions. She said that an MOU was drafted in 2011, but there was a need for it to be revised, and that there has been extensive engagement between PHA, SBNI and the Department to develop this amended MOU.

54/19.2 Miss Taylor said that the amended MOU set out the arrangements whereby the central support team in SBNI would be PHA staff, the most

	senior of whom will report directly to a nominated PHA member of staff, currently the Director of Nursing. Furthermore, she said that PHA will be responsible for information governance matters including FOI requests. She noted that the MOU will need to be kept under review given the proposed restructuring changes impacting HSCB and PHA.
54/19.3	Miss Taylor explained that following approval, the MOU will be signed by the PHA Interim Chief Executive and will then be forwarded to the Department for signing with the final signed copy incorporated into the Management Statement and Financial Memorandum between PHA and DoH.
54/19.4	Mr Drew said that the MOU is very helpful and provides the necessary reassurances. Ms Mann-Kler queried how a whistleblowing incident would be reported. Miss Taylor said that it would depend on whether it related to a staff member or to SBNI functions as to whether it would be a matter for PHA or for the Department. She reiterated that SBNI staff are PHA staff and are bound by PHA policies.
54/19.5	Members **APPROVED** the MOU between the Department of Health, PHA and SBNI.
55/19	**Item 12 – PHA Rural Needs Act Annual Report 2018/19 (PHA/06/06/19)**
55/19.1	Miss Taylor explained that the Rural Needs Act 2016 came into operation for public bodies, including the PHA from 1 June 2018 and that under the Act, PHA is required to submit an annual return for DAERA. She said that this first return confirms that PHA has a policy in place and is raising awareness of the need for rural screenings to be carried out, but there remains further work to be done.
55/19.2	Ms Mann-Kler asked if policies are rural screened to ensure they do not have a negative impact or to see if they have a positive impact. Miss Taylor said that it would depend on the individual policy, but it is to ensure that the PHA is considering the needs of the rural population when developing policies.
55/19.3	Members **APPROVED** the Rural Needs Act Annual Report.
56/19	**Item 13 – Personal and Public Involvement Update (PHA/07/06/19)**
	Ms Michelle Tennyson and Miss Roisin Kelly joined the meeting for this item
56/19.1	Ms Tennyson gave members an overview of recent achievements within PHA's Personal and Public Involvement work. She said that PHA has been enhancing its involvement and co-production approach across a number of pilots in HSC Trusts and one within the Prison Service. She went on to say that PHA is providing a lot of specialised PPI work, and

	gave the example of PHA's involvement in the follow up to the Hyponatraemia Review. She said that there is an increasing appetite for PPI with people wanting to be involved, but they remain anxious about the level of support at a strategic level.
56/19.2	Ms Tennyson advised that 100 people have undertaken bespoke involvement training. She added that there is also a bursary scheme to enhance capacity in PPI.
56/19.3	Ms Tennyson informed members that the PPI Leadership Development Programme has 20 participants signed up on this, its first official year. She said that the programme has been co-produced with key partners and covers areas such as improving partnerships, improving communication, developing leadership capacity and improving leadership skills. She said that the Permanent Secretary and the Chief Nursing Officer had attended the final session. She noted that the evaluations of the programme were positive with participants feeling more confident in providing challenge and making others aware of their responsibilities. She added that planning is under way for the next cohort.
56/19.4	The Chair said that he would like to PPI included on job descriptions, objectives and staff appraisals. He said that he is aware that this is already happening in the Southern Trust.
56/19.5	Ms Mann-Kler complimented the breadth of work being undertaken, and paid tribute to the staff who have been involved.
56/19.6	Professor Rooney asked about PHA having service users and carers as partners. Ms Kelly said that PHA has begun to develop a service user and carer forum to support PHA and is looking at how it will fit within PHA's governance structure. She said that there are regional forums, but PHA needs to build on its own accountability mechanisms.
56/19.7	Members noted the Personal and Public Involvement update.
57/19	**Item 14 – Corporate Monitoring Report (PHA/08/06/19)**
57/19.1	Miss Taylor advised that the end year corporate monitoring report showed that, of the 75 objectives set in the 2018/19 Business Plan, 1 was rated "red" at year end, 12 were rated "amber" and the remaining 62 were rated "green".
57/19.2	Miss Taylor said that the second report shows a snapshot of progress against a number of high level key indicators in the 2017-2021 Corporate Plan through the use of infographics, and then some further detailed narrative.
57/19.3	Professor Rooney noted that the infant mortality rate in Northern Ireland is much higher than anywhere else in the UK. Ms Webb said that the

	situation is complicated by the abortion laws here, but it was agreed that this would be verified by further drilling into the data.
57/19.4	Ms Mann-Kler said that the infographics are helpful. She asked whether any of the corporate objectives which are rated “red” or “amber” in terms of progress would go onto the Corporate Risk Register. Miss Taylor noted that many of the indicators are long term and that the data can inform what PHA should be doing. She added that if a corporate target is not achieved, it may be due to factors outside the control of PHA.
57/19.5	Members noted the Corporate Monitoring Report.
58/19	**Item 15 – Any Other Business**
58/19.1	There was no other business.
59/19	**Item 16 – Details of Next Meeting**
	Thursday 15 August 2019 at 1:30pm
	Board Room, Tower Hill, Armagh, BT61 9DR
	Signed by Chair:
	Date:

Public Health Agency

Finance Report

2019-20

Month 3 - June 2019

PHA Financial Report - Executive Summary

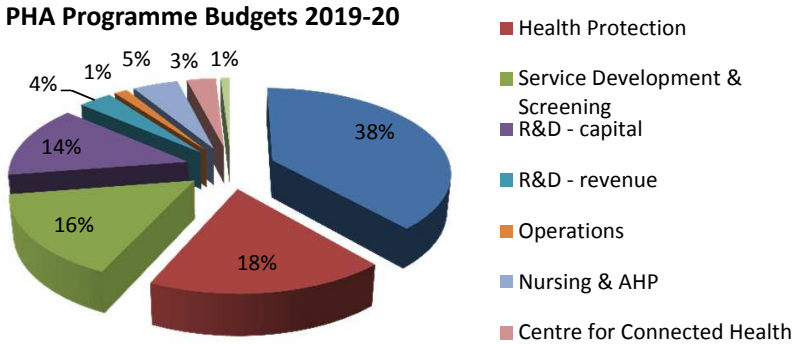
Year to Date Financial Position (page 2)

At the end of month 3 PHA is reporting a small underspend (£0.1m) against its profiled budget. This underspend is primarily the result of a year to date underspend on Administration budgets (see page 5) being offset by expenditure ahead of profile on PHA Direct budgets.

Budget managers continue to be encouraged to closely review their profiles and financial 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.

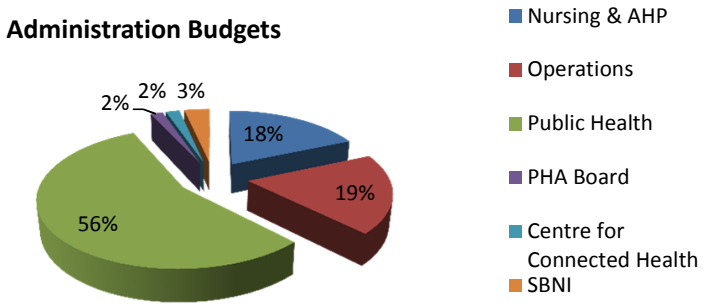


Administration Budgets (page 5)

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. Ringfenced funds, including Confidence and Supply Transformation Funds, are being monitored closely to ensure full spend by year end.

Public Health Agency
2019-20 Summary Position - June 2019

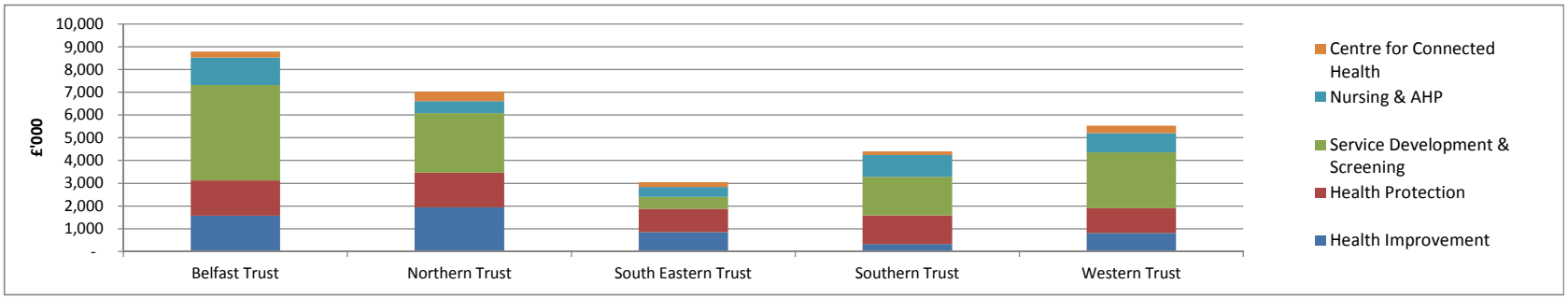
	Annual Budget					Year to Date				
	Programme		Ringfenced	Mgt &	Total	Programme		Ringfenced	Mgt &	Total
	Trust	PHA Direct	Trust & Direct	Admin		Trust	PHA Direct	Trust & Direct	Admin	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources										
Departmental Revenue Allocation	28,848	49,431	9,185	20,680	**108,143**	7,212	4,675	1,584	5,165	**18,635**
Revenue Income from Other Sources	-	31	-	712	**743**	-	31	-	178	**209**
Total Available Resources	28,848	49,462	9,185	21,392	**108,887**	7,212	4,706	1,584	5,343	**18,845**
Expenditure										
Trusts	28,848	-	4,049	-	**32,897**	7,212	-	1,012	-	**8,224**
PHA Direct Programme *	-	51,309	5,136	-	**56,445**	-	5,127	557	-	**5,685**
PHA Administration	-	-	-	19,545	**19,545**	-	-		4,877	**4,877**
Total Proposed Budgets	28,848	51,309	9,185	19,545	**108,887**	7,212	5,127	1,570	4,877	**18,785**
Surplus/(Deficit) - Revenue	-	(1,847)	-	1,847	**-**	-	(422)	14	466	**58**
Cumulative variance (%)						***0.00%***	***-8.96%***	***0.90%***	***8.72%***	***0.31%***

The year to date financial position for the PHA shows a small underspend, with the year to date underspend on Administration budgets (see page 5) being offset by expenditure ahead of profile on PHA direct budgets.

The current year end breakeven forecast is predicated on the in-year delivery of non-recurrent programmes in line with PHA priorities; this expenditure will balance out the forecast surplus in the administration budget, and ensure the organisation achieves its breakeven obligation.

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

Programme Expenditure with Trusts



Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	NIAS Trust £'000	NIMDTA Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	1,581	1,944	857	327	814	-	-	**5,523**	1,381	1,381	-
Health Protection	1,544	1,521	1,014	1,261	1,094	-	-	**6,434**	1,609	1,609	-
Service Development & Screening	4,195	2,618	538	1,697	2,457	-	-	**11,505**	2,876	2,876	-
Nursing & AHP	1,202	527	431	958	840	-	-	**3,958**	989	989	-
Centre for Connected Health	259	415	200	159	320	-	-	**1,354**	338	338	-
Other	25	13	12	12	12	-	-	**74**	18	18	-
Total current RRLs	**8,806**	**7,039**	**3,052**	**4,414**	**5,537**	**-**	**-**	**28,848**	**7,212**	**7,212**	-
Cumulative variance (%)											***0.00%***

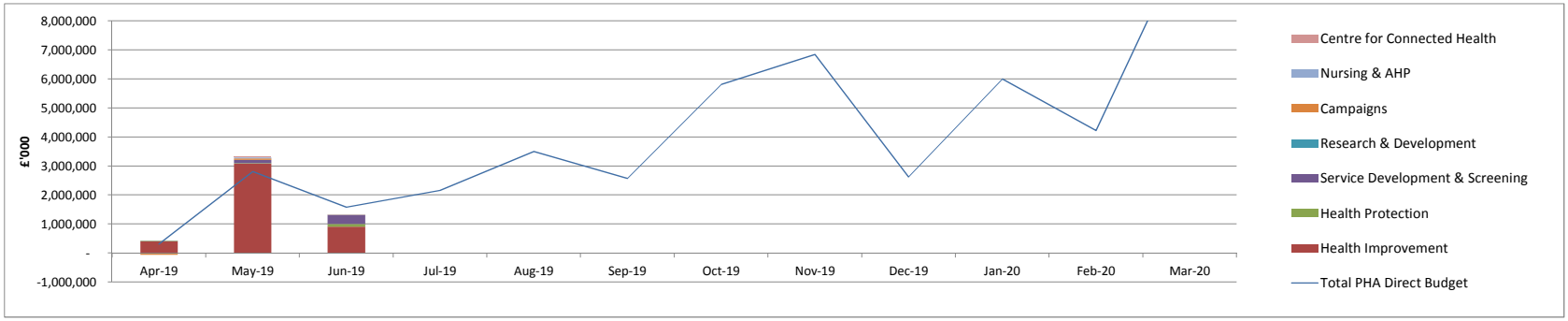
	Belfast Trust £'000	Northern Trust £'000	South Eastern £'000	Southern Trust £'000	Western Trust £'000	NIAS Trust £'000	NIMDTA Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / £'000
Ringfenced	**723**	**989**	**743**	**725**	**791**	**78**	**-**	**4,049**	**1,012**	**1,012**	-
											0.00%

The above table shows the current Trust allocations split by budget area. During the current month an exercise to re-align budgets between Trusts and PHA Direct budgets has been carried out, and profiles have been amended accordingly. This has created the year-to-date breakeven position

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

Ringfenced funds allocated to Trusts have been assumed at breakeven.

PHA Direct Programme Expenditure



	Apr-19 £'000	May-19 £'000	Jun-19 £'000	Jul-19 £'000	Aug-19 £'000	Sep-19 £'000	Oct-19 £'000	Nov-19 £'000	Dec-19 £'000	Jan-20 £'000	Feb-20 £'000	Mar-20 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000	
Profiled Budget																	
Health Improvement	249	2,369	963	1,935	2,783	1,062	2,471	3,523	1,156	3,415	3,111	6,452	**29,490**	3,581	4,388	(807)	*-22.5%*
Health Protection	38	353	79	88	485	961	3,193	1,588	1,105	940	120	1,238	**10,189**	470	141	329	*70.0%*
Service Development & Screening	2	65	517	112	112	527	124	95	336	44	292	560	**2,787**	584	514	71	*12.1%*
Research & Development	-	-	-	-	-	-	-	1,563	-	1,483	-	165	**3,211**	-	-	-	*0.0%*
Campaigns	23	23	23	23	23	23	23	47	31	102	678	256	**1,277**	70	10	60	*85.7%*
Nursing & AHP	-	-	-	1	98	-	3	32	1	17	23	220	**395**	-	47	(47)	*100.0%*
Centre for Connected Health	-	-	-	-	-	-	-	-	-	-	-	1,435	**1,435**	-	25	(25)	*100.0%*
Other	-	-	-	-	-	-	-	-	-	-	-	779	**779**	-	3	(3)	*100.0%*
Total PHA Direct Budget	**312**	**2,810**	**1,583**	**2,160**	**3,501**	**2,574**	**5,814**	**6,849**	**2,628**	**6,001**	**4,224**	**11,105**	**49,562**	**4,706**	**5,127**	**(422)**	
Cumulative variance (%)																***-8.96%***	
Actual Expenditure	**364**	**3,398**	**1,365**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**5,127**				
Variance	**(52)**	**(588)**	**218**										**(422)**				

Ringfenced Budgets	Apr-19 £'000	May-19 £'000	Jun-19 £'000	Jul-19 £'000	Aug-19 £'000	Sep-19 £'000	Oct-19 £'000	Nov-19 £'000	Dec-19 £'000	Jan-20 £'000	Feb-20 £'000	Mar-20 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000
Profiled Ringfenced PHA Direct Budget	**-**	**-**	**572**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**572**	**572**	**557**	**14**
																2.50%
Actual Expenditure	**(38)**	**461**	**134**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**557**			
Variance	**38**	**(461)**	**437**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**14**			

The year-to-date position shows a £0.5m deficit, which is mainly due to expenditure ahead of profile on a number of Health Improvement budgets.

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

In 2019/20 an amount of £1.9m has been recurrently removed from the programme budgets. This consists of £1m of savings initially allocated against the administration budget (£0.5m in each of the two years 18/19 and 19/20) and a further £0.9m 2018/19 programme savings target, achieved non-recurrently last year and now applied recurrently. DoH have given the PHA permission to vire the £1m administration savings against programme budgets. In effecting this reduction the PHA continues to seek to protect, where possible, core programmes that are central to PHA and Departmental priorities. In addition the organisation will utilise on an in-year basis the surplus which is forecast to arise in the administration budget, to further address programme priorities.

PHA Administration
2019-20 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	3,793	2,727	11,483	316	339	370	**19,028**
Goods & Services	168	1,332	403	37	58	365	**2,364**
Total Budget	**3,961**	**4,060**	**11,886**	**353**	**397**	**735**	**21,392**
Budget profiled to date							
Salaries	948	697	2,875	60	85	92	**4,757**
Goods & Services	43	333	95	9	14	91	**587**
Total	**991**	**1,030**	**2,970**	**69**	**99**	**184**	**5,343**
Actual expenditure to date							
Salaries	841	658	2,745	29	90	99	**4,463**
Goods & Services	34	255	85	(9)	2	49	**415**
Total	**875**	**912**	**2,830**	**20**	**91**	**148**	**4,877**
Surplus/(Deficit) to date							
Salaries	107	39	129	31	(5)	(7)	**294**
Goods & Services	10	79	10	18	13	43	**172**
Surplus/(Deficit)	**116**	**118**	**140**	**49**	**8**	**36**	**466**
Cumulative variance (%)	*11.73%*	*11.43%*	*4.70%*	*70.48%*	*7.93%*	*19.44%*	***8.72%***

PHA's administration budget is showing a year to date surplus , which has been generated by a number of long standing vacancies. In 2018/19 this surplus was used to achieve non-recurrently the £0.5m savings target for the organisation. However rolling forward the 2018/19 savings target has been removed recurrently from programme budgets, thus leading to an opening non-recurrent surplus in administration budgets. This was carried out with the permission of the DoH, in order to protect the funded staffing structure within the PHA, but will leave the organisation with an in-year forecast surplus for which non-recurrent plans are being developed.

Senior management continue to monitor the position closely in the context of the PHA's obligation to achieve a breakeven position for the financial year. SBNI budget is ringfenced and any underspend will be returned to DoH prior to year end.

June 2019

Public Health Agency
2019-20 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	-	12,475	-	**12,475**	-	-	-	**-**
Expenditure								
Capital Expenditure - Trusts	-			**-**	-			**-**
Capital Expenditure - PHA Direct		12,475		**12,475**		92		**92**
	-	12,475	-	**12,475**	-	92	-	**92**
Surplus/(Deficit) - Capital	-	-	-	-	-	**(92)**	-	**(92)**
Cumulative variance (%)								

PHA has received a Capital budget of £12.5m in 2019-20, most of which relates to Research & Development projects in Trusts and other organisations. Expenditure of £0.1m is shown for the year to date, and a breakeven position is anticipated for the full year.

PHA Prompt Payment

Prompt Payment Statistics

	June 2019 Value	June 2019 Volume	Cumulative position as at 30 June 2019 Value	Cumulative position as at 30 June 2019 Volume
Total bills paid (relating to Prompt Payment target)	£1,867,115	382	£10,933,492	1,640
Total bills paid on time (within 30 days or under other agreed terms)	£1,791,234	343	£10,432,480	1,529
Percentage of bills paid on time	**95.9%**	**89.8%**	**95.4%**	**93.2%**

Prompt Payment performance for the year to date shows that on value the PHA is achieving its 30 day target of 95.0% although performance on volume has slipped slightly in June. Overall 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 89.3% by value for the year to date, which significantly exceeds the 10 day DoH target for 2019-20 of 60%.

HSC Public Health Agency

item 8

Title of Meeting	PHA Board Meeting
Date	15 August 2019
Title of paper	Draft Annual Progress Report 2018-19 to the Equality Commission on Implementation of Section 75 and the Duties under the Disability Discrimination Order
Reference	PHA/02/08/19
Prepared by	Dr Karen Beattie
Lead Director	Ed McClean
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to seek approval of the PHA's Annual Report to the Equality Commission.

2 Background Information

This report presents the statutory annual return to the Equality Commission for the period covering April 2018 to March 2019. It has been prepared in conjunction with the BSO Equality Unit and was approved by the Agency's management team at its meeting on 2 July.

3 Key Issues

The report references a wide range of initiatives with tangible outcomes for specific Section 75 groups. It also highlights a series of projects that clearly demonstrate close engagement and consultation with the voluntary sector.

The following points are drawn to the attention of PHA Board members:

- Progress on equality screenings and their publication is growing, albeit slowly: 7 published in 2018-19, compared to 5 in 2017-18, and 3 in 2016-17.
- Two Equality Impact Assessments (EQIAs) were undertaken, with both at the public consultation stage.
- A number of equality monitoring activities are referenced. They demonstrate the value of improving the equality evidence base, and using it to improve service provision.

- There have also been improvements in the monitoring undertaken to date of policies equality screened previously.

It is proposed that efforts in 2019-20 are focused on:

- encouraging staff to participate in equality training, particularly the Making a Difference e-learning package;
- equality screenings and their timely publication;
- progression of EQIAs;
- monitoring, including of policies screened, and;
- engagement with Section 75 groups as part of pre-consultation exercises and collection of equality information by this means.

4 Next Steps

Following approval the Report will be submitted to the Equality Commission in advance of the 31 August deadline.

Public Authority Statutory Equality, Good Relations and Disability Duties - Annual Progress Report 2018-19

Contact:

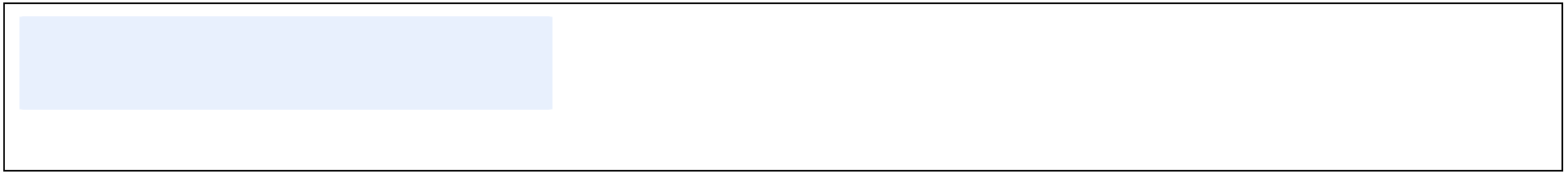
• Section 75 of the NI Act 1998 and Equality Scheme	Name: Edmond McClean Telephone: 03005550114 Email: edmond.mcclean@hscni.net
• Section 49A of the Disability Discrimination Act 1995 and Disability Action Plan	As above

We receive support services on the implementation of our Section 75 and Section 49A duties from the Equality Unit at the Business Services Organisation. For further information you can contact our equality advisor: Anne Basten, Equality, Diversity and Human Rights Manager, Business Services Organisation, Anne.Basten@hscni.net 028 9536 3814

Documents published relating to our Equality Scheme can be found at: http://www.publichealth.hscni.net/directorate-operations/planning-and-corporate-services/equality

(ECNI Q28):
Our Equality Scheme is due to be reviewed by April 2021.

Signature:



This report has been prepared adapting a template circulated by the Equality Commission. It presents our progress in fulfilling our statutory equality, good relations and disability duties. This report reflects progress made between April 2018 and March 2019.

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Chapter	Page
1. Summary Quantitative Report	4
2. Section 75 Progress Report	7
3. Equality Action Plan Progress Report **(ECNI Q2)**	49
4. Disability Action Plan Progress Report	79
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6. Mitigation Report **(ECNI Q1,3,3a,3b)**	101
Appendix – Further Explanatory Notes **(ECNI Q10,13,14,20)**	

Chapter 1: Summary Quantitative Report

(ECNI Q15,16,19)
Screening, EQIAs and Consultation

1. Number of policies screened (as recorded in screening reports). (see also Chapter 5)	**Screened in** 0	**Screened out with mitigation** 5	**Screened out without mitigation** 2	**Screening decision reviewed following concerns raised by consultees** No concerns raised
2. Number of policies subjected to Equality Impact Assessment.		2		
3. Indicate the stage of progress of each EQIA.		**Northern Ireland Diabetic Eye Screening Programme**: Public consultation stage **Review of Breast Assessment Services (jointly with HSC Board and the Department of Health):** Public consultation stage		
4. Number of policy consultations conducted		2		
5. Number of policy consultations conducted with screening presented. (See also Chapter 2, Table 2)		1		

(ECNI Q24)
Training

6. Staff training undertaken during 2018-19. (See also Chapter 2, Q6)

Course	Staff Trained	Board Members Trained
Equality screening training	15	0
Equality Impact Assessment Training	4	0
NISRA Training	6	0
Good Relations (Cultural Awareness)	24	0
Total	**49**	**0**

eLearning: Discovering Diversity

Module 1 to 4 – Diversity	1
Module 5 – Disability	2
Module 6 – Cultural Competencies	2

eLearning: Making a Difference

Part 1 – All Staff	22
Part 2 – Line Managers	2

(ECNI Q27)
Complaints

7. **Number of complaints in relation to the Equality Scheme received during 2017-18**

0

Please provide detail of any complaints/grievances:

Not applicable

(ECNI Q7)
Equality Action Plan (see also Chapter 3)

8. **Within the 2018-19 reporting period, please indicate the number of:**

Actions completed:	8	Actions ongoing:	11	Actions to commence:	1

(ECNI Part B Q1)
Disability Action Plan (see also Chapter 4)

9. **Within the 2018-19 reporting period, please indicate the number of:**

Actions completed:	7	Actions ongoing:	4	Actions to commence:	0

Chapter 2: Section 75 Progress Report

(ECNI Q1,3,3a,3b,23)

1. **In 2018-19, please provide examples of key policy/service delivery developments made by the public authority in this reporting period to better promote equality of opportunity and good relations; and the outcomes and improvements achieved. Please relate these to the implementation of your statutory equality and good relations duties and Equality Scheme where appropriate.**

Table 1 below outlines examples of progress to better promote equality of opportunity and good relations[i].

Much of the PHA work this year demonstrates improvements in **access to information** for people of different ethnicities, and those with disabilities, including learning disabilities, sight or hearing loss. Examples of good practice include the provision of information materials in Portuguese, Lithuanian, Polish and Russian for the Take Home Naloxone programme; installation of Browsealoud on our corporate website; and developing resources in easy read formats, such as the Step by Step physical activity booklet.

Other key themes demonstrated in the table below include improved **access and uptake of services** Examples include work with the Roma community to promote vaccination uptake; and development of the Abdominal Aortic Aneurysm (AAA) screening to meet the needs of specific groups of men.

A further group of examples highlight the development of **new and innovative approaches** to improving quality, safety and the patient experience for particular groups. Examples include the development of new digital technologies to improve the health of older people, and use of innovative techniques within public health campaigns, such as the use of mannequins within the Be Cancer Aware public health campaign.

Working in partnership with other agencies in the private, community and voluntary sectors over the last year, provides an important opportunity to **influence the promotion of equality issues**. This is particularly important where other organisations or agencies are not bound by the same legislative requirements as public bodies. Examples of this include proactively promoting equality of opportunity in our contracts with recruitment agencies, and for alcohol and drug services commissioned across NI as part of a regional tendering programme.

In most cases, it is not possible to ascribe developments to one single factor of Equality Scheme implementation. As mainstreaming progresses and the promotion of equality becomes part of the organisational culture and way of working, the more difficult it becomes to ascribe activities and outcomes to the application of a specific element of Equality Scheme implementation. From this point of view, engagement and consultation, coupled with staff training in equality issues are perhaps the most important factors in developing and embedding good practice.

Changes resulting directly from equality screenings are reported in Chapter 6, the Mitigation Report. Other changes due to the implementation of Equality and Disability Action Plans are reported in Chapters 3 and 4.

Table 1: Progress to better promote equality of opportunity and good relations

	Outline new developments or changes in policies or practices and the difference they have made for specific equality groupings.
Persons of different religious belief	Facilitated by the Equality Unit in BSO, and the BSO Procurement and Logistics Service, we took action to proactively promote equality of opportunity within our contracts with **recruitment agencies**. Agencies are required to demonstrate how they promote equality with reference to: training their staff; gathering feedback from agency workers; their provisions on making reasonable adjustments for agency workers; and outreach work to attract a diverse range of agency workers. Collection of this monitoring data for all nine equality groupings was audited in 2019, allowing us to monitor the diversity of agency workers placed with us and, where necessary, to engage with recruitment agencies to address under-representation and the user experience of specific equality groupings. We used equality monitoring forms for the first time for people who participated in our **Disability Placement Scheme** ending in 2018, capturing all nine equality groupings. This will enable us to see how diverse the group of people being placed with us are and where necessary work with the provider to take further outreach measures.
Persons of different political opinion	**Health and Social Wellbeing Improvement** In June 2018, the '**Expansion of Community Development Approaches'** report was launched. This was developed by the HSC Transformation Community Development Work Stream following an extensive engagement process and aims to inform the wider work of the Transformation Implementation Group (TIG), which is leading on the design, development and implementation of major change within health and social care. Community development can improve health outcomes and reduce health inequalities by building on the strengths or assets of the community, and enables participation, empowerment and the growth of self-efficacy. This builds strength and

	resilience in communities which can help reduce the negative impact of conditions on health, create greater ability to deal with adversity, and develop greater confidence to address needs holistically and in partnership with others.
Persons of different racial groups	**Health and Social Wellbeing Improvement** • Research was commissioned by the PHA during 2018, which summarises international evidence on approaches and principles of promoting and supporting the **mental health and emotional wellbeing of asylum seekers and refugees**. The findings of the report have been discussed and shared widely, including with asylum seekers and refugees, ethnic minority and migrant support groups and other stakeholders across the community, voluntary and statutory sectors. This is part of ongoing 2019 stakeholder engagement and consultation to help shape thinking and inform planning and decision-making for the forthcoming PHA commissioning of services to improve ethnic minority and migrant health and social, mental and emotional wellbeing and reduce health inequalities. • The PHA commissioned services from the Southern, Western and Belfast Trusts to deliver a range of programmes to address the **health and social wellbeing needs of Travellers**. Services include community development, family support, training and education, signposting to services e.g. smoking cessation, cancer screening, drug & alcohol, support to engage in local services for example Healthy Living Centres, as well as cultural awareness training, and support to engage in conflict resolution within families and communities. The PHA also commissioned Aware to deliver a regional mental health and emotional wellbeing programme with Travellers. • The PHA and HSCB Travellers Health and Wellbeing Forum including colleagues from TEO, Health and Social Care Trusts, Equality Commission, Education Authority, Traveller Support Groups and voluntary sector organisations, meets four times a year. During 2018-19, the Forum have developed an Outcomes Based Approach to planning services for Travellers which includes the recent establishment of the following Task Groups; **Give every Traveller Child the best start in life**, **Travellers live long, healthy lives** and **Traveller participation**.

Persons of different racial groups cont.	• Following consultation with substance misuse treatment providers, the PHA in 2018-19 developed Portuguese, Lithuanian, Polish and Russian translations of information materials for the **Take Home Naloxone programme**. **Operations** • Installation of **Browsealoud** on our corporate website assists those who have difficulty reading English, especially where English is a second language. Browsealoud allows the text on the site to be translated into different languages. This feature can also be used on PDFs that are hosted on the website. • **Translations of the antenatal screening leaflet** 'Protecting you and your baby' into 10 minority ethnic languages were added to the website after the lead in Service Development and Screening organised to have the English language version translated. This will ensure that women from ethnic minority cultures will receive written information in their own language about Antenatal screening offered. **Service Improvement and Screening** • The 'Rubella in pregnancy' leaflets have been translated into the most popularly requested 13 different languages for non-English speaking women who test non-immune to rubella. Previously this information leaflet was only available in 2 different languages. **Health Protection** Throughout 2018-19, work has been underway to maintain and improve vaccination programmes for children and young people by working with HSC organisations, and delivering a PPI study to better

Persons of different racial groups cont.	understand barriers to vaccinate hard to reach communities such as the Roma. Completion of video to promote MMR vaccine in the general population, plus text free version to eliminate language barrier within Roma community. Launched through social media networks in March 2019.
Persons of different age	The PHA (alongside the HSCB) participated in the St Vincent De Paul toy packing appeal. Staff helped to pack toys for children and teenagers during a series of 4 hour slots during the month of December 2018. **Health and Wellbeing Improvement** • A range of services have been commissioned / procured to deliver alcohol and drug services across NI as part of a regional tendering programme. Providers of services are required to address the needs of S75 groups within their service provision. A process has been put in place to allow the PHA to monitor the uptake of these services from Section 75 groups annually. These include: - **Community Based Services for Young People who are identified as having Substance Misuse difficulties** provides step 2 treatment services including psychotherapeutic interventions (talking therapies) for children and young people, aged 11-25 years, across Northern Ireland including structured family support. This includes ensuring referral pathways are in place to allow children and young people to seamlessly move between services. - **Drug and Alcohol Mental Health Service (DAMHS)** provides step 3 treatment services for children and young people with drug and /or alcohol issues which are beyond the scope of community based services as a result of complex co-morbid mental health issues. This includes the delivery of formal psychological therapies (motivational enhancement therapy, cognitive behavioural therapy, family therapy) and drug therapies where appropriate. The service is based / integrated within each of the HSC Trusts' Child and Adolescent Mental

Persons of different age cont.	Health Services (CAMHS). - **Therapeutic Services for Children, Young People and Families Affected by Parental Substance Misuse** is a Northern Ireland wide service providing therapeutic interventions and support to children affected by parental substance misuse as part of a multi-agency care plan through working directly with the young people and indirectly with non-substance misusing parents/carers. The service also provides support for families, engages with other services who work with these children and families and provides specialist advice and support to front line workers working with families affected by Hidden Harm. - **Targeted Prevention services for Young People** develops and delivers age appropriate drug & alcohol life skills/harm reduction programmes for young people in the age ranges of 11-13, 14-15 and 16+ years across Northern Ireland. These programmes are targeted / delivered to young people identified as being at risk of substance misuse (universal substance misuse education is delivered via schools). - Eight **Youth Engagement services** for young people aged 11 – 25 years (formerly called One Stop Shops) are available across Northern Ireland. The service provides up to date objective information about personal health and wellbeing issues (including drugs and alcohol), choices, where to find help / advice and support to access services when they are needed. The service has been independently evaluated and this process used to inform development. - **Workforce Development Services** delivers a range of training courses to support the implementation of the PHA/HSCB Drug and Alcohol Commissioning Framework, ensuring there is a pathway for alcohol and drug workers from all sectors to achieve a recognised qualification in substance misuse. It provides mentoring and support to those staff that require additional support to undertake specific tasks following training. A significant number of the training programmes are aimed at practitioners who work / care for children and young people. • **Stay Steady:** Falling over can happen to anyone, but for older people the risk is particularly high and the consequences potentially severe, including distress, pain, injury, loss of confidence, loss of independence and mortality. With this in mind, the Public Health Agency (PHA), in partnership with councils across Northern Ireland, produced a falls prevention video to raise awareness of

Persons of different age cont.	the measures we can take at home to prevent falls. The video is the latest in a series of awareness-raising activities to reduce the prevalence of accidents that occur in or around the home. The video was launched in January 2019. **Research and Development** • HSC R&D's **patient and public involvement panel has been expanded** to include people of working age as well as those who have retired to ensure greater representation of this age group. • The Joint Public Health Annual Conference **'Early Intervention for Life'** took place in November 2018. This was a collaborative partnership conference in conjunction with The Centre of Excellence for Public Health, Northern Ireland; The Institute of Public Health; the Department of Health and the Health Service Executive. The aim was to raise the profile of public health research, interventions and innovation and engage local professionals, practitioners and researchers working in the broad field of public health. The event included a number of parallel workshops showcasing the early intervention approaches that are currently underway across the island of Ireland under the following themes: Early Intervention in Early Years; Early Intervention in Teenage Years; Early Intervention in Adults; and Early Intervention in Older People. **Nursing and Allied Health Professionals** • During 2018, the Public Health Agency commissioned the development of a range of educational products around two priority areas of health care within the HSC, **Frailty** and **Continence**. Several educational programmes, were developed through the input of a range of multi-professional staff and service users. The programmes for both Frailty and Continence have been developed for a multi-disciplinary audience and will be accessible to staff working in the HSC and in the

Persons of different age cont.	voluntary/private/community sectors. • The PHA are working with Trusts to implement a **Pressure Ulcer Prevention Program for all adult inpatients in hospitals** and have commenced **awareness of pressure ulcer prevention** in the community. The PHA is also actively engaging with care providers to inform as many people as possible in Northern Ireland about the simple steps that can be taken to avoid pressure ulcers. • A number of workshops have held throughout 2018 to look at the issues of pressure ulcer prevention, focusing on learning and to agree a way forward for the next two years. In addition, a **Prevention of Pressure Ulcer in Adults eLearning Programme** has been developed in conjunction with the PHA, HSC Leadership Centre and the five HSC Trusts. This went live in November 2018 to coincide with WPUD. • In 2018-19, work was done to scope the emerging issues related to the provision of high quality care in the **nursing home sector**. Training and development in clinical skills, leadership and management has been delivered to care home staff. Peer facilitators have been recruited and trained to undertake patient experience interviews. Stakeholder workshops have been held in each HSCT location to engage with Independent Sector providers. • Children, Young People & Interagency Development work aims to ensure AHP Staff working across HSC will meet the requirements of the Children Cooperation Act (2015) and the SEND Act (2018). The work will support **the enhanced integration of children and young people's services** with a particular focus on education. The PHA have been working closely with DE and EA to establish integrated consistent processes across the health and education sectors to support early identification and timely support for children with underlying Special Educational Needs. • The appointment of Regional AHP Children and Young People's Safeguarding Coordinator within the PHA will provide professional leadership to a number of strategic forums on practice development related to AHPs to assist in **safeguarding children and young people** across the region. This work will build on existing networks to develop and promote appropriate linkages with policy/service developments in other agencies (e.g. SBNI). • The PHA has established an integrated model of **AHP support across all neonatal units** to support developmental care for children born prematurely and facilitate timely and supportive discharge home.

Persons of different age cont.	• **10000 More Voices** Regional Team are hosting a survey exploring audiology services for children. This survey will inform and support the implementation in standards for Audiology. The work focuses on children and young people aged between the ages 1 to 18 years. The survey was co-designed with children who are engaged in Audiology services and their parents/ carers. **Operations** • A number of different initiatives were independently organised by staff to support different voluntary agencies and advocacy groups. For example, a Christmas jumper day was spontaneously organised by staff in December, with all proceeds going to Save The Children. • A video highlighting the dangers of button cell batteries was produced in the run-up to Christmas as these batteries are used in many children's toys. The video was picked up by CBeebies and Belfast Live and received over 250,000 views across a range of platforms in less than two days. **Centre for Connected Health** 2018-19 has seen the development of innovative practices/technologies to improve health and wellbeing amongst older people. Input to EU projects has strengthened collaboration and increased knowledge and skills relating to healthy, active ageing. Projects include: • Working with Fermanagh & Omagh District Council on the EC funded PLACE-EE project to develop and implement locally derived sustainable solutions to encourage internet use and person-centred e-health amongst older people in rural communities. This has included work on the development of an educational toolkit to facilitate Intergenerational working between Older People and Young People through the use of Digital tools; • Providing NI input to EU work on development of blueprint for engagement on "Widening the support for large scale uptake of Digital Innovation for Active and Healthy Ageing";

Persons of different age cont.	• Supporting a number of Interreg VA Cross-border projects using digital tools in the area of population health (Co-Sync), older people (mPower) and mental health (iRecovery). • Telehealth - The Inhealthcare system is being used by NHSCT and SHSCT for undernutrition in care homes. This is helping to improve quality, safety and patient experience. Consideration is being given to a wider application of the service across other conditions.
Persons with different marital status	
Persons of different sexual orientation	The PHA supported **LGBT Awareness Week** in May 2018. LGBT Awareness Week NI brings visibility and awareness to Lesbian, Gay, Bisexual and Transgender (LGBT) people and their families in Northern Ireland. It is a joint effort by several community organisations, with this year's theme was Visibility. LGBT Week was publicised and a programme of events occurring over the week was included in Connect, our staff newsletter. 'Come Out for Change' was the theme for **Belfast Pride** this year. As in previous years, the PHA and the HSC LGB&T Staff Forum joined the Belfast Pride parade and celebrations in Custom House Square. PHA stalls provided information on health and wellbeing issues that affect lesbian, gay, bisexual and transgendered (LGB&T) people in Northern Ireland. The HSC LGB&T Staff Forum, supported by the Trade Unions and Lifeline, also organised information stalls in a number of HSC sites to coincide with the run up to Pride 2018. Information about Pride and the programme of events for the day was publicised on Connect, our staff newsletter. **Service Improvement and Screening** Northern Ireland GUM and HIV service providers have since July 2018 been offering HIV Pre Exposure Prophylaxis (PrEP) to **Men having sex with Men (MSM)**. By the end of March 2019, 467 people had

Persons of different sexual orientation cont.	been offered this service and 349 of these were taking PrEP. **Human Resources** The **regional Bullying and Harassment policy** was developed by HR and colleagues from other regional HSC organisations and HSC trusts. In order to give LGB people more confidence in reporting incidences of conflict, bullying and harassment, sexual orientation is clearly defined in the policy as a protected Equality Group in the definition of Harassment. Moreover, the policy states that Line managers have a specific responsibility in the prevention and resolution of conflict, bullying and harassment.
Persons of different genders and gender identities	**Service Improvement and Screening** The Abdominal Aortic Aneurysm (AAA) screening programme is currently only offered to males in Northern Ireland on the basis of evidence based research and clinical trials. • A two-tier service is currently provided to men with found to have AAAs. Men with screen detected AAAs are managed within agreed pathways with specified timescales for surveillance scans and referral to treatment. However, patients with **non-screen detected AAAs** do not routinely get scanned within the same timescales and it can take longer to be referred for treatment. Northern Ireland AAA Screening Programme (NIAAASP) commissioning staff at the PHA supported an application from the service provider at the Belfast Trust to the HSCB seeking funding for a non-screened programme to address the issue, which was approved. • Working alongside the service provider at the Belfast Trust, the PHA ensured **that armed forces personnel** who are eligible for AAA screening are invited to participate in the screening programme. Previously, as these men may not have been registered with a GP and therefore may not have been invited. • AAA screening is offered within the two **prison settings** in NI on an annual basis. This will ensure

	these men have been given opportunity to attend for screening and receive ongoing management / treatment as appropriate. **Operations** At the start of Breast Cancer Awareness Month the PHA highlighted the less well-known signs of breast cancer through the **Be Cancer Aware campaign programme**. This included partnering with Menarys Stores who hosted a unique set of mannequins in their lingerie departments. The lifelike mannequins depict some lesser-known signs of breast cancer to raise awareness and encourage women to keep an eye out for them. These were on display in Menarys Bangor, Newtownards, Lisburn, Dungannon and Cookstown during October and November 2018. **Gender Identity and Expression Employment Policy** A regional task and finish group to support the implementation of the policy was established this year. The group has met a number of times over the last year. All HSC organisations are represented by senior staff from HR and our Equality Unit in the BSO. Work this year focused on developing checklists for line managers and HR for key aspects of the transition, including handling of information records in relation to transgender and non-binary staff. Work has also included an assessment of the awareness and training needs of staff.
Persons with and without a disability	**Health and Wellbeing Improvement** • The implementation of Regional Guidelines for Adults with Learning Disabilities continued through 2018/19 via the Personal and Sexual Relationships Operational Protocol. This joint work with Trusts and PHA has resulted in the **delivery of Level 1 and Level 2 training for staff** working with and supporting adults with learning Disability. This will ensure that services for adults with a

Persons with and without a disability cont.	learning disability provide the opportunity for people to enjoy personal and sexual relationships while protecting vulnerable adults from abuse. • A partnership approach was developed with **Action on Hearing Loss** to develop a pilot project to promote public hearing heath messages which looked at both preventing hearing loss and raising awareness of hearing loss. This took place at the main music events throughout Northern Ireland in 2018, including Belsonic and Custom House Square, focusing on the mainly young population who attend these events. The focus of the pilot was around a social media campaign (#dontlosethemusic) and the development of resources which led to prevention messaging. The campaign reached over 6,000 people across the Action on Hearing Loss Northern Ireland Facebook and Twitter pages and has been engaged with (retweeted, favourited, shared and liked) more than 300 times. The pilot was completed by October 2018, and has been nationally recognised with Action on Hearing Loss winning a UK Award for 'Belfast Volunteer Initiative' from the Association of Executives. • Step By Step: This booklet has been developed for **adults with learning disabilities** to encourage them to walk more. Using simply illustrated text, it outlines the benefits of walking for everyone and encourages participants to track their daily steps in order to build up to over 10,000 a day. • In 2018-19 the PHA has funded local community and voluntary groups to promote positive mental health and emotional wellbeing, tackling the contributing factors of self-harm and suicide as well as building sustainable resilient communities through positive collaboration of organisations and groups. One of the initiatives is a **mental health awareness video** made by Everglow Health and Wellbeing group based in north Belfast. It features high profile young actors and sportspeople, to highlight the need to talk about mental health. Participants in the awareness video include actress Kerri Quinn who is currently starring in Coronation Street, HBO's 'The Pacific' actor Martin McCann, World champion boxer Carl Frampton, Irish Rugby International Jacob Stockdale, Tyrone GAA Captain Matthew Donnelly, and Irish and Ulster Rugby Captain Rory Best, among other well-known faces. • The multi-agency street triage team (MATT) pilot project was launched in July 2018 in the SEHSCT area. MATT includes a mental health practitioner & paramedics working alongside police officers

Persons with and without a disability cont.	providing **on-the-spot help to vulnerable adults with mental health difficulties**, while at the same time reducing their reliance on hospital, ambulance and PSNI resources. • The Staff Health and Wellbeing Working Group (SHWWG) aims to support PHA's commitment to the **health and wellbeing of employees**. Mental and emotional health and wellbeing in the workplace is recognised as an important issue to the PHA. Current health and wellbeing support for staff includes access to Inspire services, Occupational Health Service, Success Not Stress initiative, specific staff events and programmes such as Active Travel and walking, as well as ongoing line-management arrangements. This year the PHA offered staff the opportunity to participate in "Living Life to the Full", a 6 week course which aims to increase participant understanding of the importance of looking after their emotional health and wellbeing and improve personal resilience. **Service Improvement and Screening** AAA screening is offered within **two secure units in NI for men with learning disabilities or specific mental health needs** (Muckamore and Knockbracken) on an annual basis. This will ensure these men have been given opportunity to attend for screening and receive ongoing management / treatment as appropriate. **Operations** • The installation of **Browsealoud** this year on our corporate website and suite of websites assists those who have difficulty reading the screen. It allows the text to be read aloud, with the speed tailored to the needs of the listener and highlighters on the text to enhance understanding. Screen masks can also be applied to block online clutter so the user can focus on the text. This is particularly useful for audiences with **dyslexia, low literacy, or mild visual impairments**. • This year, there was a further reprint of the **HSC hospital passport for people with a learning disability** in contact with hospitals. This uses photos under licence from Photo symbols. Also

Persons with and without a disability cont.	developed pop-up stands for extending awareness of the availability to both staff and patients in HSCT settings. • Further reprint of *I can cook it!* community nutrition programme rolled out by HSCTs for people with a learning disability. • PHA communications presence at Physical & Sensory Disability Strategy and Action Plan stakeholder event in April 2018 to explore how the work of the 2012-2015/18 strategy and action plan could be taken forward beyond Sept 2018. • The PHA has increasingly integrated the use of **subtitles** in its video production to support accessibility for people with a hearing disability. • The Operations and Planning team continues to support the **HSC Disability Placement scheme**, which is jointly facilitated by the Health and Social Care Board, the Business Services Organisation and Supported Employment Solutions (a consortium of 7 voluntary sector organisations). The Operations team had an individual placed with us in October 2019, who is due to complete their placement in May 2019. • As part of the above placement, staff in the Operations and Planning team requested and received training from Action on Hearing Loss prior to the placement commencing. This **Deaf Awareness training** aimed to increase staff awareness of some of the issues faced by people with hearing loss, and looked at different methods of communication. This allowed existing staff within Operations to better support the individual placed with us. • **Staff independently organised fundraising activities to support charities and advocacy organisations for people with disabilities throughout 2018-19.** These included a number different informal events organised by staff themselves, including a "Great Bake Off", comprising of a competition, raffle and coffee morning, and proceeds going to Macmillan Cancer Support and the Alzheimer's Society. **Allied Health Professionals and PPI**

Persons with and without a disability cont.	• A **Regional Adult Dysphagia Group** led by PHA has been recently established, comprised of Service Users, Carers, Statutory, Independent, Voluntary and Community Sectors and relevant staff groups. The aim of the group is to improve identification and management of swallowing difficulties for adults with dysphagia. The aim is to work towards regional consistency, including consistency in protocols and care pathways, develop a regional approach to dysphagia awareness and training for all staff groups, identification of best practice and to improve public awareness of dysphagia. • An inter professional review team was established with representation from the PHA, Health and Social Care Board (HSCB), HSC Trusts, the Regulation and Quality Improvement Authority (RQIA), a service user and other members of staff from HSC. A thematic review published in February 2018 to inform future regional safety work. This review provides an analysis of SAIs relating to 'choking on food' reported across all programmes of care. • Working alongside BHSCT in Musgrave PSNI custody suite, the **Custody Healthcare Pathfinder project** was established in December 2019**.** Custody Health Care Nurses with the support of Forensic Medical Officers provide safe care for patients when they are detained in police custody. Police are obliged to request a Health Care Professional when they suspect, or are aware of any physical illness, mental health problem or injury of the detainee. Nurses will provide an independent opinion on: fitness to be detained in police custody; fitness to be released; fitness to be charged; fitness to be interviewed by the police. It is an excellent example of partnership working to improve healthcare of detainees and to reduce reoffending by signposting to appropriate liaison and diversional schemes. This work will be very beneficial for people with disabilities e.g. learning difficulties. The ability to access Appropriate Adult scheme will also be enhanced by presence of nursing team. This project will roll out to all nine PSNI custody suites subject to Department of Health/Department of Justice funding. • **A half day deaf awareness training session** was delivered to Nursing/AHP and Communications staff. The session covered deafness and communication methods used by deaf people including a crash course on the British Sign Language alphabet. The aim of the session was to have an increased knowledge and awareness of deaf and hard of hearing people and also of the methods of communication used by them as well as having an increased ability to communicate with deaf

Persons with and without a disability cont.	and hard of hearing people. As a result of the positive feedback on how useful it was and also how all staff who attended enjoyed the session, we are now looking at the possibility of running a more in-depth session on British Sign Language. • Patient Client Experience: **10000 More Voices regional team collaborated with RNIB** in the development of a training video, card and posters resource to inform staff of practical tips to support someone who is blind or partially sighted. The video was launched at our communications roadshow in March 2019 and is entitled "See it My Way" and cards and posters are currently being distributed across the Trusts. • PPI - The Engage website was developed with input from a diverse range of groups. Working in partnership with people drawn from Section 75 groups, the colour of the website, font size and layout were adjusted to ensure that it was accessible to a range of users including those with a visual impairment and those that use technology to read documentation for example. • The PHA has supported the development of First Contact Physiotherapist (FCP) roles in GP Practices. The FCPs will fully manage patients who contact a GP with a musculoskeletal condition without seeing their GP first. This has Positive impacts for people with and without a disability who will be able to receive assessment and intervention for their MSK condition more quickly. • The PHA has supported the development of a regional model for the timely assessment and provision of Augmentative and Alternative for Communication aids and devices for people of all ages with a range of disabilities that significantly affect their voice output and communication needs. **Research and Development** Findings from the dementia programme were launched at an event on 29 March 2019 attended by 83 health professionals, commissioners, managers, researchers and service users. All attendees received a summary of the research findings from the 7 projects, including pain assessment at the end of life; advance care planning; communication of risk, facilitated

Persons with and without a disability cont.	reminiscence; technology enriched housing; the prescription of medication in primary care and the evaluation of a healthcare passport for people living with dementia.Leaflets and art produced as a result of the projects were also on display. A carer provided one of the closing responses. An App developed in one of the projects to facilitate reminiscence has been commissioned by the HSC. **Service Improvement and Screening** • The NI AAA Screening Programme (NIAAASP) is part of a UK-wide group currently developing an Inequalities Toolkit for use by AAA Screening Programmes across all four nations. As part of this, the NIAAASP recently **participated in a Public Health England (PHE) Blog outlining best practice in effectively engaging with men with learning disabilities** to ensure they can make an informed decision about taking part in AAA screening. • There has also been engagement with relevant HSC professionals (e.g. Learning Disabled Health Facilitator Nurses) by the PHA AAA team. This has resulted in increased awareness of the needs of men with learning disabilities among key stakeholders. • Staff continue to **engage with community groups** and **attend a wide range of events to promote the programme** across the region. Programme staff attended 2018 Balmoral Show, Volunteer Now event at Ulster Museum in October 2018, and Crumlin Road Gaol in March 2019. This awareness raising work resulted in eleven self-referrals, as well as invitations for future awareness raising work alongside different voluntary organisations, including those supporting individuals affected by Alzheimer's, and those impacted by hearing loss. • Videos describing the screening process and testimonials from men who have been screened are now available with **sub-titles**, as well as **British sign language and Irish sign language** for individuals affected by hearing loss. These are available on NI Direct. • The NIAAASP has also **produced information materials to improve equity and access for men**

Persons with and without a disability cont.	**with learning disabilities**. A video describing screening process was produced with input and participation of men with learning disabilities. This is due to be launched at Service User Event in June this year and letters have already gone out to key stakeholders, including those from minority groups, inviting them to events and asking what format they would like copy of DVD in. This has resulted in a targeted promotion of the informed choice message for men in these groups. **Centre for Connected Health** • Phase Two of **the Dementia EHealth and Data Analytics Pathfinder Programme** for Northern Ireland including the implementation of a **PatientPortal for Dementia Patients** aims to build eHealth & data analytics capacity and capability with an initial focus on dementia, through the following workstreams: - **Development of a patient portal – 'My Care Record':** Dementia navigators in Trusts trained. Pilot Phase 1 went live in December 2018 with the first patients on the system in early 2019. This has enabled a number of people living with dementia and their carers to have fuller participation in their care. - **Analytics Capability -** A GP Intelligence Platform (GPIP) is being developed to routinely capture data from GPs with the potential to link data at patient/client level with data from other hospital and community information systems, creating virtual population registries. An analytics team is being recruited to develop and utilise the platform. - **Dementia data analytics research:** QUB have been commissioned to undertake work across 14 areas of research (early results shared with project board in September 2018). Through the data analytics research and projects, all involved in delivery of dementia care, people with dementia and their carers have gained new insights and knowledge including prevalence of dementia in NI, mortality rates, data on diagnosis, carers experience and patient journey along the dementia care pathway A Dementia Analytics Research User Group (DARUG) has been formed to tie together work on research, commissioning of data analytics projects and

Persons with and without a disability cont.	GPIP. To-date a total of 17 dementia data analytics projects have been awarded including data analytics projects in relation to people with learning disability and dementia. - **Key Information Summary (KIS):** funding to incentivise GPs to complete KIS for dementia patients which are then flagged on the NI Electronic Care Record system. In phase one, 141/152 practices have signed up to participate. - **Training:** funding for multi-disciplinary dementia training through the Extension for Community Healthcare Outcomes (ECHO) initiative. - **App development:** A dementia apps library has been commissioned, comprising of dementia apps that have been assessed, enabling healthcare professionals to refer people with dementia and/or their carers to specific apps. User engagement in relation to the use of dementia-specific apps is underway. • In 2018-19, the Centre for Connected Health have also provided eHealth input on the EU Horizon 2020 Pre-commercial Procurement MAGIC project to develop digital tools to support post stroke rehabilitation; as well as a number of other SBRI projects.
Persons with and without dependants	**Health and Wellbeing Improvement** • The Public Health Agency (PHA) currently commission a wide range of drug and alcohol services focused on meeting the drug and alcohol needs of children, young people, adults and families / carers across Northern Ireland, alongside the voluntary, community and statutory sectors. In addition, this also includes Adult Step 2 treatment services including psychotherapeutic interventions (talking therapies) to adults with substance misuse difficulties/problems. These services will also provide support to family members affected by someone else's substance misuse. (Please see the category of 'age' for further information on a range of these that have particular relevance for dependants) • **Workplace Health and well-being**: The PHA commissioned workplace health service employers to identify and address the health and wellbeing needs of their workers. In March 2019, the third booklet in a series of Work Well guides aimed at promoting health in the workplace was issued. It outlines to employers the business benefits of encouraging **mothers to continue breastfeeding** on

Persons with and without dependants cont.	return to work, the health benefits of breastfeeding for mums, the legislation affecting mothers at work, and some easy steps that employers can take to support breastfeeding mothers. • The Northern Obesity Partnership in partnership with the Public Health Agency, local councils and the Northern Health and Social Care Trust Midwifery Department, recently launched a **new Active Pregnancy programme** aimed at encouraging expectant mums to get active and stay active. The Active Pregnancy initiative aims to promote the health benefits of maintaining physical activity during pregnancy and also raise awareness of suitable activities which are available for women in their local areas through SureStart programmes and local leisure services including, leisure centres, outdoor gyms and local parks. **Research and Development** 'Cancer Caring Coping' is a new online resource created by cancer caregivers for cancer caregivers. It is based on research suggesting that cancer caregivers have poorer health compared to caregivers of other chronic conditions. The project, led by Queen's University Belfast and funded by HSC R&D Division Public Health Agency**,** is a partnership between Belfast Health and Social Care Trust and The Northern Health and Social Care Trust, as well as involvement from the Men's Health Forum in Ireland and Charis Cancer Care. The aim of this new Cancer Caring Coping website is to give carers their own voice, using carers' words and experiences. The website has been designed to provide a wide range of relevant, supportive and up to date information for carers to ensure they receive the right information and support to care for their loved ones effectively and safely. **Nursing and Allied Health Professionals** • A number of **different leaflets aimed at parents or carers of young children** were developed and/ or reviewed by speech and language therapists in the PHA alongside colleagues from other

Persons with and without dependants cont.	organisations. These included: - *Advice about Dummies*, which aimed to give parents or guardians of young children advice on managing their child's use of the dummy so that it doesn't affect his or her speech. - Healthy Child, Healthy Future is designed to reinforce a collaborative approach between speech and language therapists, referrers and parents in the identification and management of children with developmental speech and language and communication needs (including children with feeding and/or swallowing difficulties). It includes a comprehensive key skills section, which provides details on the communication-related skills a child should have acquired at each stage in his/her early years development. It also includes advice on communication and child play; speech sound development; dummies; stammering; dysphonia; bilingualism; and feeding and swallowing difficulties. • 10000 More Voices surveys for both staff and service user collect data in relation to disability, long term chronic conditions and rare diseases. In total, 14,562 stories were analysed in relation to disability and rare diseases. The analysis for rare diseases has been shared with the Northern Ireland Rare Disease Partnership (NIRDP) and has informed a project focusing upon the carer of children with rare diseases. **Operations** A wide range of communications including PR, Social media and publications have been produced and disseminated over the course of the year covering a variety of topics aimed at helping parents and carers recognise and manage issues relating to the health and wellbeing of children and young people. This has included the following: - The revised NI Birth to 5 and Pregnancy books which are distributed to all expectant new mums; - The Living Well section on NI Direct has been updated to include a range of new topics and - A new communication programme on safe sleeping for parents of young babies has been communicated via Media interviews, posters and leaflets disseminated to appropriate

Persons with and without dependants cont.	audiences/locations and targeted social media messaging including videos. **Centre for Connected Health** • **Dementia data analytics research:** QUB have been commissioned to undertake work across 14 areas of research (early results shared with project board in September 2018) which includes research about dementia carers. Similarly of the 17 awarded dementia data analytics projects there are a number in relation to carers of people living with dementia. • **App development:** A dementia apps library has been commissioned, comprising of dementia apps that have been assessed, enabling healthcare professionals to refer people with dementia and/or their carers to specific apps. User engagement in relation to the use of dementia-specific apps is underway.

(ECNI Q4,5,6)

2. During the 2018-19 reporting period

(a) were the Section 75 statutory duties integrated within…?

	Yes/No	Details
Job descriptions	**Yes**	Since December 2017, Section 75 is mentioned in all new job descriptions.
Performance objectives for staff	**No**	In order to ensure that staff fulfil Section 75 duties in relation to screening and EQIAs, these have been integrated into PHA business processes. This includes, for example, a check box on the coversheet for all papers going to the PHA Agency Management Team, which requires the author to give assurance that an equality assessment has been undertaken, where relevant.

(b) were objectives and targets relating to Section 75 integrated into…?

	Yes/No	Details
Corporate/strategic plans	**Yes**	The PHA Corporate Plan 2017-2021 includes five key outcomes. Two of these relate directly to Section 75 groups: All children and young people have the best start in life: Associated actions include, for example: Implement a range of interventions and programmes that support parents and carers to provide a safe and nurturing home environment, and address issues that adversely impact on

		children and young people. 1. All older adults are enabled to live healthier and more fulfilling lives Associated actions include, for example: Promote inclusive, intergenerational physical and mental health messages and initiatives that enable longer, healthier and more fulfilling lives
Annual business plans	Yes	In the PHA Business Plan for 2018-19 a range of objectives directly related to promoting equality and good relations for Section 75 groups were included. These actions specifically targeted: - the needs of people of different ages (e.g. implementing an Infant Mental Health Plan); - those with disabilities (e.g. implementation and evaluation of the Hospital Passport scheme for people with a learning disability); - carers (e.g. commissioning and monitoring uptake of stop smoking services specifically for pregnant smokers); - people from different community backgrounds and ethnicities (e.g. develop and implement a regional arts programme to enhance the wellbeing and quality of life of older people across Northern Ireland); - actions to meet the needs of people of a specific gender (e.g. Prepare for introduction of primary screening with Human Papillomavirus Virus (HPV) testing within the Cervical Screening Programme).

(ECNI Q11,12,17)

3. Please provide any details and examples of good practice in consultation during the 2018-19 reporting period, on matters relevant (e.g. the development of a policy that has been screened in) to the need to promote equality of opportunity and/or the desirability of promoting good relations:

Please see Table 2 below.

Table 2

Policy publicly consulted on	What equality document did you issue alongside the policy consultation document?	Which Section 75 groups did you consult with?	What consultation methods did you use? AND Which of these drew the greatest number of responses from consultees?	Do you have any comments on your experience of this consultation?
Diabetic Retinopathy Screening Programme Public Consultation on the Way the Service is Provided	☐ Screening template ☒ EQIA report ☐ none	Full 12week public consultation with all key stakeholders, including service users	Public Notice Press Release Letter regarding launch of consultation process and how to respond from DPH to all relevant stakeholders including all GP practices PHA social media posts shared by partner organisations also DUK/RNIB/QUB/BHSCT Public health lead, clinical lead and service user rep interviewed by local TV	Interest in panel days was low, however we found the Citizen Space site and use of a bespoke summary booklet aimed at service users very useful.

Policy publicly consulted on	What equality document did you issue alongside the policy consultation document?	Which Section 75 groups did you consult with?	What consultation methods did you use? AND Which of these drew the greatest number of responses from consultees?	Do you have any comments on your experience of this consultation?
			channel NVTV Information Panel Days (advertised in public notice also) – offered members of public/any other interested stakeholders an opportunity to book a 30 min appointment to discuss the consultation with a small panel of members from the project team Citizen Space- online hub with all relevant documents and questionnaire for response Summary booklet produced and distributed at screening clinics Booklet also distributed via DUK(NI) user groups and circulation lists Public health lead attendance at LCGs as requested	

Policy publicly consulted on	What equality document did you issue alongside the policy consultation document?	Which Section 75 groups did you consult with?	What consultation methods did you use? AND Which of these drew the greatest number of responses from consultees?	Do you have any comments on your experience of this consultation?
			Public health lead attendance at information meeting for DESP service staff PCC Blog article 80% of respondents to questionnaire were service users, their families/carers, 50% had heard about the consultation at their appointment i.e. via the summary booklet with the next most popular 'social media' at 15%.	
Patient Portal	☐ Screening template ☐ EQIA report ☒ none	Patient and carer advocacy groups (e.g. Alzheimer's Society, DementiaNI, Carers NI)	Engagement to understand users' requirements. A survey was used to carry out evaluation of pilot activity. Methods included telephone, face to face and email.	Regular contact with patient groups and their active involvement within project teams has enabled smoother implementation of the pilot.

(ECNI Q21, 26)

4. In analysing monitoring information gathered, was any action taken to change/review any policies?

Yes - please see Table 3 below for further information.

Table 3

Service or Policy	What equality monitoring information did you collect and analyse?	What action did you take as a result of this analysis? AND Did you make any changes to the service or policy as a result?	What difference did this make for Section 75 groups?
Health Improvement: Alcohol and Drugs services	Information continues to be gathered from commissioned / procured services using the regional Impact Measurement Tools (IMT), quarterly performance monitoring reports and annual evaluation reports. The PHA's Performance Monitoring Reports (PMRs), which are completed by service providers on a quarterly basis, require providers to document the accessibility of their services and provide details of any	The IMT, quarterly performance monitoring reports and annual evaluation reports aid good practice and identifying services to meet the needs of section 75 groups – specific actions included development of Portuguese, Lithuanian, Polish and Russian translations of information materials in regards to the PHA's Take Home Naloxone programme were also developed in	Increased understanding of and accessibly to drug and alcohol services.

Service or Policy	What equality monitoring information did you collect and analyse?	What action did you take as a result of this analysis? AND Did you make any changes to the service or policy as a result?	What difference did this make for Section 75 groups?
	actions taken to address any barriers to client engagement. Service Providers are also required to document 'trends of note', e.g. increased use of services by a particular group. The annual report submitted to the PHA by service providers also requires them to submit a summary of their Service User Profile for the year. The Regional Impact Measurement Tool, which is administered by the Public Health Information and Research Branch within the Department of Health, collects information on clients using PHA-funded substance misuse services. This tool collects information on the gender, ethnicity, country of birth, number of dependents, religion, sexual	2018/19.	

Service or Policy	What equality monitoring information did you collect and analyse?	What action did you take as a result of this analysis? AND Did you make any changes to the service or policy as a result?	What difference did this make for Section 75 groups?
	identity, marital status, employment status and long-term medical conditions of service users. This information is analysed by the Public Health Information & Research Branch of the Department of Health and provided to the PHA in the form of an annual report. A further report for 2018/19 is due to be published in October 2019.		
Antenatal Screening Patient information leaflets for rubella susceptible women in pregnancy	Information was gathered from NIMATS on the languages recorded as being the language spoken, at the woman's booking visit. This provided evidence of the most common languages spoken by pregnant women accessing services.	This analysis was then used to decide what languages we needed to translate our rubella patient leaflets into.	Rubella in pregnancy leaflets are now available translated into the top 13 languages spoken by pregnant women booking for maternity care in N.Ireland.
Cervical Screening	Coverage rates by age group. We monitored trends in the proportion	We worked with key voluntary groups and patient	Improved awareness among women aged 25-29 with an

Service or Policy	What equality monitoring information did you collect and analyse?	What action did you take as a result of this analysis? AND Did you make any changes to the service or policy as a result?	What difference did this make for Section 75 groups?
	of the eligible population in each 5 year age band who had a cervical screening test in the last 3/5 years. The analysis showed that coverage rates among younger women (aged 25-29) have decreased over the last 5 years.	representatives to develop and deliver a social media campaign aimed at this age group to raise awareness and promote participation in the screening programme. AND We did not make any changes to the service itself.	anticipated increase in attendance for screening, reducing their risk of future cervical cancer.
Cancer Screening	Ongoing monitoring of uptake and coverage rates of the three cancer screening programmes (breast, cervical and bowel), with age and geographical profiles. Additional big data analysis undertaken of breast screening uptake rates by deprivation indices.	Ongoing commissioned contract with Women's Resource and Development Agency to promote informed choice in cancer screening through community based peer led education sessions. By using the data obtained, this service is directed at the	Access to appropriate information for all groups, all groups facilitated to make informed decisions about participation in cancer screening programmes.

Service or Policy	What equality monitoring information did you collect and analyse?	What action did you take as a result of this analysis? AND Did you make any changes to the service or policy as a result?	What difference did this make for Section 75 groups?
		areas and population groups of greatest need, where uptake rates are shown to be lowest.	
<u>Service Development</u> Social media campaign for supported pain management	We monitored social media activity resulting from content developed for particular patient groups. It became apparent that young and middle aged men in particular did not engage as well with content designed for them as did women.	We are supporting pain forum members in developing inclusive sport opportunities, which appear to be more popular with this demographic than online content. We are seeking funding to explore further how the needs of different patient groups can be successfully addressed and met through social media and other sources of information	To be evaluated during 2019/20

Service or Policy	What equality monitoring information did you collect and analyse?	What action did you take as a result of this analysis? AND Did you make any changes to the service or policy as a result?	What difference did this make for Section 75 groups?
		and support.	
Patient Client Experience	10000 More Voices surveys for both staff and service user collect data in relation to disability, long term chronic conditions and rare diseases. 14,562 stories were analysed in relation to disability and rare diseases.	This analysis has informed the work plan for 2019/2020 for 10,000 More Voices with reference to the Physical Sensory strategy The analysis for rare diseases has been shared with the Northern Ireland Rare Diseases Partnership (NIRDP) and has informed a project focusing upon the carer of children with rare diseases.	This will support the service user perspective from Section 75 to be included in service improvement plans and inform strategic plans

(ECNI Q22)

5. Please provide any details or examples of where the monitoring of policies, during the 2017-18 reporting period, has shown changes to differential/adverse impacts previously assessed:

Yes - please see Table 4 below for further information.

Table 4

Policy previously screened or EQIAed	Did you gather and analyse any equality monitoring information during 2017-18? (Please tick)	What were the adverse impacts at the point of screening or EQIA?	What changes to these occurred in 2017-18, as indicated by the equality monitoring data you gathered?
Retendering of the Youth Engagement Service (formerly known as One Stop Shops)	☒ Yes ☐ No	No adverse impacts were identified. It was noted that the gender mix of service users was 55% male and 45% female	Monitoring for these services was standardised to ensure that the PHA can continue to monitor the gender mix of service users.
HSC R&D Strategy	☒ Yes ☐ No	Events and panels did not include a broad range of people from different demographic groups.	Invites to event launches (including CHITIN Launch) have targeted service user and carer groups in relation to the topics being disseminated and summaries of research findings have been produced in lay language. Analysis of results collected at a recent launch of findings from a dementia research programme and

			CHITIN project launch still shows that relatively few people with a disability attended or carers. In addition, it has been found that some people are reluctant to complete the screening questionnaire. In particular ROI attendees were unaccustomed to returning such a document at such an event. Non ROI/UK nationals expressed concern that the document could lead to them being identifiable. We will review the construct of the form before applying at other related events
Diabetic Retinopathy Screening Programme	☒ Yes ☐ No	Low uptake by people from black and minority ethnic backgrounds	After producing leaflets in different languages and working with community groups to do presentations on diabetic retinopathy screening the data shows an increase in uptake by people from black and minority ethnic backgrounds.

(ECNI Q25)

6. Please provide any examples of relevant training shown to have worked well, in that participants have achieved the necessary skills and knowledge to achieve the stated objectives:

The PHA avails of the joint Section 75 training programme that is coordinated and delivered by the BSO Equality Unit for staff across all 11 partner organisations. In total, 19 staff participated in either screening training or EQIA training.

- **Screening Training evaluation (15 participants):** Each participant is asked to complete a short evaluation form when their Screening Training is completed. In 2018-19, the majority of participants felt the aims of the training were achieved either 'Very Well' or 'Well'. These four aims focused on improving participants' understanding and skills in equality screening. These are listed below, alongside the proportion of participants who felt each aim was met 'Very Well' or 'Well'.

1. To develop an understanding of the statutory requirements for screening: **95%;**
2. To develop an understanding of the benefits of screening: **100%**;
3. To develop an understanding of the screening process: **95%**;
4. To develop skills in practically carrying out screening: **90%**.
5. When asked, "How valuable was the course to you personally?" **95%** felt the course was either 'Extremely Valuable' or 'Valuable'.

- **Equality Impact Assessment (EQIA) Training evaluation (4 participants):** As the numbers of participants who participate in the EQIA training each year from each organisation are small , the following statistics relate to all participants from all partner organisations who completed the EQIA Training during the year.

Following the training, participants were asked: “Overall how well do you think you have achieved the following learning outcomes?” The majority of participants felt that each of the four learning outcomes were achieved either ‘Very well’ or ‘Well’:

1. To demonstrate an understanding of what the law says on EQIAs: **100%;**
2. To demonstrate an understanding of the EQIA process **100%**;
3. To demonstrate an understanding of the benefits of EQIAs **100%**;
4. To develop skills in practically carrying out EQIAs **100%**.

- **Making A Difference e-learning**

In total, 32 (10 in 2018-19) PHA staff have now completed ‘Making A Difference’ e-learning. This e-learning package on equality awareness now forms part of mandatory training for all staff in our organisation. The aim of ‘Making A Difference’ is to show how staff can make a difference to the culture of their organisation by:

- Promoting positive attitudes to diversity
- Ensuring everyone is treated with respect and dignity
- Behaving in a way that is in keeping with HSC values and equality and human rights law.

(ECNI Q29)

7. **Are there areas of the Equality Scheme arrangements (screening/consultation/training) your organisation anticipates will be focused upon in the next reporting period?**

We anticipate the following areas to be focused upon:

- Equality staff training
- equality screenings and their timely publication
- progression of EQIAs

- monitoring, including of policies screened
- engagement with Section 75 groups as part of pre-consultation exercises and collection of equality information by this means.

Appendix – Further Explanatory Notes

1 Consultation and Engagement

(ECNI Q10)
targeting – During the year, where relevant, we took a targeted approach to consultation in addition to issuing an initial notification of consultation. Moreover, we engaged with targeted groups as part of our work preceding formal consultations, as for instance, in the case of the Diabetic Retinopathy Screening Programme.mThis is to inform our consultation documents.

(ECNI Q13)
awareness raising for consultees on Equality Scheme commitments – During the year, in our quarterly screening reports we raised awareness as to our commitments relating to equality screenings and their publication. In any EQIA reports we explained our commitments relating to Equality Impact Assessments. We did the same when we held consultation events, such as in relation to our Equality Action Plan, and in the action plan document itself.

(ECNI Q14)
consultation list – During the year, we reviewed our consultation list every quarter.

2 Audit of Information Systems

(ECNI Q20)
We completed an audit of information systems at an early stage of our Equality Scheme implementation, in line with our Scheme commitments.

[i] This includes as a result of

- screening / Equality Impact Assessments (EQIAs)
- monitoring
- staff training
- engagement and consultation
- improvements in access to information and services
- implementation of Equality and Disability Action Plans.

Equality Action Plan 2013 – 2019
Report on the progress we made during 2018-19

June 2019

Chapter 3: PHA Equality Action Plan Progress Report 2018-19

This document summarises progress made during 2018-19 against the actions we identified in our Equality Action Plan. The plan covers the period 2013-19 and is available on our website: http://www.publichealth.hscni.net/directorate-operations/planning-and-corporate-services/equality

Any request for this document in another format or language will be considered.

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Theme 1: Portraying Diversity

Theme 2: Cancer Screening (Service Development and Screening)

Theme 3: Childhood Immunisation (Health Protection)

Theme 4: Migrants (Health and Social Well-Being Improvement)

Theme 5: Lesbian, Gay, Bisexual and Transgender (Health and Social Well-Being Improvement)

Theme 6: Personal and Public Involvement

Theme 7: PHA as an Employer

Theme 8: Board Composition

The PHA Equality Action Plan 2013-2019

Theme 1: Portraying Diversity Link to Corporate Plan: '3. All individuals and communities are equipped and enabled to live long healthy lives'	**Key inequalities and opportunities to promote equality and good relations:** • opportunity to ensure that images we use in information resources portray diversity			
Action Point	**Intended Outcome**	**Performance Indicator and Target**	**By Whom**	**When**
1. Monitor and review resources for positive images of equalities communities	Positive images promote inclusion and recognise equality and diversity of the equalities communities we work with	Images reflect diversity Feature in CONNECT to raise awareness of need to be inclusive with images	Public and Professional Information Manager	end Mar 2019
What we did this year In 2018-19, there was a further reprint of the HSC hospital passport for people with a learning disability in contact with hospitals. This uses photos under licence from Photo symbols to ensure images reflect diversity. We also developed pop-up stands for extending awareness of the hospital passport to both staff and patients in HSCT settings. The interactive online version of a regional HSC Hospital Passport for people with learning disability in contact with hospital used licensed photos from Photo Symbols to produce the document. **ONGOING**				

Theme 2: Cancer Screening Link to Corporate Plan: '3. All individuals and communities are equipped and enabled to live long healthy lives'	**Key inequalities and opportunities to promote equality and good relations:** **BME Groups** - There are a number of factors that can influence participation by some BME groups in cancer screening, including: • Divergence in perceptions held by screening staff and migrant ethnic groups regarding cancer screening. • Suspicion of authority. • The degree of knowledge about screening. • The type of health care in individuals' native countries, i.e. no experience of these types of programmes. • Lack of access to primary care. **Learning Difficulties** - Cancer screening uptake is lower amongst the population of people with learning difficulties than among those in the general population. Barriers to accessing cancer screening include: • communication issues, including literacy problems; • consent issues; • physical health; • inability to undergo screening due to physical limitations **LGB&T** - Lesbian women are less likely to participate in preventive health care, including breast and cervical cancer screening than heterosexual women. There is an assumption that

	they do not need to undertake cervical screening. Transgender people need to have access to relevant and up to date information on accessing gender-specific health screening programmes. **Physical and Sensory Disability -** A key issue affecting those with sensory and/or physical disabilities is the availability of accessible information. The bowel cancer screening test kit is completed by individuals at home. Due to the nature of the test (collecting a stool sample) individuals with a physical or sensory disability will have difficulty accessing the screening programme. **Evidence** People from these minority groups may have problems accessing or understanding information about cancer screening and in some cases the methods of screening may create obstacles for some individuals. The PHA does not have data of uptake of cancer screening by individuals from section 75 groups. Our data collection is not specific enough. There is anecdotal evidence that uptake of cancer screening is lower amongst some section 75 groupings.			
Action Point	**Intended Outcome**	**Performance Indicator and Target**	**By Whom**	**When**
2. Monitor delivery of Women's Resource and Development Agency (WRDA) contract	The promotion of informed choice with regards to the cancer screening programmes in section 75 groups	• Number of awareness sessions delivered • Number of promotional events held • Number of Community	WRDA/ QARC	Contract to June 2019

		Facilitators recruited and trained to Level 3 Certificate in Learning and Development		

What we did this year

Progress on targets for 2018-19 was exceeded. Last year, 130 Cancer Screening Educational Awareness sessions were delivered (target 126), 30 Promotional Events attended (target 5). WRDA Contract extended until end March 2020, and targets will remain the same as those in 2019/20.

PHA commissioned an external evaluation, with the evaluation report submitted in December 2018. Evaluation findings were positive. The report states, “the programme was very well received by the participants, community representatives and care staff overall. Fundamentally, the (contracted) programme is achieving its objective to target hard to reach groups and provide information on breast, cervical and bowel cancer so that individuals can make an informed choice about their attendance when invited for screening.”

COMPLETED

Action Point	Intended Outcome	Performance Indicator and Target	By Whom	When
3. New transgender screening leaflet to be adapted for NI from Public Health England and NHS Wales leaflet and to be included within	Transgender people are in a position to make an informed choice about their participation in cancer screening	Leaflet has been produced in collaboration with gender identity groups	QARC	end Mar 2019

Communications schedule				

What we did this year

Transgender leaflet has been drafted based on the PHE and Welsh leaflets. This covered all 3 cancer screening programmes as well as AAA Screening. The AAA programme has been liaising with the Trust to get feedback on their section and are working on revisions to this. Once this has been completed a mock leaflet will be circulated to support groups for feedback before going to print.

ONGOING

Theme 3: Childhood Immunisation Link to Corporate Plan: '1. All children and young people have the best start in life'	**Key inequalities and opportunities to promote equality and good relations:** Whilst childhood immunisation uptake levels are generally very good in Northern Ireland and above the UK average there is variation in uptake. Lower levels occur in some areas of deprivation and also in some groups e.g. the Traveller community and some ethnic minority groups, such as those from the Roma community. There can also be problems with some recent migrants accessing vaccination services. **Evidence** • Vaccination uptake figures and reports from professionals working with affected groups. • NICE Public Health Guidance 21: Reducing differences in uptake of immunisations in children and young people aged under 19 years. This guidance identifies the following groups as being at risk of not being fully immunised: o those who have missed previous vaccinations (whether as a result of parental choice or otherwise) o looked after children o those with physical or learning disabilities o children of teenage or lone parents o those not registered with a GP o younger children from large families o children who are hospitalised or have a chronic illness o those from some minority ethnic groups o those from non-English speaking families o vulnerable children, such as those whose families are travellers, asylum seekers or

	are homeless. • Outbreaks of measles associated with imported cases from Romania across the United Kingdom and Ireland • Department of Health (2017), *the health status of Roma* outlines that: the Roma community often suffer poorer health and unhealthier living conditions compared to majority populations, including living in extended families, being socially isolated, and overcrowding. Roma children are particularly affected by a range of barriers in obtaining health services, with significant differences in child vaccination rates reported			
Action Point	**Intended Outcome**	**Performance Indicator and Target**	**By Whom**	**When**
4. Commission a qualitative study, through the use of focus groups, to establish reasons why the Roma community decline or accept vaccination for themselves and their children.	To gain an understanding of the barriers to vaccination for the Roma community and to explore ways to overcome them, with a focus on measles and the MMR vaccine	• Select provider to deliver qualitative study • Recruit participants for intended focus groups • Carry out focus groups with selection of male and female adults from Roma community • Analyse findings and complete written report • Provide recommendations on development of interventions to improve vaccination uptake	External provider and Health Protection Directorate PHA	End March 2019
What we did this year				

Qualitative research was commissioned by the Health Protection team to better understand the views and experiences of Roma people regarding vaccinations. Work focused on why the Roma community decline or accept vaccination for themselves or their children. Four focus groups (25 people) were carried out with the aim of making recommendations of how to overcome barriers to increase vaccine uptake and in particular uptake of MMR. No evidence was found of deep rooted ethical, cultural / religious barriers for Roma people in relation to getting vaccinated. Recommendations suggested that future interventions focus on exploring solutions to practical barriers to vaccination. Communication was one of the barriers identified, and work has already commenced to address this by developing an animated video about measles and MMR vaccination.

It is proposed that the animated video is launched at a Roma meeting and then shared on social media. It is planned that this video is available with a voice over from a member of the Roma community for those who have sight issues.

COMPLETED

Theme 4: Migrants (relevant to both duties under Section 75) Link to Corporate Plan: ' 3. All individuals and communities are equipped and enabled to live long healthy lives'	**Key inequalities and opportunities to promote equality and good relations:** • For migrants, having little or no English is considered to be one of the most significant barriers to accessing health and social care and other key services. There is a need to improve our knowledge and understanding of the challenges relating to this issue. There is a need for more partnership working among all key stakeholders, in particular with migrant groups; and • for a more co-ordinated approach in addressing migrant health and social wellbeing issues across NI. **Evidence:** • Health and Social Needs among Migrants and Minority Ethnic Communities in the Western area (Jarman, 2009); • Barriers to Health: migrant health and wellbeing in Belfast. A study carried out as part of the EC Healthy and Wealthy Together project (Johnston, Belfast Health Development Unit 2010); • Health Protection Issues Affecting Immigrants – A Literature Review (Veal and Johnston 2010 unpublished). • Poverty and ethnicity: key messages for NI (Joseph Rowntree Foundation, 2016)			
Action Point	**Intended Outcome**	**Performance Indicator and Target**	**By Whom**	**When**
5. Review delivery of the Northern Ireland New Entrant Service (NINES) to	Action taken to address the gaps in service identified by the evaluation with particular reference to	NINES will continue to offer holistic services to new entrants, including families	Belfast Trust and Southern	end Mar

reflect the findings of the service evaluation undertaken in 2017	immunisation and mental health issues.	and children.	HSC Trust working with PHA and HSCB	2019

What we did this year

The service objectives for BHSCT-based NINES were reviewed to reflect the 2017 evaluation findings. All adults and children have their vaccination history documented and are offered vaccination opportunistically, especially MMR if incomplete. A care pathway for mental health is one of a number of care pathways under review and awaiting BHSCT quality assurance and approval.

COMPLETED

Action Point	Intended Outcome	Performance Indicator and Target	By Whom	When
6. Through partnership working across the sectors explore how best to support improved access to English classes.	Improved knowledge and understanding of the issues and challenges relating to accessing English classes in NI including examples of good practice to help inform future action.	Action plan developed to implement the recommendations of the 2017 report on Partnership Approaches to Improving Access to English Classes	Cross – sectoral task and finish sub group of the Regional ME Steering Group	end Mar 2019

What we did this year

Work is ongoing to build links across sectors in order to advocate for a NI wide strategic approach to improving access to

English classes.

ONGOING

Action Point	Intended Outcome	Performance Indicator and Target	By Whom	When
7. Undertake stakeholder consultation and other preparations for procurement of the Stronger Together Regional Minority Ethnic Health and Social Wellbeing Network for sharing of information, good practice and capacity building	Improved co-ordination between agencies, in meeting the health and social wellbeing needs of minority ethnic communities.	Enhanced network established with members comprising stakeholders and network users from across HSC and ethnic minority groups across Northern Ireland.	To be commissioned	end July 2019

What we did this year

Stakeholder engagement has commenced across all the main localities where there are ethnic minority and migrant communities.

ONGOING

Action Point	Intended Outcome	Performance Indicator and Target	By Whom	When

8. Evaluation of the regional pilot programme to promote mental and emotional wellbeing for ethnic minority communities in NI	Increased knowledge of effective approaches relating to promoting minority ethnic mental health and emotional wellbeing.	Evaluation report produced including recommendations for future service delivery	South Tyrone Empowerment Programme (STEP)	end Mar 2019
What we did this year The pilot programme has been extended in line with the procurement timeframe. The evaluation is now due in November 2019. **ONGOING**				
Action Point	**Intended Outcome**	**Performance Indicator and Target**	**By Whom**	**When**
9. Continue to work with key agencies and organisations across the sectors to review, develop and implement an annual regional action plan to address minority ethnic health and social wellbeing issues	Co-ordinated, cross-sectoral action undertaken to address identified minority ethnic health and social wellbeing needs	Annual Action plan developed and being implemented	Regional ME Steering Group	Annually by end Mar 2019

What we did this year

The development of the 2019- 2020 action plan is underway and will be finalised by the end of June 2019.

ONGOING

Theme 5: Lesbian, Gay, Bisexual and Transgender Link to Corporate Plan: ' 3. All individuals and communities are equipped and enabled to live long healthy lives'	**Key inequalities and opportunities to promote equality and good relations:** Employment generally • atmosphere and culture of discrimination, exclusion, homophobia and heterosexism (language, jokes, comments, graffiti) • lack of confidence in reporting and disciplinary procedures • lack of visibility of LGB&T people in the health and social care workplace Services • research in England on LGB&T experience of healthcare suggests numerous barriers including homophobia and heterosexism, misunderstandings and lack of knowledge, lack of appropriate protocols, poor adherence to confidentiality and the absence of LGB&T -friendly resources • LGB&T people are at significantly higher risk of mental disorder, suicidal ideation, substance misuse, and deliberate self-harm than heterosexual people. Other issues include; access to services and attitudes. Issues regarding Older LGB&T in communal facilities, with concerns around negative responses on the grounds of their sexuality from institutions when life changing events occur for example, loss of independence through hospitalisation, going into residential home or having home carers. Research • To date very little general LGB&T health research has been published in Northern Ireland **Evidence**

	• publications summarised and referenced in: PHA (2011): Health Intelligence Briefing on Lesbian, Gay, Bisexual and Transgender (LGB&T) health related issues HSC (2010): Section 75 Emerging Themes across Health and Social Care. Section 9 • The Rainbow Project (2011) Through Our Eyes: Experiences of Lesbian, Gay and Bisexual People in the Workplace.			
Action Point	**Intended Outcome**	**Performance Indicator and Target**	**By Whom**	**When**
10. eLearning Engage with key stakeholders. Promote e-learning programme.	Increased capacity of staff working across HSC settings to better meet the needs of the LGB&T population.	E-learning programme promoted to staff working across HSC Settings by e-mail and on intranet sites. E-Learning programme used as part of induction programme and ongoing Equality and Diversity Training. Use of programme monitored and feedback from learners used to inform changes. Link to training publicised on dedicated LGB&T website. E-learning programme promoted as part of KSF requirements for all staff.	Hilary Parke/Marianne Ireland Human Resources Hilary Parke with Staff Forum Human Resources	end March 2019

What we did this year

The PHA e-learning programme has been in operation from 2013. To date 482 users have successfully completed the learning content. It aims to educate staff so that they better understand the difference between sexual orientation and gender identity and its equality implications. The programme helps staff to recognise the barriers associated with disclosure of sexual orientation and/or gender identity in the workplace and understand how LGB&T awareness within the workplace can help create a more welcoming, safe and productive work environment.

COMPLETED

Action Point	Intended Outcome	Performance Indicator and Target	By Whom	When
11. HSC staff forum Continue to support the HSC LGB&T Staff Forum. Maintain a dedicated website for the Forum.	LGB&T staff working within HSC organisations feels valued, equal and are empowered to contribute to effect change in the organisation. HSC organisations visibly demonstrate their commitment to promoting equality for LGB&T staff	Promotion of Forum continues through information stalls at HSC locations, posters in workplaces, articles in staff and union bulletins.	Hilary Parke	end Mar 2019

What we did this year

PHA continue to support and maintain a forum for LGB&T HSC staff. The dedicated website for the Forum exists to reduce

stigma and discrimination within the workplace by increasing awareness, understanding and skills and create a safe and open environment for people who are lesbian, gay, bisexual and transgender.

COMPLETED

Action Point	Intended Outcome	Performance Indicator and Target	Whom	When
12. Mental Health and Emotional Wellbeing Commission services to support the mental health and emotional wellbeing needs of Lesbian and Bisexual women, Gay and bisexual men and Transgender individuals and their families.	Individuals who identify as LGB&T will have access to services to help address their mental health and emotional wellbeing needs. Transgender individuals and their families will have access to support. Sexual Orientation and Gender identity training will be available across all HSC localities. Increase awareness, understanding and skills and support developments to reduce stigma and discrimination by increasing public awareness, understanding and skills to create a safe and open environment for people who are lesbian, gay, bisexual and	The Annual Action Plan will include the following:- Rainbow will provide a minimum of 45 interventions to support Gay and Bisexual men across Northern Ireland. Rainbow will provide a minimum of 45 interventions to support Lesbian and Bisexual women across Northern Ireland SAIL will provide a minimum of 45 interventions to support transgender individuals and their families across Northern Ireland	Hilary Parke	end of March 2019

	transgender. Ensure LGB+T individuals have access to services, help and support that will help maintain and improve their health & wellbeing.			

What we did this year

During 2018-19 the PHA commissioned The Rainbow Project, (under contract) to provide a range of services across NI Northern Ireland for LGB clients, including services to support the mental and emotional health needs of Lesbian, Gay, Bi-sexual men and women.

The PHA support services to support the mental and emotional health needs of **Lesbian and Bisexual Women** across Northern Ireland. This included 186 sessions (37.2 per Locality per year) counselling sessions; 26 (5.2 per Locality per year) **i**nterventions; and16 (3.2 per Locality per year) awareness raising programmes.

Services to support the mental and emotional health needs of **Gay and Bisexual Men** across Northern Ireland were also commissioned**.** In 2018-19, a total of 184 counselling sessions (36.8 per Locality); 26 (5.2 per Locality) Interventions and 16 (3.2 per Locality per year) awareness raising programmes were held.

Services to support the mental and emotional health needs of **Transgender individuals and their families** across Northern Ireland included: 90 interventions (18 per Locality per year) and 10 awareness raising sessions (2 per Locality per year).

During 2018-19 both Rainbow and SAIL exceeded on their contractual commitment in the delivery of awareness raising

and interventions sessions **COMPLETED**

<table>
<tr><td>Theme 6: Personal and Public Involvement
Link to Corporate Plan:
‘5. Our organisation works effectively’</td><td colspan="4">Key inequalities and opportunities to promote equality and good relations:
Work to embed the culture of Personal and Public Involvement (PPI) within this, and other HSC organisations. Strategically promote and enhance the concept and culture of personal and public involvement.
Evidence
Research on service user and carer involvement and experience throughout HSC</td></tr>
<tr><th>Action Point</th><th>Intended Outcome</th><th>Performance Indicator and Target</th><th>By Whom</th><th>When</th></tr>
<tr><td>13. Include Section 75 as scoring criteria in the allocation of funds from the Promotion and Advancement of PPI Programme.</td><td>Section 75 groups will have an opportunity to become engaged in PPI activity through PHA funding.</td><td>25% of PPI Projects will involve Section 75 groups.</td><td>PHA PPI Team</td><td>end March 2019</td></tr>
<tr><td colspan="5">What we did this year
The PHA had a very limited funding pot available for 2018/19 small PPI grants, but applicants were advised that they were expected to directly involve people from section 75 groups. The monitoring of these projects will be available in the summer of 2019.
ONGOING</td></tr>
</table>

Action Point	Intended Outcome	Performance Indicator and Target	By Whom	When
14. PHA to review accessibility of information provided on the Engage website.	Ensure that relevant information is available in accessible formats and appropriate formatting and technology is used.	Engage website meets appropriate guidelines for accessible websites.	PHA PPI Team	End Mar 2019
What we did this year The Engage website was developed with input from a diverse range of groups and accessibility was addressed in the design and development of the resource. Working in partnership with people drawn from section 75 groups the colour of the website, font size and layout were adjusted to ensure that it was accessible to a range of users including those with a visual impairment and those that use technology to read documentation for example. **COMPLETED**				

Theme 7: PHA as an employer Link to Corporate Plan: '5. Our organisation works effectively'	**Key inequalities and opportunities to promote equality and good relations:** • need to raise the capacity of our staff to play a positive role in implementing the gender identity and expression employment policy effectively • possibly opportunity to better promote equality for carers and older staff in relation to their information needs • opportunity to strengthen the capacity of line managers to meet the needs of their staff • lack of comprehensive staff equality data **Evidence** • feedback from engagement and consultation on the gender identity and expression employment policy • feedback from staff; submission from Older People's Advocate			
Action Point	**Intended Outcome**	**Performance Indicator and Target**	**By Whom**	**When**
15. **Gender Identity** Roll out the Gender Identity and Expression Employment Policy	Staff who identify as transgender and non-binary feel more supported in the workplace	Training Plan developed Records of awareness raising initiatives delivered	Operations & Human Resources	end Mar 2019
What we did this year Task and Finish group met throughout 2018-19. The work this year focused on developing checklists for line managers and HR for key aspects of the transition, including handling of information records in relation to transgender and non-binary staff.				

Work has also included an assessment of the awareness and training needs of staff. A training needs matrix and plan has been developed for different staff groups, and main training providers identified (eLearning, e.g. Making A Difference/ PHA's LGB&T Creating Inclusive Workplaces eLearning, as well as face to face training).

ONGOING

Action Point	Intended Outcome	Performance Indicator and Target	By Whom	When
16. **Carers** Provide information for staff on available policies and measures that might meet their needs; including sign-posting to relevant support organisations.	Staff who are carers feel more supported in the workplace	Information leaflets are provided	Operations & Human Resources	end Mar 2019

What we did this year

To date, the Equality Unit, alongside members of our Disability Staff Network, and colleagues from within BSO and other HSC organisations, have developed a leaflet to provide information to staff who are carers. This leaflet highlights the policies and support offered by HSC Regional Organisations, and also signposts staff to different local sources of help in each HSC Trust area. Details are also provided on counselling and advice services. The leaflet will be included in the Tapestry website, and forwarded to staff through a series of corporate communications.
A regional HSC staff survey and interviews are also planned to explore and highlight different issues for carers within the forthcoming year.

ONGOING

Action Point	Intended Outcome	Performance Indicator and Target	By Whom	When
17. Older people Link in with regional work on NHS "Working Longer" initiative Engage with staff to find out about support needs for working on beyond previous retirement age and suggestions for additional support	PHA staff are in a position to make informed choices in relation to working beyond previous retirement age Older staff who are choosing to work on are supported	Engagement has taken place	Operations & Human Resources	end Mar 2019
What we did this year On our behalf, the Business Services Organisation have participated in a regional working group convened by the Department of Health. The HSC Working Longer Group has made resources available which should help organisations to understand and address the challenges and opportunities which working longer will bring. One of these is a Age Awareness Toolkit. This toolkit is designed to help HSC organisations work in partnership with trade union colleagues, and to create organisational awareness of the opportunities and challenges associated with an ageing workforce. This includes different methods and approaches for engaging with staff. **ONGOING**				

Action Point	Intended Outcome	Performance Indicator and Target	By Whom	When
18. **Meeting section 75-related needs of staff** Work with BSO and partner organisations to develop a line manager guide on reasonable adjustments for staff from a range of Section 75 groups	Increased capacity of line managers to identify and respond to the range of Section 75 needs of their staff Staff feel that their needs are being met	Resource produced	Human Resources	end Mar 2019
What we did this year A resource for line managers has been developed. This resource aims to see increased capacity of line managers to identify and respond to the range of Section 75 (equality and good relations) needs of their staff through access to guidance materials. It provides practical advice on issues which can arise in the workplace and how line managers can best deal with them. This includes information on the needs of different groups, for example these of different religions for time of prayer, socialising etc. **ONGOING**				
Action Point	**Intended Outcome**	**Performance Indicator and Target**	**By Whom**	**When**
19. **Section 75 monitoring** Monitor completion figures	Robust data is in place to allow assessment of impacts and developing targeted	Quarterly downloads completed prompts issued to staff	Human Resources	end Mar 2019

Encourage staff to complete equality data section on HR system via self-service	actions			

What we did this year

Staff completion of Section 75 monitoring data has been impeded by an on-going issue with HRPTS. This action has not been completed and will be carried forward into next year.

OUTSTANDING

Theme 8: Board composition Link to Corporate Plan: '5. Our organisation works effectively'	**Key inequalities and opportunities to promote equality and good relations:** • lack of comprehensive data on the Section 75 profile of members of HSC boards; indications that some groups are under-represented (including ethnic minorities, younger people, people with a disability) **Evidence** • no robust information available; submission from Older People's Advocate			
Action Point	**Intended Outcome**	**Performance Indicator and Target**	**By Whom**	**By When**
20. Approach Office for Public Appointments or Public Appointments Unit to welcome thoughts on the matter and seek advice on how greater diversity can be achieved	The Agency uses its influence to promote diversity	Engagement undertaken	Operations	end Mar 2019
What we did this year A series of meetings aiming to improve diversity on public boards have been held throughout the year with representatives from the Office of the Commissioner for Public Appointments, Disability Action, the NI Boardroom Apprentice scheme, HSC regional organisations, and the Disability Champions Network. A key element of this work was to look at the role the HSC organisations could play in increasing diversity in public appointments. It was agreed that the Disability Champions Network and regional HSC organisations should: (a) use their position to draw attention to the lack of Board diversity; (b) try to influence other HSC Boards to adopt mechanisms to increase diversity, and (c) seek to influence review of the public				

appointments process.

COMPLETED

Conclusions

During 2018-19:

- We completed 8 actions (Numbers 2, 4, 5, 10, 11, 12, 14, and 20).
- We still have some work to do to complete 11 actions (Numbers 1, 3, 6, 7, 8, 9, 13, 15, 16, 17, and 18).
- We still have to start 1 action (Number 19).
- All of the actions in our action plan are at regional and at local level.

Disability Action Plan 2013-2019

Public Health Agency (PHA)

What we did between April 2018 and March 2019

If you need this document in another format please get in touch with us. Our contact details are at the back of this document.

You can find our Disability Action Plan on our website: http://www.publichealth.hscni.net/directorate-operations/planning-and-corporate-services/equality

Chapter 4: PHA Disability Action Plan Progress Report 2018-19

What we will do to promote positive attitudes towards disabled people and encourage the participation of disabled people in public life

(1) Awareness Raising and Training

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
1. Encourage staff to declare that they have a disability or care for a person with a disability through awareness raising and provide guidance to staff on the importance of monitoring.	More accurate data in place. Greater number of staff feel comfortable declaring they have a disability.	Increase in completion of disability monitoring information by staff to 90%	PHA end Mar 2019
What we did last year Similar to previous years, at the end of March 2019, 1% of our staff had declared on our HR IT (HRPTS) system that they have a disability. Almost 34% of staff hadn't said whether or not they have a disability. At each of our disability awareness days we encourage staff who have a disability to declare this, so that we can put in place any reasonable adjustments they may need and so they can avail of the support available. However, staff completion of disability monitoring data has been impeded by an on-going issue with HRPTS. **ONGOING**			
2. Raise awareness of specific barriers faced by people	Increased staff awareness of the range of disabilities and needs	Two annual Awareness Days profiled in collaboration with	PHA end Mar

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
with disabilities including through linking in with National Awareness Days or Weeks (such as Mind your Health Day).		voluntary sector groups. Features run on Connect (PHA intranet). >50% of staff participating in the evaluation indicate that they know more about people living with disabilities as a result of the awareness days.	2019

What we did last year

This year we held two Disability Awareness Days – one in September 2018 focusing on Multiple Sclerosis (MS), and a second day in February 2019 focusing on Autism. These Awareness Days were highlighted in a series of corporate communications to staff and were also publicised in our newsletter. Staff were also emailed with information about MS and autism, as well as details of speakers and information stands in different HSC organisations. Staff also received an electronic version of the Disability Insight bulletin, which highlights different ways staff can support colleagues with the disability, and signposts staff to further sources of support and information.

The Disability Awareness Days were evaluated using a staff survey issued to all regional HSC organisations. Evaluation results suggest that the HSC Awareness Days do improve staff knowledge about disabilities: 84% of those who were aware of the MS Day said that it had improved their knowledge of the condition and 67% of staff now know more about autism.

Chapter 4: PHA Disability Action Plan Progress Report 2018-19

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
COMPLETED			
3. **Mental Health and Learning Disability:** Increase awareness amongst staff in general hospital settings of the Regional Hospital Passport and the need to make reasonable adjustments for people with Learning Disability	Increased awareness amongst staff in general hospital settings of the needs of people with Learning disability. People with learning disability using general hospital settings will be empowered and less dependent on their family/carers.	Awareness raising materials and correspondence circulated to staff	Assistant Director of Nursing, Safety Quality and Patient Experience end Mar 2019
What we did last year The HSC Hospital Passport has been developed by the PHA and the Regional General Hospital Forum for Learning Disability for people with a learning disability to complete (with or without help). It can then be presented every time the individual has contact with a general hospital, and gives hospital staff important information on the person and how they prefer to communicate, their medical history and any support they might need while in hospital. Staff can then make any reasonable adjustments in order to provide the best possible care for people with a learning disability. In 2018-19 there was ongoing awareness-raising and promotion of the Regional Hospital Passport within General Hospitals with support provided by ARC NI's Telling It Like It Is (TILII) Group who have been facilitating Pop Up			

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
promotional events throughout each Trust. Phase one evaluation of the Regional Hospital Passport has been completed this year and Phase Two evaluation is currently underway. **COMPLETED**			
4. In collaboration with disabled people design, deliver and evaluate training for staff and Board Members on disability equality and disability legislation. **Health Protection:** Invite speaker from external organisation (e.g. Disability Action, Mental Health Charity or RNIB) to attend Health Protection staff meeting.	Increased staff and Board Member awareness of the range of disabilities and needs.	All staff trained (general and bespoke) within 2 years through eLearning or interactive sessions and staff awareness initiatives delivered Training evaluation forms Meeting minutes	PHA end Mar 2019 Assistant Director Health Protection end Mar 2019
What we did last year Disabled people and voluntary organisations were involved alongside BSO staff in the development of our new e-			

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
learning Making A Difference. The training includes a number of scenarios that involve people with a disability and asks staff to think through how best to support the individuals, as well as giving information on disability legislation. Making A Difference e-learning has been rolled out, and is replacing the Discovering Diversity e-learning training package. We have made it mandatory for all our staff to complete the module. To date, 402 PHA staff have completed either e-learning packages and/ or face to face training exploring equality and disability issues (2009/10 to 2018-19). **Health Protection** The Health Protection team have been unable to secure a speaker from an external organisation on a suitable date to attend the Health Protection staff meeting to date, but plans are still in place for this to happen. **ONGOING**			

(2) Getting people involved in our work, Participation and Engagement

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
5. Identify, provide and promote opportunities for more engagement for people with a disability in key work areas. • **10,000 Voices:** Proactively target disability groups to advise of the initiative and how they can become involved (issue press releases; send information leaflets and posters to groups) Facilitate their involvement (make surveys accessible to people with a disability): 2018-19 work plan will focus on physical and sensory disability. • **HSC Research & Development:** Disseminate specifically to relevant disability organisations information on 'OK TO ASK' Campaign being undertaken to encourage members of the public including those with disability to participate in research and clinical trials to mark	Better engagement of people with a disability (adults and children where relevant) in key areas. People with a disability are encouraged and empowered to participate in public life.	Opportunities provided in key areas. Annual review of progress to ECNI Correspondence in relation to the initiative, how to get involved and contact details will regularly be sent to a list of disability organisations Correspondence circulated to list of disability organisations and via PCC newsletter	For 10,000 Voices: Assistant Director of Nursing, Safety Quality and Patient Experience For HSC Research & Development: Assistant

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
Clinical Trials Day on May 20. • **HSC Research & Development:** Provide Personal and Public Involvement training to encourage and provide guidance to researchers on how to involve service users and carers as partners in the research process and to raise awareness of research with service users including those with disability and members of the public. Training for researchers and service users and carers provided through workshops and master classes facilitated by researchers as well as service users with disabilities. Training materials provided to give guidance on how to involve and support service users and carers including those with special needs at training days and on website. • **HSC Research & Development:** Offer opportunities to participate in funding panels as they arise, including the		Training materials provided to each participant and available on website Panel members listed on website	Director HSC Research and Development

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
doctoral fellowship scheme and Enabling Awards, depending on schemes being run. • **HSC Research & Development:** Offer opportunities to participate in project steering groups and interview panels for particular research projects as a research partner as requests are submitted (e.g. from universities). • **HSC Research & Development:** Involve carers and service users with disability as speakers at relevant conferences/workshops e.g. Launch of Dementia Research Projects. • **HSC Research & Development:** Survivors of cancer and carers will deliver Building Research Partnership Course in 2 one day workshops to encourage research collaborations between researchers and service users to be held in April and October 2019. Course will be advertised to people with a disability and		Equality monitoring forms issued for panel and steering group members PIER Request Forms Feedback Forms List of members List of speakers, Agendas Copies of presentations Handouts e.g. dissemination of personal comments from service users List of facilitators will demonstrate involvement of people who have survived cancer but maybe living with difficult symptoms or disability. List of applicants and	

Chapter 4: PHA Disability Action Plan Progress Report 2018-19

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
arrangements made to facilitate their involvement. • **Health Protection:** Liaise with disability organisations and involve them in the planning process for any HP events • **Health Protection:** Ensure that active consideration is given to those with disabilities when organising local/regional Health Protection events e.g. PHA stand at the Balmoral Show (Health Protection are displaying Hand Hygiene related events on this stand) • **Health Protection:** Liaise with Communications Team to ensure that internal/external events etc. are advertised. Ensure that Health Protection has access to e-mail circulation lists for disability organisations.		attendees Circulation List Minutes of meetings and correspondence with disability organisations Arrangements made to accommodate people with a disability e.g. loop systems/special diets/wheelchair access Equality forms issued and collated Minutes of meetings and correspondence with disability organisations Engagement with people with a disability	For Health Protection: Assistant Director Health Protection End Mar 2019

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
		Correspondence circulated to list of disability organisations	

What we did last year

10 000 Voices

- 10000 More Voices Regional Team are hosting a survey exploring audiology services for children. This survey will inform and support the implementation in standards for Audiology. The work focuses upon the experiences and needs of children aged from 1 to 18 years. The survey was co-designed with children who are engaged in Audiology services and their parents.

HSC Research and Development

- Last year we ran 2 Building Research partnership courses and 5 training events for our PIER (Public involvement Enhancing Research Group). We also held a launch event to disseminate findings from our dementia research programme attended by 83 people including people living with dementia. We facilitated the involvement of a disabled speaker and a carer gave one of the closing responses.
- Opportunities have been advertised to PIER as they arose to participate on our funding panels e.g. our doctoral fellowship scheme, on university steering groups, as well as on regional service development initiatives e.g. Encompass. On International Clinical Trials Day on May 20th a new campaign 'I am Research' was launched to raise awareness of research with the general public and events were held in the Trusts, Cancer Centre and Public Health Agency. Where necessary, people with a disability were facilitated to attend our events.

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
• Our online mailing list gives the opportunity for anyone to register to hear about our work and events. In addition our Workshops and Conferences Scheme requires that all awardees should ensure appropriate service users are invited and in attendance at funded events. • Survivors of cancer and carers: Planning has begun to develop and deliver A train the trainer course to encourage service users to train as facilitators for the Building Research Partnership course. This is planned for September 2019. **Health Protection** • The Health Protection Team attended The Balmoral show (May 2019) and ensured that access to the PHA stand was on ground level (wheelchair access available). **ONGOING**			
6. Promote and encourage staff to participate in the disability staff network and support the network in the delivery of its action plan.	Better involvement of staff with a disability in decision-making. Better support for staff with a disability.	Communication issued to staff, promoting the network and encouraging their involvement Features on intranet.	Agency Management Team (AMT) end Mar 2019
What we did last year			

Chapter 4: PHA Disability Action Plan Progress Report 2018-19

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
The PHA works alongside the other regional HSC organisations to promote and maintain an effective staff disability forum. Tapestry meets on a quarterly basis, and is promoted in a number of different ways. Details of Tapestry meetings are included in our staff newsletter, as well as in any corporate communications or our intranet to encourage new members to join. Any equality training that is provided by our Equality Unit highlights Tapestry, and details are given of forthcoming meetings, and the new Tapestry website is publicised. **COMPLETED**			
7. Explore the scope for developing a shadowing scheme for Board members and other key public life positions in engagement with the Office of the Commissioner for Public Appointments, the Public Appointments Unit and with people with a disability.	Develop capacity of people with a disability to participate in public life positions.	Engagement undertaken with key stakeholders	Director of Operations and Chief Executive's Office end Mar 2019
What we did last year The Equality Unit in BSO, on our behalf, undertook a programme of engagement with key stakeholders during 2018-19 to explore the scope of developing a Board shadowing scheme for people with disabilities. This has included representatives from the Office of the Commissioner for Public Appointments, Disability Action, the NI Boardroom Apprentice scheme, HSC regional organisations, and the Disability Champions Network. It was found that a shadowing scheme would not be feasible. Instead, other mechanisms to develop the capacity			

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
of people with a disability to participate in public life positions will be trialled. These include ensuring that public appointments are circulated within the regional Disability Champions group, as well as Tapestry, the Staff Disability Network. We will also be encouraging the arms-length HSC bodies to participate in schemes such as Boardroom Apprentice to offer opportunities for people for training and learning about boards. Also, work will be done to highlight the lack of diversity on public boards, and seek to influence review of the public appointments process. **COMPLETED**			
8. Involve disabled people in delivery and review of this plan.	Better engagement by people with a disability (adults and children where relevant).	Feedback forms from engagement (and roundtable sessions, where appropriate)	AMT with support from BSO Equality Unit end Mar 2019
What we did last year We have involved people who have a disability in the delivery of most actions in this plan. We are currently developing a new two year plan for 2019-2021. People with a disability, in particular our staff network, will play a big role in developing both our Equality Action Plans and our Disability Action Plans. We will review this plan more widely when it comes to they come to an end, to inform the development of our new plan. We will involve people with a disability in this work. **COMPLETED**			

(3) Recruitment and Retention

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
9. Create and promote meaningful placement opportunities including for people with disabilities in line with good practice and making use of voluntary expertise in this area.	People with a disability gain meaningful work experience.	At least 1 placement offered by PHA every year Feedback through annual evaluation of scheme indicates that placement meets expectations.	Agency Management Team with support from BSO Equality Unit end Mar 2019

What we did last year

- The Disability Placement Scheme is jointly facilitated by the Health and Social Care Board, the Business Services Organisation and Supported Employment Solutions (a consortium of 7 voluntary sector organisations). Each participant has an assigned Placement Manager (from one of the organisations above) and an Employment Support Officer (from a voluntary sector organisation).
- By the end of May 2018, 12 participants completed their 26-week placement (from 1st December 2017 to 31st May 2018). Of these, one person was placed in the PHA, and successfully completed the placement. A further placement was offered within the Planning and Operations Team in October 2018, with this individual due to complete in May 2019. Prior to this placement, staff received Deaf Awareness Training to allow them to better support the individual.

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
• "How to get that Job" training is also delivered to participants on the disability placement scheme. This provides participants with information and skills to apply for jobs. The training also includes a mock interview to allow participants to develop interview skills. Participants will become eligible to apply for internal jobs from 1st April and this training also helps participants to prepare for the process. • Evaluation of the scheme via a series of focus groups with participants, placement managers, and support officers found that most of those who took part were happy with the scheme. Participants reported that the scheme had given them more confidence, and had improved their skill set, particularly with regards to social and communication skills. **COMPLETED**			
10. Provide information for line managers for when a member of staff declares their disability • update Guidance on Reasonable Adjustments • include the above in training for managers, such as absence management training.	Staff members who declare their disability are better supported in the workplace	Guidance on Reasonable Adjustments updated and shared with line managers Nature of training sessions for managers in which information has been included Feedback from staff who have a disability indicates satisfaction with support provided	BSO Director of Human Resources with support from BSO Equality Unit end Mar 2019
What we did last year A resource for line managers has been developed by our Equality Team in the BSO and members of Tapestry,			

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
the HSC Disability Staff Network. This leaflet highlights the legal duty placed on employers to provide reasonable adjustments. The resource also aims to provide a signposting service and support for line managers in the regional HSC organisations in making reasonable adjustments for staff with a disability. This is currently in final draft form, and once approved it will be shared with line managers across all regional HSC organisations, and placed on the Tapestry website. **ONGOING**			
11. Promote use of employment support programmes, such as Access to Work, by staff and line managers.	People with a disability are supported to access employment opportunities and remain in employment with the PHA. Line managers and staff draw on existing expertise and resources provided through government programmes.	Number of cases where employment support programmes are drawn on	BSO Director of Human Resources with support from BSO Equality Unit end Mar 2019
What we did last year In January 2019, our Equality Unit and a representative from Tapestry met with Access to Work, an employment support programme based in the Department of Communities. The aim of this meeting was to establish how the service works, and to discuss the support Access to Work offers to staff who have disabilities, as well as their line managers/ employers. An information piece for staff and line managers has also been developed promoting the Access to Work			

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
programme, and outlining the service provided. This will be published on the Tapestry website. **COMPLETED**			

(5) Additional Measures

- We always include Disability on our list of things to talk about at our quarterly Equality Forum with our partner organisations.
- We report on progress against our Disability Action Plan to our Board and Agency Management Team every year.

(6) Encourage Others

- We include questions relating to the two duties in our equality and human rights screening form. The screening form is completed for all policies and decisions. This includes work that other organisations will do for us, for example, contracts that we have with voluntary sector organisations for health and wellbeing promotion work.

(7) Monitoring

- During the year, together with our Health and Social Care partner organisations, we held a series of focus groups with those involved in our Disability Placement Scheme. Groups were held with placement participants, their Employment Support Officers in the voluntary groups who help us run the scheme, and

their HSC Placement Managers. Findings from the focus groups allow us to evaluate and improve the scheme for future participants. Also, for the first time this year, all participants completed an equality monitoring form allowing us to examine whether the scheme diverse range of people and, if not, which groups we want the provider to reach out to specifically.

(8) Revisions

- In July 2017 we published our updated plan, which included some changes from the year before.
- Between February and March 2018, we looked at our plan again to make further changes. Some of these drew on learning from our partner organisations in Health and Social Care. We published our updated plan on our website in April 2018. An application was submitted to the Equality Commission for a further extension of our Disability Action Plan in March 2019

(9) Conclusions

- We **completed seven actions** (Numbers 2,3,6,7, 8, 9, and 11).
- We still have **some work to do to complete four actions** (Numbers 1, 4, 5, and 10).
- All of the actions in our action plan are at regional and at local level.
- Our action plan is a live document. If we make any big changes to our plan we will involve people with a disability. We will tell the Equality Commission about any changes.

Chapter 5

Equality and Human Rights Screening Report

April 2018 – March 2019

These screenings can be viewed on the PHA website under:
http://www.publichealth.hscni.net/directorate-operations/planning-and-corporate-services/equality

Key	
*1	'screened in' for equality impact assessment (EQIA)
2	'screened out' with mitigation
3	'screened out' without mitigation

Policy / Procedure and Screening Documentation	**Policy Aims**	**Date**	***Screening Decision**
Disability Action Plan 2013 - 2019, updated April 2018	The plan sets out what we will do to promote positive attitudes towards disabled people and to encourage participation by disabled people in public life.	Apr-18	2
Annual Business Plan 2018-19	The Public Health Agency (PHA) Annual Business Plan 2018-2019 details how we will make best use of our resources to achieve our core goals, as set out in our Corporate Plan 2017-2021. This plan focuses on significant new initiatives for 2018-19.	Apr-18	3
Rural Needs Policy	To assist PHA staff understands their statutory responsibilities under the Rural Needs Act, and to provide guidance on undertaking a proportionate Rural Needs Impact Assessment as a mechanism for ensuring	Jul-18	3

Policy / Procedure and Screening Documentation	Policy Aims	Date	*Screening Decision
	rural needs are appropriately taken into account.		
Development and delivery of Crisis De-escalation service to be piloted in the Belfast Health and Social Care Trust area.	The overall intention of this proposal is to develop an out-of-hours facility and service in Belfast which might be a first step towards a 24 hour service which functions as a safe place for individuals and families and enables effective de-escalation support over a period of hours following presentation to Emergency Department or to a select group of community and voluntary sector providers.	Oct-18	2
"Expansion of Community Development Approaches" Framework (Report to Transformation Implementation Group) Year 1 Recommendations 2018/2019	The Community Development Workstream is tasked to set a clear direction and expand community development approaches to reducing health inequalities in Northern Ireland. Its' remit was to assess current progress and make recommendations for how community development practice could be strengthened in the future.	Oct-18	2
Whistleblowing Policy	This policy and procedure is aimed at those issues and concerns which are not resolved, require help to get resolved or are about serious underlying concerns	Aug-18	2
Procurement of Community	The Procurement of Community Gardens Project has	Jan-19	2

Policy / Procedure and Screening Documentation	Policy Aims	Date	*Screening Decision
Garden Project	been set up to improve Health and Wellbeing, particularly for those who are currently or who are at risk of experiencing poor Health and Wellbeing outcomes and encompasses 2 Models and objectives for each model.		

No concerns were raised by consultees on any of the screenings published in 2018-19.

Equality and Human Rights Mitigation Report

April 2018 – March 2019

Annual Business Plan 2018

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
The Annual Business Plan development included ensuring that it fully reflected the PHA role in reducing health inequalities. Some of these explicitly aim to address key equality issues. Using our Communication department's expertise in public information the Annual Business Plan was written in a style to make it accessible and understandable for a wide range of external stakeholders as well as PHA staff. The feedback from the consultation on the PHA Corporate Plan 2017-21 was used to inform the development of this Annual Business Plan 2018/19.	The key actions and focus on reducing health inequalities contained within the plan will guide the work of the PHA throughout 2018/19 and will be closely monitored through a variety of established performance monitoring systems. The Annual Business Plan will be widely accessible and will be available in alternative formats. As each of the actions are taken forward equality issues will be reviewed and addressed as appropriate. Service leads have been reminded to keep under constant review the need for screening at an early stage when planning. We will also continue to implement the actions detailed in our action plan which accompanies our Equality Scheme 2013-18. Ultimately, however, we remain committed to equality screening, and if necessary equality impact assessing, the policies we develop and decisions we take.

Disability Action Plan

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
Work Placements • We work with a range of disability organisations to ensure opportunities are offered to people from a wide spectrum of disabilities, as well as different gender and age groups. • Ensuring that reasonable adjustments are at the heart of placements. Tapestry Disability Staff Network • We ensure that the way the forum operates allows people with a range of disabilities and from a range of age and ethnic backgrounds to be involved (for example, by providing information in accessible formats and choosing accessible venues). • Accessible formats and inclusiveness integrated into Terms of Reference • Strict confidentiality provisions apply	Awareness Days • Work to feature specific disabilities will take into consideration the need to include a range of age groups, ethnic groups and genders when testimonials and case studies are selected. • Information distributed to staff will take on board the needs of both staff with a particular disability and staff who are carers. • This is important for the selection of disabilities to be featured and the information distributed, including support services in the community signposted to. Work Placements • We will work with a range of disability organisations to ensure opportunities are offered to people from a wide spectrum of disabilities, as well as different gender and age groups. • Provider to monitor diversity of participants and

	consider outreach measures to address under-representation • Provisions for Information materials in accessible formats; provision of interpreters at events.

Development and delivery of Crisis De-escalation service to be piloted in the Belfast Health and Social Care Trust area.

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
Gender and Age: Hospital Emergency Dept and the Lifeline service are both open access (all genders, ages, etc.) and are the primary routes in to being assessed as suitable for signposting/referring on to the proposed Crisis Service. Those under 18 will be directed to the exiting BHSCT CAIT service and those 18 and above will receive help and support via Lifeline, ED or the Crisis Service dependent on the outcome of a standardised risk assessment and capacity within the Crisis Service at any given time. Those identifying as transgender or non-binary will be signposted on to relevant support services, as and when appropriate, by staff within the	Section 75 information Section 75 information will be monitored at point of entry and this information will then be analysed by the service providers and the commissioners to assess how all, and particular, groups are accessing (or not) the service. Direct and/or indirect work may then be undertaken in terms of raising awareness with particular

Crisis Service. Religious Belief and Political Opinion and Disability: The Crisis Service will be located in a neutral and accessible (including being able to meet the needs of those with a disability and/or special needs) venue, close to hospital ED, likely a city centre location (this requirement will be built in to the tender specification for the service). Marital and Dependent Status: The Crisis Service will have a 'hardship fund' budget built in and will therefore be able to provide short-term immediate financial assistance to people (and their family members/carers) presenting to it in crisis to help with issues such as poverty, debt, childcare and social exclusion. Ethnicity: Any communication strategies developed will be accessible and culturally sensitive to the needs of BME groups and travellers. The Crisis Service will be able to access the NI HSC Interpreting Service and will ensure that it has knowledge of, and links made with, relevant support groups and programmes working with BME groups and travellers when signposting people on for further help and support (post crisis) – again tender specification requirement. Sexual Orientation: The LGBT sector is represented on the Belfast Alliance for Suicide Prevention (BASP) by the Rainbow Project – and the Co-Chairs of the Alliance have been instrumental in the development of the Crisis Service.	groups or gaining feedback re. experience by those groups to date. The pilot will be subject to both internal and external monitoring and evaluation with the findings then influencing future commissioning direction and decisions at local – and regional levels.

Engagement with BASP and its memberswill continue throughout the life of the pilot allowing members to be updated, to raise awareness of the pilot with them and amongst the groups and organisations that they represent, and to discuss any queries or concerns that they may have in relation to service delivery. Poverty, Deprivation – Immediate Practical Support Needs: NB The Crisis Service provider will also be able to access a hardship fund on behalf of service users and their families.	

Expansion of Community Development Approaches" Framework (Report to Transformation Implementation Group) Year 1 Recommendations 2018/2019

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
	<u>Collate and share tools and resources</u> • Any tools and resources that are collated should include tools specifically for people with a learning disability, people with visual impairment, people who identify as transgender or non-binary, ethnic minority groupings, people who identify as lesbian, gay or bisexual and other more marginalised groups.

	• Acknowledge the following groups when establishing the online portal and resources; people with a learning disability, people with visual impairment, people who identify as transgender or non-binary, ethnic minority groupings, people who identify as lesbian, gay or bisexual and other more marginalised groups. • The service specification will include accessibility standards • Ensure all case studies include examples from all S.75 groupings **Capacity Building** • Check who all providers are against S.75 groupings • Strengthen skills and knowledge of those involved regarding the various groupings. • Curriculum will be equality screened. **System Mapping** • Ensure that there are no gaps as regards the S.75 groupings when mapping all relevant stakeholders and how they incorporate CD Framework into their operations. **Evaluation and Evidence** • Ensure baseline data is collated for all equality groupings. • **Evaluation framework will be equality**

	screened

Whistleblowing Policy

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
Every effort will be made to provide information in an alternative format if written format is not accessible to a member of staff. The policy includes a range of people at different levels and different Directorates as well as a designated non-executive director to give staff options for reporting. The PHA has also identified a whistleblowing advisor whom staff can talk to. Information about sources of independent advice is also provided with the policy. The PHA has also organised training for staff, to ensure all staff are aware of how to raise an issue, and that line managers are aware of what to do when an issue is raised. Bespoke training is also being organised for whistleblowing champions and advisor so	If any further equality issues are identified either externally or internally the PHA is committed to revising the policy to ensure all staff members have equity of protection.

that they are skilled and resourced in supporting and helping all staff, including those who may be less confident in raising an issue.	

Procurement of Community Garden Projects

In developing the policy or decision what did you do or change to address the equality issues you identified?	What do you intend to do in future to address the equality issues you identified?
• The providers will be requested to ensure they are flexible in delivering the programme and any identified barriers to delivery are addressed to ensure it is tailored to meet the needs of the children and parents, any equality issues should be identified and addressed. • All staff delivering the service to complete equality and diversity training, in line with their employer.	• The equality screening has identified equality issues to be taken into account when delivering the programme. • The tender specification and responses will consider work actions relating to particular needs of Section 75 groupings in relation to communication and engagement. • The tender specification and responses will consider training each provider with knowledge of the potential communication needs of particular Section 75 groupings e.g. information in different languages / possibility of a translation service. • The programme will seek the views and

	experiences of service users though monitoring of compliments and complaints and actively seek feedback as part of the evaluation process of the programme which could capture information from a range of section 75 or other groups. • The tender specification should include the requirement for diversity issues to be integrated into the content of the programme / the ability for the programme to be adjusted to address diversity issues.

HSC Public Health Agency

item 9

Title of Meeting	PHA Board Meeting
Date	15 August 2019
Title of paper	Draft Commissioning Plan 2019/20
Reference	PHA/03/08/19
Prepared by	Dr Miriam McCarthy, HSCB
Lead Director	Dr Miriam McCarthy, HSCB
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

Members are asked to approve the attached draft Commissioning Plan 2019/20 (Appendix 1) for submission to the Department of Health.

The Commissioning Plan has been produced collaboratively by the HSCB/PHA, led by a multi-disciplinary editorial group. The Plan seeks to respond to the key four aims outlined within the draft Commissioning Plan Direction 2019 (Appendix 2), namely:

- To improve the health of the population;
- To improve the quality and experience of health and social care;
- Ensure the sustainability of health and social care services; provided and;
- Support and empower staff delivering health and social care services.

The Plan also identifies the key priority areas to be commissioned regionally and locally. However, it should be noted that the Plan does not seek to highlight all of the work being taken forward by HSCB/PHA in 2019/20. Rather, the Plan focusses on a number of key strategic and service priorities which are likely to yield the greatest benefit in terms of patient outcomes and experience of health and social care services at both a regional and local level.

The Commissioning Plan has been produced within a challenging commissioning and financial context. Trusts have already been provided with indicative allocations – from these allocations Trusts will be asked to respond appropriately to the changing patient and client needs and to the specific service pressures identified within the Plan.

Trust responses to the Commissioning Plan (in the form of Trust Delivery Plans) will demonstrate how they propose to address these needs and pressures while living within available financial resources. TDPs will be subject to HSCB Board consideration at a future meeting.

Should members approve the attached draft Plan, it will be considered for approval by the PHA Board on 15 August 2019. Following approval by both Boards, the finalised document will be submitted to the Department no later than week beginning 19 August 2019.

2 Funding Requirements

The Commissioning Plan has been drafted on the basis of the assumed recurrent financial allocations for 2019/20 received from DoH.

3 Assessments

Consistent with statutory obligations, Board and Agency staff have undertaken a detailed assessment of the draft Commissioning Plan to identify any potential equality issues arising from the recommendations within the draft Plan. An equality screening report has been drafted which outlines the cumulative impact of the Plan on the population of N.Ireland.

The screening document also specifies mitigating action to be taken to avoid any potential negative impact on the specified Section 75 groups. A copy of the screening document is attached at Appendix 3.

The equality screening exercise indicates that there would be no priorities which would have impact that are detrimental to any specific Section 75 group.

HSC Public Health Agency

item 10

Title of Meeting	PHA Board Meeting
Date	15 August 2019
Title of paper	Consultation Report for Northern Ireland Diabetic Eye Screening
Reference	PHA/04/08/19
Prepared by	Claire Armstrong
Lead Director	Adrian Mairs
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

This report is an analysis of the public consultation which took place between 7th January and 29th March 2019. The consultation sought feedback from stakeholders on potential models of future service delivery. Feedback was also sought on future planning considerations and also the equality and rurality implications of any potential change. The document makes two recommendations as a result of this analysis and sets out some of the next steps.

This paper is being brought to the PHA Board for approval of both the document, and its recommendations, and also approval to move forward with implementation of the proposed revised service model.

2 Background Information

The development of a new model of service delivery for the Diabetic Eye Screening Programme is a specific objective in PHA's Business Plan for 2019/20 under the corporate objective, "All individuals and communities are equipped and enabled to live long healthy lives".

The Northern Ireland Diabetic Eye Screening Programme (NIDESP) aims to detect diabetic eye disease at an early stage and prevent sight loss in those with diabetes aged 12 years and over in Northern Ireland. The programme is currently undergoing a modernisation project to ensure that it remains a sustainable service and continues to improve in line with national standards. Phase 2b of this project involves reviewing the model for service delivery. A public consultation highlighting three shortlisted options (option 1: fixed HSC sites, option 2: fixed GP sites and option 3: high street

optometry sites) for the future model of service delivery was launched on 7th January 2019 for 12 weeks until 29th March 2019. This report provides a summary of the responses to that consultation.

The communication and engagement strategy for this consultation included several methods of engagement with key stakeholders including public notice, press release, correspondence with professional groups/HSC bodies and charities, social media messaging and blog. An online consultation hub on citizen space was created with all key documents and information available, including access to the feedback questionnaire. Public information sessions were advertised and a summary booklet, which provided an overview of the work and how to respond, was produced and distributed at random across screening clinics in each HSC Trust area throughout the consultation period. Members of the Public Health Agency DESP team also attended other key meetings and events during the consultation period to engage with key stakeholders including public LCG meeting, a DESP staff meeting and completing a television interview for a local broadcaster (National Vision Tele Vision).

Feedback was largely received via the online consultation questionnaire but also verbally at relevant meetings and events and in written letters from various professional and voluntary sector groups.

3 Key Issues

Given the increasing number of people with diabetes, and therefore eligible for diabetic eye screening, it is likely that the NIDESP will remain under pressure for some time to come. The consultation has set out the potential service delivery options to best meet such pressure.

Responses to this consultation have indicated majority support for fixed site screening sites.

Recommendation 1: Model of service delivery

It is recommended that screening is delivered at fixed sites throughout Northern Ireland. These should be HSC sites or larger GP sites. In practice this is likely to be determined by availability and feasibility of implementation, recognising that access to timely screening is a key requirement for the DESP.

Several factors seem to be important when considering implementing a future service model for the screening programme.

Recommendation 2: Future planning considerations

Accessibility, car parking and public transport links are consistently high ranking criteria for respondents with co-location of services and extended hours of opening appearing relatively less important. These key factors should be considered when determining screening sites.

4 Next Steps

Following approval by the PHA Board, the required implementation process to take forward the fixed site model will be established. The service delivery model will be guided by a service specification. This will be developed by the PHA DESP team in partnership with stakeholders, including Trusts, Local Commissioning Groups and primary care.

Diabetic Eye Screening

Consultation Report

Consultation on how the Northern Ireland Diabetic Eye Screening Programme is provided

Version 1.3
26th June 2019

HSC Public Health Agency

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Acknowledgements

The DESP team in the Public Health Agency would like to acknowledge the contributions of all those who helped in not only the public consultation process but also the extensive preparation involved in the lead up. We would also like to thank all those who have participated in the consultation, helping to provide a holistic overview of the future models and their potential impacts.

Recognition must also go to those who have continued to provide this invaluable screening programme during a period of upheaval and uncertainty.

Executive Summary

Introduction

The Northern Ireland Diabetic Eye Screening Programme (NIDESP) aims to detect diabetic eye disease at an early stage and prevent sight loss in those with diabetes aged 12 years and over in Northern Ireland. The programme is currently undergoing a modernisation project to ensure that it remains a sustainable service and continues to improve in line with national standards. Phase 2b of this project involves reviewing the model for service delivery. A public consultation highlighting three shortlisted options (option 1 fixed HSC sites, option 2 fixed GP sites and option 3 high street optometry sites) for the future model of service delivery was launched on 7th January 2019 for 12 weeks until 29th March 2019. This report provides a summary of the responses to that consultation.

Consultation methodology

The communication and engagement strategy for this consultation included several methods of communication with key stakeholders including public notice, press release, correspondence with professional groups/HSC bodies and charities, social media messaging and blog. An online consultation hub on citizen space was created with all key documents and information available including access to the feedback questionnaire. Public information sessions were advertised and a summary booklet which provided an overview of the work and how to respond was produced and distributed at random across screening clinics in each HSC Trust area throughout the consultation period. Members of the Public Health Agency DESP team also attended other key meetings and events during the consultation period to engage with key stakeholders including public LCG meeting, a DESP staff meeting and completing a television interview for a local broadcaster National Vision Tele Vision.

Feedback was largely received via the online consultation questionnaire but also verbally at relevant meetings and events and in written letters from various professional and voluntary sector groups.

Results and analysis

A: Questionnaire responses

- Respondent profile

268 questionnaire responses were received with 81% (217) being completed by those living with diabetes/their families/carers and a further 8.6% (23) from those working in primary care.

- Feedback on models

Responses to the consultation indicate majority support for a fixed site model, with both HSC fixed sites (76.2% (205/269) strongly agreeing or agreeing) and GP fixed sites (69.5% (187/269) strongly agreeing or agreeing) appearing popular options. This is consistent with the preferred option of the project structures (option1- fixed HSC sites).

Responses to option 3 the high street optometry model are mixed with smaller proportions supportive of this model (37.2% (94/271) strongly agreeing or agreeing) and 43.5% (118/271) either disagreeing or strongly disagreeing that this model could provide safe, high quality service and meet the demands of the increasing diabetic population.

This is also reinforced by feedback from those living with diabetes/their families/cares that they would attend screening at fixed HSC sites (78% (170/218) or fixed GP sites (71.6% (156/218)). However only 37.2% (81/218) agreed they would attend screening at high street optometry sites and 15.1% (33/218) did not know if they would attend screening at a high street optometry service as opposed to 9.2% (20/218) at fixed HSC sites, or 9.6% (21/218) at fixed GP sites respectively.

- Future planning considerations

Respondents were asked to rank criteria in relation to importance for future service provision. Two different methods were used to analyse this feedback, producing slightly different orders of importance. However accessibility, car parking and public transport links appear to be consistently high ranking criteria for respondents with co-location of services and extended hours of opening appearing relatively less important.

- Equality & rurality implications

90.3% (242/268) of respondents felt that all equality impacts had been identified. The majority of comments regarding equality implications were from those who were not sure/had not read the supporting documentation or were unaware of how to find it. Other comments highlighted the importance of transport and accessibility for those with limited mobility, the elderly, the working population and those in rural areas.

With regards to rurality, 84.7%% (227/268) of respondents agreed that all implications for rural areas have been identified. Travel and transport implications and access were the most common themes in additional responses. It was suggested that potential solutions included to group invitations by locality, care home, facility to allow for travel together, also to provide information on alternative local transport arrangements. Ensuring geographic coverage of sites was also highlighted.

- Satisfaction with consultation

Satisfaction levels with the consultation process were high, with 78.7% of these replying (211/268) stating they were satisfied or very satisfied with the process. 6.7% (18/268) of respondents advised they were dissatisfied or very dissatisfied.

The majority of the comments from those who were dissatisfied or very dissatisfied stated that they felt they had not been consulted directly, had found out on social media, or were unhappy they had not received individual letters/correspondence regarding the consultation. There were also a small number who felt that there should have been more publicity

<u>B&C: Meetings and written feedback from professional and voluntary groups</u>

Feedback from meetings with key stakeholders including Local Commissioning Groups and staff currently providing the screening programme are summarised within results section B of this report with a range of issues considered.

Written and questionnaire feedback from professional and voluntary sector groups is also considered and summarised within results section C of this report with any relevant issues highlighted.

Conclusion and recommendations

Given the context of the steadily rising number of people eligible for diabetic eye screening and the multiple potential options for models of how to deliver the programme, it is clear that securing the optimal delivery of the NIDESP is a complex issue. There is no nationally agreed, or recommended, gold standard model for how to deliver the screening programme.

The project team and board have worked with key stakeholders over the last 24 months to review a longlist of potential options and agree the best way forward for the programme in Northern Ireland.

Responses to this consultation have indicated majority support for fixed site screening sites.

Recommendation 1: Model of service delivery

It is recommended that screening is delivered at fixed sites throughout Northern Ireland. These should be HSC sites or larger GP sites. In practice this is likely to be determined by availability and feasibility of implementation, recognising that access to timely screening is a key requirement for the DESP.

Several factors seem to be important when considering implementing a future service model for the screening programme**.**

Recommendation 2: Future planning considerations

Accessibility, car parking and public transport links are consistently high ranking criteria for respondents with co-location of services and extended hours of opening appearing relatively less important. These key factors should be considered when determining screening sites.

Next Steps

- Approval process

Once agreed by the modernisation project team and board the consultation recommendations will be presented to the PHA Board for approval.

- Planning and implementation

<u>Agreeing number and location of fixed screening sites</u>

It is anticipated that this will initially involve the DESP producing a specification of what is required for a screening site, and working with Trusts, Local Commissioning Groups and primary care to determine availability of and select suitable sites within each Trust area (*excluding WHSCT where fixed sites are already operational)*.

Introduction

The NIDESP

The Northern Ireland Diabetic Eye Screening Programme (NIDESP) aims to detect diabetic eye disease at an early stage and prevent sight loss in those with diabetes aged 12 years and over in Northern Ireland. Diabetic eye disease remains one of the leading causes of blindness in people of working age in the UK.[1] It is a potential complication of diabetes which if left untreated can cause sight loss and have a devastating effect on individuals and their families.

The programme is commissioned and quality assured by the Public Health Agency (PHA) in collaboration with Belfast Health and Social Care Trust (BHSCT) who are responsible for the management and delivery of the programme. Screening is delivered locally in line with national quality standards and protocols.

The programme is currently undergoing a modernisation project to ensure that it remains a sustainable service and continues to improve in line with national standards. Phase 2a of this project involves reviewing the model for service delivery.

Diabetes in Northern Ireland

Reflecting trends worldwide, the number of people living with diabetes continues to grow each year in Northern Ireland. The number of those aged 17 years and older living with diabetes has almost doubled in the last decade from 57,000 in 2006/7 to over 90,000 in 2016/17[2]. The number of people eligible for diabetic eye screening is expected to continue to increase as the number of people living with diabetes grows (estimated by 5% per year). It is predicted, that by 2020/21 around 110,000 people a year would be eligible for screening[3].

[1] Diabetes UK https://www.diabetes.org.uk/retinopathy
[2] Source: QOF datasets 'Raw Disease Prevalence Data for Northern Ireland', www.health-ni.gov.uk/publications
[3] Projected eligible population, based on current eligible population, OptoMize Programme Performance Report

The case for change

The current mobile model of delivering clinics in individual GP practices has been coming under increasing pressure, due to the growth in the number of people eligible for screening and a number of factors impacting on quality and operational issues.

Maintaining the screening interval at 12 months is posing a key operational challenge. From 1St April 2016 to 31st March 2017 the average screening interval for a practice was 13 months, however this average only takes account of 262 of the 338 GP practices in Northern Ireland (76.2%) who had their eligible diabetic participants screened[4].

The review of the service delivery model forms one stage of a multi-phase modernisation project which aims to ensure that the Northern Ireland Diabetic Eye Screening Programme is a safe, high quality, sustainable service into the future, a service that can continue to improve in line with national standards.

Why consult?

The aim of the 12 week public consultation was to seek the views and feedback from key stakeholders on the shortlisted options, their potential impacts and the important considerations for implementation planning.

[4] NIDESP Annual Report 2016/17

Background to the consultation

The consultation process

Appendix 1 shows the steps involved in the consultation process since the launch of the pre-consultation in October 2017.

Option appraisal/costing

An initial stakeholder event was held in 2016 to establish a list of potential model options and the key objectives by which these should be assessed. As a result of this and preparatory analysis the Project Team drafted an options appraisal document detailing an initial long list of 10 options, along with a costs paper, which provided an overview of how these options might work and estimated costs. Through discussions with national colleagues and early analysis, two of the options were 'sifted out' i.e. no longer considered viable. The team brought these documents to the Project Board for approval, however it was felt that further stakeholder engagement should take place, before any final recommendation could be made.

Pre-consultation

The Project Board recommended that a 12 week pre-consultation take place. This was carried out from 1st October to 31st December 2017. Screening staff from the PHA and BHSCT engaged with multiple stakeholders including service users, primary care, commissioners and voluntary organisations. A total of 39 responses were received. The majority of responses were from high street optometrists and members of the public/service users.

As a result of the analysis of the responses, the Project Team revised the options appraisal, clarifying the advantages and disadvantages of each of the remaining options and strengthened the costs paper, providing a range of costs and referencing the assumptions made within the document.

Shortlisting

The Project Team conducted a shortlisting exercise in May 2018, which scored each of the options against the previously agreed criteria. Some of

the highest scoring options included the current model and expanding the mobile model of screening in individual GP practices across the whole of Northern Ireland. However the Project Board recognised that fundamentally both of these models are unable to address the current drivers for change, including meeting the screening interval standards, reducing pressure on GP practices and ensuring the ability to introduce the variable screening interval.

Cost was not considered as a criteria/factor as part of the formal options appraisal scoring. In terms of revenue, indicative costings suggest that all shortlisted models will be more expensive than the current model with option 5 (high street optometry) being the most expensive.

Recommended options

Having considered all of this, the Project Board recommended that three options be considered via public consultation:

Option 2a- Preferred option (Referred to as option 1 in the consultation questionnaire and summary booklet) Regional fixed location service provided at HSC locations e.g. local hospitals, community hospitals, health and wellbeing centres, and suitable larger GP practices. Provided in at least 22 sites across Northern Ireland (including the current 6 sites in WHSCT).
Option 2b (Referred to as option 2 in the consultation questionnaire and summary booklet) Regional fixed location service with sites, within selected groups of GP practices, identified in collaboration with Local Medical Committees. Provided in at least 22 sites across Northern Ireland (including the current 6 sites in WHSCT).
Option 5 (Referred to as option 3 in the consultation questionnaire and summary booklet) High-street optometry based service with digital photography and visual acuity provided at approximately 60 high street optometrists' premises throughout Northern Ireland. The current fixed site model in WHSCT would cease.

The preferred option for the programme was Option 2a, which ranked highest in the option appraisal scoring process. This model would have the capability to meet the drivers for change and allow the programme to invite those eligible as an individual rather than as a patient within a specific GP practice. It would also have scope to expand and meet the increasing capacity demands associated with the growing diabetic population.

Option 2a has benefits for individual participants, whilst also maintaining the current tight control over programme quality which is essential for minimising potential harms to all of the individuals who require screening.

Public consultation

The public consultation was launched on 7th January 2019 for 12 weeks until 29th March 2019. The following section describes the methodology used to conduct the consultation. Whilst the consultation was led by staff from the DESP Team in the Public Health Agency (PHA), it involved collaboration with colleagues, particularly the communications team within the PHA and NIDESP staff within the Belfast HSC Trust.

Consultation methodology

Communication and engagement strategy

A communication action plan for the consultation was developed which identified the following key objectives:

i. To create awareness and understanding of the consultation and the drivers for change

ii. To encourage participation in the consultation

iii. To signpost ways in which stakeholders can respond

iv. To increase awareness of the programme and its aims

Delivery included several methods of communication with key stakeholders:

- *Public Notice* – notice of the consultation was placed in each of the three key regional newspapers (Belfast Telegraph, Newsletter and Irish News) on Friday 4th January with dates for public information sessions provided.
- *Press Release* - this was issued to all key media outlets for release on 7th January and included details on the programme, reason for the consultation, details of the citizen space consultation hub and relevant contact details.
- *Correspondence with Professional Groups/HSC Bodies* - letters were sent to key organisations and professional bodies notifying them of the consultation and providing contact details for participation in the information sessions.
- *Social Media* - regular posts were issued from PHA social media account. Members of the project structure including Diabetes UK (NI) and RNIB reposted/retweeted via their organisational accounts to increase circulation. Posts were issued throughout the consultation period.
- *Patient Client Council Blog* – the programme was invited to write an article for the PCC blog. This article provided an overview of the programme, the consultation and how to participate.

Citizen space

The main platform both for accessing documentation/information related to the consultation and to complete the questionnaire was a consultation website hosted within Citizen Space at http://pha.site/DESPconsultation. Here stakeholders could access the questionnaire, details of the information sessions, contact details and the following documentation:

- Consultation report
- Consultation report appendices
- Equality Impact Assessment
- Rural Needs Impact Assessment
- Printable version of consultation questionnaire

Public information sessions

Information sessions open to the public and all other interested parties, were offered to provide individuals/groups with an opportunity to book a 30 minute appointment to meet with a small panel from the DESP modernisation project team to discuss the consultation, provide feedback and seek clarification on any issues.

Such sessions have the advantage of offering personal convenience for participants, providing a chance for those who may otherwise not have contributed to speak in confidence, and a chance to speak one on one with a small panel of the project team

It was agreed the panel would hold four dates throughout the consultation period, with the first two booked and advertised via public notice, social media and the consultation hub to take place on:

- 18th January 2019 at Grosvenor House, Belfast
- 28th January 2019 at Community House, Omagh

Unfortunately uptake of these events was poor with 1 attendee scheduled for Belfast and 2 attending in Omagh. The remaining days did not proceed, due to lack of interest

Summary booklet

A summary booklet was produced, which provided a brief overview of the drivers for change, each of the proposed options and details about how to respond to the consultation. A random sample of approximately 800 booklets was handed out by screening staff at screening clinics in each of the five HSC trust areas. It should be noted that the distribution of these booklets was limited by the screening clinic venues scheduled to take place during the consultation period.

Posters were also developed to be placed in screening clinic waiting areas advertising the consultation.

Other events, meetings and engagement

Meeting of the Local Commissioning Group (LCG) Chairs – representatives from the PHA screening team were invited to present on the NIDESP consultation at a meeting of the LCG Chairs on 30th January 2019.

Presentations at Belfast and South Eastern LCGs - the PHA team also presented at both the South Eastern (7th March) and Belfast (21st March) LCG public meetings.

Interview with NVTV – NVTV is a local TV station within the Greater Belfast Area. NIDESP were invited by the station to film an interview to inform viewers of both the screening programme itself and the public consultation. The Public Health and Clinical Leads for the programme participated, along with the project team service user representative. The interview was broadcast on 11th February and the video is available at the station's Vimeo site https://vimeo.com/316557920.

DESP Staff Event – members of the PHA screening team and HSCB met with staff from the screening service on 12th February 2019 to provide information on the consultation, answer any questions and receive feedback.

Feedback methods

Questionnaires - The main method for stakeholders to provide feedback was via the online questionnaire, which could be completed at the Citizen Space hub. Links to this site were provided in various places including the PHA

website, via social media, the summary booklet, press release, public notice and relevant correspondence.

On request the PHA screening team also posted out hard copies to those who requested them via telephone or email, along with freepost envelope for return.

Letters - letters in response to the consultation were received from a number of professional and charity organisations.

Verbal – PHA screening staff attended various meetings to present an overview of the consultation and the proposed options as detailed above. Discussion and feedback from these meetings is summarised in section B.

PHA DESP contact details were included in the consultation documents, hub and staff also received phone calls from a number of service users who had heard about the consultation, were seeking further information or to provide an opinion.

An email account was also created (screening.diabeticeye@hscni.net) to allow for any queries, this was publicised in any outgoing communication.

Results and analysis

There were a large number of responses to the consultation, mainly via the online Citizen Space platform.

In results section A questionnaire responses will be considered, including examining each question/group of questions in turn. This will include a review of:

1. Respondent profile
2. Feedback on models
3. Future planning considerations
4. Equality and rurality implications

Given the high response rate and considerable amount of qualitative data, free text comments have been grouped within broader themes to provide an overview for analysis. Comments themes are shown for each section.

Results section B will look at discussion generated at the various events and section C will focus on letter and questionnaire feedback from professional and voluntary groups.

Responses

Table 1 provides an overview of the responses received.

Table 1: Consultation response method - a breakdown

Response Type	No.
Questionnaire – online	258
Questionnaire – hard copy	13
Letters	4

It should be noted that 2 of the online questionnaires and 1 hard copy questionnaire were excluded from the final analysis as:

- 1 response was for a different consultation
- 1 was a duplicate response
- 1 was insufficiently complete to be included

Therefore in total 3 questionnaires were excluded from the final number for analysis which was 268.

SECTION A: QUESTIONNAIRE RESPONSES

1 – RESPONDENT PROFILE (Questions 1-6)

Question 1: Please tell us if you are responding on your own behalf or on behalf of an organisation by selecting one of the following options *(Required)*

This question was completed by all those who participated, with, as shown in table 2, the vast majority 81% (217/268) of responses being from those living with diabetes or their carers/family members. Such a large response from service users is encouraging Most of the remaining responses were from those working in health and social care services, the optometry sector and other professional groups (47/268). The breakdown of those identified as 'other' is also shown below in table 3.

Table 2: Questionnaire respondent type

Respondent type	Count (No.)	Proportion (%)
I'm a person living with diabetes or their carer/family member	217	81.0
I work within the primary care sector	23	8.6
I work within the Diabetic Eye Screening Programme	6	2.2
I'm an optometrist/work in the optometry sector	6	2.2
Other (please specify)	16	6.0
Total	**268**	**100**

Table 3: Responses identified as 'other'

Other	No.
Diabetes Services (secondary care 5, support group 1)	6
Ophthalmology (College of Optometrists, QUB and Belfast HSCT)	3
Diabetes Services – Retired	1
Diabetes UK(NI)	1
Southern HSCT	1
Learning Disability Services	1
South Eastern Local Commissioning Group	1
Member of Public	1
Prison Healthcare, South Eastern HSCT	1
Total	16

Questions 2 - 5 sought further contact details and were answered with varying completeness

Question 2: What is your name? 268 responses (100%)

Question 3: What is your organisation? 135 responses (50.4%)

Question 4: What is your contact address? 239 responses (89.2%)

Question 5: What is your email address? 234 responses (87.3%)

Question 6: May we contact you to get further information on your response?

Question 6 asked if respondents could be contacted for further information on their responses. This was completed by 100% of respondents, with 82.5% (221/268) agreeing that they could be contacted and 17.5% (47/268) preferring not to be contacted.

Responses by HSC Trust area

A proxy location for those who responded to the questionnaire can be provided using the postcodes listed within question 4 (contact address), where given. Postcodes were provided by 87% (234/268) of respondents

Table 4a - Number of respondent addresses within each trust area (numbers. less than five are not listed)

	BHSCT (n)	NHSCT (n)	SEHSCT (n)	SHSCT (n)	WHSCT (n)	Not answered (n)	Outside NI (n)	Grand Total (n)
Person living with diabetes/their carer/family member	33	70	36	32	17	29	0	217
All other respondents	16	10	9	*	*	*	*	51
Total								**268**

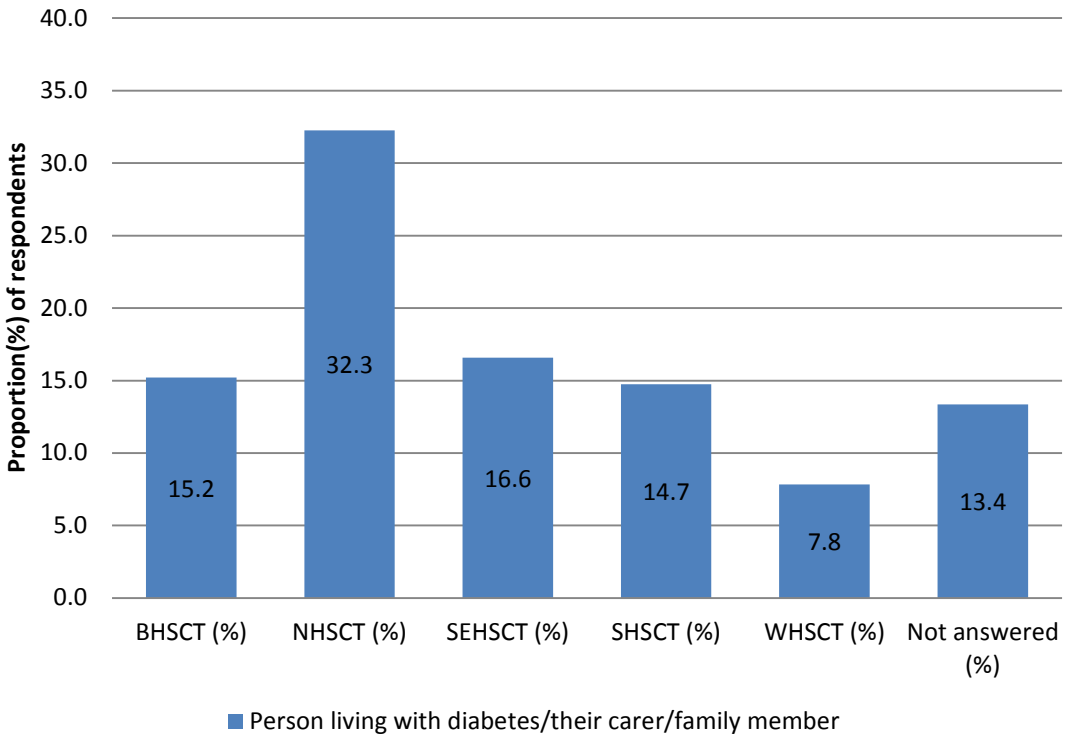
* =numbers 5 or less

Table 4b - Proportion (%) of respondent address within each Trust area

	BHSCT (%)	NHSCT (%)	SEHSCT (%)	SHSCT (%)	WHSCT (%)	Not answered (%)	Outside NI (%)	Total (%)
Person living with diabetes/ their carer /family member	15.2	32.3	16.6	14.7	7.8	13.4	0.0	100
All Other Respondents	31.4	19.6	17.6	*	*	*	*	100

As highlighted in tables 4a & b and figure 1, in relation to people living with diabetes/their families/carers who responded to the questionnaire, the largest proportion (32.3%) listed an address postcode in the Northern HSC trust area. Similar proportions listed addresses in Belfast (15.2%), South Eastern (16.6%) and Southern HSC trust (14.7%), with 13.4% not listing a postcode. The smallest proportion was listed in the Western HSC trust area (7.8%).

Figure 1: Proportion of respondents living with diabetes/their family/carers addresses by HSCT area



2 – FEEDBACK ON MODELS (Questions 7 -9)

Question 7: Do you believe that all of the advantages and disadvantages of the shortlisted models have been identified?

This question was completed by all but 2 participants (266/268, 99.3%), with 85.1% agreeing that all the advantages and disadvantages of the shortlisted models had been identified, as shown in figure 2 and table 5.

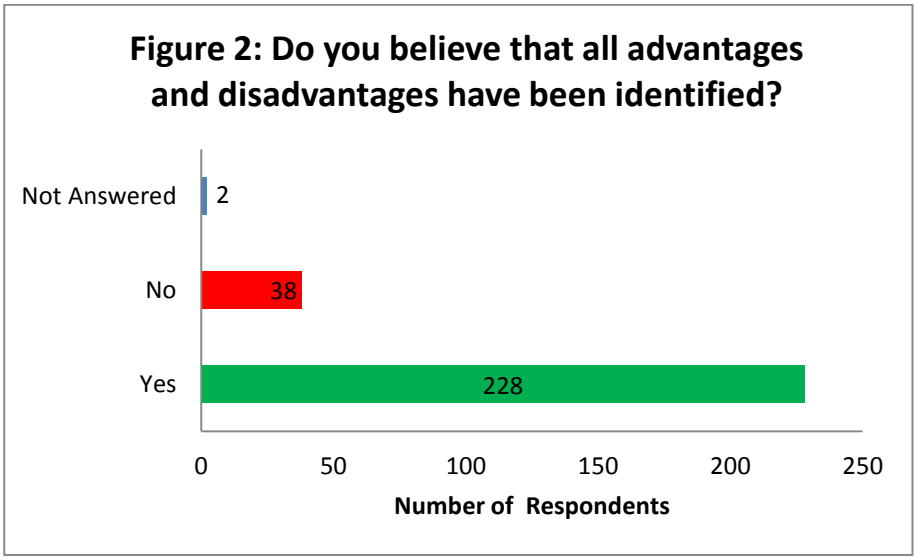


Table 5: Number and proportion of respondents who believe all advantages and disadvantages of shortlisted models have been identified

	Yes	No	Not Answered	Total
Number (No.)	228	38	2	268
Proportion (%)	85.1	14.2	0.7	100

Respondents were given the opportunity to leave any further comments in a free text box. 36 respondents added comments, 34 of whom answered 'no'. The comments have been grouped in Table 6 below. It is noted that the total number of themes may exceed 36 as an individual's comments may cover several themes.

Themes are summarised in table 6 in order of frequency of occurrence. They can be further aggregated into wider themes, shown for ease of reference here by colour coding (key attached).

Table 6: Comments related to question 7 grouped by theme

Theme	No
Couldn't find information/didn't read	4
Travel & Transport (parking, increased distance, public transport and location)	4
Concerns re option 3 – these comments included poaching of patients, reduction in quality control, creeping privatisation, travel and that high street optometrists would be driven by profit not care	4
Not happy with shortlist – felt there should be other options (none suggested)	3
Advantages of option 3 – available technology/equipment, reduced number of appointments, convenient locations and opening hours, accessibility, suggestion of reduced costs	2
Insufficient notice of appointments	2
Extended hours/needs of working population	2
Unhappy with current service (location, issuing of results)	2
Accessibility for those with learning difficulties	1
Concern re introduction of variable screening interval, risk of waiting 2 years to screen	1
Employ more staff	1
12 month interval not included in description of option 3	1
Importance of training/monitoring	1
Keep service in HSC	1
Benefit of local relationships in GP practices re DNA patients	1
Many variables across models, will depend upon personal circumstances	1
Not sure	1
Query training requirement in option 3 – felt it was unnecessary	1
Rural accessibility	1
Sharing data outside HSC – wanted further detail on implications of sharing with external providers	1
Increasing diabetic population	1
Prefers mobile unit	1
Total	**37**

Key

	Information
	Travel and transport
	Models of service delivery
	Operational/delivery factors
	Programme principles
	Not sure

Theme 1 - Models of service delivery (18/37)

Most comments in response to this question related to the models for delivery of the service (18 out of 37).

Option 3 (10/18)

In relation to models most comments related to option 3 the high street optometry model (10/18). This included 4 responses highlighting concerns (poaching of patients, reduction in quality control, creeping privatisation, travel and that high street optometrists would be driven by profit not care), 2 highlighting advantages (available technology/equipment, reduced number of appointments, convenient locations and opening hours, accessibility, suggestion of reduced costs) and 1 each regarding: the impact on the screening interval, sharing of data outside HSC, need to keep services within HSC, and training requirements.

Shortlisted models (3/18)

Other comments related to model of delivery suggested dissatisfaction with the shortlist, with 3 responses outlining that there should be more options, however no additional options were suggested.

Current service (2/18)

In relation to the current service 2 comments suggested dissatisfaction; 1 regarding the inconvenience of the location and 1 regarding results issuing.

Mobile service (1/18)

1 comment expressed a preference for a mobile service.

GP relationships (1/18)

1 response stressed the benefit of local GP relationships,

Multiple variables (1/18)

1 comment highlighted that there are many variables affected and personal circumstances will impact.

Theme 2- Information (4/37)

4 comments suggested that the respondents were unable to find the information related to this question or admitted they had not read it.

Theme 3- Travel and transport (4/37)

4 comments highlighted the need to consider travel and transport including parking, potential increased distance, availability of public transport and location.

Theme 4- Operational/Delivery (7/37)

These comments related to the logistics of attending a screening appointment, insufficient notice given for appointments (2) difficulties of those of working age attending during the work day (2), accessibility for those with learning disabilities (1), rural accessibility (1) and advising to employ more staff (1).

Theme 5- Programme principles (3/37)

Other comments highlighted programme wide issues including the increasing diabetic population (1), and programme principles such as the importance of training and monitoring (1) and perceived risk regarding the introduction of the variable screening interval (1).

Question 8: To what extent do you agree that the shortlisted models could provide a safe, high quality service and meet the demands of Northern Ireland's increasing diabetic population?

This question was completed by 100% (268) of respondents, with 70 additional comments received. Table 7 provides a breakdown of responses for each option, both numbers and corresponding proportions, for all respondents.

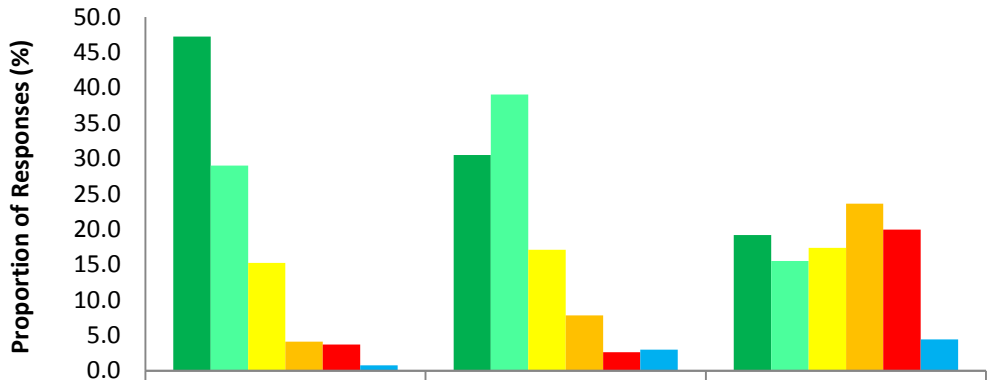
Table 7 - Responses to question 8 (all respondents)

	Option 1		Option 2		Option 3	
	No.	**%**	**No.**	**%**	**No.**	**%**
Strongly Agree	127	*47.2*	82	*30.5*	52	*19.2*
Agree	78	*29.0*	105	*39.0*	42	*15.5*
Neither Agree nor Disagree	41	*15.2*	46	*17.1*	47	*17.3*
Disagree	11	*4.1*	21	*7.8*	64	*23.6*
Strongly Disagree	10	*3.7*	7	*2.6*	54	*19.9*
No Opinion	2	*0.7*	8	*3.0*	12	*4.4*
Total	269*	*100.0*	269*	*100*	271*	*100.0*

**for each option a number of respondents selected more than one answer (1 for option1, 1 for option 2, 3 for option 3)*

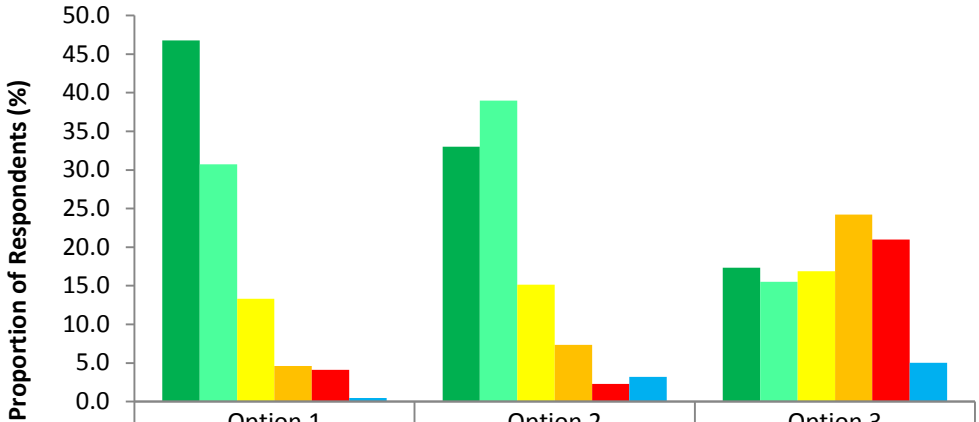
Figure 3 shows the proportion of responses for each of the shortlisted options. Both option 1 and 2 are perceived as being able to provide a safe, high quality service which would meet the demand of NI's increasing diabetic population, with 76.2% and 69.5% of respondents respectively stating that they agree or strongly agree with this statement. Responses for option 3 are more mixed with 34.7%either strongly agreeing/ agreeing and 43.5% strongly disagreeing/disagreeing with the suitability of the proposed model. Figure 4 highlights the responses for those living with diabetes only and shows that these reflect similar patterns

Figure 3: To what extent do you agree that the shortlisted models could provide a safe, high quality service and meet the demand of NI's increasing diabetic population? (All Respondents)



	Option 1	Option 2	Option 3
Strongly Agree	47.2	30.5	19.2
Agree	29.0	39.0	15.5
Neither Agree nor Disagree	15.2	17.1	17.3
Disagree	4.1	7.8	23.6
Strongly Disagree	3.7	2.6	19.9
No Opinion	0.7	3.0	4.4

Figure 4 : To what extent do you agree that the shortlisted models could provide a safe, high quality service and meet the demand of NI's increasing diabetic population? (Those living with diabetes)



	Option 1	Option 2	Option 3
Strongly Agree	46.8	33.0	17.4
Agree	30.7	39.0	15.5
Neither Agree nor Disagree	13.3	15.1	16.9
Disagree	4.6	7.3	24.2
Strongly Disagree	4.1	2.3	21.0
No Opinion	0.5	3.2	5.0

70 respondents commented on this question (the largest number for any question). Themes are summarised in table 8 in order of frequency of

occurrence. They can be further aggregated into wider themes, shown for ease of reference here by colour coding (key attached). Please note that some responses will have included several themes, therefore the total number in Table 8 is not 70.

Table 8: Comments related to question 8 grouped by theme

Theme	No.
Concern re Option 3 (inc commercial, quality, training, standards, equipment and information governance issues)	27
Travel & Transport (accessibility, rural links, decrease uptake, eye drops and car parking)	11
Benefits of Option 3 - e.g. opening hours, accessibility, equipment	8
Confusion re screening vs routine eye check/assumption that it would be 1 appointment in Option 3	7
Happy with current service	7
Prefer fixed site options	5
Prefer option 3	5
Benefit of Fixed Sites	3
Accessibility best at GP practices	2
Any model	2
Benefit of co-location at GP practices	2
Should remain at GP practices	2
Importance of programme management, call/recall, communication with ophthalmology	2
Concern re attending unfamiliar locations (all options)	1
Concern re staff job losses with option 3	1
Importance of screening programme	1
None of the shortlisted models	1
Prefer mixed model – all 3 options	1
Not sure	1
Total	**89**

Key

	Travel and transport
	Models of service delivery
	Operational/delivery factors
	Programme principles
	Not sure

Theme 1: Models of service delivery (72/89 comments)

Most feedback related to models of service delivery (72/89) comments

Option 3 (47/72 comments)

Most comments received on models of service delivery related to option 3 (47/72) the high street model. The majority (27/47) of these were relating to concerns regarding this model including commercial, quality, training, standards, equipment and information governance issues. 8 out of 47 comments expressed the benefits of this model including opening hours, accessibility, and equipment. A further 5/47 declared a preference for this model.

7 comments suggested confusion over what would be offered in this model in relation to screening vs routine eye check/ an assumption that it would be 1 appointment in Option 3.

Current service (7/72 comments)

7 out of 72 comments related to models of service delivery highlighted happiness related to the current service.

Fixed sites (options 1 and/or 2) (8/72 comments)

8 out of 72 comments on models related to fixed sites with 5 highlighting the potential benefits of these (including integration with other services, proximity, opening hours, continuity of location and quality) with 3 expressing a preference for fixed sites.

GP practice (4/72 comments)

There were 4 comments related to GP practices 2 advising this has the best accessibility and 2 regarding the benefits of colocation on GP sites (having combined appointments/integration with other diabetes checks).

There were a further 4 comments related to models. 2 suggested any model would be ok, 1 preferred a mixed model (using all 3 options) and 1 was unhappy with all shortlisted models, however did not specify any alternatives.

Theme 2: Travel and transport (11/89 comments)

The next most common theme was travel and transport, with 11 comments related to this. These included reference to accessibility, rural links, risk of decreased uptake related to increased travel, eye drops (being unable to drive following drops) and parking.

Theme 3: Operational/delivery factors (2/89)

These 2 comments related to concern re attending unfamiliar locations (1) and concern re staff job losses in relation to option 3 (1).

Theme 4: Programme principles (3/89)

This included comments highlighting the importance of programme management including adequate call/recall (1), communication with treatment services (1) and the importance of the screening programme (1).

Question 9: If you are a person living with diabetes would you be happy to attend screening at the shortlisted options?

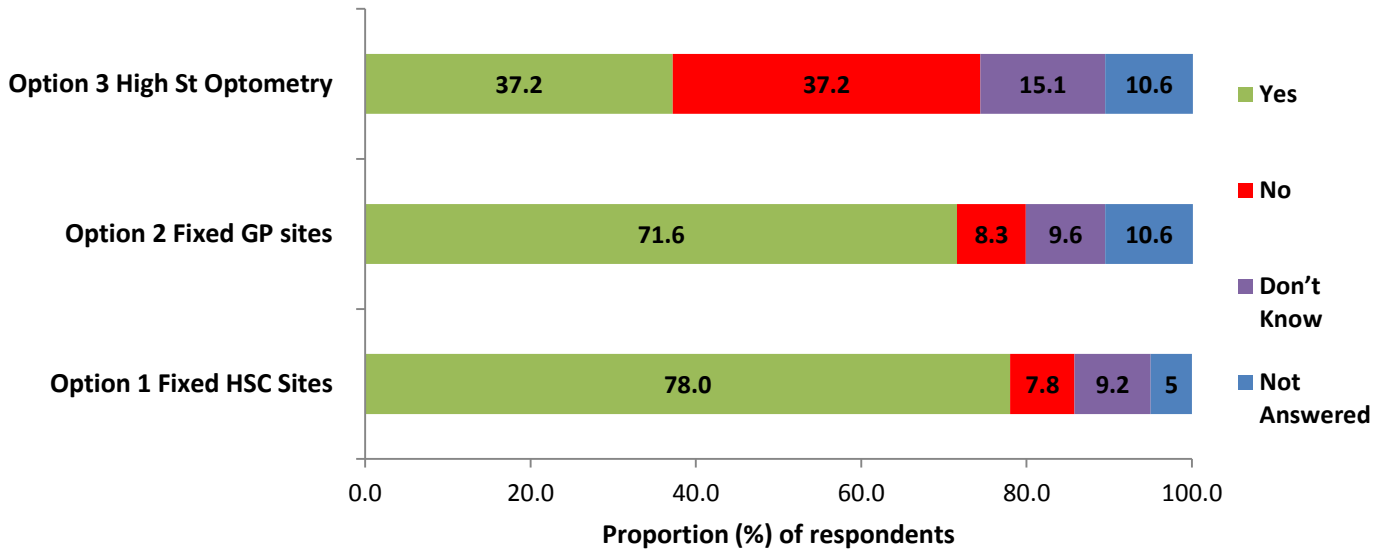
This question was aimed only at those living with diabetes. It was answered by 228 respondents, however a number of those from other respondent types also answered the question. For the purposes of analysis, only responses from those who had identified as living with diabetes, their carers/families (n= 217) were considered. All options had 1 person who ticked 2 answers, e.g. 'Yes' + 'Don't Know' therefore the total for each is 218.

Table 9: Responses to question 9

	Option 1		**Option 2**		**Option 3**	
	No.	***%***	**No.**	***%***	**No.**	***%***
Yes	170	*78.0*	156	*71.6*	81	*37.2*
No	17	*7.8*	18	*8.3*	81	*37.2*
Don't Know	20	*9.2*	21	*9.6*	33	*15.1*
Not Answered	11	*5.0*	23	*10.6*	23	*10.6*
Total	218	*100*	218	*100*	218	*100*

As shown in table 9 and figure 5, option1 (fixed HSC sites) had the largest proportion of respondents agreeing that they would attend screening at these sites (78%). This was similar to option 2 with 71.6% agreeing with screening at fixed GP sites. Responses to attending screening at option 3 high street optometry were however mixed with 37.2% answering yes they would attend and 37.2% advising no, they would not attend. 15.1% answered they 'don't know' if they would attend screening at option 3 which was the largest proportion who were unsure and answered 'don't know' across all models (vs 9.2% and 9.6% for options 1 and 2 respectively).

Figure 5: Would you attend screening at options 1, 2 , 3? (Respondents living with diabetes/their families/carers only)



When responses are examined by those who ticked 'yes' to an option (n=217, as excludes one of the responses that the person who ticked 'yes' and 'do not know' for all options), it shows that:

- 67 (30.9%) were willing to attend any fixed site option (1 and 2)
- 62 (28.6%) were willing to attend all three options
- 36 (16.6%) would only attend option 1
- 20 (9.2%) would only attend option 2
- 7 (3.2%) would only attend option 3
- 7 (3.2%) were willing to attend options 2 or 3
- 5 (2.3%) were willing to attend options 1 or 3
- 13 (6.0%) answered 'no' or 'don't know' to all options

42 respondents provided additional comment, these are grouped by theme where possible below.

<u>Comments grouped by theme</u>

Themes are summarised in table 10 in order of frequency of occurrence. They can be further aggregated into wider themes, shown for ease of reference here by colour coding (key attached).Please note that some comments will have included several themes, therefore the total number in Table 10 is 55.

Table 10: question 9 comments grouped by theme

Theme	No.
Concerns re Option 3	7
Travel and Transport (inc increased distance, public transport and carparking)	7
Prefer 1 or 2	5
Depends on sites	4
Happy with any option	4
Working population (travel and opening hours)	4
Prefer 2	3
Prefer 3 - but only with own optometrist	3
Happy with current service	2
Prefer 1	2
Any - but within 15 miles of home	1
Benefits of Option 3	1
Concern re parking at Option 1	1
If Option 3 only with own optometrist	1
Prefer 2 - but only with own practice	1
Prefer 2 or 3	1
Wants mobile service	1
More notice of appointment	1
Integration of services not realistic	1
Benefits of integration of services	1
Suggested location	1
Travel for older population/those with mobility issues	1
Travel for rural areas	1
Unsure	1
Total	**55**

Key

	Travel and transport
	Models of service delivery
	Operational/delivery factors
	Unsure

Theme 1: Models of service delivery (37/55)

Most of the comments received relate to the models for service delivery (37/55).

Option 3 (12/37)

Most comments on models were related to option 3 (12/37). 7 of these were concerned regarding option 3 (including lack of confidence in service, commercial concerns and potential cost to the health service), 1 further comment highlighted the benefits of option 3. 3 preferred option 3 but only if their own optometrists provided this service and 1 advised if option 3 was providing the service they would only attend if it was at their own optometrist.

Any option (5/37)

4 comments suggested that they would be happy to attend any model, with 1 further comment advising they would be happy to attend any model but only within 15 miles from home.

Option 1 or 2 (5/37)

5 comments suggested a preference for either option 1 or 2

Option 2 (4/37)

3 comments preferred option 2 with 1 comment highlighting they prefer option 2 but only at their own practice.

Depends on sites (4/37)
4 comments regarding models suggested it depends on which sites are chosen for each.

Option 1 (3/37 comments on models)

2 comments received preferred option 1. A further comment highlighted concern about car parking with this option

Option 2 or 3 (1/37)

1 comment had a preference for either option 2 or 3

Current service – 2 comments were happy with the current service

Mobile service – 1 comment preferred a mobile service

Theme 2: Operational/delivery factors (8/55)

4 responses highlighted the impact of travel and opening hours on the working population

1 comment requested more notice of appointments, and 1 further comment suggested a potential fixed location. 1 comment stated that integration of diabetes services was unrealistic, in particular the difficulties in scheduling multi-disciplinary appointments, whilst 1 comment highlighted its potential benefits.

Theme 3: Travel (9/55)

7 comments highlighted the impact of travel, increased distances, availability of public transport and parking. 1 comment related to the impact of travel for rural areas, with 1 further comment on the impact on those who are older/ with mobility issues.

3 - FUTURE PLANNING CONSIDERATIONS (Question 10)

Question 10: In planning the future model we would use a specification to choose screening sites. Please rank the criteria below in order of importance to you (1=most important, 6=least important)

This question was included to help inform which key considerations should be taken into account when planning and implementation processes begin.

The question style appeared to pose some difficulties in terms of selecting ranking, which was restricted within the Citizen Space platform with one answer against numbers 1 to 6. In addition hard copy responses were often incomplete or ticked as opposed to ranked. Therefore there is a variation between the response rates for each criteria.

Table 11: Important considerations ranking (all respondents)

	Accessibility		Carparking		Public Transport		Co-location		Extended Hours		Proximity to Home	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
1	79	**29.5**	48	**17.9**	12	**4.5**	23	**8.6**	28	**10.4**	65	**24.3**
2	34	**12.7**	82	**30.6**	44	**16.4**	31	**11.6**	31	**11.6**	33	**12.3**
3	39	**14.6**	44	**16.4**	64	**23.9**	49	**18.3**	28	**10.4**	30	**11.2**
4	40	**14.9**	33	**12.3**	32	**11.9**	72	**26.9**	44	**16.4**	27	**10.1**
5	28	**10.4**	21	**7.8**	37	**13.8**	48	**17.9**	66	**24.6**	42	**15.7**
6	34	**12.7**	23	**8.6**	55	**20.5**	29	**10.8**	47	**17.5**	48	**17.9**
Answered	**254**	**94.8**	**251**	**93.7**	**244**	**91.0**	**252**	**94.0**	**244**	**91.0**	**245**	**91.4**
Not Answered	14	**5.2**	17	**6.3**	24	**9.0**	16	**6.0**	24	**9.0**	23	**8.6**

Tables 12 and 13 represent two different methods for analysing the answers to this question.

Table 12: Criteria rankings- Proportion (%) of votes for each criteria that had rankings 1-3, and 4-6

Proportion (%) Ranked	Accessibility	Car Parking	Public Transport	Co-location	Extended Hours	Proximity to Home
1 to 3	56.8	64.9	44.8	38.5	32.4	47.8
4 to 6	38	28.7	46.2	55.6	58.5	43.7
Not answered	5.2	6.3	9	6	9	8.6
Total	100	100	100	100	100	100

In table 12 each individual criterion (accessibility etc) is examined to show what proportion of votes received for each criteria were cumulatively ranked 1-3 (important), or 4-6 (less important). This analysis suggests that based on the criteria with the largest proportion of votes ranked 1-3 to the smallest proportion ranked 1-3 they would be ordered: car parking (64.9%), accessibility (56.8%), proximity to home (47.8%) public transport (44.8%) colocation (38.5%) and extended hours (32.4%).

Table 13: Votes for ranks 1-6, criteria with highest proportion (%) of votes at each rank

Rank	Criteria with highest proportion of all votes at this rank	% of all votes at this rank	Number of votes for this criteria	Total number of votes at this rank
1	accessibility	31	79	255
2	car parking	32.2	82	255
3	public transport	25.2	64	254
4	co-location	29	72	248
5	extended hours	27.3	66	242
6	public transport	23.3	55	236
not answered	public transport and extended hours	20.3	24	118

Alternatively table 13 shows the results when the number of votes for each individual ranking 1-6 is examined. This suggests a slightly different arrangement of criteria from most to least important. Accessibility receiving the highest proportion of all rank 1 votes, car parking receiving the highest proportion of all rank 2 votes, public transport receiving the highest proportion of all rank 3 votes, co-location rank 4 highest, extended hours highest rank 5 proportion and public transport again receiving the highest proportion all rank 6 votes.

Table 14: Comments on question 10 grouped by theme

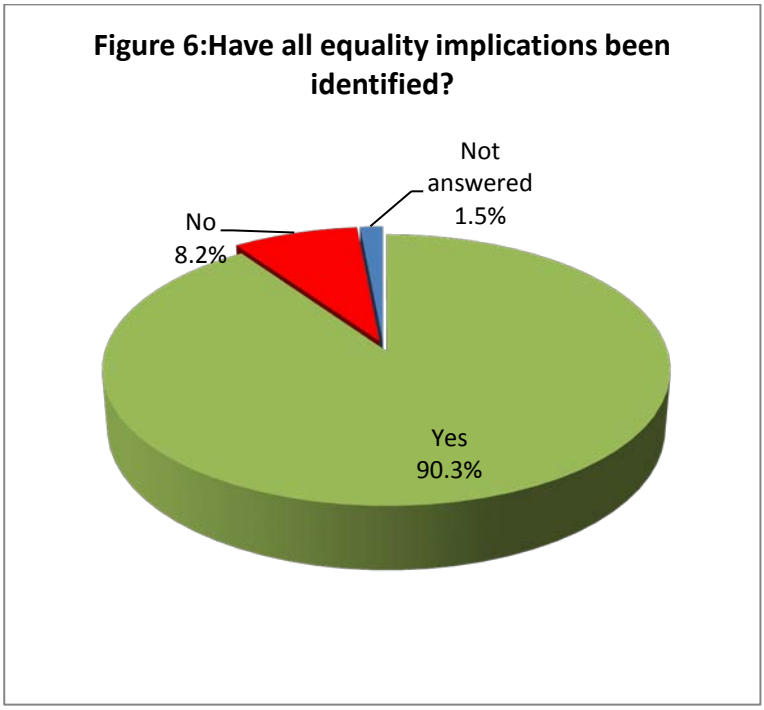
Theme	No.
Difficulties completing question	5
Local amenities	2
Adequate notice of appointment	1
All important issues	1
Appointment within Interval	1
Extended hours (for those working full-time)	1
Importance of co-location	1
Quality technology	1
Suggested location	1
Training/Qualifications of Staff	1
Total	**15**

Comments returned regarding criteria that are important in implementation highlight that there was some difficulty completing this question (5/15). Local amenities were also suggested as being important (2/15). It was recognised by 1 comment that all the criteria are important issues (1/15). Further single comments were received regarding adequate notice for appointment time, importance of appointment within the interval, importance of quality technology, training and qualifications for staff. The importance of colocation and extended hours for those of working age were also flagged and 1 response suggested a specific location for screening.

4 – EQUALITY AND RURALITY IMPLICATIONS (Questions 11-14)

Question 11: Do you believe that all key implications for equality groups have been identified?

This question was answered by all respondents with 90.3% (242/268) stating that they agreed that all key equality implications had been identified.



Answer	No.	%
Yes	242	90.3
No	22	8.2
Not answered	4	1.5
Total	268	100

Comments grouped by theme

20 respondents provided additional comments for this question, these are grouped by theme where possible. Themes are summarised in table 15 in order of frequency of occurrence. They can be further aggregated into wider themes, shown for ease of reference here by colour coding (key attached). Please note that some comments will have included several themes, therefore the total number in Table 15 is 21.

Table 15: Comments to question 11 grouped by theme

Theme	No.
Not sure	6
Answer not clear/not relevant	2
Not aware/haven't read	2
Rural Needs	2
Access to transport	1
GPs are more accessible	1
More research required	1
Specialist services for those with learning difficulties	1
The older population	1
Those in Prison	1
Those with limited mobility	1
Those working	1
Not relevant to me	1
Total	**21**

Key

	Operational/delivery factors (accessibility)
	Groups to consider
	Information
	Unsure

Theme 1: Unsure/not relevant (9/21)

6 responses indicated that they were unsure if all equality implications had been addressed, with 1 further comment stating the question was not relevant to them. The meaning of 2 further comments was unclear/not relevant to the question posed.

Theme 2: Groups to consider (7/21)

There were 2 responses highlighting needs of the rural population. Each of the following groups were highlighted, receiving 1 comment each:

those in prison, those with learning disabilities, those with limited mobility, those who work, and the older population.

Theme 3: Information (3/21)

3 comments were related to information, with 2 stating they had not read/were unaware of the information and 1 advising more research was required.

Theme 4: Operational/delivery factors (2/21)

1 comment highlighted that GP practices are usually part of a community and therefore more accessible. 1 comment added that not everyone has access to transport.

Question 12: What do you suggest we could do to address the equality issues identified?

52 respondents provided comments for this question; these are grouped by theme where possible. Themes are summarised in table 16 in order of frequency of occurrence. They can be further aggregated into wider themes, shown for ease of reference here by colour coding (key attached). Please note that some comments will have included several themes, therefore the total number in Table 16 is 57.

Table 16: comments for question 12 grouped by theme

Unsure	8
Nothing	6
Consultation/Engagement with Stakeholders	4
Ease of access for working population	3
Ensuring accessibility for users	3
Out of Hours Opening	3
Keep as it is	3
Not applicable/not relevant	3
Needs of non-English speakers (inc leaflet translations and interpreters)	3
Co-location of services	2
Should concentrate on other factors (cost effectiveness, quality and working environment)	2
Adequate notice of appointment	1
Assisted parking charges for carers	1
Equality is using up scarce resources	1
Feedback/Satisfaction sheet	1
Screen in (specific location named)	1
Use facilities more efficiently	1
Use population statistics for planning	1
Transport & Travel	2
Continuity of care for those in prison	1
Disability training	1
Ease of access for those with restricted mobility/sensory difficulties	1
Ensure rural areas are covered	1
Familiarisation with Language Matters	1
Needs of those attending Hospital Eye Services	1
Have experts treating people	1
Recruit majority of High St optometrists	1
Total	**57**

Key

	Travel and transport
	Model of service delivery
	Operational/delivery factors
	Groups to consider
	Unsure/N/A
	Programme principles

Theme 1: Unsure/not relevant (17/57)

17 out of 57 responses suggested the respondent was unclear or felt the question was not relevant. 8 responses indicated that they were unsure what actions could address the equality issues identified, with 3 further comments stating the question was not relevant/applicable to them. There were 6 comments which advised that there was nothing which could address issues identified.

Theme 2: Operational/Delivery Factors (17/57)

There were 3 comments regarding the importance of accessibility for programme users, with a further 3 suggesting that appointments should be available during extended hours e.g. evenings. 2 comments suggested co-locating the screening programme with other diabetes services. There were 2 comments highlighted that the programme should concentrate on other factors such as cost effectiveness and quality standard rather than equality, with 1 further comment advising that ensuring equality was using scarce NHS resources.

Other suggestions included a feedback/satisfaction sheet at clinics (1), assisted parking fees for carers (1), adequate notice of appointments 1), use facilities more efficiently (1) and use population statistics to identify sites (1). 1 further comment suggested a named location for a fixed site.

Theme 3: Groups to consider (16/57)

There were 4 comments suggesting that further engagement/consultation with those affected should take place. An additional 3 responses highlighted the needs of the working population, with a further 3 highlighting needs of non-English speakers. Each of the following groups were highlighted receiving 1 comment each: those in prison, those in rural areas, those with mobility/sensory difficulties, and those in Hospital Eye Services. 1 comment

stated the importance of disability training for staff, whilst 1 other recommended familiarisation with the document ‘Language Matters’.

Theme 4: Model of service delivery (4/57)

Current model (3/4)

Of the 4 comments related to the model of service delivery- 3 suggested that the current model of delivery should not change.

Option 3 (1/4)

A further (1) response related to models of service delivery 1 suggested recruiting the majority of high street optometrists (option 3) would address equality issues.

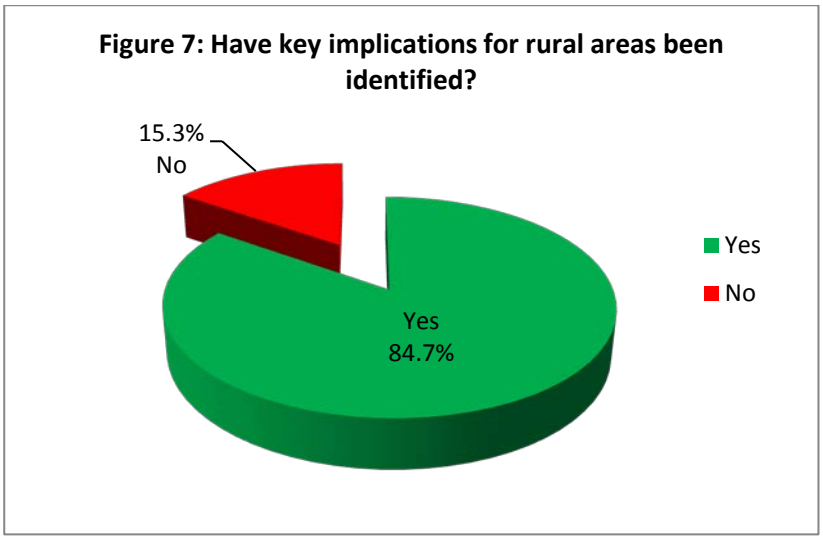
Theme 5: Travel and transport (2/57)1 response advised that services should be as close to patients as possible and a further comment (1) suggested provision of local transport for the elderly and those with limited mobility.

Theme 6: Programme principles (1/57)

It was suggested in 1 comment that the programme should have experts providing the service.

Question 13: Do you believe that all key implications for rural areas have been identified?

This question was answered by all respondents, with 84.7% (227/268) stating that they agreed that all key rural implications had been identified.



Answer	No.	%
Yes	227	84.7
No	41	15.3
Total	268	100

Comments grouped by theme

34 respondents provided additional comments for this question, these are grouped by theme where possible. Themes are summarised in table 17 in order of frequency of occurrence. They can be further aggregated into wider themes, shown for ease of reference here by colour coding (key attached). Please note that some comments will have included several themes, therefore the total number in Table 17 is 37.

Table 17: comments grouped by theme

Don't know	7
Access to public transport	6
Increased travel	3
Mobile service for rural areas	3
Need named sites	2
Community transport	2
Travel for older population	2
Access in rural areas essential	1
Access to local towns easier than centralised services	1

Close to home	1
Consideration of centralised locations in rural areas	1
Geographical catchment areas	1
Retain services in a named area	1
Need to be driven to appointments (eyedrops)	1
Bus - like Breast Screening Programme	1
Option 3 would be better; more sites	1
Recruit majority of High St optometrists	1
Inequality throughout health	1
There will always be inequality	1
Total	**37**

Key

	Travel and transport
	Model of service delivery
	Operational/delivery factors
	Unsure/N/A

Theme 1: Travel and Transport (14/37)

There were 6 comments highlighting the importance of availability of public transport, with a further 2 suggesting the provision of community transport. 3 comments highlighted potential increase travel, with 2 additional comments concerned that increased travel would impact on the older population. 1 comment advised that those getting eyedrops need to be driven to appointments.

Theme 2: Unsure/not relevant (11/37)

7 comments were unsure ('don't know') whether all implications had been identified, with a further 2 comment(s) advising they need to know the sites before they provided a response.

1 comment stated that there was inequality throughout healthcare and 1 stated that there will always been inequality.

Theme 3: Operational/Delivery Factors (6/37)

1 comment suggested that access in rural areas was essential, with 1 further response advising that access for those in rural areas would be easier in local towns rather than centralised locations. However 1 other comment stated that consideration should be given to using centralised locations with easy

access to public transport. 1 comment wanted the service close to home, 1 stated that geographical catchment areas should be considered and the remaining comment named a site where screening should remain.

Theme 4: Models of service delivery (6/37)

Mobile service (4/6)

3 comments suggested that a mobile service should be provided in rural areas, with an additional (1) comment suggesting that a bus, similar to those used in the Breast Screening Programme, should be provided.

Option 3 (2/6)

1 response advised that option would be better for rural areas as there would be more sites and 1 further comment stated that recruiting the majority of high street optometrists would address rurality issues

Question 14: What do you suggest we could do to address the rural issues identified?

54 respondents provided comments for this question; these are grouped by theme where possible. Themes are summarised in table 18 in order of frequency of occurrence. They can be further aggregated into wider themes, shown for ease of reference here by colour coding (key attached). Please note that some comments will have included several themes, therefore the total number in Table 18 is 63.

Table 18: responses to question 14 grouped by theme

Theme	No.
Unsure/Don't know	9
Not applicable	4
Engage/consult with rural groups	4
Mobile service	4
Provide transport	4
Screen locally	4
Extended opening hours	3
Importance of parking	3
Avoid centralisation	2
Geographical spread in rural areas	2
Don't change service	2
Use GP surgeries	2
Importance of public transport	2
Community bus provision	1
Engage with public transport	1
Provide information on local transport/drivers	1
There will be travel implications for all	1
Travel shouldn't be significantly increase	1
Travelling practices	1
Group invite for those in rural areas with mobility issues/elderly	1
Group invite for those in rural areas and offer transport	1
Needs of carers	1
Mixed model - mobile and fixed	1
Outsource to accredited High St Optoms	1
Recruit majority of High St optometrists	1
More notice of appointments	1
Three month feedback questionnaire	1
Use community locations (shopping, leisure areas)	1

Financial incentives to get GPs to settle in rural areas	1
Reimbursement of travel costs	1
Think outside the box	1
Total	**63**

Key

	Travel and transport
	Model of service delivery
	Operational/delivery factors
	Groups to consider
	Financial considerations
	Unsure/not relevant

Theme 1: Travel and transport (15/63)

Travel and transport was the most common theme with 4 comments stating that consideration should be given to providing transport, with 1 further comment suggesting provision of a community bus. 2 responses highlighted the importance of public transport, with 1 suggestion to engage with public transport services and another 1 to provide information to users on local services/drivers.

There were 3 comments highlighting the importance of adequate parking. 1 response stated that travel should not increase significant with any change and 1 other suggested there will be travel implications for all. 1 comment suggested the provision of travelling practices.

Theme 2: Unsure/not relevant (14/63)

9 comments were unsure what actions could be taken, 4 stated that the question was not applicable. 1 comment suggested that the programme 'thinks outside the box'.

Theme 3: Operational/Delivery Factors (14/63)

Many comments also related to logistical issues in delivery of the programme (14/63) with 4 comments suggested that screening should be carried out locally, 2 discouraging centralisation and a further 2 encouraging adequate geographical spread in rural areas. 1 response suggested the use of community locations such a shopping and leisure areas.

A further 3 comments highlighted the importance of extended opening hours and 1 stated that more notice of appointments should be given. 1 comment suggested the use of a three month user feedback questionnaire.

Theme 4: Models of service delivery (11/63)

There were 11 comments related to models of service delivery

Mobile service (4/11)

There were comments related to models of service delivery that advised the provision of a mobile service in rural areas.

GP surgeries (2/11)

There were 2 suggestions that GP surgeries should be used.

Current model (2/11)

2 responses suggested the current model of service delivery should not be changed

Option 3 (2/11)

2 comments encouraged the selection of option 3

Mixed fixed and mobile model (1/11)

1 response suggested a mixed fixed site and mobile model should be used.

Theme 5: Groups to consider (7/63)

Many comments highlighted particular groups that should be considered with 4 comments encouraging the programme to engage with rural groups. A further 2 responses suggested group invites for those with mobility issues and those in rural areas. 1 comment highlighted the need to consider carers.

Theme 6: Financial considerations (2/63)

Of the 2 remaining comments, 1 suggested financial incentives for GPs to settle in rural areas and 1 reimbursement of travel costs.

5 – FINAL COMMENTS AND CONSULTATION SATISFACTION (Questions 15-17)

Question 15: Do you have any other comments?

Answer	No.	%
Yes	42	15.7
No	226	84.3
Total	268	100

42 respondents provided comments for this question; these are grouped by theme where possible. Themes are summarised in table 19 in order of frequency of occurrence. They can be further aggregated into wider themes, shown for ease of reference here by colour coding (key attached). Please note that some comments will have included several themes, therefore the total number in Table 19 is 58.

Table 19: responses to question 15

Theme	No.
Uptake - How to improve - Potential drop in uptake if moved away from GP practices (loss of relationship) - Reword invitation letter - Increase travel distance may mean decreased uptake - Working population – increased choice of location and time, may result in higher uptake	6
Travel & Transport (inc location) - Travel and eye drops - Impact of increased distance - Transport for those with mobility issues/elderly/eye drops - Impact on rural communities	6
Happy with the current service	5
Unhappy with the current service - Cancellation of appointment - Insufficient notice of appointment - Delay in appointment	3
Importance of 12 month screening interval	3
Programme funding	3
Confusion re screening test vs routine eye check (one	2

appointment)	
Advantages of option 3 - one appointment for both screening and routine eye check - trained, skilled staff - equipment - accessibility of sites	2
Questioning the description of option 3 (costs, excessive governance and training, potential commercial implications)	2
Happy with potential shortlisted options	2
Why change the model?	2
Eye drops – should be an alternative method/technique	2
Importance of communication with other diabetes services/professionals	2
Potential benefit of co-location of diabetes services	2
Importance of the programme	2
Importance of communication with ophthalmology services	1
Importance of commissioned and clear referral pathway	1
Concern re introduction of variable screening interval	1
Results letter should be reviewed	1
Efficiency within service should be improved	1
Suggestion to have contact details on card to hand out at podiatry clinics	1
Patients will take hospital sites more seriously	1
Prefers option 1	1
Importance of keeping service within Health and Social Care (maintenance of control and coordination)	1
Recognition of the difficulties in implementing change	1
Difficulty completing the questionnaire	1
Education re the difference between screening and routine eye checks	1
Importance of diabetes prevention in younger population	1
This exercise is to please you not the client	1
Total	**58**

Key

	Travel and transport
	Model of service delivery
	Operational/delivery factors
	Groups to consider
	Financial considerations
	Unsure/Other
	Programme principles

Theme 1: Models of service delivery (16/58)

The majority of comments related to models of service delivery (16/58).

Current service (7/16)

Most comments related to the models of service delivery related to the current service with 5 comments stating they were happy with the current service and 2 querying the need to change

Option 3 (5/16)

There were mixed comments regarding option 3, with 2 responses highlighting the advantages of option 3 (including one appointment, experience of optometry staff and equipment), and 2 comments questioning the description of option 3. 1 further response highlighted the importance of keeping the service within health and social care for coordination and control.

Option 1 (2/16)

1 response favoured option 1 and another (1) suggested patients will take hospital sites more seriously.

Shortlisted options (2/16)

2 comments were happy with the potential shortlisted options.

Theme 2: Operational/delivery factors (12/58)

The next most common theme was related to operational factors with 3 comments expressing dissatisfaction with the current service in relation to the timing of appointments. Other comments (2) highlighted the importance of communication with other diabetes services, 2 discussed the benefits of co-location. A further 2 comments queried whether there are available alternatives to eye drops, with 1 response suggesting efficiency could be improved. There were also some practical suggestions such as reviewing the results letter (1) and handing out NIDESP business cards at podiatry clinics (1).

Theme 3: Programme principles (8/58)

Several important aspects of the screening programme were highlighted, including the importance of the programme (2) and the importance of the screening interval standard (3) and the commissioning and referral pathway (1). Other important issues highlighted included communication with

ophthalmology services (1), and concern re the introduction of the variable screening interval (1).

Theme 4: Unsure/Other (7/58)

2 comments suggested confusion regarding the difference between screening and routine eye checks, with an additional (1) comment suggesting further education on this issue. 1 comment recognised the difficulties in implementing change, 1 highlighted the importance of diabetes prevention in young people. 1 comment stated they experienced difficulties completing the questionnaire, whilst the remaining (1) comment felt that consultation was not for the benefit of users.

Theme 5: Uptake (6/58)

There were 6 comments concerning uptake within the programme, the potential impact of the models, but also ways to improve the number of people choosing to attend their screening appointment, e.g. rewording of invitation letter.

Theme 6: Travel and transport (6/58)

As with many question comments, was the impact of change on travel, particularly for those needing eye drops, with restricted mobility, the older population, those living in care homes and those within rural areas.

Theme 7: Financial considerations (3/58)

The remaining 3 comments concerned programme funding and suggested it was under resourced /required further investment.

Question 16 – Please indicate how satisfied you are with the way you have been consulted with about these proposals

This question was completed by 100% of respondents, with 29 leaving additional comments.

Table 20: Levels of satisfaction with consultation

Level of satisfaction	No.	%
Very satisfied	81	30.2
Satisfied	130	48.5
Neither satisfied nor dissatisfied	34	12.7
Dissatisfied	14	5.2
Very dissatisfied	4	1.5
Don't know	3	1.1
Not Answered	2	0.7
Total	**268**	**100**

All comments received by those who selected 'dissatisfied' or 'very dissatisfied' are listed below. These largely indicate an expectation that there would be engagement on the individual level/within their GP practices, with most indicating they became aware via social media (2), online resources (2), attendance at appointment (3), work (2).

- Wasn't consulted at all. Found out from a friend.
- Knew nothing about it and only I seen it on social media probably would not have known.
- Came across it on Facebook. Thought there would be info in GP surgeries or patients contacted by email/letter by GP surgery
- Only that I can go online I wouldn't have known about same
- I didn't know about the consultation until I read about it on The Patient and Client Council.
- Little or no information provided to me directly, first awareness from a work blanket email
- I would not be aware of this survey if I did not work in a GP practice.
- As a diabetic it would have been useful to be notified about the consultation even if through my GP practice - poster on noticeboard etc. I only found out by someone sharing a post on social media
- Only found out yesterday when I attended my eye screen in local GP surgery with the mobile unit

- Literally I was told briefly and given this leaflet.
- ONI feel we have been misinformed about the model from the outset. The High Street Optometry model is now a different model than was first proposed and we feel there is an issue here.

Question 17: How did you hear about this consultation?

This question was completed by all respondents. The majority (48.5%) of respondents became aware of the consultation at their screening or Hospital Eye Services appointment, with a further 14.9% finding out via social media and 14.2% at their workplace. Table 21 provides a breakdown of responses.

Table 21 - Responses to question 17

Source	No.	%
GP Practice	22	8.2
Screening/ Hospital Eye Services appointment	130	48.5
Professional body	14	5.2
Social media	40	14.9
Workplace	38	14.2
Other	24	9.0
Total	**268**	100.0

The 24 responses categorised as other, can be broken down as follows:

- 9 Patient Client Council
- 4 email
- 4 friends/family
- 2 Diabetes UK
- 1 by chance
- 1 diabetes support group
- 1 local insight group
- 1 public notice/newspaper
- 1 RNIB

SECTION B: Feedback from engagement events

DESP Staff Event – 12th February 2019

Two members of the PHA screening team and a few other members of the modernisation project team attended a dedicated meeting with screening staff. All staff members (including community optometrists providing the western area service) and a representative from HR in Belfast HSC trust, had been invited to attend in advance and the meeting was organised to coincide with a DESP training day to help maximise attendance. The public health lead for the DESP in PHA provided a presentation regarding the consultation and shortlisted models, with the rest of the meeting allowing an open discussion. Issues discussed included:

- clarification on HSC fixed sites versus GP/primary care sites,
- how the number of sites was estimated and whether this could change,
- why slit lamp biomicroscopy and surveillance were not included in the high street optometry model,
- clarification of model 3
- potential timescales for implementation of the new model
- working in collaboration with others involved in diabetes care
- current operational issues and suggestions for service improvement outside the scope of the consultation

Local Commissioning Group Meetings

LCG Chairs – 30th January 2019

The PHA lead for DESP provided a presentation overview of the programme, consultation proposal and shortlisted models. The meeting was positive, with a considerable amount of feedback and discussion. The variability of the uptake rates within the programmes was discussed, how this can be influenced by the actions of general practice, and how this may be affected by a move away from practice based screening. The potential increase in efficiency within the fixed site model was noted. Discussion ensued regarding the geographical implications of fixed sites across Northern Ireland.

South Eastern LCG (Public meeting) – 7th March 2019

An overview presentation was provided to the South Eastern LCG by the PHA public health lead for the programme, which resulted in much positive discussion and feedback. The increasing diabetic population was highlighted. Members recognised the difficulties regarding arranging screening at many GP practices, welcoming the proposed changes but raising some concern regarding the potential loss of the 'personal touch' within practices.

Belfast LCG (Public meeting) – 21st March 2019

An overview presentation was provided to the Belfast LCG, by the PHA public health lead for the programme, which resulted in much positive discussion and feedback. The number of proposed fixed sites was discussed, with suggestion that engagement with local communities should be held if fixed sites are chosen. The potential for integration of diabetes services was discussed at length, with some members suggesting it should be implemented where possible. A service user present at the meeting highlighted the convenience of having several diabetes checks at one appointment.

Public information sessions

Belfast (Belfast City Mission, Grosvenor House) – 18th January 2019

There were no attendees at the panel day in Belfast, 1 service user who had booked an appointment was unable to attend on the day due to illness. The low response may have been due to the event being scheduled early in the consultation period, or it may have been that stakeholders felt it unnecessary to discuss the issues any further.

Omagh (Omagh Community House) – 28th January 2019

There were 2 attendees at the panel day in Omagh, a person living with diabetes and a local community optometrist.

SECTION C: Feedback from professional bodies and charity/voluntary sector organisations

In addition to completed questionnaires and feedback at meetings, written letters were also received from some interested professional bodies and charity/voluntary sector organisations.

These responses are considered in this section with salient points summarised. Where a professional body/charity group also completed a questionnaire, these responses have also been included in the analysis of questionnaire returns.

Northern Ireland General Practitioners Committee (NIGPC) of the British Medical Association (BMA) – (Written letter)

The NIGPC (BMA) state that their preferred option is 2 fixed sites at GP practices (previously 2b), as it will continue to maintain the link with general practice. They highlighted that the programme is already beginning to move to fixed sites in some areas. Also noted was the removal of the option for the continuation of screening provision in all GP practices (the current mobile model), which they stated afforded the opportunity to undertake other necessary checks.

Further in their response it was outlined that there was no detail on the costings carried out by the department and whether there was any funding identified for the roll out of changes.

Programme Response

We welcome the comments received from the NIGPC. Whilst we recognise that GP practices may avail of the opportunity of DESP screening within their practice to carry out other essential diabetes checks, NIGPC have not clarified this further by outlining the proportion of practices that offer these additional checks at the time of diabetic eye screening. DESP screening staff report anecdotally that this occurs in a minority of practices. This potential advantage should also be balanced against the challenge posed by an increasing number of practices finding it difficult to offer the screening programme timely access to suitable accommodation within their sites. This can impact upon maintaining the screening interval – one of the main drivers

for change within the current mobile model. In relation to the current model the consultation documents clearly outline why this will no longer remain a sustainable option in the future, with contributing factors including the growing pressure on primary care and availability of rooms to screen.

This is one of the main reasons why as a temporary measure, the screening programme has found it necessary to use a number of larger community hospital and health and wellbeing sites to try to help improve timely access to screening in some areas.

The summary of costs for the different models was included as an appendix in the consultation paper published on the consultation hub and as described in the consultation document the indicative costs paper was available on request. NIGPC will be aware that approval for funding for a proposed future model cannot be sought in advance of a decision on the future model.

Optometry NI – (Online questionnaire)

The Chair of Optometry NI completed an online questionnaire on behalf of the organisation and as such their feedback considered in the analysis thereof, however given their representation some of their additional comments included in their questionnaire response are also considered here.

The group query why it would be necessary for optometrists to attend 10 training sessions per year, given that they would only be providing imaging and felt this would be excessive.

They state that they had been previously advised that the proposed optometry model would include grading provision as well as imaging and that they had felt they had been misinformed from the outset. Further feedback from their members included:

- It would make sense that the screening appointment should be tied in with routine eye examinations, i.e. one appointment. If patients were asked if they would prefer one or two appointments , the answer would likely be ‘a resounding yes’
- Option 3 would provide a better continuity of care
- Cost presented are unrealistic as majority of practitioners have the hardware in place
- Suggested governance is totally unnecessary given the task required.

Programme Response

The programme were concerned with some points included in this response, namely that ONI felt that they had been misinformed regarding the scope of Option 3. Throughout the review, pre-consultation and consultation processes this model was considered and costed for digital photography only and there is no reference in any of the associated pre consultation or consultation documents to a model that involved high street optometry providing grading.

All staff participating in the DESP, regardless of their other roles, have to complete ongoing and frequent essential training to maintain and improve skills, and also to share best practice and learning.

Whilst we recognise that when a patient is offered the choice of one appointment versus two they are likely to choose one, this assumes that the same optometry provider will offer both services to the participant and this could not be guaranteed in all cases as not all providers would be offering the DESP retinal screening test. Therefore a patient may have to change optometrists or continue to have two separate appointments. Also the timing of these appointments cannot be assumed to be aligned as the intervals between successive appointments may be different, e.g. frequently routine eye checks may be two yearly as opposed to annual and in future the variable screening interval for DESP will have an impact.

In relation to costs, a summary of costs for different models was included as an appendix in the consultation paper published on the consultation hub and as described in the document the indicative costs paper was available on request. The indicative costs for this model included a cost per screen and the capital costs estimated only included the non-recurrent cost of a laptop/cryptocard for each practice to connect to the screening IT system and an initial training outlay, no costs for retinal equipment were included.

The College of Optometrists – (Online questionnaire)

The College of Optometrists completed an online questionnaire. Their response highlighted the key advantages of option 3 for service users, such as convenient locations, extended opening hours and accessibility. They further highlighted potential advantages to the programme including the fact that retinal equipment would already be in place and that overhead and maintenance costs would be covered by the supplier.

The College stated that more detail was needed on what the logistical, training, standardisation and governance issues are for provision in high street optometrist. It was pointed out that the College's Professional Certificate in Medical Retina has been mapped to the new Level 3 Diploma for Health Screeners course, allowing candidates to be exempt from some of the national DESP training.

With regard to costs, the college queried how these were determined and why the high street option was the most expensive, suggesting that in fact it should be the cheaper option as optometrists will already have the relevant equipment and facilities and stating that savings would be made regarding mileage, wear and tear of equipment and accommodation costs. The College further suggested that a 'no-poaching' of other practice's patients clause could be added to any contract to help alleviate concerns regarding the commercial environment.

The importance of accessibility for those with limited mobility, older age groups and those living in rural areas was highlighted. Their suggestion to address equality and rurality issues was to recruit the majority of high street optometrists across Northern Ireland.

Within their final comments the College highlighted that the delay in screening interval and its causes are not adequately covered in the options, stating that a review of the reasons why the standard is not currently being met should be carried out and inform future commissioning.

Programme Response

We welcome the comments received from the Royal College of Optometrists. The training, logistical and governance issues they query are further clarified in table 4, page 28 in the consultation paper as:

- *Increased complexity of programme management, quality control and quality assurance processes*
- *Less central programme oversight and control of quality, safety and failsafe procedures, with potential for less control over improvements to maintain national standards including screening interval.*
- *Requirement to tender for suitable providers, with potential although likely low risk of insufficient interest*
- *Private (non HSC) providers will have access to participant records via Optomise. This will require robust information governance, IT and security arrangements in line with GDPR and data protection principles.*
- *Programme standards and SOP for training- external quality assurance/other policy documents outline the process and rationale for this. As a screening programme quality assurance activities are essential. There ethical duty to minimise harm in screening pathways and to work in line with national guidance and standards.*

The programme welcomes the potential alignment of the College's Certificate in Professional Medical Retina with the national screening qualification which could reduce the time commitment needed for newly trained optometrists in the future. However this may not lessen the resource commitment that would be needed to ensure all 60 proposed practices meet training criteria prior to implementation.

A summary of the overview of the indicative revenue and capital costs for each model was referenced in the consultation document and available as an appendix on the consultation hub. The full indicative costs paper for the proposed options was also referenced in the consultation document and was available on request, as detailed in the consultation paper. Recurrent revenue costs for the optometry model (which included a range of costs per screen per patient) were estimated as higher than all other models. It was recognised in this paper that high street optometrists would have the relevant retinal equipment and premises in places and as such no additional cost was included for these. However capital costs were included for laptops/cryptocards.

A summary of factors affecting the screening interval are listed in figure 2 of the consultation document page 16. The primary cause of interval delay when the project commenced was difficulty in accessing dedicated space in primary care in a timely way within the mobile model. Further issues include

staff resilience and lone working related to travelling to multiple sites. The fixed site model has been in operation in the western area since the programme began and historically the screening interval has been maintained.

Diabetes UK (NI) – (Online questionnaire and written letter)

Diabetes UK completed an online questionnaire and also responded by letter, both responses have been considered here.

Diabetes UK highlighted the length of time the process has taken from the initial stakeholder workshop in 2016 and the time taken to produce the shortlist. However they agreed with the preferred option of option 1. This opinion comes as a result of discussion with their support groups across Northern Ireland, including young people:

'**People living with diabetes, including young people, have told us that their most important consideration is that their screening is high quality and the risk of false results will be as low as possible. We consider that Option 1 provides the greatest assurances for people living with diabetes in relation to this concern.**'

They considered that option 1 would facilitate the development of 'one-stop services' where DESP could be integrated with other essential diabetes checks.

Within the questionnaire DUK welcomed the inclusion of question 10 which draws attention to the issues important in planning the future model and the choosing of screening sites.

Programme response

We welcome the response from Diabetes UK and are grateful for their commitment to seeking the opinions of their support groups, including their younger members, and our service users. With regards to the length of time taken to launch the public consultation, a considerable amount of work and preparation has gone into this review, to ensure that all stakeholders can be confident in the process and ultimately any decision made. However we recognise the need to address the drivers for change in a timely fashion,

agreeing that some stages in the process have taken longer than would have been hoped.

We also recognise the potential benefits of integrated services, for service users and their families/carers. However given the complexities of the screening pathway within DESP and the requirements for other recommended checks for people living with diabetes, in practice a 'one stop shop' approach based around eye screening would be aspirational and very difficult to implement and manage on a large scale.

Some of the practical challenges include:

- ***Cohort identification/management*** *- not all patients with diabetes are eligible for routine digital diabetic eye screening. Approximately 10% are either excluded as they opt out of screening or are medically unfit or are suspended as they are attending digital surveillance clinics or hospital eye services.*
- ***Timing of appointments****- Not all clinical checks for those with diabetes are annual, higher risk patients may need more frequent appointments. In addition the screening programme has introduced surveillance appointments for those who have some changes identified but do not require referral to hospital eye services, which could be every 3, 6 or 9 months. Furthermore in line with national guidance the DESP will have to work towards introducing a variable screening interval with screening reducing to every 24 months for those identified as at lower risk. Therefore scheduling of appointments to ensure they coincide would be challenging and should not impact detrimentally upon eye screening.*
- ***Estates considerations*** *– the number of rooms and, waiting area space required to be available simultaneously for a one stop service would make it difficult to implement on multiple sites and it is unlikely to be universally available.*
- ***Commissioning arrangements and governance structures*** *-for providers of additional clinical checks for those with diabetes is outside the scope, remit and control of the diabetic eye screening programme.*

The programme would highlight however its recent work with secondary care colleagues to provide screening at special clinics for particular groups of service users, including pre-pregnancy, pregnancy and dialysis. The programme has contributed to integration initiatives when feasible, however this varies according to local service provision in each trust area.

Royal National Institute of Blind People (RNIB) – (Written letter)

The RNIB provided a detailed letter in response to the consultation which provided feedback on each of the options, equality and rurality implications, and other policy issues which should be considered in any future implementation. The organisation was impressed with the efforts made to explore every available option for reforming the screening programme and that continuing with the current service delivery model did not seem practical.

They agreed with the preferred option of 1 stating that it appeared the most effective potential option and that it '…would be the best option to proceed with to ensure quality of care, flexibility of appointment times and integration with wider diabetic care.' Also, that whilst they understood the appeal of option 2 they were concerned about the capacity to provide the service solely through GP services.

With regards to option 3 they stated that they had some concerns that would need to be addressed before they could support the option.

1. The care pathway – separating the screening programme from wider HSC care could reduce effectiveness
2. Ability to ensure high quality – having looked at other national regions they were concerned about the inconsistencies in quality.
3. Cost – they felt that the high cost would act as a barrier to people seeking regular screening.

RNIB further highlighted the importance of introducing visual acuity testing and the variable screening interval for those at low risk.

Programme Response

We welcome the response of the RNIB. This view agrees with the preferred option identified by the project team and board. Whilst we understand the concerns regarding the care pathway and the ability to ensure quality within option 3, we would highlight that the potential higher screening costs would not impact directly on the eligible population as these costs would have to be met by the programme itself, rather than those invited for screening. We also recognise the importance of location and accessibility for fixed sites.

Belfast HSC Trust (Online questionnaire)

A questionnaire response was received on behalf of the Belfast HSC Trust, who provide and manage the screening programme. They stated their support for the preferred option as 'this option would enable a safe, high quality, person centred service to be delivered by trained staff within a robust quality assurance framework'.

South Eastern HSC Trust (written letter)

The trust highlighted the 'importance of the inclusion and consideration of prison healthcare in the future model of service delivery'.

Programme Response

The programme welcomes the response from South Eastern HSC Trust and recognises the importance of ensuring adequate access to screening programmes for those in prison. Within the DESP the screening test is currently delivered to those in prison by screener/graders via the mobile model.

Southern HSC Trust – (online questionnaire)

The Southern HSC Trust completed an online questionnaire, however as with other professional organisations, their comments are also considered here:

With regard the suitability of the three options

- Strongly agreed that Option 1 would be a suitable option. They also stated that this option offers better patient accessibility while ensuring quality control
- Agreed that Option 2 would be a suitable option. However highlighted that it could have restricted opening hours
- Disagreed with the suitability of Option 3, stating that it could be difficult to monitor.

With regards considerations for the specification for sites they highlighted the benefits of the creation of one centre for diabetes care.

The trust queried whether 4 sites per trust area (outside the west) would be adequate to provide a sufficiently accessible service. They urged that consideration be given not only to demographic population indicators but also the rurality of trust areas. Also any option to provide extended hours would give some flexibility for patients in organising transport arrangements.

Programme Response

The programme welcomes the response from the Southern HSC Trust. We will take these comments on board in particular regarding the number of sites per trust and would look forward to working with the trust to identify appropriate sites if this model is selected. It should be highlighted that the consultation outlines that there would be at least four sites per trust area.

Patient Client Council – (Briefing paper submitted)

Whilst the PCC did not feel they were in a position to put in a full response to the consultation they did forward a briefing paper 'The Experience of People with Diabetes Accessing Allied Health Professional Services in Northern Ireland – April 2018'. Within this document it was highlighted that participants in earlier panels had queried why 'eye screening had to be conducted by an ophthalmologist and why results from eye tests performed by opticians could not be accepted.' As a result the PCC welcomed the fact that one of the proposed models was option 3.

Programme Response

The programme welcomes the response from the PCC and the opportunity to be included in their blog as part of our stakeholder engagement. We would like to address the queries raised in their paper. Diabetic eye screening must be carried out by a suitably trained individual, however this is not necessarily an ophthalmologist, and rather the vast majority of screening clinics are carried out by trained screener/graders.

Outside of the screening programme optometrists can provide a range of different examinations/tests but these are not necessarily testing for the same conditions or equivalent to the test offered by the DESP.

Currently results from eye tests taken by high street optometrists are not used by the screening programme because all screening images used within the screening programme must meet specific nationally agreed quality

standards and be taken by staff trained in delivering the programme to these required standards. This is highlighted in our patient information leaflets which recommend that patients also continue to visit their optometrists for their routine eye care as this is not the same as the screening test offered by the DESP. Within option 3, diabetic eye screening would still be a separate result and whilst many may still be able to attend their normal optometrist for their screening, this is not guaranteed as their optometrist may not provide the service.

Discussion

Questionnaire responses

1-Respondent Profile

It is encouraging that almost 90% of the responses to the consultation questionnaire are from two of the key stakeholder groups directly affected by a change to the current service; with 81%, being service users/their family/carers (216/268) and 8.6%, (23/268) of responses from those in primary care).

2-Feedback on models

Just under half (47.2%, 127/268) of all respondents strongly agreed that Option 1 would be able to provide a 'safe, high quality service and meet the demands of Northern Ireland's increasing diabetic population', with a further 29% agreeing (76.2% in total). Option 2 had a similarly positive response with 69.5% strongly agreeing or agreeing with this model. However the response regarding option 3 was mixed with 43.5% of respondents strongly disagree and disagreeing with this model, compared with 7.8% and 10.4% for options 1 and 2 respectively. The response rates for 'neither agree nor disagree' with this statement were similar for all 3 options. These results are broadly reflective of the patterns observed when only responses from those living with diabetes/their families and carers are considered.

When respondents living with diabetes were asked whether they would be willing to attend each of the options the responses were consistently positive for fixed sites with 78% selecting 'yes' for option 1 and 71.6% for option 2. However only 37.2.1% stated they would be willing to attend screening at option 3, with 15.1% advising that they 'don't know' if they would attend screening at option 3.

3 - Future planning considerations

Whilst question 10, on the relative importance of different criteria for selecting screening sites, may have caused difficulty for some respondents to complete it does provide a snapshot of what is important to those affect by service change. Examining each individual criterion (accessibility etc) to what proportion of votes received for each criterion cumulatively ranked 1-3 (more

important), or 4-6 (less important), suggests their relative importance for all respondents as:

1. Car parking
2. Accessibility
3. Proximity to Home
4. Public Transport
5. Co-location
6. Extended Hours

Using an alternative method of analysis, whereby the number of votes for each individual ranking 1-6 is examined to reveal which criteria had the highest proportion of votes for each rank, suggests a slightly different arrangement of criteria from most to least important :

1. Accessibility
2. Car parking
3. Public Transport
4. Co-location
5. Extended Hours
6. Public transport

4 - Equality and rurality considerations

90.3% (242/268) of respondents felt that all equality impacts had been identified, with 1.5% (4/268) not answering the question. Most comments (9/21) regarding equality implications suggested respondents those who were unsure/hadn't read the documentation or were unaware of how to find it. Other comments highlighted the importance of transport and accessibility for those with limited mobility, the elderly, the working population and those in rural areas.

When asked for suggestions to address equality issues, many responses (17/57) advised they were unable/unsure of potential solutions. The importance of involving those affected in the planning process was highlighted. Out of hours appointments, adequate notice and accessibility for working age participants were recurring suggestions.

With regards to rurality, 84.7% (227/268) of respondents agreed that all implications for rural areas have been identified. Travel and transport implications and access were the most common themes in additional

responses (14/37). It was suggested that potential solutions included to group invitations by locality, care home, facility to allow for travel together, also to provide information on alternative local transport arrangements. Ensuring geographic coverage of sites was also highlighted.

5 - Feedback on the consultation process

Satisfaction levels with the consultation process were high, with 78.7% of these replying (211/268) stating they were satisfied or very satisfied with the process. 6.7% (18/268) of respondents advised they were dissatisfied or very dissatisfied.

The majority of the comments from by those who selected dissatisfied or very dissatisfied stated that they felt they had not been consulted with directly, had found out on social media, or were unhappy they had not received individual letters/correspondence regarding the consultation. There were also a small number who felt that there should have been more publicity. The response from ONI stated they felt they had been misinformed regarding option 3 (see section C for further details).

42 respondents provided final comments and these covered a wide range of areas, reflecting many of the comment themes from the preceding questions including models for service delivery, travel and transport, operational/delivery factors and programme principles. Additional themes included uptake, both concern that it may be affected by a change to the service and suggestions on how to increase attendance.

Conclusion, recommendations and next steps

Given the context of the steadily rising number of people eligible for diabetic eye screening and the multiple potential options for models of how to deliver the programme, it is clear that securing the optimal delivery of the NIDESP is a complex issue. There is no nationally agreed, or recommended, gold standard model for how to deliver the screening programme.

The project team and board have worked with key stakeholders over the last 24 months to review a longlist of potential options and agreed the best way forward for the programme in Northern Ireland. It is accepted that all of the shortlisted models have both advantages and disadvantages however it is important that we identify the best potential way forward and begin work to implement this.

One of the key objectives of the DESP is to offer timely screening and early intervention therefore preserving the screening interval must be a priority within the programme.

Recommendations

Model of service delivery

Responses to the consultation indicate majority support for a fixed site model, with both HSC fixed sites (76.2% (205/269) strongly agreeing or agreeing) and GP fixed sites (69.5% (187/269) strongly agreeing or agreeing) appearing popular options. This is consistent with the preferred option of the project structures (option1- fixed HSC sites).

Responses to option 3 the high street optometry model are mixed with smaller proportions supportive of this model (37.2% (94/271) strongly agreeing or agreeing) and 43.5% (118/271) either disagreeing or strongly disagreeing that this model could provide safe, high quality service and meet the demands of the increasing diabetic population.

This is also reinforced by feedback from those living with diabetes/their families/cares that they would attend screening at fixed HSC sites (78% (170/218) or fixed GP sites (71.6% (156/218)). However only 37.2% (81/218) agreed they would attend screening at high street optometry sites and 15.1% (33/218) did not know if they would attend screening at a high street

optometry service as opposed to 9.2% (20/218) at fixed HSC sites, or 9.6% (21/218) at fixed GP sites.

Recommendation 1: Model of service delivery

It is recommended that screening is delivered at fixed sites throughout Northern Ireland. These should be HSC sites or larger GP sites. In practice sites are likely to be determined by availability and feasibility of implementation, recognising that access to timely screening is a key requirement for the DESP.

Future planning considerations

Several factors seem to be important when considering implementing a future service model for the screening programme**.**

Recommendation 2: Future planning considerations

Accessibility, car parking and public transport links are consistently high ranking criteria for respondents with co-location of services and extended hours of opening appearing relatively less important. These key factors should be considered when determining screening sites.

It is recognised that integration with other health services required by those living with diabetes is desirable. However this goal remains aspirational and is unlikely to be universally achievable, facing several practical implementation challenges which are beyond the direct scope and control of the diabetic eye screening programme.

The diabetic eye screening programme can continue to work with providers of wider diabetes care to avail of opportunities to enhance access and experience for patients wherever possible.

Next steps

Approval process

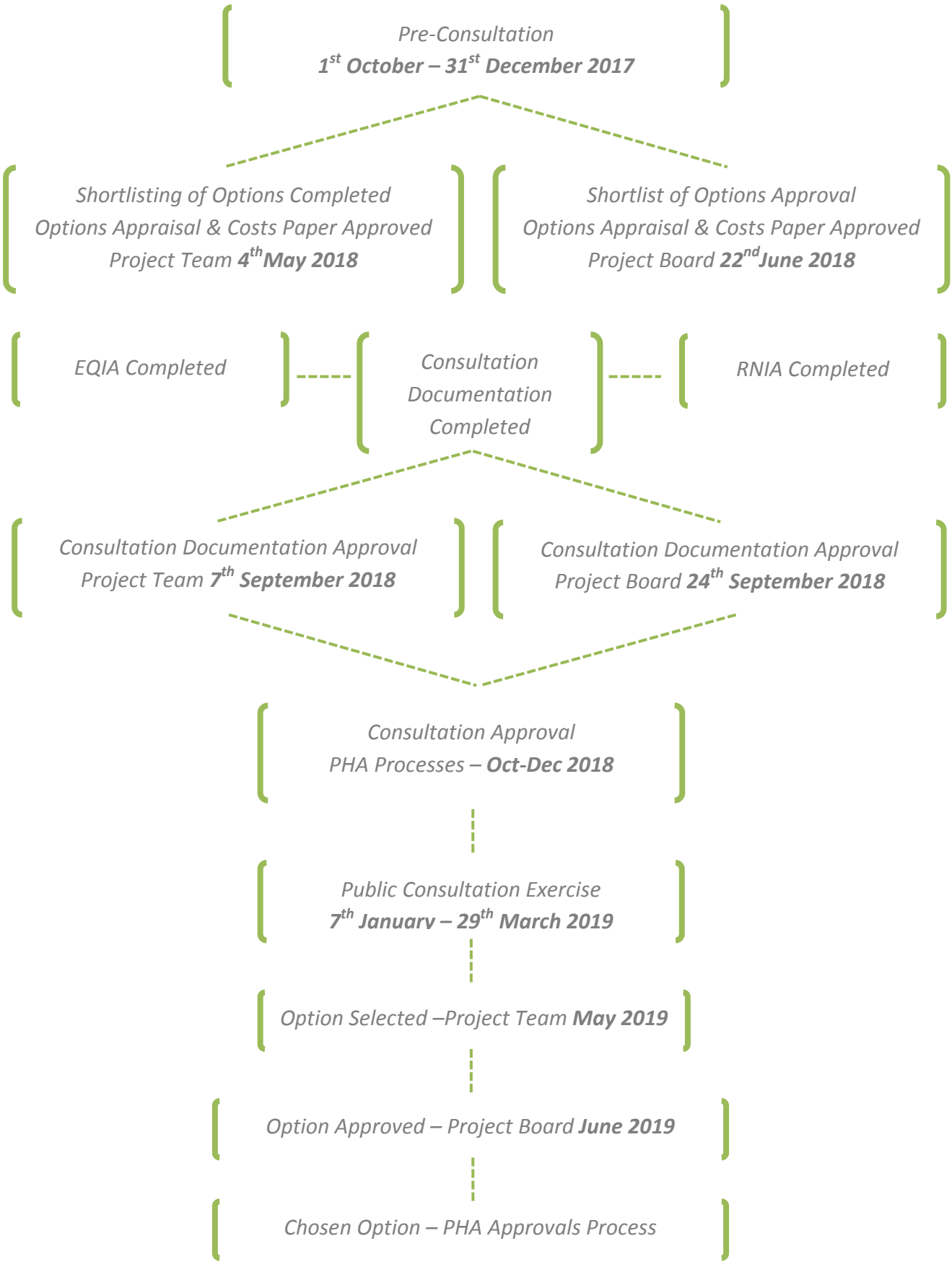
Once agreed by the modernisation project team and board the consultation recommendations will be presented to the PHA Board for approval.

Planning and implementation

Agreeing number and location of fixed screening sites –

It is anticipated that this will initially involve the DESP producing a specification of what is required for a screening site, and working with Trusts, LCGS and primary care to determine availability of and select suitable sites within each Trust area (excluding WHSCT where fixed sites are already operational). The number of fixed sites will be kept under review.

Appendix 1 – The Consultation Process



Appendix 2 – List of Events

18th January 2019 – Public information session, Belfast

28th January 2019 – Public information session, Omagh

30th January 2019 – LCG Chairs meeting, Belfast

7th February 2019 – Public information session CANCELLED

7th February 2019 – NVTV Interview, Belfast

12th February 2019 – NIDESP Screening Staff Event, Belfast

7th March 2019 – South Eastern LCG meeting, Bangor

21st March 2019 – Belfast LCG meeting, Belfast

Appendix 3 – Sample of hard copy questionnaire

CONSULTATION ON THE WAY THE NORTHERN IRELAND DIABETIC EYE SCREENING PROGRAMME IS PROVIDED

RESPONSE QUESTIONAIRE

Response Questionnaire

This consultation offers an opportunity for you to consider, and comment on the shortlisted options and whether you feel that all key aspects have been taken into consideration.

You can respond by completing an online questionnaire or returning this questionnaire to the details below.

1. Email us at **screening.diabeticeye@hscni.net**
2. Write to us at:

Diabetic Eye Screening Programme
Public Health Agency
9th Floor, Linum Chambers
2 Bedford Square
Belfast
BT2 7ES

A copy of this questionnaire and the corresponding consultation document can be found at

http://pha.site/DESPconsultation

Or on the Public Health Agency's website;
http://www.publichealth.hscni.net/modernising-diabetic-eye-screening-programme.

Before you submit your response please read the annex of this document regarding the confidentiality of responses in the context of the Freedom of Information Act 2000.

Please tell us if you are responding on your own behalf or on behalf of an organisation by placing a tick in the appropriate box:

I am person living with diabetes or their carer/family member ☐

I am an optometrist/work in the optometry sector ☐

I work within the Diabetic Eye Screening Programme ☐

I work within the primary care sector ☐

Other *(please detail)* _____

Name	
Organisation	
Address	
Telephone	
Email	

May we contact you to get further information on your response?

Yes ☐

No ☐

OPTIONS

1 Do you believe that all of the advantages and disadvantages of the shortlisted models have been identified?

Yes ☐ No ☐ (please tick a box)

If you have answered 'no', please provide further detail

2 To what extent do you agree that the shortlisted models could provide a safe, high quality service and meet the demands of Northern Ireland's increasing diabetic population?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	No opinion
Option 2a – Fixed HSC Sites						
Option 2b – Fixed Primary Care Sites						
Option 5 – High Street Optometry						

Please provide any further comment

3 If you are a person living with diabetes would you be happy to attend screening at the shortlisted options? (please tick a box)

	Yes	No	Don't know
Option 2a – Fixed Health And Social Care Sites			
Option 2b – Fixed Primary Care Sites			
Option 5 – High Street Optometry			

Please provide any further comment here

4 In planning the future model we would use a specification to choose screening sites. Please rank the criteria below in order of importance to you (1 = most important, 6 = least important)

Availability of public transport ☐

Availability of car parking ☐

Extended opening hours (i.e. evenings/weekends) ☐

Proximity to your home ☐

Accessibility for those with sensory/mobility issues ☐

Co-location with other diabetes care services, e.g. podiatry ☐

Other _____

5 Do you believe that all key implications for equality groups have been identified?

Yes ☐ No ☐ (please tick a box)

If no please provide further comment here

6. What do you suggest we could do to address the equality issues identified?

7 Do you believe that all key implications for rural areas have been identified?

Yes ☐ No ☐ (please tick a box)

If no please provide further comment here

8 What do you suggest we could do to address the rurality issues identified?

FINAL COMMENTS

9 Do you have any other comments?

Yes ☐ No ☐ (please tick a box)

If you ticked ‘Yes’ please comment here

10 Please indicate how satisfied you are with the way you have been consulted with about these proposals?

Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very Dissatisfied	Don't know

Please provide any further comments here

11 How did you hear about this consultation?

- At my Screening/Hospital Eye Services appointment ☐
- At my GP Practice/Primary Care ☐
- Public Notice/Newspaper ☐
- Social Media ☐
- Professional Body ☐
- Workplace ☐
- Other *(please specify)*_____

Thank you for your comments.

Annex

Freedom of Information Act (2000) – Confidentiality of Consultations

It is expected that we will publish a summary of responses following the completion of this engagement exercise. Your responses and all other responses may be disclosed on request. We can only refuse to disclose information in exceptional circumstances.

Before you submit your response, please read the paragraphs below on confidentiality as they will give you guidance on the legal position about any information given by you in response to this consultation.

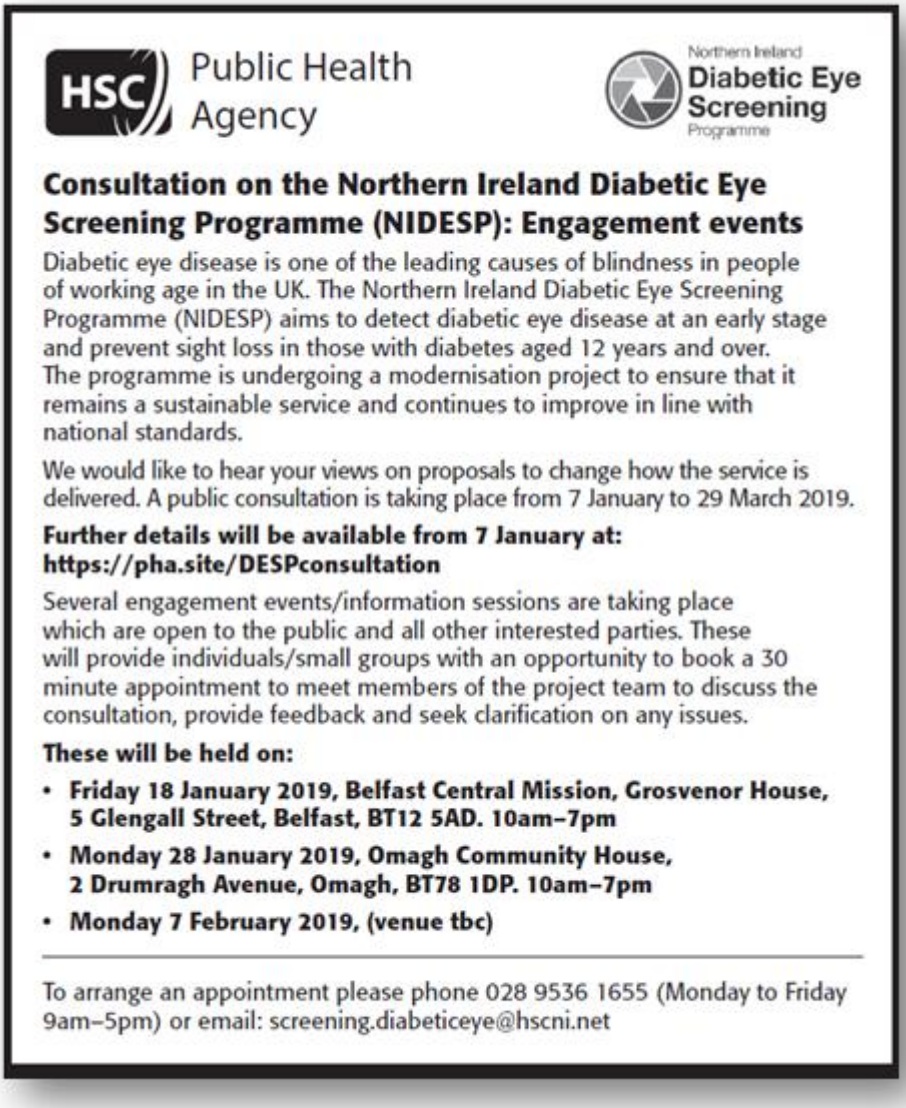
The Freedom of Information Act gives the public a right of access to any information held by a public authority, namely, the Public Health Agency (PHA) in this case. This right of access to information includes information provided in response to this consultation. The PHA cannot automatically consider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

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

The PHA should not agree to hold information received from third parties "in confidence" which is not confidential in nature. Acceptance by the PHA of confidentiality provisions must be for good reasons, capable of being justified to the Information Commissioner.

For further information about confidentiality of responses please contact The Information Commissioner's Office, or see website at: https://www.gov.uk/government/organisations/information-commissioner-s-office.

Appendix 4 – Public Notice



HSC Public Health Agency

Northern Ireland Diabetic Eye Screening Programme

Consultation on the Northern Ireland Diabetic Eye Screening Programme (NIDESP): Engagement events

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

We would like to hear your views on proposals to change how the service is delivered. A public consultation is taking place from 7 January to 29 March 2019.

Further details will be available from 7 January at: https://pha.site/DESPconsultation

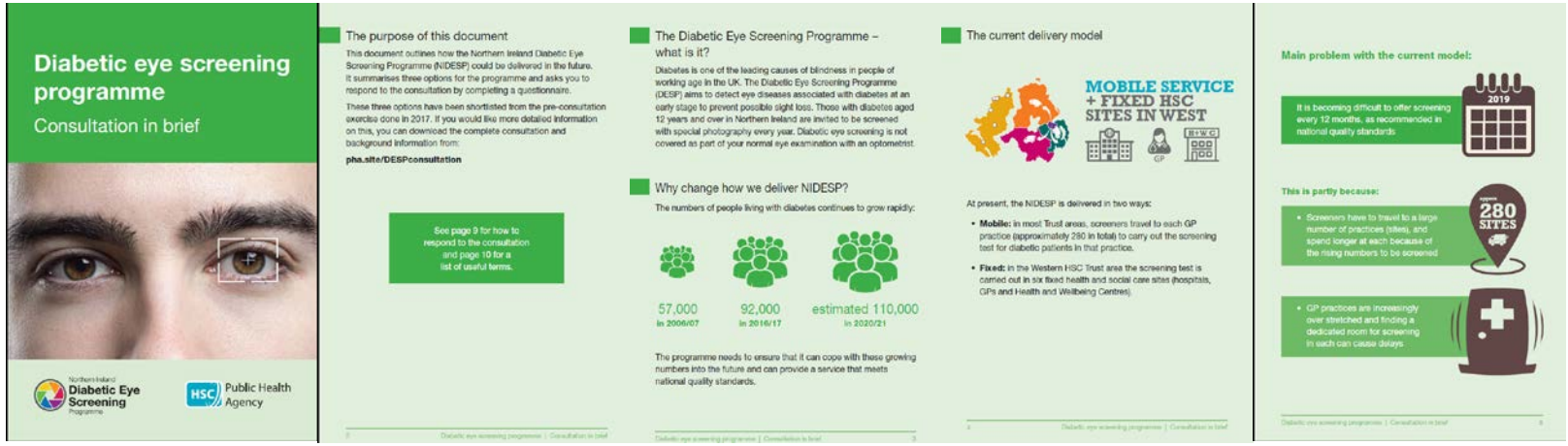
Several engagement events/information sessions are taking place which are open to the public and all other interested parties. These will provide individuals/small groups with an opportunity to book a 30 minute appointment to meet members of the project team to discuss the consultation, provide feedback and seek clarification on any issues.

These will be held on:

- **Friday 18 January 2019, Belfast Central Mission, Grosvenor House, 5 Glengall Street, Belfast, BT12 5AD. 10am–7pm**
- **Monday 28 January 2019, Omagh Community House, 2 Drumragh Avenue, Omagh, BT78 1DP. 10am–7pm**
- **Monday 7 February 2019, (venue tbc)**

To arrange an appointment please phone 028 9536 1655 (Monday to Friday 9am–5pm) or email: screening.diabeticeye@hscni.net

Appendix 5 – Summary booklet



Diabetic eye screening programme

Consultation in brief

Northern Ireland Diabetic Eye Screening Programme

HSC Public Health Agency

The purpose of this document

This document outlines how the Northern Ireland Diabetic Eye Screening Programme (NIDESP) could be delivered in the future. It summarises three options for the programme and asks you to respond to the consultation by completing a questionnaire.

These three options have been shortlisted from the pre-consultation exercise done in 2017. If you would like more detailed information on this, you can download the complete consultation and background information from:

pha.site/DESPconsultation

See page 9 for how to respond to the consultation and page 10 for a list of useful terms.

The Diabetic Eye Screening Programme – what is it?

Diabetes is one of the leading causes of blindness in people of working age in the UK. The Diabetic Eye Screening Programme (DESP) aims to detect eye diseases associated with diabetes at an early stage to prevent possible sight loss. Those with diabetes aged 12 years and over in Northern Ireland are invited to be screened with special photography every year. Diabetic eye screening is not covered as part of your normal eye examination with an optometrist.

Why change how we deliver NIDESP?

The numbers of people living with diabetes continues to grow rapidly:

57,000 in 2006/07

92,000 in 2016/17

estimated 110,000 in 2020/21

The programme needs to ensure that it can cope with these growing numbers into the future and can provide a service that meets national quality standards.

The current delivery model

MOBILE SERVICE + FIXED HSC SITES IN WEST

At present, the NIDESP is delivered in two ways:

- **Mobile:** in most Trust areas, screeners travel to each GP practice (approximately 280 in total) to carry out the screening test for diabetic patients in that practice.
- **Fixed:** in the Western HSC Trust area the screening test is carried out in six fixed health and social care sites (hospitals, GPs and Health and Wellbeing Centres).

Main problem with the current model:

It is becoming difficult to offer screening every 12 months, as recommended in national quality standards

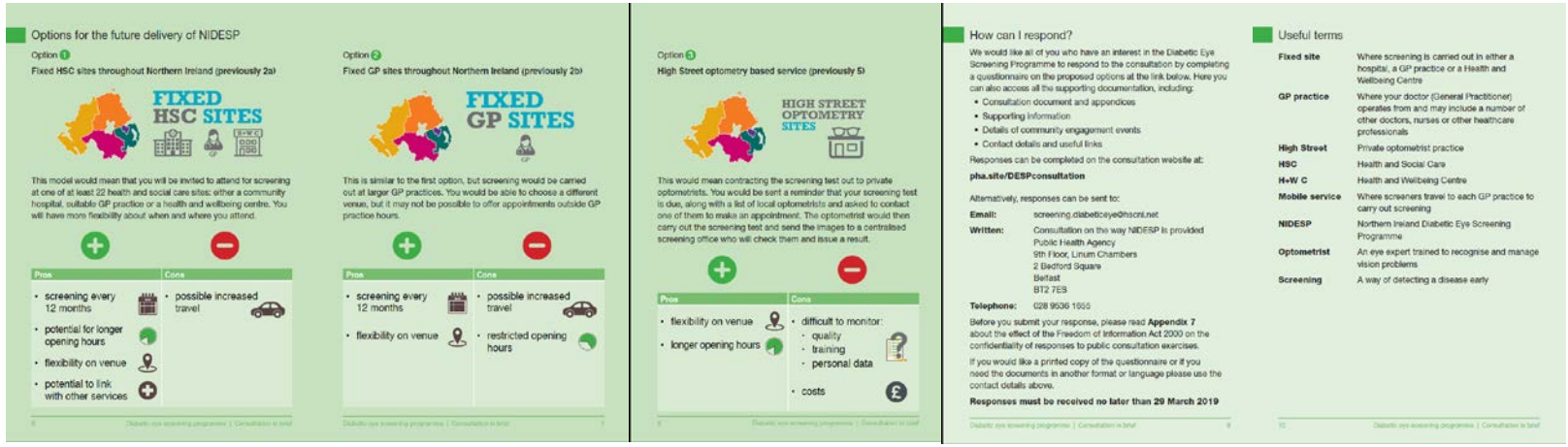
2019

This is partly because:

- Screeners have to travel to a large number of practices (sites), and spend longer at each because of the rising numbers to be screened

280 SITES

- GP practices are increasingly over stretched and finding a dedicated room for screening in each can cause delays



Options for the future delivery of NIDESP

Option 1

Fixed HSC sites throughout Northern Ireland (previously 2a)

FIXED HSC SITES

This model would mean that you will be invited to attend for screening at one of at least 22 health and social care sites: either a community hospital, suitable GP practice or a health and wellbeing centre. You will have more flexibility about when and where you attend.

Pros	Cons
• screening every 12 months	• possible increased travel
• potential for longer opening hours	
• flexibility on venue	
• potential to link with other services	

Option 2

Fixed GP sites throughout Northern Ireland (previously 2b)

FIXED GP SITES

This is similar to the first option, but screening would be carried out at larger GP practices. You would be able to choose a different venue, but it may not be possible to offer appointments outside GP practice hours.

Pros	Cons
• screening every 12 months	• possible increased travel
• flexibility on venue	• restricted opening hours

Option 3

High Street optometry based service (previously 5)

HIGH STREET OPTOMETRY SITES

This would mean contracting the screening test out to private optometrists. You would be sent a reminder that your screening test is due, along with a list of local optometrists and asked to contact one of them to make an appointment. The optometrist would then carry out the screening test and send the images to a centralised screening office who will check them and issue a result.

Pros	Cons
• flexibility on venue	• difficult to monitor: quality, training, personal data
• longer opening hours	• costs

How can I respond?

We would like all of you who have an interest in the Diabetic Eye Screening Programme to respond to the consultation by completing a questionnaire on the proposed options at the link below. Here you can also access all the supporting documentation, including:

- Consultation document and appendices
- Supporting information
- Details of community engagement events
- Contact details and useful links

Responses can be completed on the consultation website at:

pha.site/DESPconsultation

Alternatively, responses can be sent to:

Email: screening.diabeticeye@hscni.net

Written: Consultation on the way NIDESP is provided
Public Health Agency
9th Floor, Linum Chambers
2 Bedford Square
Belfast
BT2 7EB

Telephone: 028 9536 1555

Before you submit your response, please read **Appendix 7** about the effect of the Freedom of Information Act 2000 on the confidentiality of responses to public consultation exercises.

If you would like a printed copy of the questionnaire or if you need the documents in another format or language please use the contact details above.

Responses must be received no later than 29 March 2019

Useful terms

Fixed site	Where screening is carried out in either a hospital, a GP practice or a Health and Wellbeing Centre
GP practice	Where your doctor (General Practitioner) operates from and may include a number of other doctors, nurses or other healthcare professionals
High Street	Private optometrist practice
HSC	Health and Social Care
H+W C	Health and Wellbeing Centre
Mobile service	Where screeners travel to each GP practice to carry out screening
NIDESP	Northern Ireland Diabetic Eye Screening Programme
Optometrist	An eye expert trained to recognise and manage vision problems
Screening	A way of detecting a disease early

HSC Public Health Agency

item 11

Title of Meeting	PHA Board Meeting
Date	15 August 2019
Title of paper	Northern Ireland Cervical Screening Programme – Annual Report for 2016/17
Reference	PHA/05/08/19
Prepared by	Stephen Bergin
Lead Director	Adrian Mairs
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to approve the 2016/17 Annual Report for the Northern Ireland Cervical Screening Programme.

2 Background Information

Under PHA's corporate objective 2, "All older adults are enabled to live healthier and more fulfilling lives" and objective 3, "All individuals and communities are equipped and enabled to live long healthy lives", PHA has a responsibility to develop and deliver screening programmes. Part of PHA's work in this area is to also produce an annual report.

The aim of the Northern Ireland Cervical Screening Programme is to reduce the incidence, morbidity and mortality associated with cervical cancer. Screening is offered to all eligible women aged 25-49 every three years, and to women aged 50-64 every five years.

3 Key Issues

This annual report covers activity within programme from 1 April 2016 to 31 March 2017 inclusive. Key information and statistics are provided along with performance against national standards and benchmarks. Collectively, these statistics are used to monitor and continuously improve the quality of the screening programme: the main service and quality improvements undertaken during this period are highlighted

within the report. Overall, the programme is performing well and in line with national standards and benchmarks.

4 Next Steps

The commissioning and quality assurance of the Northern Ireland Cervical Screening Programme is a key priority of the PHA. This will be evidenced on an ongoing basis through the commissioning and quality assurance efforts of PHA screening leads, and likewise demonstrated within future annual reports.

HSC Public Health Agency

Cervical Screening

Annual Report 2016-17

Northern Ireland Cervical Screening Programme

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1 Summary and Highlights for 2016-17

This report covers activity within the Northern Ireland Cervical Screening Programme from 1 April 2016 to 31 March 2017 inclusive. The key statistical headlines are:

- At 31 March 2017, 76.8% of eligible women (aged 25-64) in Northern Ireland had been screened at least once in the previous five years. The coverage has decreased from 77.2% at end March 2016.
- Between 1st April 2016 and 31st March 2017, the regional call/recall centre issued letters to 138,917 women aged 25-64 years, inviting them to attend for screening.
- A total of 115,048 women (all ages) had a screening test reported in 2016-17. Of these, 110,961 women were in the 25-64 age group. A proportion of women will have more than one sample reported in a given year.
- 122,817 cervical samples were reported by Northern Ireland cytology laboratories in 2016-17. Of these, 110,920 samples (90.3%) were undertaken in primary care or at a community based Sexual and Reproductive Healthcare clinic.
- 76.0% of samples were reported by the laboratory within 14 days of the sample being taken, and 98.2% within 28 days.
- In 2016-17, 3.9% of samples from eligible women were reported as inadequate.
- 0.8% of samples from eligible women were reported as having high grade abnormalities.
- Of the recorded first attendances at colposcopy, 67.3% of women had some treatment or procedure.

The learning from an incident in primary care prompted work to augment guidelines on training for cervical sample takers. This included the publication "*Northern Ireland Standards for Nurse and Midwife Education Providers: Cervical Screening Sample Taking*" in December 2016, which was endorsed by the Chief Nursing Officer for Northern Ireland.

2 Introduction

2.1 Background and programme objectives

The aim of the Northern Ireland Cervical Screening Programme is to reduce the incidence, morbidity and mortality associated with cervical cancer. It achieves this by detecting early changes in cervical cells that could, if left untreated, develop into cancer. While the programme succeeds in detecting a small number of cancers each year, its main role is in detecting these precancerous changes.

Screening is offered to all eligible women aged 25-49 every three years, and to women aged 50-64 every five years. This policy is in line with the recommendations of the UK National Screening Committee.

Screening is intended for women who do not have symptoms. Women of any age who present to their General Practitioner with symptoms suggestive of a cervical abnormality (such as bleeding or pain) should be examined and referred for onward investigation as clinically appropriate.

This report presents key information about the NI Cervical Screening Programme for 2016-17 and benchmarks performance against national standards where available. It also describes new service and quality improvements undertaken during this period. The statistics presented here are used to monitor and continuously improve the quality of the screening programme.

2.2 Programme Delivery and Screening Pathway

2.2.1 Call recall process

The Business Services Organisation (BSO) provides the regional call and recall functions for the screening programme. This involves identifying those women who are eligible for cervical screening and issuing invitation letters to attend for screening when their next test is due. A patient information leaflet about the programme, *'Cervical Screening: It's best to take the test',* is included with the invitation letter. Women are encouraged to make an appointment with their GP Practice to have their screening test.

Screening starts from the age of 25, with women invited to attend for their first screening test up to 6 months in advance of their 25th birthday. Women remain eligible for inclusion in the programme up to the age of 64yrs + 364 days. They are usually ceased from screening on the basis of age once their next test due date exceeds this threshold. Women over 65 years who

require on-going surveillance due to a previous cervical abnormality will continue to be followed up within the programme.

Screening tests can also be undertaken opportunistically and are not always the direct result of an invitation letter from the programme: for example, when a woman attends her GP Practice for another issue and is also offered a screening test when she is there as her test is overdue. This means that a significant proportion of screening tests are undertaken in Northern Ireland without a formal invitation being issued and are recorded as being taken 'outside programme'.

2.2.2 Cervical cytology

Cervical screening samples collected at GP Practices and community clinics (i.e. Sexual and Reproductive Healthcare Services) are sent to a cytopathology laboratory to be processed and reported. There are four cytopathology laboratories in Northern Ireland participating in the cervical screening programme, located at:

- Belfast City Hospital
- Craigavon Area Hospital
- Antrim Area Hospital
- Altnagelvin Area Hospital

The Belfast laboratory provides a cytology service for both the Belfast and South Eastern Health and Social Care Trust areas.

The results of all screening tests are returned to the professional who took the test (sample taker) as well as to the woman's registered GP. The test result is electronically notified to the call/recall centre to be included on the cervical screening database and form a part of the woman's screening history. This will also trigger the next test due date to be set for that woman.

Most women receive a negative result and are recalled for another routine screening test in 3 or 5 years' time dependent on her age (routine recall).

When the laboratory identifies cell changes that require further investigation, an abnormal result is issued. These may be high grade abnormalities (severe or moderate changes) or low grade abnormalities (mild or borderline changes). All women with high grade changes are referred for colposcopy. Those with low grade changes are triaged, with a test for high risk human papilloma virus (hr-HPV) carried out on the sample. Depending on the outcome of the hr-HPV test, the woman may be referred to colposcopy or returned to routine recall.

Antrim and Altnagelvin laboratories provide the hr-HPV testing service for Northern Ireland.

In a small number of cases there are not enough cells in the sample for the laboratory to issue a result. These are reported as inadequate and a repeat test is advised.

2.2.3 Colposcopy

Women referred for further investigation attend a colposcopy clinic provided by their local Trust. A colposcopy is an examination of the cervix using a lighted, low powered microscope (a colposcope). A biopsy may be taken during the examination for diagnosis, and treatment may also be carried out at the same time.

Women who have confirmed cancer are managed within the multidisciplinary team setting.

3 Programme Performance

Standard data returns are used to collect and present data on the cervical screening programme:

- KC53 – information sourced from the call and recall system via the NHAIS system.
- KC61 – information on screening samples processed by the cytology laboratories. Data is sourced from the four screening laboratories via Cyres Statistical Analysis Software.
- KC 65 – information gathered from colposcopy clinics via the Excelicare Colposcopy Management System.

These standard data returns are used to support the quality assurance of the screening programme and facilitate benchmarking of the Northern Ireland programme against national standards and similar programmes elsewhere in the UK.

This report outlines the performance of the NI Cervical Screening Programme for the year 2016-17. It contains information compiled from the standard data returns, reports on performance against national standards and describes significant trends in the programme over recent years.

The colposcopy section of the report is incomplete, containing data from four of the five Trusts. All input of colposcopy data was suspended by Belfast Trust in June 2016 due to software limitations.

3.1 Call and recall

3.1.1 Eligibility

In 2016-17, approximately 492,000 women aged 25-64 were eligible to participate in the cervical screening programme in Northern Ireland (Table 1).

Table 1: Number of women eligible for cervical screening, by age group and Trust. Northern Ireland at 31 March 2017.

Age group (years)	Trust					
	Belfast	South Eastern	Northern	Southern	Western	Northern Ireland
25-29	17,113	9,846	14,648	14,043	10,710	66,360
30-34	17,479	10,403	15,245	15,013	11,458	66,598
35-39	15,720	10,626	15,215	14,359	11,314	67,234
40- 44	13,862	10,164	14,541	13,188	10,865	62,620
45-49	14,186	11,053	15,855	13,577	11,117	65,768
50-54	14,689	10,700	14,603	12,463	10,501	62,956
55-59	12,721	9,657	12,630	10,742	8,984	54,734
60-64	9,266	7,706	10,124	8,337	7,290	42,723
Total	115,036	80,155	112,861	101,702	82,239	491,993

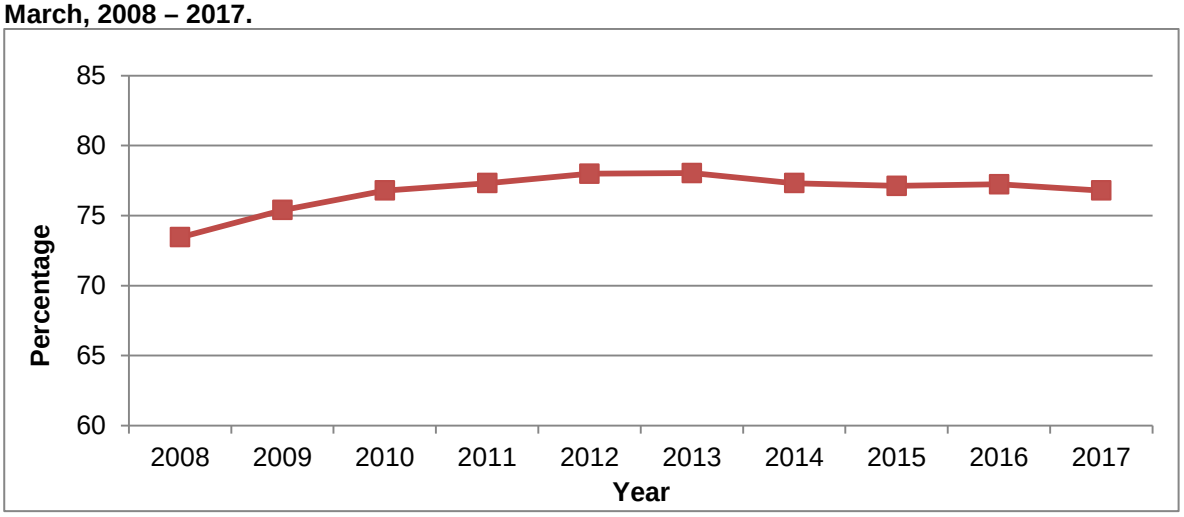
Source: KC53 Part A

3.1.2 Coverage

Coverage is used as a measure of participation in the cervical screening programme. It is defined as the percentage of women in the population who are eligible for screening at a given point in time, who were screened adequately within a specified period. The trend in five year coverage over the last ten years is shown in Figure 1.

As can be seen, the five year coverage has been relatively stable in Northern Ireland in recent years. At end March 2017, 76.8% of women in the eligible age group (25-64 years) had been screened with an adequate result recorded at least once in the last 5 years. This compares to 77.2% at end March 2016. Work to ensure that all eligible women can make an informed choice about participation in the cervical screening programme is described in Section 4 of this report.

Figure 1: Cervical Screening five year coverage (25-64 years) by year. Northern Ireland, at 31 March, 2008 – 2017.



Source: KC53 Part A

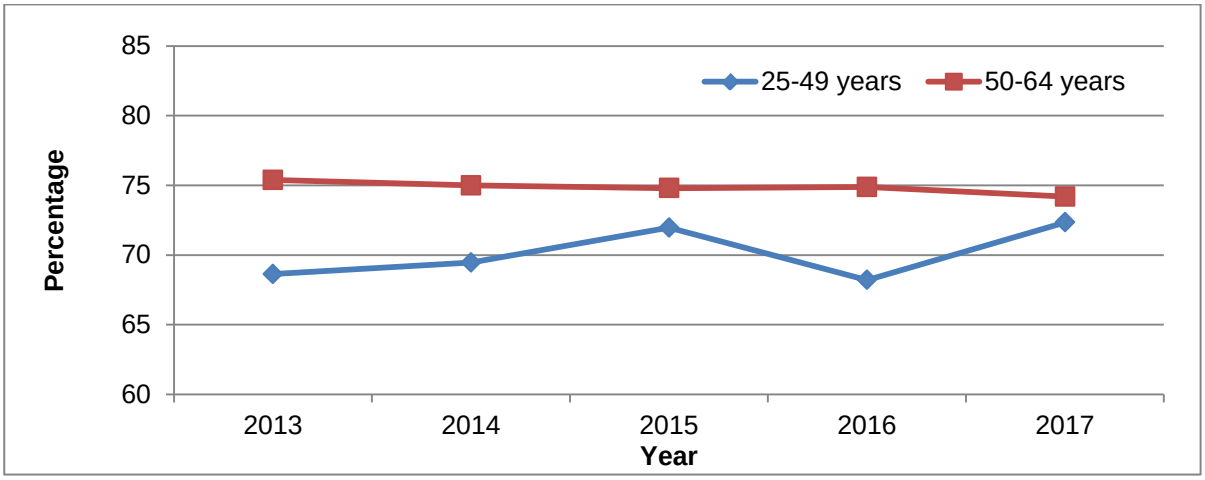
3.1.3 Age appropriate coverage

At 31 March 2017, 72.3% of women aged 25-49 had been screened at least once in the last 3.5 years, and 78.1% in the last 5 years

74.2% of women aged 50-64 had been screened at least once in the last 5 years

A three year screening interval was introduced in Northern Ireland for women aged 25-49 in early 2011. Women aged 50-64 continue to be invited for screening every five years. The achievable standard is that >=80% of eligible women have an adequate screening test result in the age appropriate timescale. The trend in age-appropriate coverage by age group for the last five years is shown in Figure 2. This shows that coverage is higher in women aged 50-64.

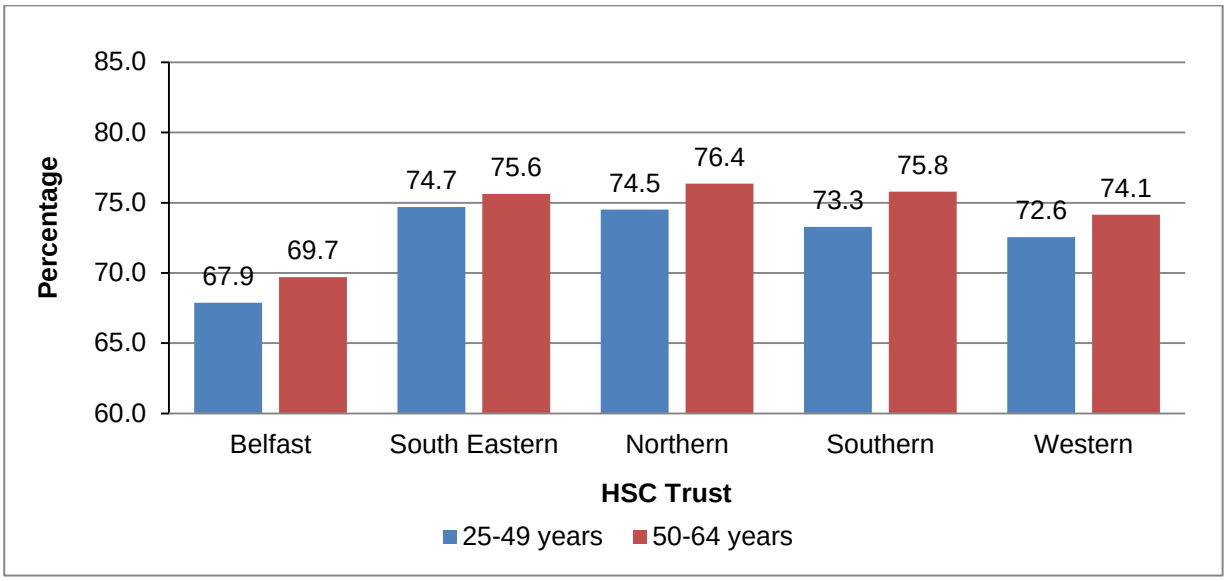
Figure 2: Cervical Screening age appropriate coverage by year. Northern Ireland, at 31 March, 2013 – 2017.



Source: KC 53 Part A

There is variation between Trusts in the coverage rates. Belfast has the lowest coverage with 67.9% of women aged 25-49 having a screening test recorded in the 3.5 years up to 31 March 2017. This compares to 74.7% in the South Eastern Trust area. Belfast Trust also has the lowest coverage rates for older women with 69.7% of women aged 50-64 having a screening test in the last 5 years, compared to 76.4% in the Northern Trust. No Trust area in Northern Ireland met the 80% achievable standard for coverage at end March 2017.

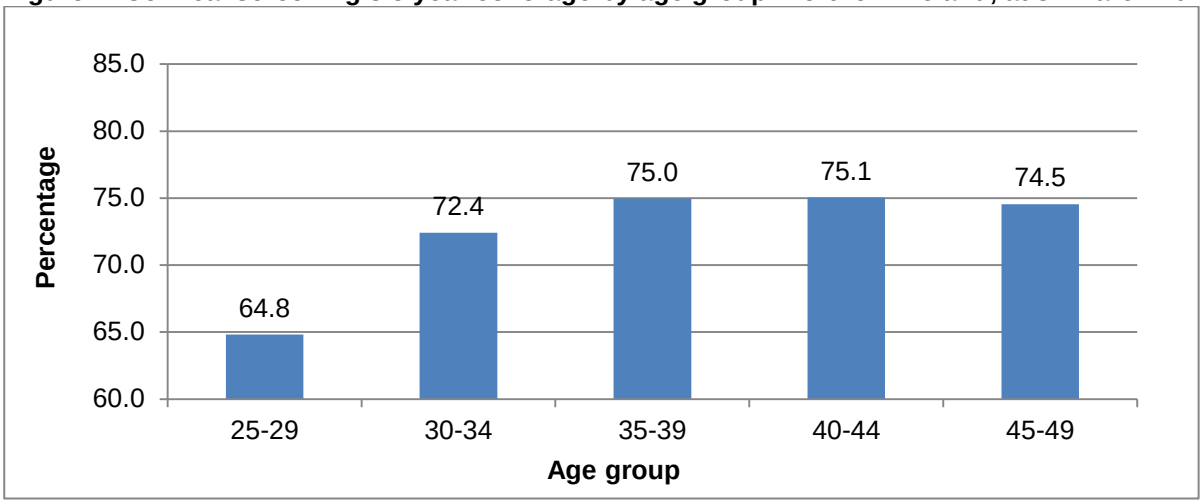
Figure 3: Cervical Screening age appropriate coverage by Trust. Northern Ireland, at 31 March 2017.



Source: KC 53 Part A

A more detailed analysis by five year age bands shows that women aged 25-29 have the lowest coverage with 64.8% of this group having been screened with an adequate result in the 3.5 years to end March 2017. This compares to 72.4% of women aged 30-34.

Figure 4: Cervical screening 3.5 year coverage by age group. Northern Ireland, at 31 March 2017.



Source: KC53 Part A

3.1.4 *Invitations for screening*

The regional call/recall service invited 138,917 women aged 25-64 to attend for screening between 1 April 2016 and 31st March 2017.

The programme categorises screening invitations into the types shown in Table 2.

Table 2: Percentage of women (aged 25-64) invited, by type of invitation. Northern Ireland, 2016-17.

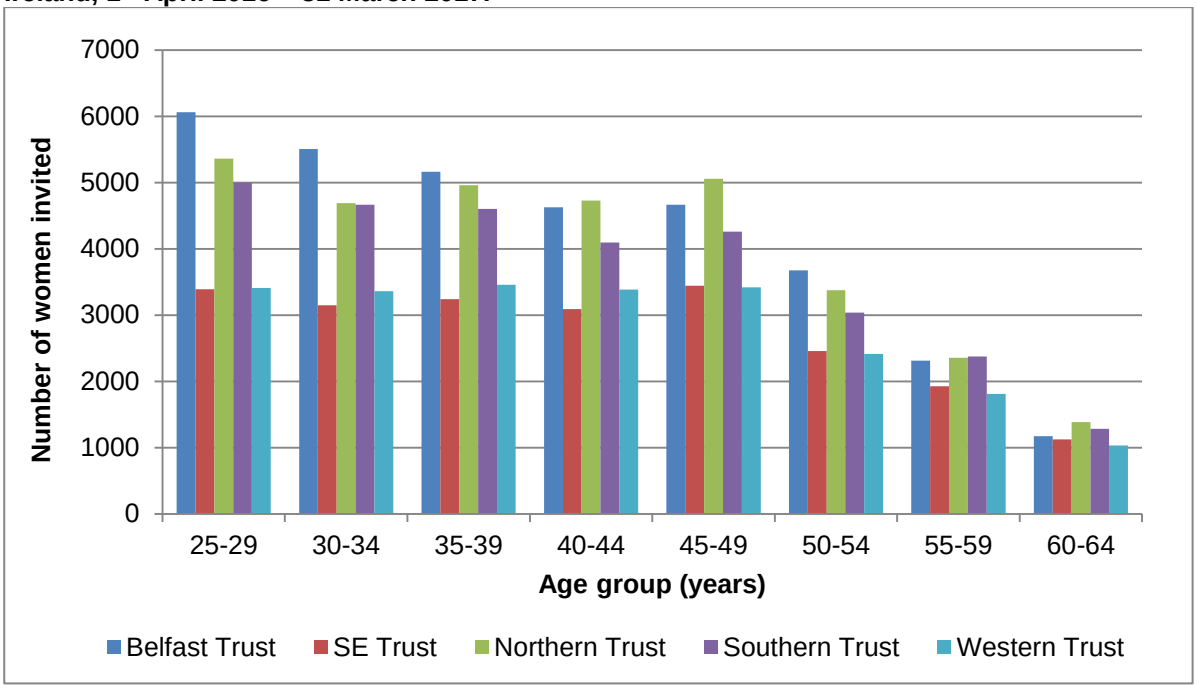
				Repeat in less than 3 years for reasons of		
Year	Total	Call	Routine Recall	Surveillance	Abnormality	Inadequate Sample
2016-17	138,917	18.2%	58.6%	17.9%	3.2%	2.1%

Source: KC53 Part B

Although most women were invited for screening as a result of a call or routine recall, 17.9% were invited for an early repeat as part of surveillance. A 'call' is an invite sent to a woman who has never attended screening before. This will include women entering the programme age range for the first time, as well as women who have previously been invited but never attended. A small proportion (5.3%), were followed up for abnormalities or previous inadequate samples.

The breakdown of the age of women invited and by Trust is shown in Figure 5. There are fewer eligible women in the older age groups as this population is smaller and they are more likely to have been ceased from screening due to clinical reasons (e.g. previous total hysterectomy).

Figure 5: Women aged 25-64 invited to attend for screening, by age group and Trust. Northern Ireland, 1st April 2016 – 31 March 2017.



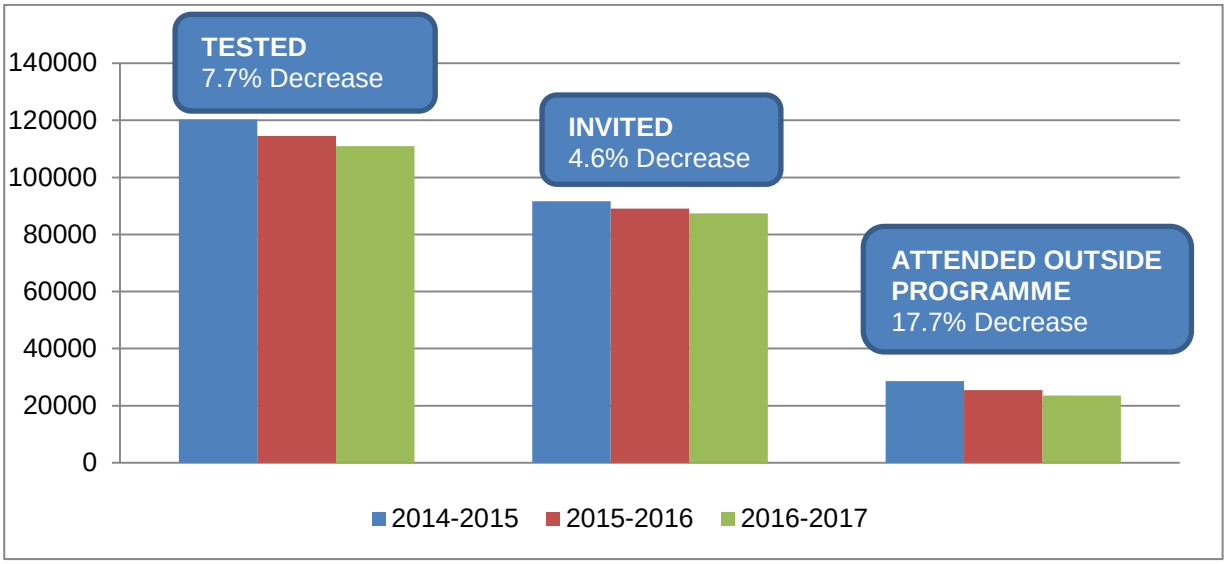
Source: KC53 Part B

3.1.5 Number of women tested

A total of 110,961 women aged 25-64 were tested during 2016-17.

Of these, 23,552 (21.2%) had tests not prompted by the screening programme. This will include tests initiated opportunistically by the sample taker or the woman herself, without an invite having been issued by the programme in the previous six months. There has been a 17.7% decrease in the number of women tested outside the programme in the last three years. This is likely to be due to significant efforts to encourage all primary care practices in Northern Ireland to participate in the regional call/recall service provided by BSO, which includes additional quality measures, rather than undertake these functions at practice level.

Figure 6: Number of women aged 25-64 tested in the year by invitation status. Northern Ireland, 2014-15 to 2016-17.



Source: KC53 Part C1

3.2 Cervical Cytology

3.2.1 Samples examined

A total of 122,817 samples were examined by cytopathology laboratories in 2016-17

110,920 (90.3%) of these were submitted by GP practices or through community clinics (i.e. Sexual and Reproductive Healthcare clinics). Samples from hospitals, including colposcopy clinics, accounted for 6.5% of the total.

Table 3: Number of samples examined by cytopathology laboratory, by source of sample. Northern Ireland, 2016-17.

Laboratory	Total Samples	GP	Community clinics	Genito-urinary medicine	Hospitals	Private	Other
Belfast	37,699	32,668	1,265	3	3,543	140	80
Antrim	28,738	26,857	438	0	1,412	31	0
Craigavon	24,705	22,777	13	2	1,889	24	0
Altnagelvin	31,675	26,257	645	0	1,134	3,639[1]	0
Northern Ireland	122,817	108,559	2,361	5	7,978	3,834	80

Source: KC61 Part A1

3.2.2 Time from sample taken to issue of results

76.0% of samples examined by laboratories in 2016-17 were reported within 14 days of the sample being taken. Overall, 98.2% of samples were reported within 28 days

There was some variation between laboratories in their turnaround times and these are described in Table 4. The standard is that 80% of samples should be reported within 4 weeks. All laboratories met the Northern Ireland standard for turnaround times in 2016-17.

Table 4: Percentage of cervical cytology samples reported within 14 days and 28 days, by laboratory. Northern Ireland, 2016-17

Laboratory	14 days	28 days
Belfast	61.2%	99.1%
Antrim	69.6%	97.9%
Craigavon	78.9%	95.3%
Altnagelvin	97.4%	99.9%
Northern Ireland	76.0%	98.2%

Source: KC61 Part A2

[1] Cytology samples on patients from the Republic of Ireland tested by the Altnagelvin laboratory as part of a private contract, account for 3,614 of this total.

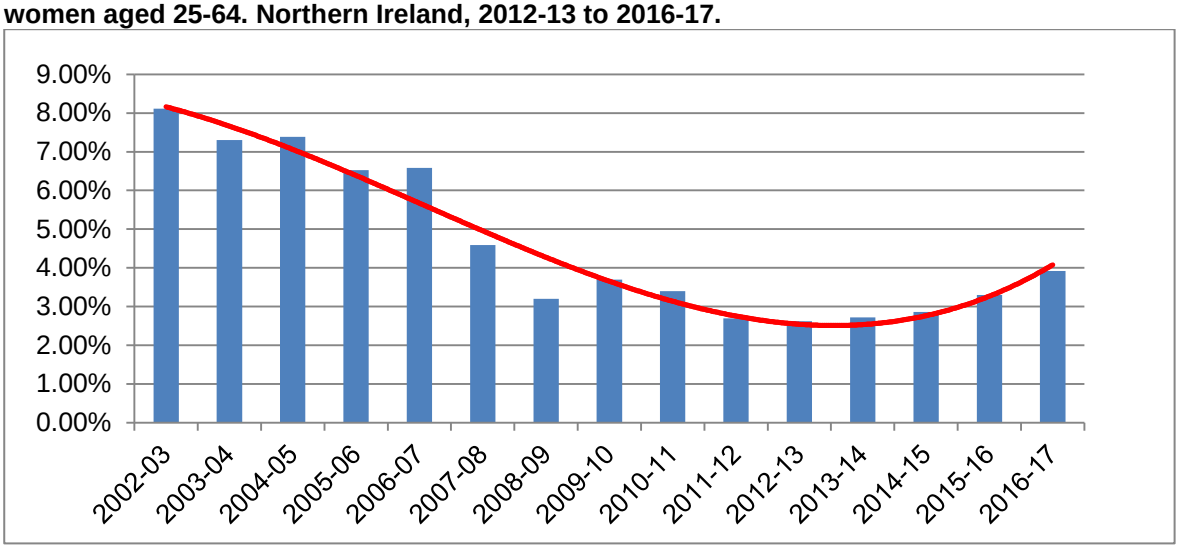
3.2.3 Results

3.9% of all samples submitted by GP and community clinics from women aged 25-64 were reported as inadequate

An inadequate sample is one which does not contain enough cellular material suitable for analysis.

The trend in inadequate rates since 2002/03 is shown in Figure 7. The marked reduction in inadequate rates seen from 2007/08 is a result of the introduction of liquid based cytology (LBC). However, it is noted that inadequate rates have started to increase above 3% again in the last 2 years.

Figure 7: Percentage of samples from GP and community clinics reported as inadequate, from women aged 25-64. Northern Ireland, 2012-13 to 2016-17.



Source: KC61 Part B

There was variation between individual laboratories in their reported inadequate rates in 2016-17, ranging from 2.05% to 8.61%. This is considered to be due to differences in the processing and reporting protocols used by laboratories.

Of the adequate samples submitted by GP and community clinics for women aged 25-64, 93.1% were reported as negative in 2016-17 (Table 5).

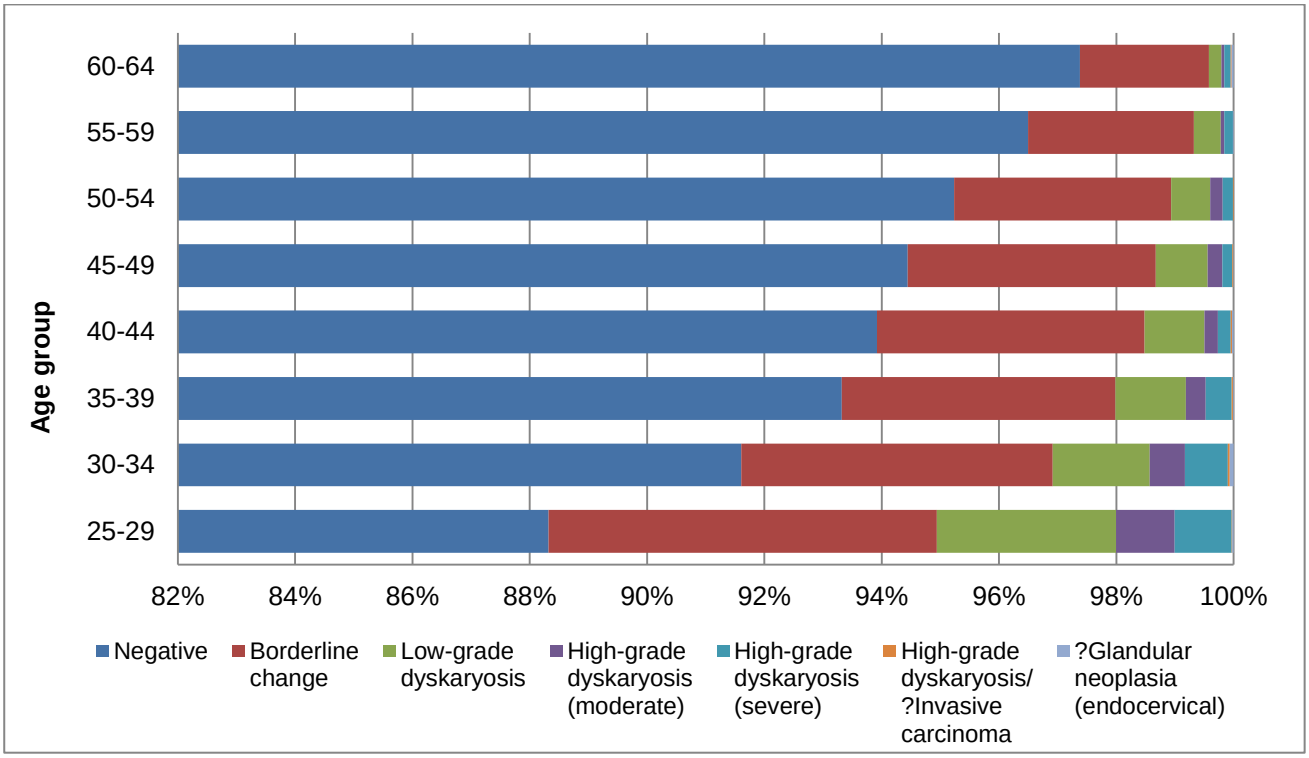
Table 5: GP and Community Clinic adequate samples from women aged 25-64, by results. Northern Ireland, 2016-17.

Result of test	Number	Percentage (%)
Negative	95,263	93.1
Borderline changes	4,737	4.6
Low grade dyskaryosis	1,369	1.3
High grade dyskaryosis (moderate)	418	0.4
High grade dyskaryosis (severe)	446	0.4
High grade dyskaryosis/?Invasive carcinoma	17	0.0
?Glandular Neoplasia (endocervical)	25	0.0
Total adequate samples	102,275	100.0

Source: KC61, Parts A1 and B

When results are analysed by age group, it is noted that women aged 25-29 are more likely to have an abnormal test result than older women (Figure 8). The proportion receiving an abnormal test result reduces with age.

Figure 8: Adequate results in women aged 25-64 by result type and age group. Northern Ireland, 2016-17.



Source: KC61 Part B

3.2.4 Outcome of colposcopy referrals

Laboratories record the outcomes of colposcopy referrals by the category of the referring sample. Table 6 shows the documented colposcopy outcomes for women referred following a sample that was registered in a Northern Ireland laboratory during the 3 month period April – June 2016.

During this quarter, 62.3% of women referred following a high grade cervical abnormality on cytology were found to have cervical cancer, cervical intra-epithelial neoplasia (CIN3) or adenocarcinoma in situ. This compares to 8.8% of women referred following a persistent inadequate or low grade dyskaryosis/positive HPV result.

Table 6: Outcome of colposcopy referrals for samples registered at a laboratory between 1st April and 30th June 2016. Northern Ireland.

		Women referred after persistent inadequate or low grade/positive HPV sample	Women referred after high grade (moderate) or worse sample
Total outcomes with known result		721	305
		%	%
Cervical Cancer		0.1	2.6
CIN3 & Adenocarcinoma in situ		8.7	59.7
CIN2		10.5	19.3
CIN1		28.0	9.2
Non Cervical Cancer		0	0
	HPV only	16.5	3.0
	No CIN/No HPV	5.4	1.3
Other	Seen in Colposcopy – result not known	6.4	2.3
	Inadequate biopsy	0.1	0.7
	Colposcopy – No abnormality detected	23.7	0.7
	Result known – none of above	0.4	0.3

Source: KC61 Part C1

3.2.5 Achievable standards for laboratory reporting

The range of individual laboratory results published for England is used for benchmarking and quality assuring laboratory performance in Northern Ireland. Achievable standards for laboratory reporting are set from the 5th to the 95th percentiles of the distributions of key indicators across all laboratories in England. The performance of each Northern Ireland laboratory benchmarked against the English achievable standards for 2016-17 is shown in Table 7.

Table 7: Performance against achievable standards for laboratory reporting. Northern Ireland, 2016-17.

	Laboratory				England Standard/ 5th - 95th percentile range
	Altnagelvin	Antrim	Belfast	Craigavon	
Inadequate as a % of all samples[1]	1.8%	8.6%	1.9%	3.7%	1.0 – 4.3%
Positive Predictive Value (PPV) for CIN2 or worse[2]	95.6%	83.3%	78.5%	86.7%	76.7% – 92.3%
Referral Value for CIN2 or worse[2]	2.5	2.5	2.4	2.2	2.0 – 5.0
Abnormal Predictive Value (APV) for CIN2 or worse[2]	22.4%	16.8%	23.9%	20.3%	6.8% – 26.7%

Source: Cyres Statistical Analysis Software
[1] based on results for women aged 25-64 tested in GP and community clinics only
[2] Percentile ranges for PPV, RV and APV are calculated using data from the previous year (e.g. PPV for 2016-17 is based on data from 2015-16).

It is noted that Antrim laboratory had a higher than expected inadequate rate. All other indicators for Northern Ireland laboratories were within the achievable standards.

The definitions of the each of the indicators are described in the glossary at Appendix 3.

3.2.6 Testing for Human Papilloma Virus

Cervical samples are tested for hr-HPV as part of the triage or test of clearance pathway. The volume of hr-HPV testing and the results are shown in Table 8. This shows that Belfast laboratory has the highest rate of hr-HPV positive results in samples which are reported with low grade cytology. This is likely to be due to population factors in their catchment area (e.g. younger age profile).

Table 8: hr-HPV testing activity and results by reporting cytology laboratory. Northern Ireland, 2016-17.

	Altnagelvin	Antrim	Belfast	Craigavon	Northern Ireland
Number of samples tested for hr-HPV	1893	2982	4039	2534	11,448
hr-HPV positive rate for cytology borderline/low grade samples	47.8%	40.7%	53.6%	40.0%	46.4%
hr-HPV positive rate for cytology negative samples	28.4%	27.4%	27.8%	29.0%	28.1%

Source: Cyres Statistical Analysis Software

3.3 Colposcopy

The colposcopy data presented in this report represents four of the five Trusts. All input of colposcopy data to the Excelicare colposcopy management system was suspended by Belfast Trust in June 2016 due to software limitations, so no data is available for Belfast Trust.

3.3.1 Referrals for Colposcopy

A total of 2,999 new referrals were made to colposcopy services in 2016-17. The majority of these referrals were as the result of a screening test, but 6.2% of referrals were due to a clinical indication. Of those referred following an abnormal screening test, 688 (26.3%) had reported high grade dyskaryosis (moderate or severe) and 9 (0.3%) had reported suspected invasive carcinoma. There were 26 referrals following cervical cytology of suspected glandular neoplasia.

3.3.2 Appointments for Colposcopy

Clinics collected data on the time taken between the date of a woman's referral letter and her first offered outpatient appointment, regardless of whether she attended or not. As all cytology laboratories in Northern Ireland operate a direct referral process to colposcopy, the referral date for these is taken as the date the test was reported.

Table 9: Time from referral to first offered appointment at colposcopy, by indication. Northern Ireland excluding Belfast Trust, 2016-17.

Total number of referrals	2,999		
Waiting time	Northern Ireland %	Range across Trusts %	Standard* %
All referrals			
Less than or equal to 2 weeks	14.8	-	-
Less than or equal to 4 weeks	50.1	-	-
Less than or equal to 8 weeks	88.4	-	90
Less than or equal to 12 weeks	94.9	-	-
High grade dyskaryosis (moderate or severe)			
Less than or equal to 4 weeks	80.3	51.1 - 90.4	90
High grade dyskaryosis/ ?invasive carcinoma			
Less than or equal to 2 weeks	77.8	75.0 - 100	90
?Glandular neoplasia			
Less than or equal to 2 weeks	53.8	41.7 - 100	90

Source: KC65 Part A

**Standard from Colposcopy and Programme Management (2nd edition), NHSCSP Publication 20, May 2010.*

Of all new appointments to colposcopy offered in 2016-17, 79.2% of appointments were attended. Of those not attended, 3.3% were cancelled by the clinic, 1.7% were cancelled by the patient on the day and in 4.0% of cases the patient did not attend and gave no advance notice.

3.3.3 First Attendances at Colposcopy

Colposcopy services record details of treatments and procedures undertaken at first attendance at clinic. In the case of deferred treatment the woman is recorded as having no treatment at her first attendance.

In 2016-17, a total of 2,827 first attendances at colposcopy were recorded.

Of all of first attendances at colposcopy, 67.3% of women had some treatment or procedure.

For those referred with high grade abnormalities, the proportion was 88.7%. For those with low grade abnormalities (borderline change or low-grade dyskaryosis), it was 64.4%.

Table 10: Women referred to colposcopy – first attendance by type of procedure and result of referral. Northern Ireland excluding Belfast Trust, 2016-17.

	Referral indication					
Treatment	All referrals	Inadequate	Borderline changes or low-grade dyskaryosis	High-grade dyskaryosis or worse	Clinical indication urgent	Clinical indication non-urgent
Total First Attendances	2,827	51	1,784	698	113	40
	%	%	%	%	%	%
No procedure	32.7	80.4	35.6	11.3	55.8	42.5
Procedure used	67.3	19.6	64.4	88.7	44.2	57.5
Diagnostic biopsy	45.3	17.6	52.9	36.1	31.0	30.0
Excision	16.3	2.0	6.7	46.1	5.3	5.0
Ablation without biopsy	2.4	0.0	2.2	2.1	5.3	10.0
Ablation with biopsy	2.9	0.0	2.6	4.1	0.9	0.0
Other	0.5	0.0	0.1	0.0	1.8	12.5

Source KC65 Part C1

The most common treatment or procedure at first attendance was diagnostic biopsy, which was carried out at 45.3% of all first attendances. The use of this procedure was most common amongst those referred with low-grade abnormalities (52.9%), with 6.7% of this group undergoing excision.

For those women referred with high grade abnormalities the most common treatment at first appointment was excision (46.1%) followed by diagnostic biopsy (36.1%).

The Northern Ireland Cervical Screening Programme uses published comparative data from services in England for benchmarking purposes (Table 11).

Table 11: Women referred to colposcopy – first attendance by type of procedure. Northern Ireland and England, 2016-17.

	No Procedure	Procedure used	Diagnostic Biopsy	Excision	Ablation without biopsy	Ablation with biopsy	Other
Northern Ireland	32.7%	67.3%	45.3%	16.3%	2.4%	2.9%	0.5%
NHSCSP	41.4%	58.6%	45.5%	11.0%	0.4%	0.1%	1.5%

Source KC65 Part C1

It is acknowledged that there are differences between the data for Northern Ireland and England with an apparent higher procedure rate in Northern Ireland. This may be due in part to how "procedure" is defined and recorded. Going forward, steps are being taken to standardise definitions and coding.

3.3.4 Biopsies

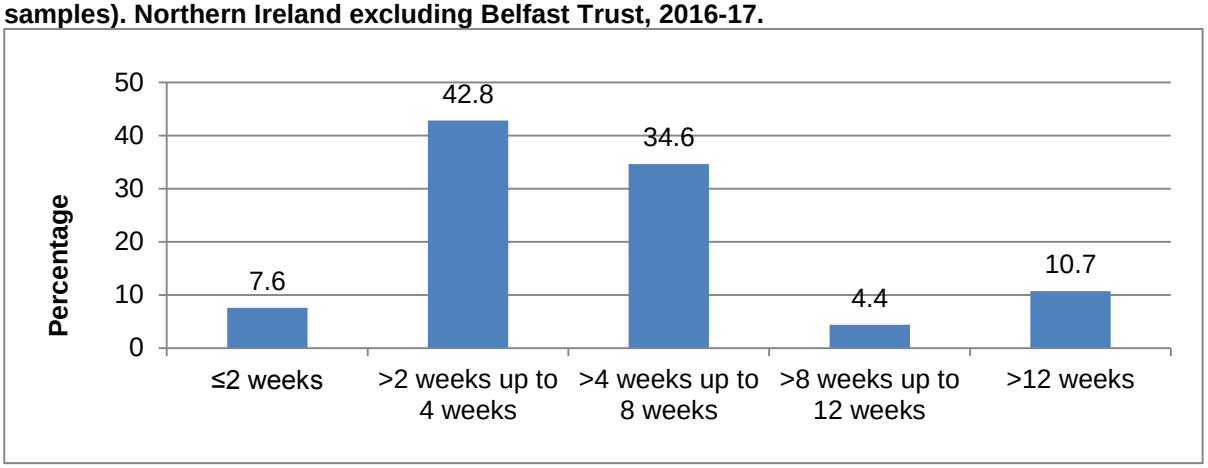
For each biopsy taken at colposcopy, the time between the biopsy being taken and the result being made available to the clinician on the colposcopy management system is monitored. To allow time for follow up of results, the data relates only to biopsies taken in the first month of each quarter during the year.

In 2016-17 there were 2,018 biopsies taken at colposcopy in the four sample months.

The biopsy result was available in the patients' record within 2 weeks in 7.6% of cases, and within 4 weeks in a further 42.8% of cases.

In 10.7% of cases the biopsy result was recorded more than 12 weeks after the sample was taken. It should be noted that some of these delays are likely to have been due to the fact that the system initially required a manual matching process by administrative staff to attach the result. It does not reflect the availability of results to clinical staff. This issue has since been resolved, with an automated results process being rolled out from mid-2016.

Figure 9: Time from biopsy until the result is available in the patients' record (4 one month samples). Northern Ireland excluding Belfast Trust, 2016-17.



Source: KC65 Part D

Non-diagnostic biopsies taken at colposcopy are mostly those performed as a treatment to remove abnormal cells from the cervix. Of the non-diagnostic biopsies taken in 2016-17, where the result was known, 87.9% showed evidence of Cervical Intra-epithelial Neoplasia (CIN) or worse. CIN2 or worse was found in 69.1% of non-diagnostic biopsies (Table 12).

Table 12: Non-diagnostic biopsies taken at colposcopy by outcome (4 one month samples). Northern Ireland excluding Belfast Trust, 2016-17.

Outcome	Northern Ireland
Number of biopsies reported	810
Biopsies with unknown result	11
Biopsies with known result (=100%)	799
Cancer	1.4%
Adenocarcinoma in situ	3.3%
CIN 3	45.9%
CIN 2	18.5%
CIN 1	18.8%
HPV / Cervicitis only	4.6%
No CIN / No HPV	6.8%
Inadequate / unsatisfactory biopsy	0.8%
Total showing CIN or worse	87.9%

Source: KC65 Part E

4 Promoting Informed Choice

Participation in cervical screening in Northern Ireland remains below the target coverage rate of 80%. However, it is recognised that there are likely to be areas and subpopulations of women who are less likely to take up their invite for screening. This can be due to a range of factors, such as cultural and community issues, programme organisation issues, and individual personal choice.

The PHA continues to work with the service and key stakeholders to ensure that all eligible women can make an informed choice about participation and that the service is accessible to them.

Key actions in 2016-17 included:

- Promotion of key messages through media releases to coincide with cervical cancer prevention and screening awareness weeks
- Commissioning of a programme to raise awareness and promote informed choice on the three cancer screening programmes. This programme is delivered by the Women's Resource and Development Agency (WRDA) and provides peer education sessions though community networks to include the following targeted groups:
    - Members of deprived communities (e.g. 20% most deprived wards in each Trust area as per the NISRA Index of Multiple Deprivation)
    - People from a black or ethnic minority group
    - Members of the Traveller community
    - Members of the LGBT community
    - People with learning, physical or sensory disabilities.

    In 2016-17, WRDA delivered 162 educational awareness sessions on breast, cervical and bowel cancer screening to targeted service users throughout Northern Ireland, and attended 19 health awareness events to provide information on cancer screening.

5 Quality Improvement Activity

A number of quality improvement activities were undertaken within the cervical screening programme during 2016-17:

- Programme updates and were communicated to the wider service providers through the publication of the "*Screening Matters*" newsletter, throughout the year

- The PHA team worked closely with the Defence Medical Service to develop and operationalise protocols to ensure that serving personnel in Northern Ireland have access to the cervical screening programme and appropriate follow up services.
- In response to a serious adverse incident in early 2016, the PHA commenced work with colleagues in the Directorate of Nursing, PHA and the Directorate of Integrated Care, Health and Social Care Board on a number of quality improvement initiatives. This resulted in the publication of the following guidance in 2016-17.

Document	Publication date
NI Training and Audit Requirements for Cervical Sample Takers	May 2016
A Guide to Understanding Sample Taking Performance Data	May 2016
NI Standards for Nurse & Midwife Education Providers: Cervical Screening Sample Taking	December 2016

Further aspects of this work will continue into 2017-18.

- The laboratory QA team developed and implemented a new cytology request form for use by sample takers. The form now includes the ability to record a unique sample taker code against each sample taken. It is planned to introduce a new process in 2017-18 to facilitate sample takers in monitoring their ongoing performance.

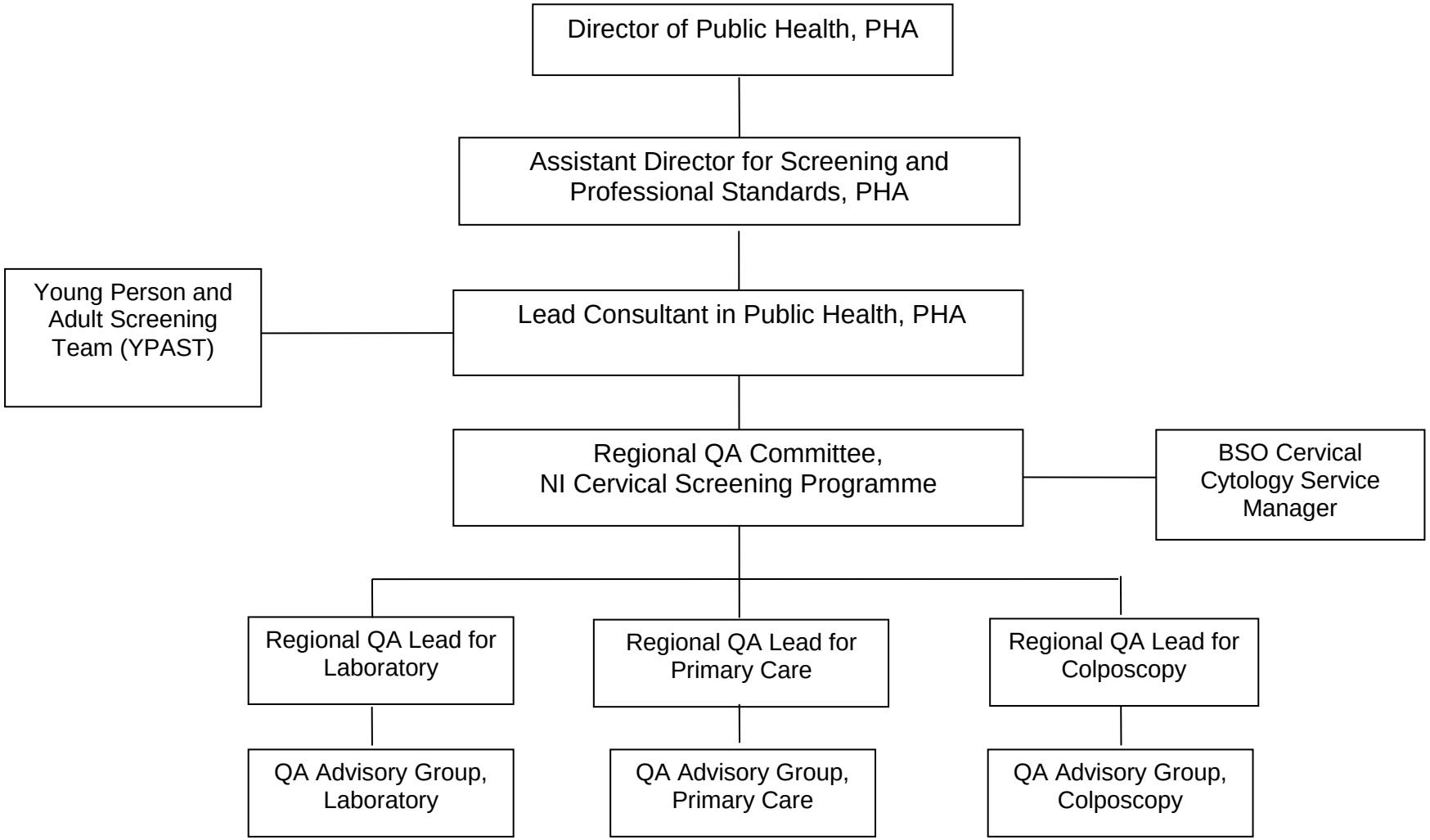
6 Quality Assurance

The purpose of quality assurance is to monitor, maintain and improve on minimum standards of service, performance and quality across all aspects of the cervical screening programme. This function is led and facilitated by the PHA and supported through the structured input of a range of professionals across key clinical disciplines (see Appendix 1).

Ongoing quality assurance activities include:

- Regular disciplinary led meetings across the programme
- Annual colposcopy led conference
- Annual data review meetings with all Trusts
- Regular performance review with BSO on call/recall service
- Rolling programme of formal quality assurance visits to Trusts

Appendix 1: Quality Assurance Structure



Appendix 2: Data Tables

KC53 Part A1/A2: Coverage at 31 March 2017									
AGE OF WOMAN AT 31/3/2017	NUMBER OF WOMEN IN RESIDENT POPULATION	NUMBER OF WOMEN WITH RECALL CEASED FOR			ELIGIBLE POPULATION	NUMBER OF WOMEN WHOSE MOST RECENT TEST WAS NO MORE THAN 3.5 YEARS AGO	COVERAGE (%) - LESS THAN 3.5YRS SINCE LAST ADEQUATE TEST	NUMBER OF WOMEN WHOSE MOST RECENT TEST WAS NO MORE THAN 5 YEARS AGO	COVERAGE (%) - LESS THAN 5YRS SINCE LAST ADEQUATE TEST
		CLINICAL REASONS	AGE REASONS	OTHER REASONS					
UNDER 20	237,656	0	0	0	237,656	202	0.08%	202	0.08%
20-24	59,369	2	0	0	59,367	5,402	9.10%	5,857	9.87%
25-29	66,377	17	0	2	66,360	43,014	64.82%	45,527	68.61%
30-34	69,698	100	0	1	69,598	50,404	72.42%	54,967	78.98%
35-39	67,569	335	0	5	67,234	50,413	74.98%	54,508	81.07%
40-44	63,768	1,148	0	6	62,620	46,997	75.05%	50,822	81.16%
45-49	68,751	2,983	0	10	65,768	49,023	74.54%	52,984	80.56%
50-54	68,318	5,362	0	14	62,956	43,804	69.58%	49,297	78.30%
55-59	61,838	7,104	0	9	54,734	28,896	52.79%	39,884	72.87%
60-64	50,785	8,062	15,817	3,839	42,723	21,221	49.67%	29,826	69.81%
65-69	45,987	8,633	29,876	5,878	37,354	8,543	22.87%	15,479	41.44%
70-74	41,555	8,438	25,289	5,777	33,117	827	2.50%	1,634	4.93%
75-79	30,655	6,344	14,611	458	24,311	140	0.58%	253	1.04%
80 & OVER	47,472	4,105	3,628	25	43,367	33	0.08%	81	0.19%
TARGET AGE GROUP (25-64)	**517,104**	**25,111**	**15,817**	**3,886**	**491,993**	**333,772**	**67.84%**	**377,815**	**76.79%**
TOTAL ALL AGES	**979,798**	**52,633**	**8,9221**	**16,024**	**927,165**	**348,919**	**37.63%**	**401,321**	**43.28%**

KC 53 Part B: Number of women invited 2016-17						
		Number of women invited in the year as a result of:				
Age of woman at 31/03/2017	TOTAL			Repeat in < 3 years for reasons of:		
		Call	Routine recall	Surveillance	Abnormal sample	Inadequate
Under 20	**20**	0	0	3	12	5
20-24	**1,409**	757	53	233	302	64
25-29	**23,193**	12,128	7,596	2,158	1,029	282
30-34	**21,449**	3,548	12,459	4,189	934	319
35-39	**21,500**	2,633	13,172	4,643	709	343
40-44	**19,954**	2,189	13,088	3,783	512	382
45-49	**20,865**	2,114	14,361	3,556	466	368
50-54	**15,066**	1,413	9,918	2,944	390	401
55-59	**10,838**	1,217	6,739	2,186	237	459
60-64	**6,052**	101	4,072	1,341	143	395
65-69	**787**	2	253	343	42	147
70-74	**143**	0	0	111	11	21
75 & over	**59**	0	0	43	7	9
Target age group (25-64)	**138,917**	**25,343**	**81,405**	**24,800**	**4,420**	**2,949**
Total all ages	**141,335**	**26,102**	**81,711**	**25,533**	**4,794**	**3,195**

KC53 Part C1: Number of women tested in the year 2016-17									
Age of woman at 31/03/2017	**TOTAL**	as a result of:		Repeat in < 3 years for reasons of:			While recall suspended	While recall ceased	Attended outside the programme
		Call	Routine recall	Surveillance	Abnormality	Inadequate smear			
Under 20	**141**	0	0	0	6	0	4	0	131
20-24	**2,446**	15	12	144	143	27	163	0	1,942
25-29	**17,916**	5,422	4,817	1,476	170	137	1,836	0	4,058
30-34	**17,393**	577	7,573	2,962	232	147	1,658	0	4,244
35-39	**17,351**	350	8,491	3,414	238	154	1,080	0	3,624
40-44	**15,440**	175	8,463	2,765	175	178	657	0	3,027
45-49	**15,692**	128	9,368	2,487	210	167	611	0	2,721
50-54	**12,002**	102	6,651	1,993	190	181	464	0	2,421
55-59	**8,767**	98	4,252	1,485	99	203	266	0	2,364
60-64	**6,400**	42	3,362	812	58	175	159	699	1,093
65-69	**1,305**	1	325	177	16	56	68	630	32
70-74	**155**	0	0	27	0	3	14	107	4
75 & over	**40**	0	0	8	0	1	5	20	6
Target age group(25-64)	**110,961**	**6,894**	**52,977**	**17,394**	**1,372**	**1,342**	**6,731**	**699**	**23,552**
Total all women	**115,048**	**6,910**	**53,314**	**17,750**	**1,537**	**1,429**	**6,985**	**1,456**	**25,667**

KC53 Part D: Woman's most severe test result in the year, 2016-17								
Age of woman at 31/03/2017	**TOTAL**	Negative	Borderline	Mild dyskaryosis	Moderate dyskaryosis	Severe dyskaryosis	Severe/ ?invasive	?Glandular neoplasia
Under 20	**137**	116	15	5	1	0	0	0
20-24	**2,410**	1,946	238	164	38	24	0	0
25-29	**17,670**	15,323	1,314	623	219	185	2	4
30-34	**17,123**	15,473	995	371	132	137	5	10
35-39	**17,081**	15,818	845	260	58	89	6	5
40-44	**15,189**	14,156	742	193	46	43	3	6
45-49	**15,401**	14,448	705	173	41	31	2	1
50-54	**11,725**	11,058	488	116	37	23	3	0
55-59	**8,412**	8,063	261	55	9	22	0	2
60-64	**6,123**	5,917	150	41	4	7	1	3
65-69	**1,234**	1,190	33	6	0	2	2	1
70-74	**146**	136	6	2	0	2	0	0
75 & over	**35**	30	1	0	1	1	2	0
Target age group(25-64)	**108,724**	**100,256**	**5,500**	**1,832**	**546**	**537**	**22**	**31**
Total all ages	**112,686**	**103,674**	**5,793**	**2,009**	**586**	**566**	**26**	**32**

KC 61 Parts A1 and B: Samples from GP and NHS Community Clinics, Laboratory cytology results, 2016-17									
	Total samples examined			Total adequate samples (ages 25-64)	Result (as a percentage of total adequate)				
	All sources all ages	GP & NHS CC (ages 25 - 64)	Inadequate (%)		Negative (%)	Borderline (%)	Low-grade dyskaryosis (%)	High-grade dyskaryosis (moderate) (%)	High-grade dyskaryosis (severe or worse) (%)
Belfast Laboratory	37,699	32,492	*1.9%*	31,865	*92.6%*	*4.3%*	*2.1%*	*0.5%*	*0.6%*
Antrim Laboratory	28,738	26,392	*8.6%*	24,132	*92.2%*	*6.3%*	*0.8%*	*0.4%*	*0.4%*
Craigavon Laboratory	24,705	21,932	*3.7%*	21,119	*93.0%*	*3.9%*	*1.2%*	*0.4%*	*0.6%*
Altnagelvin Laboratory	31,675	25,620	*1.8%*	25,159	*94.9%*	*3.4%*	*1.1%*	*0.3%*	*0.4%*
Northern Ireland	**122,817**	**106,436**	***3.9%***	**102,275**	***93.1%***	***4.6%***	***1.3%***	***0.4%***	***0.5%***

Appendix 3: Glossary

Ablation: a treatment that destroys tissue rather than removes it.

Abnormal predictive value (APV): the percentage of samples reported as borderline or low grade that led to referral for colposcopy and subsequent diagnosis of CIN2 or worse.

Biopsy: a procedure that involves taking a small sample of tissue that can be examined under a microscope.

CIN (cervical intra-epithelial neoplasia): CIN is not cancer but an indicator of the depth of abnormal cells within the surface layer of the cervix, and is divided into 3 grades. The higher the number/grade the more severe the condition:

> **CIN 1** – one third of the thickness of the surface layer of the cervix is affected.
>
> **CIN 2** – two thirds of the thickness of the surface layer of the cervix is affected.
>
> **CIN 3** – full thickness of the surface layer of the cervix is affected (also known as carcinoma in situ).

Colposcopy: a detailed examination of the cervix

Coverage: the percentage of women in a population eligible for screening at a given point in time, who were screened within a specified period. Women ineligible for screening, and thus not included in the numerator or denominator of the coverage calculation, are those whose recall has been ceased for clinical reasons (most commonly due to hysterectomy).

Cytology: the examination of cell samples

Dyskaryosis: the small changes which are found in the cells of the cervix

Eligible: eligible women are those within the defined age range, resident in Northern Ireland and registered with a GP.

Excision biopsy: a procedure that involves removing a larger area of tissue for further examination

Human Papilloma Virus (HPV): a family of viruses. Infection of the cervix with some types of HPV (high risk types) can cause abnormal tissue growth and changes to cells which can lead to cervical cancer

Non-diagnostic biopsy: a biopsy taken which is intended to remove/treat the cervical abnormality

Positive predictive value (PPV): the percentage of women referred to colposcopy with high grade cytology or worse, whose biopsy is reported as CIN2 or worse.

Referral value: the number of women referred to colposcopy to detect one CIN2 or worse lesion