agenda

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

standing items

1 1.30	Welcome and apologies		Chair
2 1.30	Declaration of Interests		Chair
3 1.30	Minutes of Previous Meeting held on 18 April 2019		Chair
4 1.30	Matters Arising		Chair
5 1.35	Chair's Business		Chair
6 1.40	Chief Executive's Business		Chief Executive

committee updates

7 1.50	Update from Governance and Audit Committee	**PHA/01/06/19**	Mr Drew

items for approval

8 2.00	PHA Draft Budget 2019/20	**PHA/02/06/19**	Mr Cummings
9 2.25	Corporate Risk Register	**PHA/03/06/19**	Mr McClean
10 2.35	Breast Screening Programme Annual Report 2016/17	**PHA/04/06/19**	Dr Mairs
11 2.50	MOU between the Department of Health, PHA and SBNI	**PHA/05/06/19**	Mr McClean

12 3.00	PHA Rural Needs Act Annual Report 2018/19	**PHA/06/06/19**	Mr McClean

items for noting

13 3.10	Personal and Public Involvement Update	**PHA/07/06/19**	Mrs Hinds
14 3.25	Corporate Monitoring Report	**PHA/08/06/19**	Mr McClean

closing items

15 Any other Business
3.35

16 Details of next meeting:

Thursday 15 August 2019 at 1.30pm

Board Room, Tower Hill, Armagh, BT61 9DR

HSC Public Health Agency

minutes

Title of Meeting	111th Meeting of the Public Health Agency Board
Date	18 April 2019 at 1.30pm
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

Present

Mr Andrew Dougal	-	Chair
Mr Edmond McClean	-	Interim Deputy Chief Executive / Director of Operations
Mrs Mary Hinds	-	Director of Nursing and Allied Health Professionals
Dr Gerry Waldron	-	Assistant Director (*on behalf of Dr Mairs*)
Mr John-Patrick Clayton	-	Non-Executive Director
Mr Leslie Drew	-	Non-Executive Director
Ms Deepa Mann-Kler	-	Non-Executive Director
Mr Joseph Stewart	-	Non-Executive Director

In Attendance

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

Apologies

Mrs Valerie Watts	-	Interim Chief Executive
Dr Adrian Mairs	-	Acting Director of Public Health
Councillor William Ashe	-	Non-Executive Director
Alderman Paul Porter	-	Non-Executive Director
Professor Nichola Rooney	-	Non-Executive Director
Mrs Joanne McKissick	-	External Relations Manager, PCC

30/19	**Item 1 – Welcome and Apologies**
30/19.1	The Chair welcomed everyone to the meeting. Apologies were noted from Mrs Valerie Watts, Dr Adrian Mairs, Councillor William Ashe, Alderman Paul Porter, Professor Nichola Rooney and Mrs Joanne McKissick.
31/19	**Item 2 – Declaration of Interests**
31/19.1	The Chair asked if anyone had interests to declare relevant to any items

on the agenda. No interests were declared.

32/19 **Item 3 – Minutes of previous meeting held on 21 March 2019**

32/19.1 The minutes of the previous meeting, held on 21 March 2019, were approved as an accurate record of that meeting.

33/19 **Item 4 – Matters Arising**

22/19.3 Lifeline funding

33/19.1 The Chair asked whether the Lifeline budget is ring fenced. Mr McClean explained that the budget is not ring fenced, but PHA does seek to ensure that any slippage is used in other related suicide prevention initiatives.

24/19.3 Homelessness

33/19.2 The Chair asked whether PHA work next year would include looking at homelessness. Mrs Hinds advised that there is work ongoing within both HSCB and PHA, and that in order to reduce duplication of effort, Louise McMahon from HSCB will be leading a co-ordination group, working with the Department for Communities and the Department of Justice, and PHA will contribute to this work.

34/19 **Item 5 – Chair's Business**

34/19.1 The Chair presented his Report to members and began by commenting on the most recently released unemployment figures which show that 3% of people in Northern Ireland are unemployed. He said that more effort needed to be made to increase employment opportunities for people with disabilities. Mr Clayton expressed caution at the figures, and said that the quality of jobs needed to be taken into consideration as these figures would include individuals on zero hours contracts. He said that there is a clear link with health inequalities. Ms Woods added that employment is classed as 1 working hour per fortnight. Mr Stewart said that PHA needed to focus on health inequalities, and the links between unemployment and poor life expectancy.

34/19.2 The Chair referred to the issues of filling public health consultant posts. Dr Waldron clarified that these posts are open to people of all academic backgrounds, but that training is the issue.

34/19.3 The Chair updated members on the work of the duty of candour workstream resulting from the Hyponatraemia Inquiry. Mr Stewart advised that he is participating in the education and training workstream, but it is awaiting outputs from other workstreams. He said that there is a real risk of duplication of effort which will result in additional pressures being put on healthcare professionals. The Chair said that he has been pressing to get an end date for the work of the various workstreams. He

	added that candour should not focus solely on mistakes, but should permeate the operation of the whole health and social care service.
34/19.4	The Chair noted that a report has been prepared by PHA Health Intelligence following the recent press release on life expectancy, and that this will be presented at a future PHA Board meeting or workshop.
35/19	**Item 6 – Chief Executive's Business**
35/19.1	In the absence of the Interim Chief Executive, Mr McClean gave members an overview of some of the matters highlighted by the Interim Chief Executive in her Report which was issued to members in advance of the meeting.
35/19.2	Mr McClean advised that the EU Exit planning which was being overseen by the Department of Health has now been put on hold, but that the Permanent Secretary had written to thank staff for their work so far in this area.
35/19.3	Mr McClean gave members an overview of some of the Transformation work that has taken place since the last meeting.
35/19.4	Mr McClean informed members that HSCB and PHA staff had worked alongside colleagues in Mid Ulster Council, and other organisations, in the aftermath of the tragic events in Cookstown on St Patrick's Day.
35/19.5	Mr McClean said that events were held in the local offices to mark the 10th anniversary of the establishment of HSCB and PHA. He informed members of the success of the PHA and HSCB Communications Teams in the recent Public Sector Communications Forum awards for the Stay Well This Winter campaign. He finished his update by passing on congratulations to Ms Roulston who had recently received her OBE at Buckingham Palace.
35/19.6	Ms Mann-Kler asked about the service outcome motivation behind the decision to reshape stroke and breast assessment services. Mr Cummings said that the main reason is to improve quality outcomes as Northern Ireland is falling behind other parts of the UK. Mrs Hinds added that the service is too fragmented, and that is time to take stock, but she added that difficult decisions may have to be made.
35/19.7	Mrs Hinds said that although the centres may be further away, the interventions at these centre will be swift and people can complete their recovery in their local area. The Chair recalled that in regard to stroke "time is brain loss" and expressed a concern that an additional journey time to a thrombolysing centre may thus reduce the effectiveness of treatment. She said that teams in the HSCB and PHA have spent a lot of time looking at this. Mr Cummings said that under the new arrangements, any centre would require to be staffed 24 hours a day, 7 day a week.

35/19.8 Mr Clayton sought confirmation that the “no deal” planning scenario arrangements have been stood down. Mr McClean confirmed that this was the case, pending further advice from the Department of Health.

35/19.9 The Chair asked about how success can be measured on a social media campaign. Mr McClean said that various metrics are used including through evaluation to the number of hits, though the true barometer would be uptake of the vaccine itself.

35/19.10 The Chair asked about physician associates. Mrs Hinds explained that this is a programme run for Ulster University psychology graduates which will enable them to provide a level of care in support of medical staff, but they will not be registered medical professionals. She pointed out that nurse practitioners are also being trained. The Chair suggested that GPs should be delegating more. Mrs Hinds said that this is happening.

36/19 Item 7 – Finance Report (PHA/01/04/19)

36/19.1 Mr Cummings presented the Finance Report for the period up to the end of February. He said that while there remained some small surpluses at that point, he hoped that the final year-end position will see a reduction in the overall surplus. He added that his staff are currently working on the final position with regard to confidence and supply monies.

36/19.2 The Board noted the Finance Report.

37/19 Item 8 – Update from Governance and Audit Committee (PHA/02/04/19)

37/19.1 Mr Drew advised that the Governance and Audit Committee had met yesterday, and that many of the papers considered by the Committee were on the agenda for today’s Board meeting.

37/19.2 Mr Drew advised that the Committee had received an update on how Controls Assurance was being managed this year and that Internal Audit were content. He said that the Committee had approved the updated PHA Fire Safety Policy and PHA Security Policy. He added that the Committee had heard that Internal Audit was reporting that 69% of PHA’s outstanding audit recommendations had now been fully implemented, with the remainder being partially implemented.

37/19.3 Mr Drew shared with members the Governance and Audit Committee Annual Report, and he thanked Ms Mann-Kler, Mr Clayton and Mr Stewart for their commitment to the work of the Committee. He also thanked those PHA officers who support the Committee.

37/19.4 Mr Drew said that the Committee is satisfied in respect of the reliability and integrity of the assurances provided and of their comprehensiveness in meeting the needs of the PHA board and the

Accounting Officer. He added that the Committee is also of the opinion that a sound system of internal governance is in place, and that the assurances available are sufficient to support the PHA Board and the Accounting Officer in the decisions taken by them and in their accountability obligations.

37/19.5 Mr Drew noted that he has now completed his first full year as Chair of the Committee and he wished to thank other members of the Governance and Audit Committee for their expertise.

37/19.6 The Chair thanked Mr Drew and the other Committee members, on behalf of the Board, for their work in dealing with a formidable range of papers and reports.

37/19.7 The Board noted the update from the Committee Chair.

38/19 Item 9 – PHA Assurance Framework 2019/20 (PHA/03/04/19)

38/19.1 Mr McClean said that the Assurance Framework had been considered by the Governance and Audit Committee at its meeting yesterday and that it outlines the range of documents which are routinely brought to the Board. He advised that the changes to the Framework were minimal and were outlined in the front section of the document.

38/19.2 Mr Drew said that the summary of the changes was very helpful, and showed the thought which had put into the new document. Mr McClean paid tribute to Mr Graham for his work in compiling the cover sheet which outlined the key changes.

38/19.3 The Board **APPROVED** the PHA Assurance Framework.

39/19 Item 10 – Newborn Hearing Screening Programme Annual Report 2016-17 (PHA/04/04/19)

39/19.1 Dr Stephen Bergin joined the meeting for this item. He gave members an overview of the Report and said that although this programme has been running for many years, this is the first Annual Report. He advised that the aim of this programme is to identify babies who have a significant permanent childhood hearing loss. He said that one to two babies in every 1,000 is born with a hearing loss.

39/19.2 Dr Bergin explained that there are screening co-ordinators and screeners in each Trust area, but it is the role of PHA to ensure that the programme is being delivered to a high standard.

39/19.3 Dr Bergin said that for the year 2016/17, there were 23,936 babies who were eligible for screening, and that 99.6% were offered screening. He outlined some of the circumstances whereby a baby was not screened, e.g. if they have been in intensive care or have meningitis or a deformity. Dr Bergin advised that the programme is running well.

39/19.4 Ms Mann-Kler asked how the procurement of an IT service to support the programme was progressing. She also asked why the number of babies screened by the age of 4 weeks was lower than the number offered screening. In terms of the IT system, Dr Bergin advised that this has been procured, and should be able to go "live" by the end of this year. He explained that ideally the hearing tests should be undertaken within 4 days, but performance is improving whereby the test is undertaken within 4 weeks.

39/19.5 The Chair asked if it is the parent's responsibility to bring the child to a healthcare facility to take the test. Dr Bergin confirmed that this was the case. He added that screening does not stop there, but is repeated when a child starts school.

39/19.6 Mr Clayton asked what reasons there are for people refusing to let their child take the test. Dr Bergin that screening is not compulsory, but it is about increasing people's understanding.

39/19.7 The Board **APPROVED** the Newborn Hearing Screening Programme Annual Report.

40/19 Item 11 – Annual Vaccine Preventable Diseases Report for Northern Ireland 2019 (PHA/05/04/19)

40/19.1 Dr Jillian Johnston thanked the Board for the invitation to attend the Board meeting to present the Vaccine Preventable Diseases Report. She explained that two reports are produced each year, one which looks at the level of uptake, and the second which looks at the numbers of diseases.

40/19.2 Dr Johnston said that overall, the Report was a good news story. She said that the burden of vaccine preventable diseases in Northern Ireland is low and the numbers of cases of diseases continues to fall. She explained that the Report covers bacterial vaccine preventable diseases and also includes viral diseases – MMR, diphtheria, tetanus and polio. She advised that the number of cases of meningococcal disease (17) continued a trend of year-on-year reduction. Furthermore, she said that no cases of measles have been reported since summer 2017 which shows the benefit of the high uptake of the MMR vaccine here. However, despite this, she said that PHA will continue to message the benefits of the vaccine through its social media channels.

40/19.3 The Chair asked how PHA can counter the anti-vaccination messages being posted on social media. Dr Johnston said that there will always be people who are anti-vaccination, but PHA provides training for healthcare professionals, and has produces leaflets and other information resources to outline the benefits of vaccination. Dr Waldron said it is counterproductive to challenge every anti-vaccination message, but PHA can use its own social media channels to promote its own

message. Dr Johnston said that an analysis of PHA's social media has shown that there is very little local anti-vaccination support, but she said that there is a small pilot programme in the Southern Trust area assessing the reasons why people may show hesitancy in taking up vaccinations.

40/19.4 Ms Mann-Kler noted that PHA had held a focus with hard to reach groups. Dr Johnston confirmed that this was held with members of the Roma community, and other church and local representatives following an outbreak. She said that the overall sense was that this community was not against vaccinations, their issues related to access and language barriers.

40/19.5 Ms Mann-Kler Kler asked about what awareness raising activities are planned in advance of the HPV vaccine for boys which will be commencing in 2019/20. Dr Johnston said that preparations are under way, as school nurses have been aware for some time that this is happening and are currently receiving the required training to enable the programme to commence in September 2019.

40/19.6 Mr Clayton noted that the UK Government has launched a consultation on social media, but he was not sure what impact this will have in Northern Ireland. He said that as well as the public health issues, there are also mental health issues. Ms Mann-Kler said that this is a very complicated area. Dr Johnston acknowledged that there are individual who are very entrenched in their anti-vaccination opinion.

40/19.7 The Chair asked how information about children who have not been vaccinated is communicated to GPs. Dr Johnston said that through the school programme, GPs will receive notifications. The Chair about the shingles vaccine. Dr Johnston explained that this programme was introduced for 70 and 78 year olds in 2013 and that men will receive an invitation each year to attend. In response to a further question, she advised that the take up has increased from 50% to around 65%.

40/19.8 The Board noted the Vaccine Preventable Diseases Report.

41/19 Item 12 – Point Prevalence Survey of Healthcare Associated Infection and Antimicrobial Use in Northern Ireland Acute Hospitals (PHA/06/03/19)

41/19.1 Mr Mark McConaghy and Dr Tony Crockford joined the meeting for this item. Mr McConaghy introduced the survey saying that antimicrobial resistance is becoming a major issue and infections are placing more pressure on the healthcare system. He said that this survey was carried out across many European countries and was a complex project. He explained that the project was used as a training opportunity and that the training carried out in Northern Ireland was evaluated, with very positive feedback received. Furthermore, he said that the ECDC (European Communicable Disease Centre) had run a validation exercise

alongside this project which was led by PHA.

41/19.2 In terms of the findings, Mr McConaghy said that healthcare associated infection (HAI) prevalence had increased in Northern Ireland since 2012 with pneumonia being the most common infection. He noted that UTI was the most common infection in England.

41/19.3 Mr McConaghy explained that patients with devices are more likely to get infections and that the rates in this area had also increased, but at a rate that is comparable with other regions. He moved on to say that antimicrobial prevalence has increased since 2012. He added that for this, there is local data available for each HSC Trust, and that 4 of the 5 Trusts had seen an increase.

41/19.4 Mr McConaghy advised that the World Health Organisation had a list of antimicrobials and how important they are to patient safety. He said that a lot of work has gone on to look at antimicrobial consumption over time in hospital and community settings, and a question was asked as to whether antimicrobial prescriptions were reviewed after 72 hours. He advised that 83% of prescriptions in Northern Ireland were not reviewed after 72 hours.

41/19.5 With regard to next steps, Mr McConaghy outlined some of the recommendations that will be taken forward. He said that these will form part of the work plan of the regional HCAI and AMR Improvement Board.

41/19.6 Mr Stewart said that this was a very comprehensive report, but he was concerned as some of the trends and said that the follow up work is going to be important. He said that he would want to have seen more information in the report on the training and feedback.

41/19.7 Ms Mann-Kler asked if there are any global trends, with regard to HAI, and if these are showing signs of reversing. Mr McConaghy said that there is a lot of work ongoing and he was confident that trends can be reversed. He advised that in terms of peripheral lines, this will be taken forward on a Trust by Trust basis, but that this would also need to involve working with the Northern Ireland Ambulance Service. Mrs Hinds noted that people are spending more time in A&E and there is a need to review lines and switching from intravenous to oral antibiotics. Dr Crockford said that reviewing the use of lines can reduce infection. He said that in Northern Ireland, there is a 65% rate of intravenous antibiotics, but in Scotland this is only 50%.

41/19.8 Mr Clayton expressed concern that the Belfast Trust is the only Trust where local policy on antimicrobial use is improving. Mr McConaghy said that is being looked at and will be picked up through antimicrobial stewardship. Mr Clayton asked what the cause of the increase in the other Trusts and if it relates to staffing, culture, or practice. Mrs Hinds said that when patients are on a pathway, it can be difficult to change that pathway and that there is more work to be make improvement. She

	also noted that this is made difficult by the high turnover on wards.
41/19.9	Dr Waldron said that there are valuable lessons to be learnt from the Report, but the Report is a snapshot of a point in time. Mr McClean said that the Report contains a lot of information, but it is important for the Trusts to take this forward and act on the findings.
41/19.10	The Board noted the point prevalence survey.
42/19	**Item 13 – Any Other Business**
42/19.1	There was no other business.
43/19	**Item 14 – Details of Next Meeting**
	Tuesday 11 June 2019 at 2:15pm (Special Board Meeting) *Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast* Signed by Chair: Date:

HSC Public Health Agency

minutes

Title of Meeting	Meeting of the Public Health Agency Governance and Audit Committee
Date	17 April 2019 at 10.00am
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

Present

Mr Leslie Drew	-	Chair
Mr John Patrick Clayton	-	Non-Executive Director
Mr Joseph Stewart	-	Non-Executive Director

In Attendance

Mr Ed McClean	-	Interim Deputy Chief Executive / Director of Operations
Miss Rosemary Taylor	-	Assistant Director, Planning and Operational Services
Mr Paul Cummings	-	Director of Finance, HSCB
Ms Jane Davidson	-	Head Accountant, HSCB
Mrs Catherine McKeown	-	Head of Internal Audit, BSO
Mr David Charles	-	Internal Audit, BSO
Ms Christine Hagan	-	ASM Chartered Accountants
Mr Roger McCance	-	Northern Ireland Audit Office
Ms Nicola Woods	-	Boardroom Apprentice
Mr Robert Graham	-	Secretariat

Apologies

Ms Deepa Mann-Kler	-	Non-Executive Director

		Action
14/19	**Item 1 – Welcome and Apologies**	
14/19.1	Mr Drew welcomed everyone to the meeting.	
14/19.2	Apologies were noted from Ms Deepa Mann-Kler.	
15/19	**Item 2 - Declaration of Interests**	
15/19.1	Mr Drew asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.	

16/19	**Item 3 – Minutes of previous meeting held on 28 February 2019**
16/19.1	The minutes of the previous meeting, held on 28 February 2019 were **approved** as an accurate record of that meeting.
17/19	**Item 4 – Matters Arising**
	4/19.1 Transformation Funding
17/19.1	Mr Drew asked if PHA had been advised of its financial allocation for 2019/20. Mr McClean said that PHA was awaiting this.
	6/19.1 Corporate Risk Register
17/19.2	Mr Drew asked if the output of the task and finish group looking at PHA's procurement processes was available yet. Mr McClean advised that a draft report had been considered by the Agency Management Team (AMT), but it still required some work in terms of an action plan. He said that he hoped that it will be brought to a PHA Board meeting shortly.
	7/19.3 Shared Services Update
17/19.3	Mrs McKeown confirmed that a follow up audit of Payroll Shared Services had been undertaken and the report presented to the BSO Audit Committee yesterday. She advised that limited assurance had been given, but she acknowledged that there had been some improvement and a reduction in the number of recommendations. Mr Drew said he was pleased to hear that progress has been made.
17/19.4	Mr Cummings said the process will shortly commence for the procurement of a new payment system. Mr Drew suggested that when the new system is procured there will be more staff on the ground who are experts in Payroll. Mr Cummings said that the key issue will be the specification for the new system, and improved testing of the system before implementation.
18/19	**Item 5 – Chair's Business**
18/19.1	Mr Drew advised that he, along with the PHA Board Chair, had attended a session regarding the budget process for 2019/20.

19/19	**Item 6 – Corporate Governance** *Assurance Framework 2019-20 [GAC/12/04/19]*
19/19.1	Mr McClean advised that the PHA Assurance Framework undergoes a periodic review, and that the main changes in this review are highlighted on the cover sheet. He said that there are some new items which help give a sense of the spectrum of reports that come to the PHA Board.
19/19.2	Mr Clayton asked about the Board Self-Assessment and said that last year there was a commitment for members to be involved in its completion at an earlier stage. He added that in terms of updates on programmes, the Framework seems light. Mr McClean said that although this document helps inform the Board agenda, there are other updates that may come to the Board. In terms of the Self-Assessment, Miss Taylor advised that a first draft of this has been given to the Chair. Mr Stewart complimented the summary at the front of the Report which he said was very helpful in ensuring members could see where the key changes have been made.
19/19.3	Members **approved** the PHA Assurance Framework which will be considered at the PHA Board meeting on 18 April. *Controls Assurance – Process for providing assurance for year ending 31 March 2019 [GAC/13/02/19]*
19/19.4	Miss Taylor reminded members that previous papers had been brought to the Committee outlining the process for assurance following the ending of Controls Assurance Standard. She added that his report now showed the outcome of that work. She said that in terms of Emergency Planning and Information Management, PHA has used the new checklists provided by the Department and for other areas, PHA has used the CAS checklists from 2017/18, with Finance being the only exception, as it was agreed there were existing assurances.
19/19.5	Miss Taylor advised that Karen Braithwaite from PHA worked with colleagues in HSCB and BSO in this work, and that there were no major gaps found. She noted that Internal Audit agreed that PHA processes were found to be adequate which she hoped gives the Committee the assurance it requires.
19/19.6	Members noted the Controls Assurance process.

	PHA Fire Safety Policy [GAC/14/02/19] *PHA Security Policy [GAC/15/04/19]*
19/19.7	Miss Taylor advised that no major changes had been made to either the Fire Safety or the Security Policy. She said that the Fire Safety Policy now includes information on PEEPs (Personal Emergency Evacuation Plans). She added that the policy emphasises the need for Directors to remind their staff to complete fire safety training.
19/19.8	Mr Drew asked how these policies will be shared with staff. Miss Taylor said that following approval the policies will be published on the Intranet and featured in the weekly staff magazine. She said that training will be organised by HSCB for those premises that PHA shares with HSCB, and that PHA organises training for Linum Chambers.
19/19.9	Mr Stewart asked about the responsibility for these policies, particularly in buildings where PHA shares accommodation. Miss Taylor said that PHA works with HSCB colleagues. Mr Cummings added that where PHA is accommodated in HSCB premises, then HSCB is responsible for training, security and fire safety.
19/19.10	Mr Stewart asked about the oversight of ensuring that the policies are being adhered to. Miss Taylor advised that health and safety checks are undertaken, and that in each office there is an HSCB Premises Committee, on which there is PHA representation.
19/19.11	Mr Clayton noted that although responsibilities are clearly set out in the first section of the document, it is not clear throughout the document who has responsibility for each aspect.
19/19.12	Members **approved** the updated PHA Fire Safety and Security Policies.
20/19	**Item 7 – Internal Audit** *Progress Report [GAC/16/04/19]*
20/19.1	Mrs McKeown informed members that Internal Audit had completed its assignments for 2018/19.
20/19.2	Mrs McKeown advised members that the recent Financial audit had resulted in a satisfactory level of assurance being provided, and that there were no significant findings, but 5 key findings. She said that these findings were in the areas of incorrect mileage claims, promptness of payments,

	expenditure on taxis, non-pay expenditure pathways and contract management.
20/19.3	Mr Drew asked about the increase in the usage of taxis, but Miss Taylor said that there was no specific reason for this. Mr Clayton asked whether the prompt payments issue was a Payroll matter, but Mrs McKeown said it was to do with PHA managers approving travel claims on a timely basis.
20/19.4	Mrs McKeown moved onto the summary of the post Controls Assurance Standards work. She said that in the absence of the previous Standards, Internal Audit was seeking to ensure that there was a satisfactory system for providing assurance. She said that she was happy that PHA's processes are adequate but there were a number of recommendations made going forward. She noted that one recommendation had not been accepted by management, and this related to the suggestion that all completed checklists be returned to the governance department. Miss Taylor explained that while the governance department conducts the majority of the checklists, relevant directorates are responsible for holding their own evidence of assurance. Mr Stewart suggested a "dip" sample could be done of these other lists.
20/19.5	Miss Taylor said that PHA's current priority is to obtain the necessary assurances from BSO, but also to work with other organisations.
20/19.6	Mr Drew said that it was disappointing that the Department did not issue more guidelines to ensure that there is a consistent approach.
20/19.7	Members noted the Internal Audit Progress Report.
	Year End Follow Up on Previous Recommendations [GAC/17/04/19]
20/19.8	Mrs McKeown said that this Report showed that 69% of the 61 recommendations that were outstanding are now fully implemented, with the remaining 19 partially implemented. She said that there were no specific issues that she wished to draw members' attention to.
20/19.9	Mr Clayton noted that the return of the PPI self-assessment from the Northern Ireland Ambulance Service remained outstanding. Mr McClean agreed to look into this.
20/19.10	Members noted the year end follow up.

	External Quality Assessment [GAC/18/04/19]
20/19.11	Mrs McKeown said that Internal Audit is required to have an assessment undertaken every 5 years. She thanked who participated in the survey, and she highlighted the positive comments received from Internal Audit customers.
20/19.12	Mrs McKeown advised that overall, Internal Audit was found to have met 60 of the 62 fundamental principles that were applicable, with the two outstanding areas being in terms of co-ordination and maximising assurance. She said that three recommendations had been made, and although Internal Audit did not fully accept one of them, it would work to implement these.
20/19.13	Members noted the External Quality Assessment.
	Internal Audit Strategy
20/19.14	Mrs McKeown advised that this would be presented at the next meeting in June. Mr Drew said that he had seen the draft Strategy and was content that it focused on the right areas.
21/19	**Item 8 – Finance**
	Fraud Liaison Officer Update Report [GAC/19/04/19]
21/19.1	Mr Cummings advised that there were no new cases of fraud to be brought to the attention of the Committee. He advised that case reference 1858 has now been closed and he is content with the steps that have been taken. Mr Drew added that the PHA could not have done any more in relation to that case.
21/19.2	Mr Cummings advised that the data matches for PHA have been received in relation to the National Fraud Initiative, and that these would be reviewed over the coming months.
21/19.3	Members noted the Fraud Liaison Officer Update report.
22/19	**Item 9 – Draft PHA Annual Report [GAC/20/04/19]**
22/19.1	Mr McClean explained that PHA has adopted a different approach in relation to the Annual Report this year, where previously the Report would have been written by directorate, it is now reflective of the objectives within PHA's Corporate Strategy and Business Plan. He added that it is hoped that this style of Report is more usable, and can help give readers a sense of the diversity of the work undertaken

	by the PHA, but noting that is not possible to cover every aspect of the Agency's work.
22/19.2	Mr McClean shared with members a proposed addition to the document in the form of a "Year in the Life of the PHA".
22/19.3	Mr Drew said that the Report was more readable in this style and it was clear that a lot of effort had been taken to reduce the amount of duplication. He asked what the audience was for the Report. Mr McClean said that PHA is mindful of the guidance in terms of what must be included in the Report, but the aim is to make it more interesting for the public.
22/19.4	Mr Stewart complimented the additional section on the "Year in the Life of the PHA" and said that this is the type of document that could be distributed to GP surgeries.
22/19.5	Mr Clayton said that he found the Report to be more accessible than the previous year's Report. He suggested that there should be some narrative within the Chair or Chief Executive forewords about the future direction of the PHA.
22/19.6	Members **approved** the draft PHA Annual Report which will be presented at the confidential section of the PHA Board meeting on 18 April.
21/19	**Item 10 – Draft PHA Governance Statement [GAC/21/04/19]**
21/19.1	Mr McClean said that the draft Governance Statement follows the normal format and drew members' attention to the internal governance divergences. He said that as PHA was able to proceed with campaigns in 2018/19, this narrative has been moved to the section on control issues which are no longer considered to be control issues.
21/19.2	Of those control issues that continue to be considered control issues, Mr McClean advised that the section on quality, quantity and financial controls required to be updated. He said that the section on management of contracts with the community and voluntary sector would remain, and that the section on the reduction in the PHA management and administration budget also needed to be updated.
21/19.3	Mr Clayton sought clarity on the wording regarding the funding of pay rises, but Mr Cummings said that this may have been the wording used in last year's Statement, and will be updated in the final version.

21/19.4	Members **approved** the draft PHA Governance Statement which will be presented at the confidential section of the PHA Board meeting on 18 April.
22/19	**Item 11 – PHA GAC Annual Report [GAC/22/04/19]**
22/19.1	Mr Drew said that the Report showed that the Committee is satisfied in respect of the reliability and integrity of the assurances provided and of their comprehensiveness in meeting the needs of the PHA board and the Accounting Officer. He said that Report highlights the amount of work that is undertaken by the Committee.
22/19.2	Members noted the Governance and Audit Committee Report.
23/19	**Item 12 – Any Other Business**
23/19.1	There was no other business.
24/19	**Item 13 – Date and Time of Next Meeting** *Wednesday 5 June 2019 at 10am* *Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast.* Signed by Chair: Leslie Drew Date: 5 June 2019

Public Health Agency

2019-20 Draft Budget

For Approval

PHA Draft Budget 2019-20

Introduction

This paper sets out the total resources which the PHA has available in 2019-20. These funds have been set out in their high level summary areas including Commissioning with HSC Trusts, PHA Direct Programme activity, Ringfenced Funding and the Administration costs of the PHA.

Available Resources

The PHA receives an allocation from the Department of Health (DoH) each year and this is supplemented by income from other sources such as receipts for PHA staff on secondment to other organisations.

A summary of the total funding available for 2019-20 is set out in the table below.

Source of Funding	£m
Department of Health allocation (incl. C&S Transformation funds)	104.967
Assumed allocation for the Safeguarding Board (SBNI)	0.659
Other assumed allocations for Administration (incl. Clincial Excellence Awards, NIMDTA trainees funding, etc.)	1.024
Assumed Ringfenced allocations (SBNI EITP project)	0.968
Assumed income	0.564
Total Resources Available	**108.182**

Please note the funding for SBNI is included within this paper as it is consolidated within the PHA Financial Accounts. However, the responsibility for financial breakeven lies between the Chair of SBNI and the DoH.

Savings Requirement

The opening allocation letter from DoH included a recurrent reduction to Administration funds of £0.5m in 2019-20. In addition to this, the 2018-19 savings retraction was met non-recurrently last year, and needs to be identified on a recurrent basis.

The temporary withdrawal of the Campaigns budget of £1m, which was first implemented in 2017-18, has been reinstated for 2019-20.

	£m
2018-19 Programme retraction	0.920
2018-19 Administration retraction	0.500
Recurrent 18-19 Savings target	**1.420**
2019-20 Administration retraction	0.517
Total Recurrent Savings target	**1.937**

Proposals to achieve these savings have been sent to DoH for approval, utlising the flexibility in the opening allocation letter to achieve the savings across the overall PHA funding allocation (Programme and Admin). This Budget assumes the implementation of these proposals.

Research & Development Capital Funding

The majority of the Research & Development programme is funded from a capital budget and no longer forms part of the revenue breakeven requirement. However, these funds are set out in this paper and will be monitored in the monthly Finance reports during 2019-20.

Recommendation

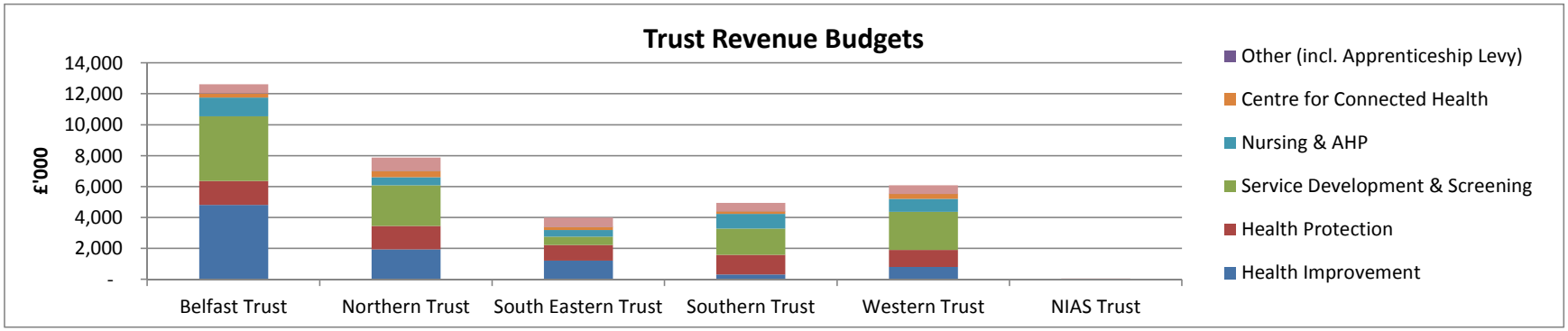
This Draft Budget is recommended to the Board for approval.

Public Health Agency
2019-20 Budget

		Programme		Ringfenced Funds	Mgt & Admin	Total
		Trust	PHA Direct			
		£'000	£'000	£'000	£'000	£'000
Revenue Funding	*Page*					
Trust Allocations	*3*	32,437	-	3,162	-	**35,599**
PHA Direct Programme *	*4*	-	45,912	6,211	-	**52,123**
PHA Administration	*6*	-	-	-	20,460	**20,460**
Total Budget		32,437	45,912	9,373	20,460	**108,182**
Capital Funding	*Page*					
Research & Development	*5*	7,685	4,790	-	-	**12,475**

* *Includes amounts which may transfer to Trusts during the year.*

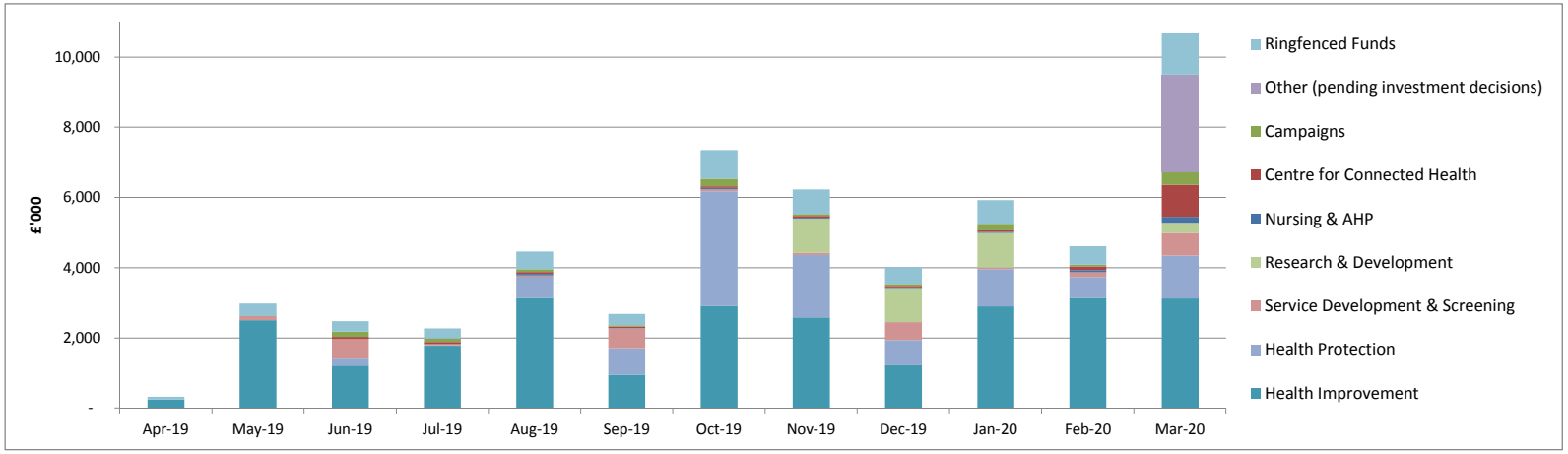
Trust Programme
2019-20 Budget



	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	NIAS Trust £'000	Total £'000
Revenue Budget							
Health Improvement	4,819	1,944	1,209	327	814	-	**9,113**
Health Protection	1,544	1,521	1,014	1,261	1,094	-	**6,434**
Service Development & Screening	4,195	2,618	538	1,697	2,457	-	**11,505**
Nursing & AHP	1,202	527	431	958	840	-	**3,958**
Centre for Connected Health	259	415	200	159	320	-	**1,354**
Other (*incl. Apprenticeship Levy*)	25	13	12	12	12	-	**74**
Total Revenue funding	**12,044**	**7,039**	**3,403**	**4,414**	**5,537**	**-**	**32,437**
Ringfenced Budget							
C&S Transformation Funds	580	851	586	532	545	68	**3,162**

The confirmed Trust allocations from the opening SBAs have been coded to the respective budget areas and summarised above, with Price Inflation now included. Budget holders will be provided with reports each month which detail all Trust commitments relating to their budget area.

PHA Direct Programme
2019-20 Budget



Revenue Budget	**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**
Health Improvement	244	2,507	1,214	1,780	3,146	959	2,925	2,593	1,228	2,903	3,144	3,133	**25,775**
Health Protection	-	-	202	9	606	752	3,253	1,778	719	1,057	599	1,215	**10,189**
Service Development & Screening	-	116	562	48	33	566	67	56	506	54	135	644	**2,787**
Research & Development	-	-	-	-	-	-	-	970	970	980	-	290	**3,211**
Campaigns	-	5	156	101	84	38	214	54	52	187	37	351	**1,277**
Nursing & AHP	-	6	1	3	48	4	30	31	16	29	56	171	**395**
Centre for Connected Health	-	-	50	50	50	50	50	50	50	50	115	920	**1,435**
Other (pending investment decisions)	-	-	-	-	-	-	-	-	-	-	-	2,780	**2,780**
Savings target	-	-	-	-	-	-	-	-	-	-	-	(1,937)	**(1,937)**
Total Revenue Budget	**244**	**2,633**	**2,185**	**1,990**	**3,966**	**2,369**	**6,539**	**5,533**	**3,541**	**5,259**	**4,085**	**7,568**	**45,912**
Ringfenced Budgets													
C&S Transformation Funds	27	294	239	217	438	259	726	613	390	582	444	1,014	**5,243**
EITP Trauma Informed Practice	55	55	55	65	65	65	90	90	90	90	90	158	**968**
Ringfenced Funds	**82**	**349**	**294**	**282**	**503**	**324**	**816**	**703**	**480**	**672**	**534**	**1,172**	**6,211**

The budgets and profiles are shown after adjusting for retractions and new allocations in the Allocation Letter from DoH. The Campaigns budget has been re-instated after having been entirely retracted for last two financial years. Price Inflation has been applied to the respective budgets. A savings paper has been sent to DoH and PHA awaits an official response regarding this paper.

The Other budget line shows funds which are not committed recurrently, and will be used to fund strategic investment priorities during the year.

Ringfenced funding includes C&S Transformation Funding and the EITP project managed by the Safeguarding Board.

Public Health Agency
2019-20 Capital Allocation

	Annual Budget Programme		
	Trust £'000	**PHA Direct £'000**	**Total £'000**
Capital Funding			
R&D Expenditure - Trusts	7,685	-	**7,685**
R&D Expenditure - PHA Direct	-	4,790	**4,790**
Total	7,685	4,790	**12,475**

The majority of the Research & Development programme is funded from a capital budget and no longer forms part of the revenue breakeven requirement. PHA has received a Capital budget of £12.5m for this activity in 2019-20, of which approximately £8m relates to Research & Development projects in Trusts.

PHA Administration
2019-20 Budget

	Nursing & AHP £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Salaries	3,626	2,624	11,035	116	325	370	**18,096**
Goods & Services	166	1,332	406	37	58	365	**2,364**
Savings target 2018-19				(500)			**(500)**
Savings target 2019-20				(517)			**(517)**
Savings transferred to Programme budgets				1,017			**1,017**
Total Administration Budget	**3,792**	**3,956**	**11,441**	**153**	**383**	**735**	**20,460**

Savings targets of £0.500m and £0.517m were applied to the PHA's Administration budget in 2018-19 & 2019-20 respectively. Both are currently held centrally within PHA Board, and will be managed across the Agency through scrutiny and other measures. A savings paper has been sent to the DoH and the PHA await a official response regarding this paper. This Budget assumes the proposal in the savings paper to achieve the Administration savings from Programme budgets is accepted by DoH.

HSC Public Health Agency

item 9

Title of Meeting	PHA Board Meeting
Date	20 June 2019
Title of paper	Corporate Risk Register
Reference	PHA/03/06/19
Prepared by	Karen Braithwaite
Lead Director	Ed McClean
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to seek approval of the PHA's Corporate Risk Register as at 31 March 2019.

2 Background Information

In line with the PHA's system of internal control, a fully functioning risk register has been developed at both directorate and corporate levels. The purpose of the Corporate Risk Register is to provide assurances to the Chief Executive, Agency Management Team, the Governance and Audit Committee and the PHA Board that risks are being effectively managed in order to meet corporate objectives and statutory obligations.

To support these assurances, a process has been established to undertake a review of both directorate and corporate risk registers on a quarterly basis i.e. the end of each financial quarter.

In line with the PHA Assurance Framework, the Corporate Risk Register is brought to the full PHA Board annually, or more frequently if required.

The attached Corporate Risk Register reflects the review as at 31 March 2019 and has been carried out in conjunction with individual directorate register reviews for the same period. This Register was approved by AMT on 21 May 2019 the Governance and Audit Committee at its meeting on 5 June 2019.

3 Key Issues

One risk has been added to the Corporate Risk Register this quarter:

- CR 46 - Failure to meet statutory and legal requirements in relation to Emergency Planning (EPRR)

Two risks have been removed from the Corporate Risk Register this quarter:

- CR 41 - Reduction in PHA Campaigns Budget
- CR 43 - Lifeline Service

4 Next Steps

The next review of the Corporate Risk Register will be undertaken as at 30 June 2019.

PHA Corporate Risk Register

Date of Review:
31 March 2019

Introduction

Managing risk is a key component of the wider governance agenda for the PHA. It is therefore essential that systems and processes are in place to identify and manage risks as far as reasonably possible.

The purpose of risk management is not to remove all risks but to ensure that risks are identified and their potential to cause loss fully understood. Based on this information, action can then be taken to direct appropriate levels of resource at controlling the risk or minimising the effect of potential loss.

The PHA has recognised the need to adopt such an approach and has a systematic and unified process in place to ensure a fully functioning risk register at both corporate and directorate levels as set out in the PHA Risk Management Srategy and Policy.

The Corporate Register that follows identifies corporate risks, all of which have been assessed using a 'five by five' risk grading matrix (see below) which is in line with DoH guidance. This ensures a consistent and uniform approach is taken in categorising risks in terms of their level of priority so that appropriate action can be taken at the appropriate level of the organisation.

IMPACT	Risk Quantification Matrix				
5 - Catastrophic	High	High	Extreme	Extreme	Extreme
4 – Major	High	High	High	High	Extreme
3 - Moderate	Medium	Medium	Medium	Medium	High
2 – Minor	Low	Low	Low	Medium	Medium
1 – Insignificant	Low	Low	Low	Low	Medium
LIKELIHOOD	A Rare	B Unlikely	C Possible	D Likely	E Almost Certain

Overview of Risk Register Review as at March 2019

Number of new risks identified	1 CR 46: Failure to meet statutory & legal requirements in relation to Emergency Planning (EPRR)
Number of risks removed from register	2 CR 41: Reduction in PHA Campaigns Budget CR 43: Lifeline Service
Number of risks where overall rating has been reduced	**0**
Number of risks where overall rating has been increased	**0**

CONTENTS

Key:

Risk rating:

↑ increased from previous quarter

↓ decreased from previous quarter

→ remained the same as previous quarter

Corporate Risk 26

RISK AREA/CONTEXT:
Delays in market testing health and social care contracts, as set out in the PHA Procurement Plan.

DESCRIPTION OF RISK:	**DATE RISK ADDED:**
The PHA has an extensive range of Health and Social Care contracts with non HSC providers (primarily health improvement contracts with voluntary and community sector). An approved PHA Procurement Plan is in place, and a range of large and smaller services have been procured. Some contracts are however rolled forward year on year, without the benefit of market testing. Full compliance with the PHA Procurement Plan has not been achieved due to limited capacity, skill constraints and the complexity of some contracts. It is therefore likely that the timescales in the current plan will not be met, with an additional challenge in respect of the requirement to re-procure the first contracts tendered by 2020. There is a risk that VFM is not being achieved in the current contracts and a potential reputational risk to the PHA.	September 2012 (Amalgamated with Corporate Risk 28, September 2013) Revised June 2018

LINK TO ASSURANCE FRAMEWORK: Operational Performance and Service Improvement Dimension

LINK TO ANNUAL BUSINESS PLAN 2018/19: Corporate Objective 5 Our Organisation Works Effectively

GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	Possible	Moderate	**MEDIUM**

LEAD OFFICER: ~~,~~ MrsValerie Watts, Acting Chief Executive

Existing Controls	**Internal and External Assurances to the Board**	**Gaps in Controls and Assurances**	**Action Plan/Comments/ Timescale**	**Review Date**
Procurement Plan has been developed and agreed by AMT setting out the timescales for achieiving the re-tendering of baseline contracts. Revised processes and documentation developed for PHA in liaison with PALS to ensure tender process is applied where required in line with Procurement regulations. Suite of documentation and guidance for tendering in place.	Progress reports on implementing the Procurement Plan will be provided to PHA Procurement Board and annually to PHA board Leadership at AMT and Assistant Director level via PHA Procurement board. PIDs for larger procurements (including pre-procurement)	Legacy contracts may not be providing value for money Limited capacity within BSO PALS Limited capacity and planning skills to undertake essential pre-procurement planning, business cases etc	Task and Finish Group has been established to review Procurement Plan and processes and consider how appropriate capacity and skills can be created within PHA to deliver the procurement plan. The draft ~~final~~ report ~~will be~~ has been considered by AMT and an action plan is being developed (by June 2019). Report will be shared with PHA board (by July 2019)~~by mid February 2019.~~	June ~~March~~ 2019

Training has been provided for relevant staff, including legal aspects of procurement. Internal management structures established to oversee implementation of the Procurement Plan. Review of Procurement Plan and wider support requirements standing item on agenda of Procurement Board Review of procurement processes and future approach undertaken taking into account lessons learnt from experience over the past 3 years and the introduction of the new Procurement regulations in Feb 2015 and the introduction of a Light Touch Regime. Temporary arrangement from core OPs admin to support social care procurement, kept under review, with Director of Operations. PHA membership and attendance at HSCNI Regional Procurement Board	brought to AMT and, where appropriate, PHA board.			

Corporate Risk 39			
RISK AREA/CONTEXT: Cyber Security			
DESCRIPTION OF RISK: Information security across the HSC is of critical importance to delivery of care, protection of information assets and many related business processes. If a cyber incident should occur, without effective security and controls, HSC information, systems and infrastructure (including those used by the PHA, as well as Trusts providing services for the PHA) may become unreliable, not accessible when required (temporarily or permanently), or compromised by unauthorised 3rd parties including criminals. This could result in significant business disruption. It could also lead to unauthorized access to any of our systems or information, theft of information or finances, breach of statutory obligations, substantial fines and significant reputational damage.			**DATE RISK ADDED:** June 2017
LINK TO ASSURANCE FRAMEWORK: Operational Performance			
LINK TO ANNUAL BUSINESS PLAN 2018/19: Corporate Objective 5 Our Organisation Works Effectively			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	Likely	Major	**HIGH**
LEAD OFFICER: Mr E McClean, Deputy Chief Executive (interim) and Director of Operations			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
Technical Infrastructure: • HSC security hardware (eg firewalls); • HSC security software (threat detection, antivirus, email & web filtering); • Server/client patching; • 3rd party Secure Remote Access; • Data & system backups	Internal Audit/BSO ITS self-assessment against 10 Steps towards NCSC; Technical risks assessments and penetration tests; HSC SIRO Forum for shared learning and collaborative action planning and delivery; Reports to GAC/PHA board on reported incidents as appropriate.	Insufficient corporate recognition and ownership of cyber security threat as a service delivery risk Full extent of gaps are not understood at this point – a gap analysis regionally and by HSC organisations is required to capture a considered extent of vulnerabilities	BSO ITS provides PHA IT services. PHA will continue to work with BSO ITS, HSCB e-health and through the HSC SIRO forum Regional Cyber Security Programme Board ~~Business Continuity Group Link between cyber security programme board and emergency planning lead established to take forward regional incident plan~~ is finalising a draft incident management plan and	~~Dec 2018~~ Sept 2019

• Regional funding provided & Sophos Intercept X & Sophos Sandstorm software & PKI hardware purchased & being installed. **Policy, Process:** • Regional & local ICT/information security policies; • Data protection policy; • Change Control Processes; • User Account Management processes; • Disaster Recovery Plans; • Emergency Planning & Service/Business Continuity Plans; • Corporate Risk Management Framework, processes & monitoring; • Regional & local incident management & reporting policies & procedures; **User Behaviours – influenced through:** • Induction; • Mandatory Training; • HR Disciplinary Policy; • Contract of employment; • 3rd party contracts/data access agreements		Insufficient User Awareness of impact of personal behaviours in relation to cyber threat	handbook, with the intention of undertaking a desk top test across the region (December 2019) (~~April 2019~~); Regional cyber security programme board (BSO representing PHA) taking forward actions arising from DXC report and recommendations (June 2019)	

PHA BCP tested and updated February 2018 with a focus on cyber security PHA member of the Regional HSC Cyber Security Business Continuity Group BSO cyber security project manager co-ordinating regional cyber security work.				

Corporate Risk 42			
RISK AREA/CONTEXT: Transformation Funding			
DESCRIPTION OF RISK: The PHA has received allocations of approximately £4.4m for a number of projects across the PHA from the Confidence and Supply Transformation Fund. The funding is strictly ring-fenced non-recurring, and although bids were prepared on the basis of funding over two years, there is no guarantee at this stage that funding will be available in the second year (i.e. 2019/20). Whilst acknowledging the significant planning and focus on transformation projects within the PHA and across the HSC, there is risk to the successful implementation of the projects, given the tight timescales and due to factors outside of the control of the PHA, eg time to recruit and availability of staff.			**DATE RISK ADDED:** June 2018
LINK TO ASSURANCE FRAMEWORK: Operational Performance			
LINK TO ANNUAL BUSINESS PLAN 2018/19: Potentially all Corporate objectives, particularly Corporate Objective 5 Our Organisation Works Effectively			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	Likely	Major	**HIGH**
LEAD OFFICER: Mrs Valerie Watts, Interim Chief Executive			

Existing Controls	**Internal and External Assurances to the Board**	**Gaps in Controls and Assurances**	**Action Plan/Comments/ Timescale**	**Review Date**
• Chief Executive and Executive Directors engaged in discussion with DoH • Finance reports to AMT and PHA board • DoH approved bids in respect of the transformation monies allocated • On-going performance management • Reporting to DoH SROs	• Finance reports to AMT and PHA board • Standing item and regular progress reports to AMT • Regular briefings to board members	Potential that full implementation may not be possible and n/r transformation budget may not be fully used,	Ongoing discussion at AMT and senior level within PHA (to be reviewed ~~March~~ March 2020 ~~2019~~) Discussion ongoing with DoH (to be reviewed March 2020 ~~2019~~) PHA leads progressing each of the funded programmes/projects (review March 2020 ~~March 2019~~) (As year 1 of transformation funding ended & moving into year 2, ongoing review & oversight date now 2020.)	~~March~~ Sept 2019

Corporate Risk 44			
RISK AREA/CONTEXT: Potential impact on PHA programmes as a result of the UK exit from the EU			
DESCRIPTION OF RISK While the impact of any changes to PHA programmes as a result of the EU exit may be limited, this is as yet unknown. The PHA therefore needs to be aware of potential impacts, in line with any information and guidance provided by the Department. The process will continue to be refined as more clarity emerges on the arrangements for leaving the EU.			**DATE RISK ADDED:** September 2018
LINK TO ASSURANCE FRAMEWORK: Operational Performance			
LINK TO ANNUAL BUSINESS PLAN 2018/19: Corporate Objective 5 Our Organisation Works Effectively			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	Possible	Moderate	**Medium**
LEAD OFFICER: Mr E McClean, Deputy Chief Executive (interim) and Director of Operations			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
• Business Continuity Plans • Communication with DoH policy leads • Assistant Director attendance at DoH EU Exit Forum	Chief Executive assurance statement to DoH (June 2018)	Impact of EU exit not yet clear, pending details of the final arrangements	PHA will work closely with DoH and other HSC bodies to determine potential impacts and any necessary actions ~~(March~~ October 2019) (date moved to October 2019, as EU Exit delayed)	~~March~~ Sept 2019

Corporate Risk 45	
RISK AREA/CONTEXT: PHA Staffing Issues including Public Health Consultant Staff Vacancies	
DESCRIPTION OF RISK: Currently the PHA has a significant number of vacancies and posts filled on a temporary basis across all Directorates and at all levels of the organisation. This includes a particular issue in respect of Public Health Consultants. ~~In the Public Health Directorate there is~~ ~~Out of a~~ ~~funded complement of 21.50 WTE consultants in public health. There~~ There are currently ~~4 WTE posts vacant (18.6% vacancy rate). In addition, another public health consultant has resigned and will leave in early January 2019. This will bring the total number of vacancies to 5~~ 5.4 WTE consultant posts are currently vacant (a ~~23~~22% vacancy rate out of the PH consultant funded complement). It is also expected that another consultant will retire in the ~~first half~~ autumn of 2019, with a further retirement expected early 2020. The vacancies and the increasing demands mean that the existing ~~consultants~~ staff are stretched. This is not a sustainable position, ~~both~~ in terms of potential delays taking forward new initiatives, the potential for significant issues to be missed, reduced organisational resilience at times of pressure or emergency and the personal strain on individuals, with the potential for increased sickness absenteeism and further loss of staff. ~~Ultimately~~ In particular this has the potential to lead to the PHA failing in its requirements to commission and quality assure population screening programmes, its statutory obligations in respect of health protection and/or failing to deliver in other key areas of work e.g. those identified by the DoH.	**DATE RISK ADDED:** October 2018 Revised March 2019
LINK TO ASSURANCE FRAMEWORK: Operational Performance	
LINK TO ANNUAL BUSINESS PLAN 2018/19: Potentially all corporate objectives; particularly corporate objectives 4 (working together to ensure high quality services) and 5 (our organisation works effectively).	

GRADING	LIKELIHOOD	IMPACT	RISK GRADE
	Likely	Major	**HIGH**

LEAD OFFICER: ~~Dr Adrian Mairs, Acting Director of Public Health~~ Chief Executive (with all Directors)

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
• ~~The Public Health Directorate conducted two recruitment exercises and failed to attract~~	• Reports to AMT. • PHA/DoH working group established.	• Protracted delay in getting permission to advertise a non-	• ~~Following recent recruitment exercises the Directorate failed to attract any suitable~~	~~Mar 2019~~ Dec 2019

~~a suitable candidates for both posts. One of the posts was advertised permanently earlier in the year.~~ • PH consultant recruitment exercises have been undertaken, although they have not had successful outcomes. • ~~Two posts have also been advertised as locum posts and failed to attract any applicants, the Directorate is re-advertising shortly.~~ • Contact has been made with ~~indemnified~~ individuals working elsewhere to see if they would consider applying for any of the public health consultant posts. • Funding has been made available for 2 additional public health trainee posts in 2019. • ~~The Directorate is working with DoH to develop a non-medical training post.~~ • Papers have been presented and the issue has been discussed at AMT. These include actions to support existing consultants.		medical training post. • None of the local public health trainees will be able to take up these posts until ~~December 2019~~ March 2020, as none will complete their training until ~~December 2019~~ March 2020 (at the earliest) when ~~2 are expected~~ one is expected to do so. • We seldom attract candidate from outside Northern Ireland. • Recent PH consultant recruitment exercises failed to attract any suitable candidates. • Number of temporary posts. • Skill mix issues	~~candidates.~~ • ~~The Directorate~~ Public Health Directorate is looking at other options with HR to recruit public health specialists as we cannot fill the vacant Consultant posts by ~~31st March 2019~~. 31 December 2019 • ~~The Directorate is seeking planning and project management support for consultant staff. By 31st March 2019.~~ • PH Directorate is working with DoH to introduce a non medical training post.(Dec 2019) • A business case is being developed to use programme funds to support appointment of additional non-consultant screening staff (Dec 2019) • Discussions are on-going regarding stopping particular pieces of work or withdrawing cover for particular areas of work which will be reviewed by the ~~31st March 2019~~. 31 December 2019 • Planned PH consultant recruitment drive to take place over next 3 months with aim to recruit October 2019 • Plans are being developed to identify funding & recruit additional planning staff to address skill mix issues (Dec	

			2019); • An action plan to address issues beng prepared for DoH (July 2019)	

APPENDIX

RISKS ADDED TO THE CORPORATE RISK REGISTER AS AT 31 March 2019

Corporate Risk 46			
RISK AREA/CONTEXT: **Failure to meet statutory & legal requirements in relation to Emergency Planning (EPRR)**			
DESCRIPTION OF RISK: Disruption, loss of reputation, inefficient response, failure to meet statutory and legal requirements for Emergency Preparedness, Resilience and Response (EPRR); The PHA Health Protection Team has a statutory responsibility for emergency response. Inadequate mechanisms to financially compensate staff (across all pay bands) who are not on a service rota, has meant that staff are reluctant to participate in training or emergency response. This directly contributes to the following areas of risk for organisational resilience and emergency response; Inability to fully operationalise the Joint Response Emergency Plan. Absence of identified group of staff for activation of the Emergency Operation Centre Plan Vulnerability to organisational resilience for a sustained emergency response, management of an outbreak and Pandemic Response.			**DATE RISK ADDED:** April 2019
LINK TO ASSURANCE FRAMEWORK: Operational Performance			
LINK TO ANNUAL BUSINESS PLAN 2019/20: Potentially all corporate objectives; particularly corporate objectives 4 (working together to ensure high quality services) and 5 (our organisation works effectively).			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	Likely	Major	**HIGH**
LEAD OFFICER: Dr Adrian Mairs, Acting Director of Public Health			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
• Minimal number of senior staff trained in emergency response.	• Reports to AMT.	• Availability for out of hours response. • Sustaining an out of hours response. • Compensation under AFC T&Cs for	• The PHA and HSCB are engaging with BSO HR with reference to this risk recommending that the terms and conditions of AFC are reviewed or that alternative	Sept 2019

		extended working hours.	payment arrangements are put in place by the organisation to ensure staff across all pay bands who support an emergency response receive an appropriate level of compensation with reference to the following. By 30 Sept 2019. • Review of service business continuity plans and business impact analysis to support the redeployment of staff to support an emergency response and activation of the EOC (in hours and out of hours). By 31 Oct 2019.	

APPENDIX

RISKS REMOVED FROM CORPORATE RISK REGISTER AS AT 31 March 2019

Corporate Risk 41			
RISK AREA/CONTEXT: ~~Reduction in PHA Campaigns Budget~~ **Removed – Allocation identified for 2019/20, further risks pertaining to campaign budgets will be considered as required.**			
DESCRIPTION OF RISK ~~A cut of the campaigns budget by £1.0m in year. This is the second year that this non-recurring cut has been made to the campaigns budget, and it has significant implications for one of the PHA core functions- to provide information, advice and assistance to help the public improve their health and wellbeing and there is a risk the PHA may not be able to deliver key ountcomes around this.~~			**DATE RISK ADDED:** ~~June 2018~~ **Removed March 2019**
LINK TO ASSURANCE FRAMEWORK: ~~Operational Performance~~			
LINK TO ANNUAL BUSINESS PLAN 2018/19: ~~Potentially all Corporate objectives, particularly Corporate Objective 5 Our Organisation Works Effectively~~			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	~~Almost Certain~~	~~Moderate~~	~~**HIGH**~~
LEAD OFFICER: ~~Mr E McClean, Deputy Chief Executive (interim) and Director of Operations~~			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
~~The PHA is using lower cost and lower impact means of messaging.~~ ~~Key messages are being disseminated via other available communication channels including PR, social media and digital platforms.~~ ~~Paper evidencing the value of Public Information Health Campaigns submitted to DoH in 1st quarter.~~	~~Finance reports to AMT/Board~~ ~~Performance reports to AMT/Board~~	~~Ongoing budget reduction makes it impossible to discharge all functions as previously planned in an effective manner achieving best value and outcomes.~~	~~Plans are in place to ensure delivery of campaigns between Jan and March 2019, together with a specific programme of activity aimed at promoting pharmacy based stop smoking services (Feb/Mar 19)~~ ~~DoH confirmed in late December permission for the following programmes to run Jan – Mar19:~~ ~~1) AMR campaign approved following a Transformation proposal bid.~~ ~~2) FAST campaign rerun approved to run February 2019. Partnering~~	~~March 2019~~

~~Revised campaign programme bid for 2018/19 developed and shared with DoH as part of the wider Transformation programme. Confirmation received from DoH of funding/permission to progress campaigns for last quarter of year.~~			~~with NI charities to build on advertising and further promote FAST message.~~ ~~Rerun of Mental Health campaign *Ask, Listen, Talk*, approved to run March 2019. This is a joint campaign with Inspire with investment from Comic Relief.~~	

Corporate Risk 43			
RISK AREA/CONTEXT: ~~Lifeline Service~~ **Removed - SLA in place, contract extended & BAU**			
DESCRIPTION OF RISK: ~~The Lifeline Service successfully transferred from the management of Contact NI to BHSCT on 1 April 2018 (with the management of the communications element of the service transferring to the direct management of the PHA). On the instruction of DoH the contract for the current service is a contingency arrangement for 18 months, to enable review and informed decisions on the future model, including the possibility of re-procurement. There is a risk that further uncertainty regarding the service provider into the medium term will cause concern to service users, staff instability and public/political disquiet.~~			**DATE RISK ADDED:** ~~June 2018~~ **Removed March 2019**
LINK TO ASSURANCE FRAMEWORK: ~~Operational Performance~~			
LINK TO ANNUAL BUSINESS PLAN 2018/19: ~~Corporate Objective 3 – All individuals and communities are equipped and enabled to live long healthy lives.~~			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	~~Likely~~	~~Moderate~~	
LEAD OFFICER: ~~Dr Adrian Mairs, Acting Director of Public Health~~			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
• ~~Regular meetings between PHA and BHSCT regarding IPT, contract management, KPIs etc;~~ • ~~Internal PHA reporting and monitoring structure (Lifeline Roundtable Group)~~ • –	• ~~Reports from Senior Managers to Directors;~~ • ~~Reports to AMT and PHA Board where applicable~~ • ~~Final costs for running of the service (18 months) agreed.~~ • ~~Performance Monitoring arrangements finalised and implemented.~~ • ~~Project Structure established to review current LL IMS, with view to developing system to meet future service needs.~~	~~Lack of clarity on future of service from October 2019~~ • ~~Contract with BHSCT has now been extended until 31 March 2021.~~	• ~~Discussions with DoH to extend the interim contract until March 2021.~~ • –	~~March 2019~~

	~~BC for IMS development currrently being developed~~ • ~~PHA have undertaken a full review of the Clinical Report and Action Plan for 2014 and are now satisfied all issues have been addressed.~~ • ~~New contract governance arrangements have been agreed and are now in place.~~ • ~~IPT with BHSCT has been approved and signed off.~~			

HSC Public Health Agency

item 10

Title of Meeting	PHA Board Meeting
Date	20 June 2019
Title of paper	Breast Screening Programme Annual Report 2016/17
Reference	PHA/04/06/19
Prepared by	Dr Damien Bennett
Lead Director	Dr Adrian Mairs
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to seek approval of the Breast Screening Programme Annual Report for 2016/17.

2 Background Information

The Public Health Agency monitors, and quality assures, the regional Breast Screening Programme to ensure women have access to a high quality service that meets agreed national standards. This annual report describes key issues relating to the Northern Ireland Breast Screening Programme and its performance in 2016/17. It compares performance with previous years. The aim of breast screening is to prevent deaths from breast cancer.

Eligible women aged 50 – 70 are invited for breast screening, by GP practice, every 3 years.

3 Key Issues

The key findings from the Report are as follows:

<u>Uptake</u>

- 81,882 women aged 50-70 years were invited and 63,127 were screened giving an uptake rate of 77% (national standard > 70%).
- This compares with 75% in 2014/15 and 76% in 2015/16).

Cancer Detection

- 466 cancers were detected with 373 invasive cancers, 89 (19%) ductal carcinoma in situ (DCIS), 2 micro-invasive and 2 with unknown invasive status.
- Of the 373 invasive cancers, 208 (56%) were less than 15 mm in diameter (small invasive cancers).
- 5.7 per 1,000 women screened for the first time (aged under 53) were diagnosed with invasive breast cancer (standard ≥3.6) and 5.1 per 1,000 women attending subsequent screening tests (standard ≥4.1).

Small Cancer Detection

- 2.9 per 1,000 women screened for the first time (aged under 53) had a small invasive cancer identified (standard ≥2.0, target ≥2.8).
- The incident (subsequent screen) small cancer detection rate was 2.9 per 1000 women screened, above the minimum standard (>2.3 per 1000).

Screening round length

- 98.2% of women were offered an appointment for mammography screening within 36 months of their previous normal screen (standard 100%).

Diagnosis before surgery

- 96.5% of women had their diagnosis confirmed before surgery (standard >80%).
- The diagnostic adequacy of biopsies taken at assessment clinics was high with 99.5% of women only requiring one visit to the assessment clinic to obtain a diagnosis.

Timeliness of normal screening results

- 98.8% of women received their normal test results within 2 weeks (standard >90%).

Timeliness of assessment following abnormal screening results

- The % of women referred for assessment after prevalent (first) screen was 9.3%, which meets the national standard (<10%). The % referred after their incident (subsequent) screen was 2.8%, which also meets national target (<7%).
- However, only 85.9% were offered an assessment within 3 weeks (standard 100%) and only 78.8% attended their appointment within 3 weeks of their mammogram (standard ≥90%).

4 Next Steps

In conclusion this report shows that in 2016/17 the Breast Screening Programme provided a good quality service, although there were some areas for improvement.

The Report for 2017/18 is currently being prepared and will be brought to the PHA Board later this year.

Annual Report 2016/17

Breast Screening Programme

Contents

1 - Summary and Highlights 2016/17

The Public Health Agency monitors, and quality assures, the Northern Ireland Breast Screening Programme to ensure women have access to a high quality service that meets agreed national standards.

This annual report describes key issues relating to the Northern Ireland Breast Screening Programme and its performance in 2016/17. It compares performance with previous years.

The aim of breast screening is to prevent deaths from breast cancer.

In Northern Ireland eligible women aged 50 – 70 are invited for breast screening, by GP practice, every 3 years. Due to this 3 yearly round of invites, about a third of women will be invited for the first time before their 51st birthday (the year they turn 50), a third before their 52nd birthday (the year they turn 51) and the rest before their 53 birthday (the year they turn 52). All eligible women should be invited for the first time before their 53rd birthday. As the women who are invited before their 51st birthday are invited in the year they turn 50, some women will be invited for breast screening for the first time when they are 49.

Women invited for the first time the year they turn 50 are invited for the last time the year they turn 68. Women invited for the first time the year they turn 51 are invited for the last time the year they turn 69, and women invited for the first time the year they turn 52 are invited for the last time the year they turn 70. Everyone receives a total of 7 invitations.

Women aged over 70 years are not automatically invited for screening, but are encouraged to continue attending every 3 years by phoning their local screening unit and requesting an appointment.

Breast screening, like all screening programmes, results in both benefits and harms. The main benefit is that screening saves about 1 life from breast cancer for every 200 women screened. This adds up to about 1,300 lives saved from breast cancer

each year in the UK.[1]

The main harm is overdiagnosis, as about 3 in every 200 women screened are diagnosed with a cancer that would never have been found without screening and would never have become life threatening.

On balance, however, the National Screening Committee has determined (working on behalf of the four UK Departments of Health), that the overall benefits outweigh potential harms.

In 2016/17, a total of 81,882 women aged 50-70 years were invited; 63,127 were screened giving an uptake rate of 77% (the national standard is > 70%). This compares with 75% in 2014/15 and 76% in 2015/16. Uptake is the percentage of women who attend each year, following an invitation. This means that just under a quarter of women who were invited did not take up the offer of screening mammography. This highlights an area where increased effort is required to promote informed choice in breast screening and to understand the reasons for low uptake, particularly among those from lower socio-economic / disadvantaged groups.

The PHA, in partnership with other stakeholders, continues work to ensure that all eligible women can make an informed choice about attending for breast screening and that the service is as accessible as possible. Key actions relating to promoting informed choice in breast screening are outlined in Section 5 of this report.

Most women who attend for breast screening mammography (96 out of every 100) will be identified as having normal mammograms. In 2016/17, 98.8% of women received their test results within 2 weeks (standard >90%).

In 2016/17, the percentage of women referred for further assessment after their prevalent (first) screen was 9.3%, which is within the national standard (<10%). The percentage referred after their incident (subsequent) screen was 2.8%, which is within the national target (<7%). Of these women, 85.9% were offered an assessment clinic appointment within 3 weeks (standard 100%) and 78.8% attended their appointment within 3 weeks of their mammogram (standard ≥90%). The screening programme therefore failed to meet these standards in 2016/17. The Young Person and Adult Screening Team (YPAST) is working with the Breast

[1] www.nhs.uk/conditions/breast-cancer-screening

Screening Units to improve performance against this standard.

Diagnosis before surgery is made by taking a biopsy at the assessment clinic. In 2016/17, 96.5% of women with cancers detected by screening had the diagnosis confirmed before surgery (standard >80%). The diagnostic adequacy of biopsies taken at assessment clinics was high, as demonstrated by 99.5% of women only requiring one visit to the assessment clinic to obtain a diagnosis.

A total of 466 cancers were detected in 2016/17. Of these, 373 were invasive cancers and 89 (19%) were ductal carcinoma in situ (DCIS), 2 were micro-invasive and in 2 the invasive status was not known. Of the 373 invasive cancers, 208 (56%) were less than 15 mm in diameter (small invasive cancers).

5.7 per 1,000 women screened for the first time (aged under 53) were diagnosed with an invasive breast cancer (standard ≥3.6). The figure for women attending subsequent screening tests was 5.1 per 1,000 (standard ≥4.1). This shows that Northern Ireland is performing well against the national standards for invasive cancer detection.

Detection of small invasive cancers through breast screening can mean that treatment is more likely to reduce the risk of death from the disease. In 2016/17, 2.9 per 1,000 women screened for the first time (aged under 53) had a small invasive cancer identified (standard ≥2.0, target ≥2.8). The incident (subsequent screen) small cancer detection rate was also 2.9 per 1000 women screened, above the minimum standard (>2.3 per 1000).

The screening round length is the interval between each offered invitation for screening mammography. Measurement of screening round length provides an indicator of the efficiency with which a screening programme is managed. The long-term effectiveness of the programme is dependent on women in the target age group continuing to be screened at regular intervals. In 2016/17, 98.2% of women were offered an appointment for mammography screening within 36 months of their previous normal screen (standard 100%).

Overall, while there are some areas that require improvement, these statistics demonstrate that the Northern Ireland Breast Screening Programme provided a good quality service in 2016/17.

2 - Introduction

The aim of breast screening is to prevent deaths from breast cancer. Breast screening, like all screening programmes, results in both benefits and harms. The main benefit is that screening saves about 1 life from breast cancer for every 200 women screened. This adds up to about 1,300 lives saved from breast cancer each year in the UK.[2]

The main harm is overdiagnosis, as about 3 in every 200 women screened are diagnosed with a cancer that would never have been found without screening and would never have become life threatening.

In Northern Ireland eligible[2] women aged 50 – 70 are invited for breast screening, by GP practice, every 3 years. Due to this 3 yearly round of invites, about a third of women will be invited for the first time before their 51st birthday (the year they turn 50), a third before their 52nd birthday (the year they turn 51) and the rest before their 53 birthday (the year they turn 52). All eligible women should be invited for the first time before their 53rd birthday. As the women who are invited before their 51st birthday are invited in the year they turn 50, some women will be invited for breast screening for the first time when they are 49.

Women invited for the first time the year they turn 50 are invited for the last time the year they turn 68. Women invited for the first time the year they turn 51 are invited for the last time the year they turn 69, and women invited for the first time the year they turn 52 are invited for the last time the year they turn 70. Everyone receives a total of 7 invitations.

Women aged over 70 years are not automatically invited for screening, but are encouraged to continue attending every 3 years by phoning their local screening unit and requesting an appointment.

Women who have a significantly increased risk of breast cancer (× 8 the normal risk and higher) are invited to participate in surveillance screening. **Appendix 3** gives an

[2] www.nhs.uk/conditions/breast-cancer-screening

overview of the guidelines for inclusion in this programme. The Northern Ireland Higher Risk Breast Screening Surveillance Programme commenced in 2013. See section 4 for further details.

There are 4 Breast Screening Units (BSU) in Northern Ireland (figure 1). These are the:

Eastern BSU	12-22 Linenhall Street, Belfast Tel: 028 9033 3700	This covers the Belfast and South Eastern Trust areas
Northern BSU	Antrim Area Hospital Tel: 028 9442 4425	This covers most of the Northern Trust area. The Northern Unit provides surveillance screening for women at higher risk of breast cancer for the region.
Southern BSU	Craigavon Area Hospital Tel: 028 3756 0820	This covers the Southern Trust area.
Western BSU	Altnagelvin Area Hospital Tel: 028 7161 1443	This covers the Western Trust, and part of the Northern Trust area.

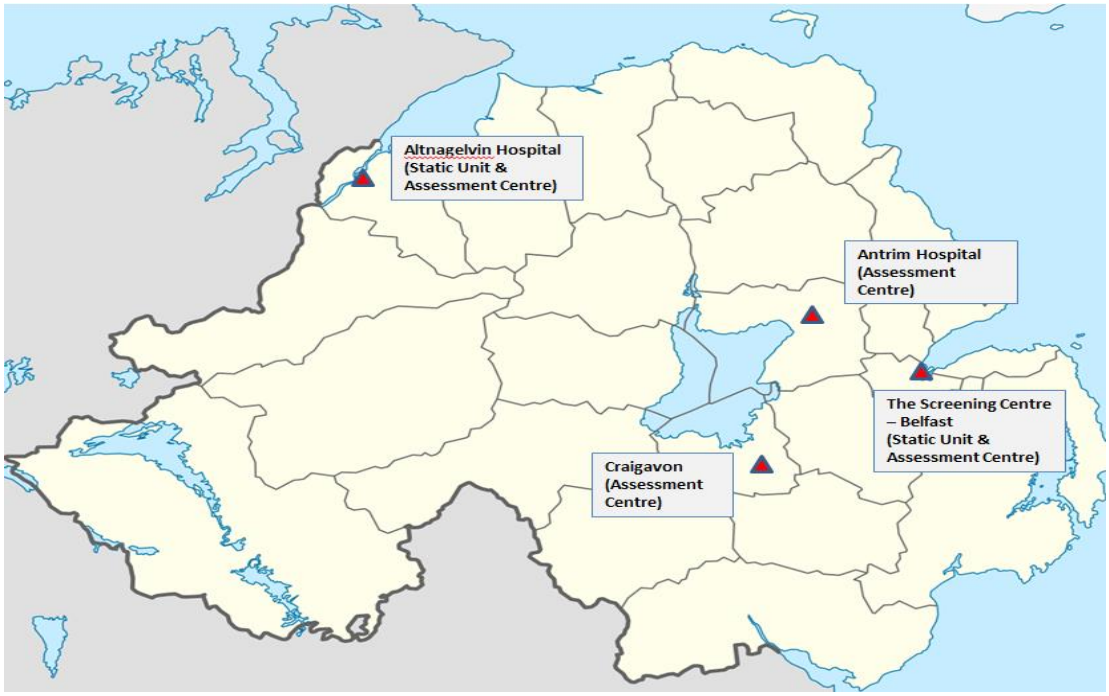


Figure 1 - Location of Breast Screening Units in Northern Ireland

Some breast screening mammography is carried out at the Eastern Unit, 12-22 Linenhall Street, Belfast and in Altnagelvin Hospital. However, most breast screening in Northern Ireland is now carried out on mobile breast screening trailers at a variety of locations throughout Northern Ireland.

The Young Person and Adult Screening Team is part of the Public Health Agency. It provides the quality assurance function for the three cancer screening programmes (breast, bowel and cervical).

The purpose of quality assurance in the breast screening programme is to ensure that it is performing in accordance with the national standards; and continuous improvement in the performance of all aspects of the screening programme. This is conducted to ensure that women have access to a high quality service, wherever they reside.

The Northern Ireland Breast Screening Programme operates to the same standards as the NHS Breast Screening Programme in England[3].

[3] Available at: www.gov.uk/topic/population-screening-programmes/breast

3 - Programme Performance

The YPAST monitors the performance of each of the four Breast Screening Units against national standards using Körner[4] returns:

KC62 – This is an annual return made by Trusts on: outcome of initial screen, outcome of assessment (including cytology and histology), cancers diagnosed (by size and type) and overall outcome measures (uptake, referral rate, non-invasive cancers, benign biopsy rate, invasive cancer detection rate, referral for cytology/biopsy, the malignant to benign ratio for surgery, early recall rate); by 1st invitation, previous non-attenders, last screen within 5 years, last screen more than 5 years, early recall, self-referrals, all women; by age.

KC62 data are obtained from the National Breast Screening System (NBSS). This is the IT system that supports the breast screening programme.

KC63 – This is an annual return made by trusts on: numbers of eligible women, invited and screened by age, numbers recalled, numbers self or GP referred, and time since most recent screen in 12 month blocks.

Women with a date of first offered screening appointment between 01/04/2016 and 31/03/2017 were used to produce this report. Comparative figures for previous years and from the English NHS Breast Screening Programme are also shown.

These data allow the evaluation of the quality of the Northern Ireland Breast Screening Programme. Performance is compared to the minimum standards and targets which are set out in NHS Breast Screening Programme (NHSBSP) Publication No. 60 (Version 2) *Consolidated Guidance on Standards for the NHS Breast Screening Programme*, *April 2005* and revised in NHSBSP Publication No. 59 *Quality Assurance Guidelines for Breast Cancer Screening Radiology (Second edition), March 2011*.

[4] https://www.datadictionary.nhs.uk/data_dictionary/messages/central_return_data_sets/data_sets/nhs_breast_screening_programme_central_return_data_set_(kc62)_fr.asp?shownav=1

The standards in place during the period 2016-17 are summarised in **Appendix 1**.[5]

The KC62 data for women aged 50 – 70 are shown in **Appendix 2**.

It should be noted that this report provides information on both the individual performance of the four Breast Screening Units and also the overall programme. Information on the performance of individual staff is not provided.

Minimum standards[6]: These figures represent the levels of performance which are the minimum acceptable for any Breast Screening Unit. Where the minimum standard is shown "greater than or equal to", any level of performance below that standard is investigated by the Quality Assurance team. Where the minimum standard is shown as "less than or equal to", any level of performance above that standard is similarly investigated.

Targets[7]: These are the quantitative goals that are considered to be achievable individually by one third of units within the NHSBSP. All units should aim to achieve the targets. If the specified cancer detection rates etc. are achieved, then the programme is on target to replicate the mortality reduction achieved in the original clinical trials.[8]

[5] It should be noted that in 2017, the NHSBSP adopted new standards for the Breast Screening Programme. Rather than referring to a minimum standard and a target, the new document refers to acceptable and achievable standards.

These new standards were endorsed for use in Northern Ireland in July 2017 by the NI Screening Committee and a letter from the NI Chief Medical Officer was circulated to confirm this. As this annual report focuses on the period of April 2016 – March 2017, all data have been compared against the previous, rather than the new, standards.

[6] 'Minimum' standard replaced with 'acceptable' standard in 2017.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/612739/Breast_screening_consolidated_standards.pdf

[7] 'Target' replaced with 'achievable' standard in 2017.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/612739/Breast_screening_consolidated_standards.pdf

[8] The Swedish two County Trial : https://pubs.rsna.org/doi/10.1148/radiol.11110469

All English programme data used in this report are taken from the NHS Information Centre for Health and Social Care, *Breast Screening Programme, England 2016-17* Report[9].

[9] https://digital.nhs.uk/data-and-information/publications/statistical/breast-screening-programme/breast-screening-programme-england---2016-17

Number of Women Screened

81,882 women were invited for breast screening in 2016/17; 63,127 (77%) attended for breast screening.

A total of 81,882 women aged 50-70 were invited for breast screening in 2016/17. Of these, 63,127 attended for screening. Figure 2 below illustrates how many were screened by each unit over a four year period. The number screened in each unit fluctuates year on year depending on the area being screened within the three year round length.

It should be noted that the four Breast Screening Units in Northern Ireland cover screening populations of different sizes. Approximately one third of the eligible screening population is invited each year.

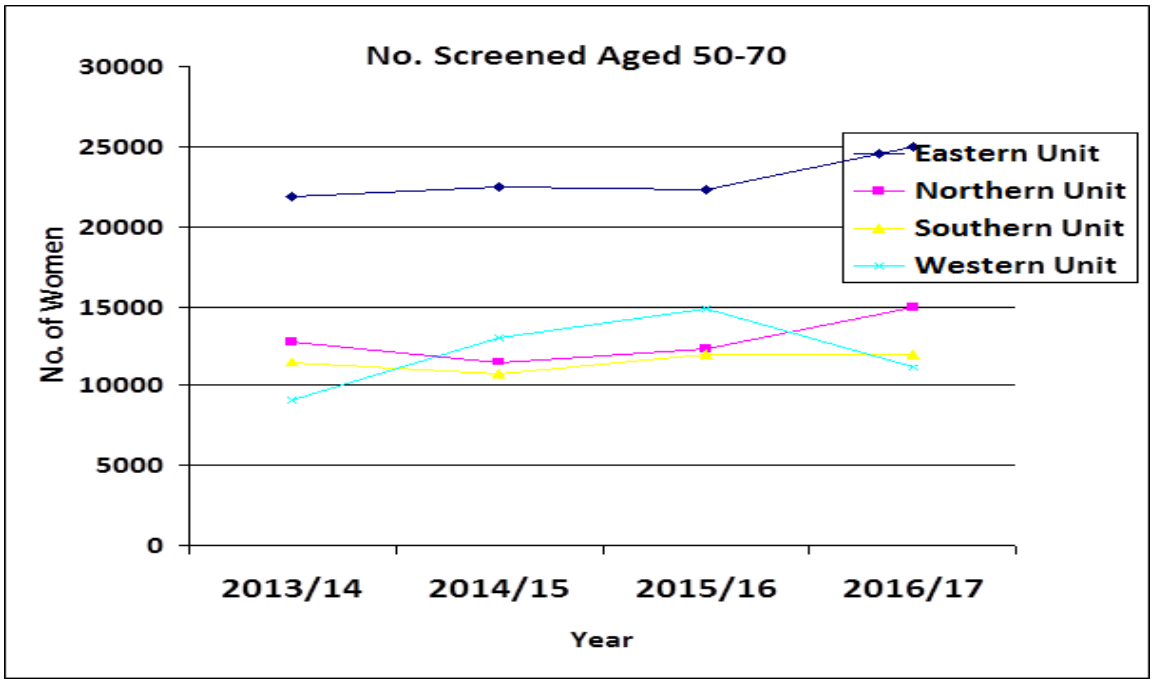


Figure 2 - Number of women aged 50-70 who were screened each year from 2013/14 to 2016/17

Uptake

Uptake measures the percentage of women who attend for breast screening each year, following an invitation. Figure 3 shows the uptake rates over the 6 year period between 2011/12 – 2016/17.

In 2016/17, 77.1% of those invited took up the offer and attended for breast screening.

Average uptake for Northern Ireland in 2016/17 was 77.1%, meaning that over three quarters of all women who were invited accepted the offer of breast screening (a total of 63,127 women). Uptake in 2016/17 was higher than in previous years, i.e. 2015/16 (76.1%) and 2014/15 (75.3%). Uptake for England, in contrast, was **71.1%** in 2016/17, 72.1**%** in 2015/16 and 71.1% in 2014/15

Each of the four Breast Screening Units achieved an uptake of over 70%, therefore exceeding the national minimum standard. Uptake was highest in the Northern unit and lowest in the Eastern unit.

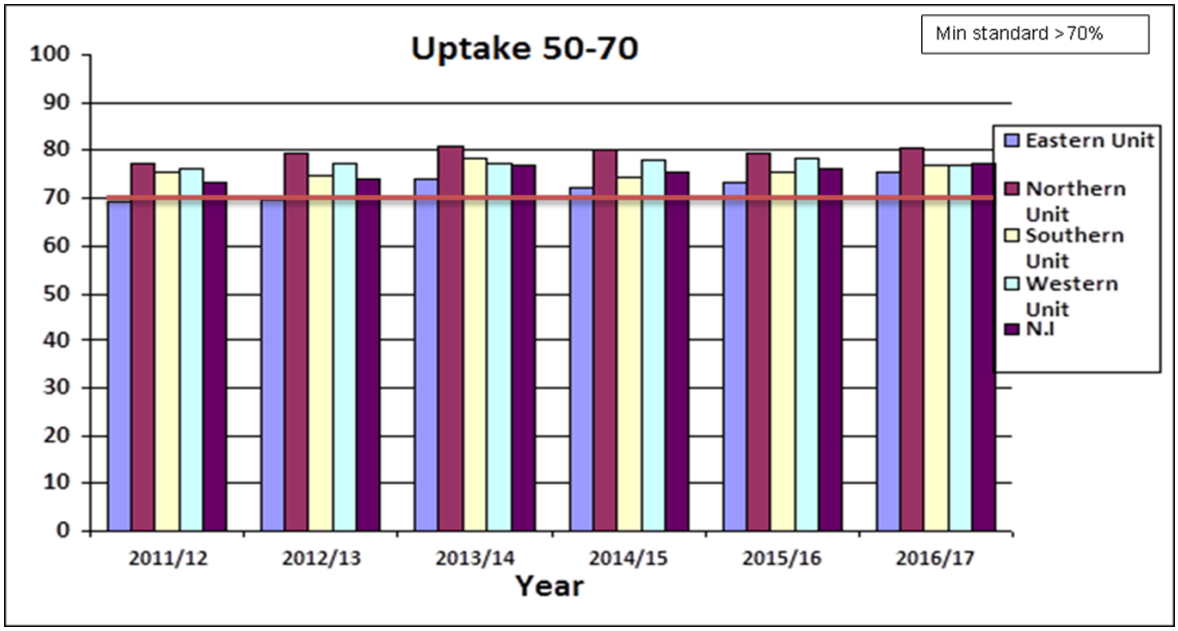


Figure 3 - Uptake for women aged 50-70 by unit and for Northern Ireland 2011/12 – 2016/17

Although women over 70 are not routinely invited for breast screening, the

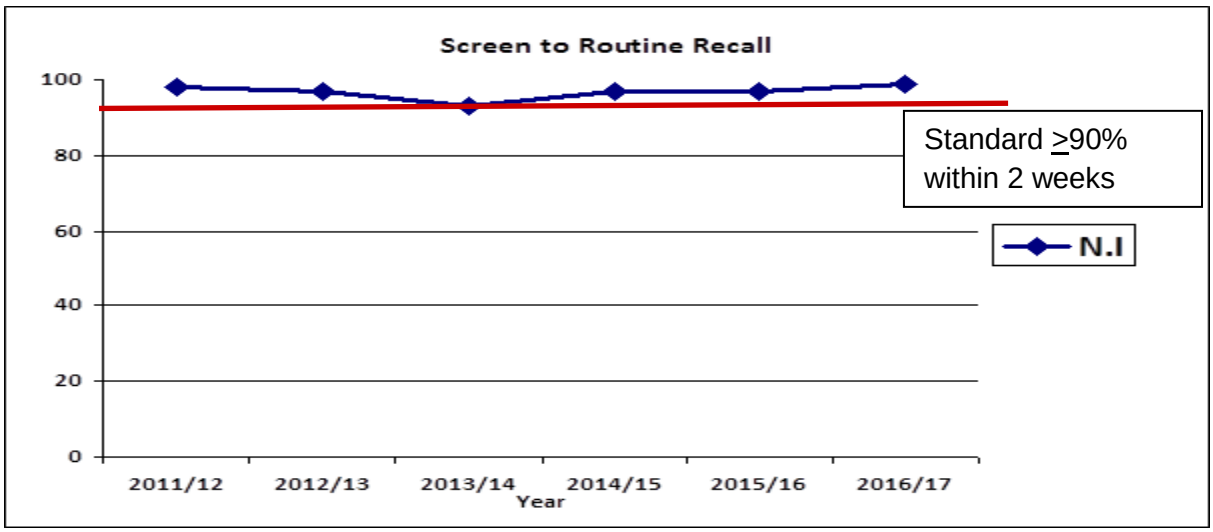
programme actively encourages these women to call their local Breast Screening Unit to make an appointment every three years: 1,769 such women attended screening in 2016/17 (1,101 attended in 2015/16 and 718 in 2014/15). At their last breast screening appointment, women are given a leaflet and a reminder card to self-refer in 3 years' time.

Screen to Routine Recall

99% of women (who had a normal test result) received their results within 2 weeks.

Most women (96%) who attend for breast screening mammography will be identified as having normal mammograms[10]. Screen to Routine Recall is the interval between a woman attending for screening (the date her mammograms were taken) and the date that her episode is closed on the NBSS[11], i.e. the date the result is entered (taken as a proxy for the date she is sent her results letter).

The minimum standard is that ≥ 90% of women should receive their results within two weeks. This was achieved in 2016/17, with 99% achieving the standard, and approaches the target of 100%. Figure 4 outlines programme performance over the 6 year period between 2011/12 to 2016/17.



[10] https://www.gov.uk/government/publications/breast-screening-helping-women-decide
[11] National Breast Screening System.

Figure 4 - Screen to routine recall for Northern Ireland by year from 2011/12 to 2016/17

Figure 5 shows that each unit achieved the minimum standard in 2016/17.

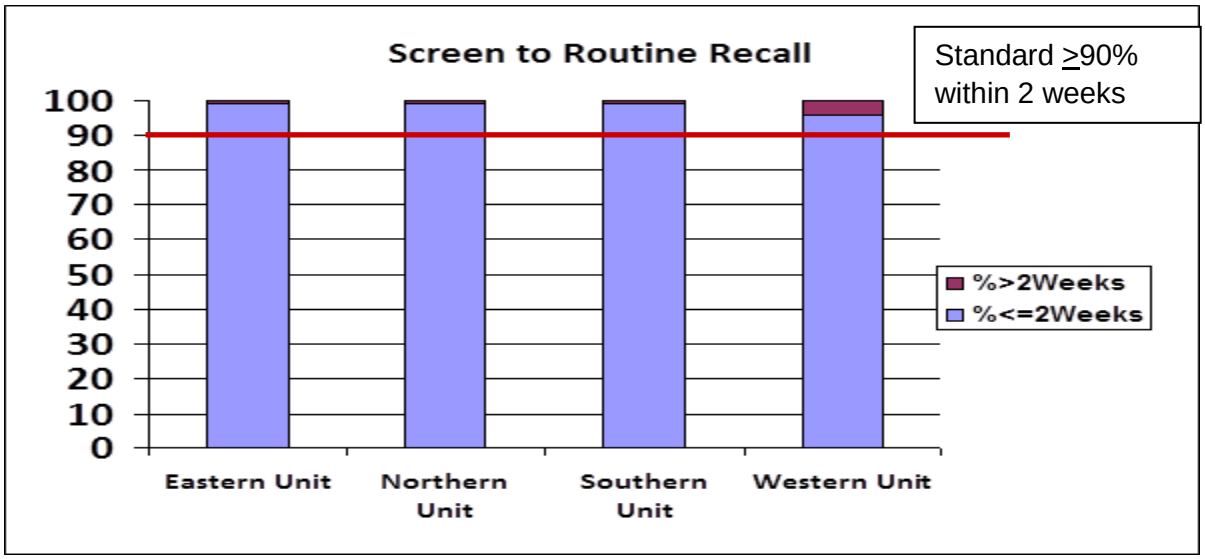


Figure 5 - Screen to routine recall by unit in 2016/17 (%)

Screen to Assessment

85.9% of women referred for assessment were offered an appointment within 3 weeks.

About 4 in every 100 women are asked to come back for more tests after screening as the mammogram looks abnormal. These women are invited to attend an assessment clinic for further tests (e.g. breast examination, ultrasound scan, fine needle aspiration (FNA) etc.) which help confirm if the woman has breast cancer.[12]

[12] https://www.nhs.uk/conditions/breast-cancer-screening/results/

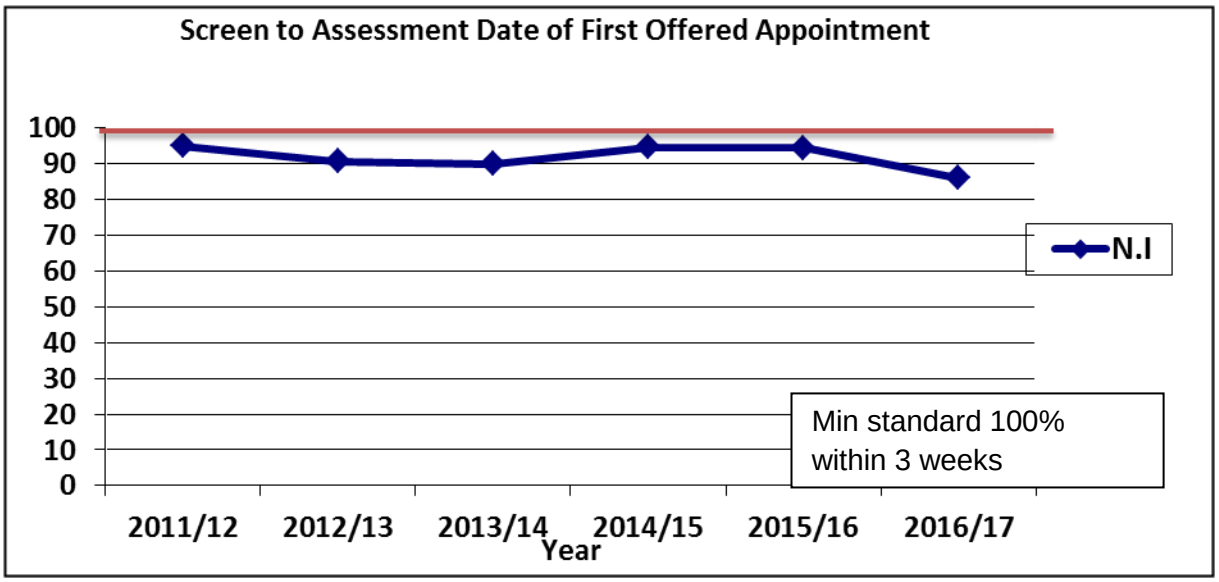


Figure 6 - Screen to assessment for Northern Ireland by year from 2011/12 to 2016/17—date of first offered appointment

On average, 1 in 4 women called back are found to have cancer with the rest, confirmed as not having cancer, returned to the routine screening programme (and therefore invitations are issued every 3 years).

Screen to Assessment (date of first offered appointment) is the interval between a woman's screening mammogram and the date she is offered an appointment for the assessment clinic. The minimum standard in 2016/17 was that 100% of women should be offered an appointment within 3 weeks of attendance for mammography.

Table 1 - Screen to assessment (DoFoA[13])

	2014/15	2015/16	2016/17
BHSCT	93.3	96.7	87.7
NHSCT	93.7	93.5	94.5
SHSCT	94.9	90.6	73.1
WHSCT	91.3	94.3	99.3
N.I	94.4	94.3	85.9

[13] DoFoA – Date of First Offered Appointment

Figure 6 outlines programme performance over the 6 year period between 2011/12 to 2016/17. Figure 7 shows performance in 2016/17 by Breast Screening Unit.

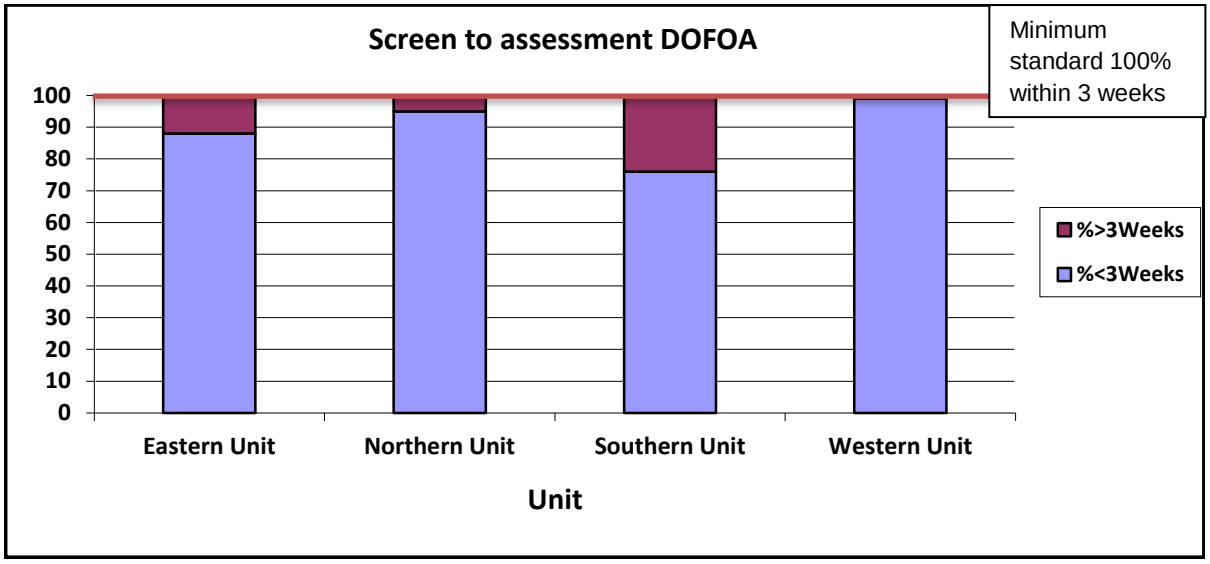


Figure 7 - Screen to assessment (date of first offered appointment) by unit 2016/17

86% of women were offered an appointment for assessment following screening within 3 weeks, which is below the minimum standard (100%) and has reduced from 94% in 2014/15 and 2015/16. This decrease was mainly due to reductions in screen to assessment rates in the Southern Unit (73% in 2016/17) and, to a lesser extent, Eastern Unit (88% in 2016/17). In the Southern Unit a shortage of radiologists contributed to this, while in the Eastern Unit there were issues around clinic capacity and cancellations. A review of breast assessment services (comprising both symptomatic and screening assessment services) began in 2016 and aimed to "secure a service model which will provide a high quality, safe, sustainable, accessible and timely service"[14]. The Breast Assessment Services Reconfiguration Review Project Board (BASPB) has recently published its initial proposals and these are currently open to public consultation[14].

The YPAST also monitors the interval between a woman's screening mammogram and the date she actually attends her appointment (Figure 8). This is because some

[14] https://www.health-ni.gov.uk/consultations/reshaping-breast-assessment-services

women may choose to change the date of their appointment, some may not turn up (DNA) and are offered another date, or (rarely) because an assessment clinic is cancelled. Although the Northern Ireland standard in 2016/17 was that ≥90% should be seen within 3 weeks, the programme actual performance was 78.8% regionally.

The YPAST have been working with the Breast Screening Units to improve performance against this standard.

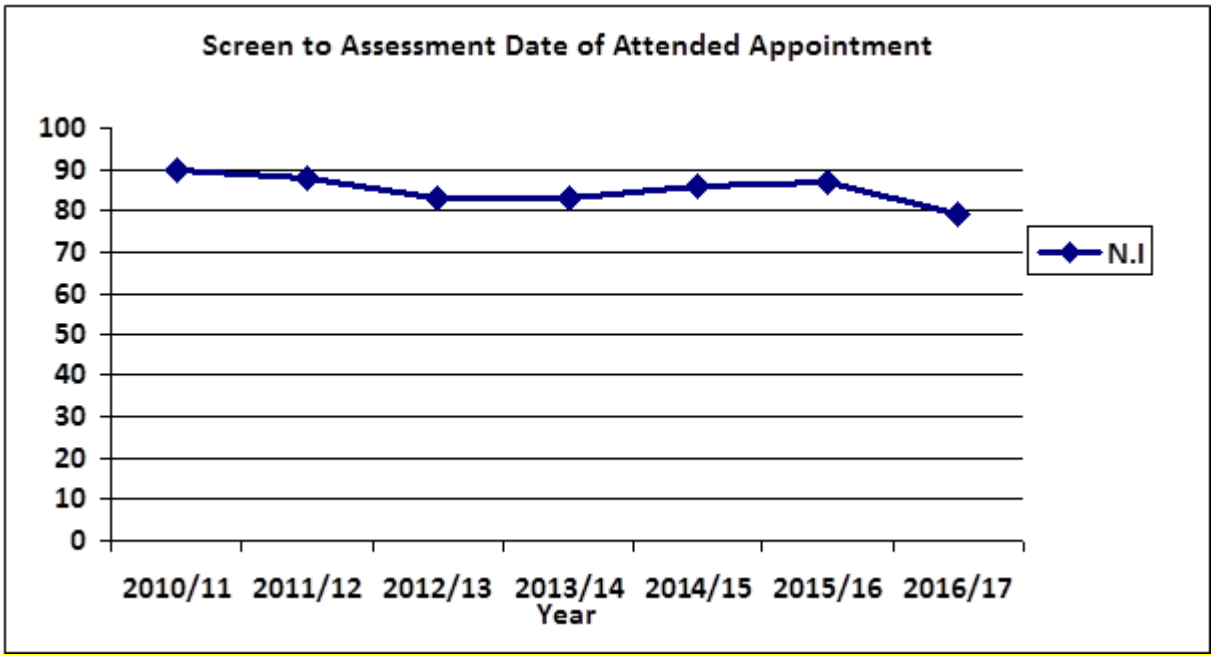


Figure 8 - Screen to assessment for Northern Ireland by year from 2010/11 to 2016/17 — date attended appointment

Referred for Assessment

In 2016/17 2,669 women, equivalent to 4.1% of all those screened, were referred for assessment.

The percentage of women who are recalled to an assessment clinic is normally higher in those attending their first screening mammogram (the prevalent screen) than in those attending for subsequent screening mammography (incident screens). The objective is to minimise the number of women referred for further tests. However, a recall rate that is too low can reduce the number of cancers detected.

Prevalent screen

The programme, with a performance level of 9.3%, achieved the minimum standard that <10% of women should be recalled for assessment in the prevalent (first) screen (the target being 7%).

Incident screen

With a performance level of 2.8%, the programme achieved both the minimum standard (<7%) and target (<5%) of women recalled for the incident (subsequent) screen.

Table 2 shows the performance by unit.

Table 2: Percentage of women aged 50-70 recalled for assessment, by unit, in 2016/17

Unit	Prevalent %	Incident %
Eastern	11.6	2.5
Northern	10.4	3.3
Southern	7.5	3.6
Western	4.4	1.8
Northern Ireland	9.3	2.8
Standard and target	Standard < 10% Target < 7%	Standard < 7% Target < 5%

Northern Ireland performance compares well with the English regions, for incident screens, as shown in Table 3.

Table 3 - Percentage of Women Aged 50-70 Recalled to Assessment by Region.

(Green indicates that the standard and the target have been met; orange/yellow indicates that the standard has been met).

NHS BREAST SCREENING PROGRAMME INCLUDING NORTHERN IRELAND: % RECALLED TO ASSESSMENT BY REGION PREVALENT SCREEN AGE 50 – 70 2016 - 2017 Standard <10% Target <7%	
East Midlands	6.1
North East	6.2
East of England	6.3
North East, Yorkshire and the Humber	6.6
Yorkshire and the Humber	6.8
West Midlands	7.2
England	**7.8**
North West	8.1
South East	8.4
South	8.6
South West	9.1
London	9.2
Northern Ireland	**9.3**

NHS BREAST SCREENING PROGRAMME INCLUDING NORTHERN IRELAND: % RECALLED TO ASSESSMENT BY REGION INCIDENT SCREEN AGE 50 – 70 2016 - 2017 Standard <7% Target <5%	
East Midlands	2.5
East of England	2.5
North East	2.6
West Midlands	2.6
Northern Ireland	**2.8**
North East, Yorkshire and the Humber	2.9
England	**3.0**
South East	3.1
Yorkshire and the Humber	3.2
London	3.3
North West	3.3
South	3.4
South West	3.6

Figures 9 and 10 show the percentage of women referred to assessment over a 6 year period, by Breast Screening Unit. In 2016/17, all units met the target for referral to assessment at incident screens. However, the Northern unit (at 10.4%) and Eastern unit (at 11.6%) did not meet the standard for referral to assessment at prevalent screen. This is being monitored.

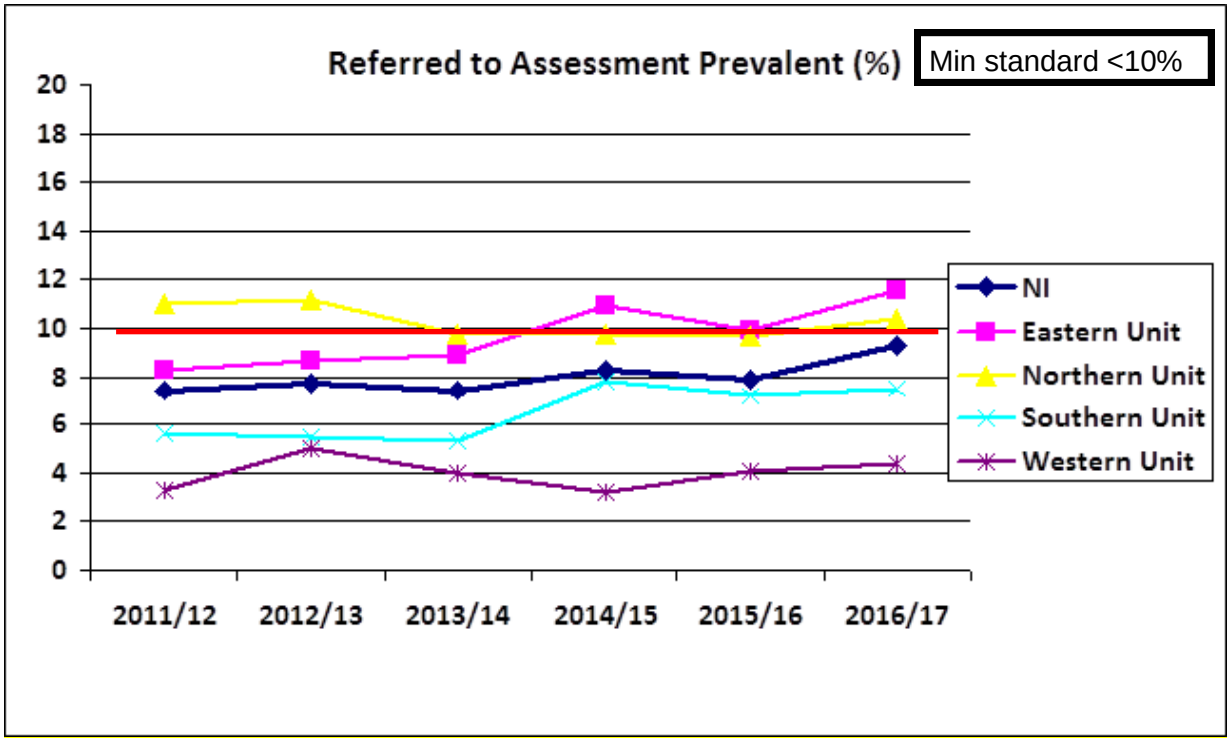


Figure 9 - % referred to assessment for prevalent (first) screen by unit and for Northern Ireland, 2011/12 to 2016/17 (Minimum Standard 10%)

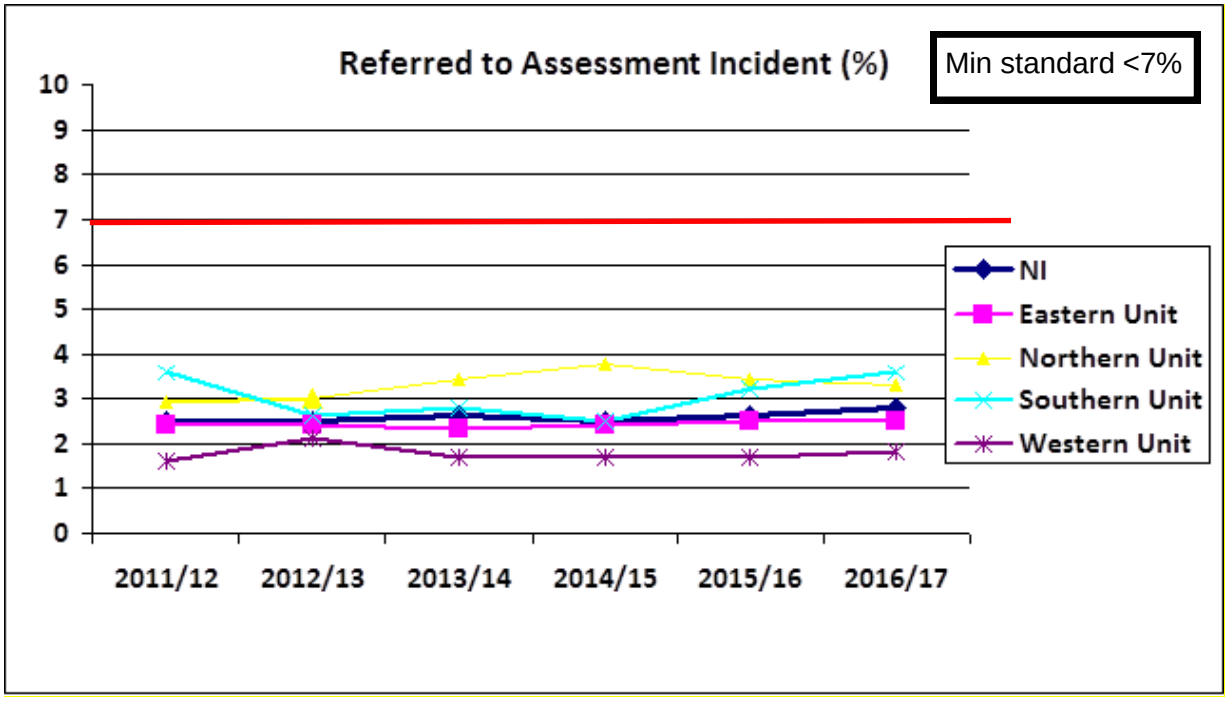


Figure 10 - Percentage referred to assessment for incident screen for women aged 50-70 by unit and for Northern Ireland, 2011/12 to 2016/17- Minimum standard <7%

Outcomes of Screening

Younger women are more likely to be called back for assessment, but cancer is more likely to be found in older women.

Figure 11 shows the outcomes of screening by age bands. Younger women are more likely to be called back to an assessment clinic for further testing. The result of this further testing is, for most women, reassurance. These women are returned to routine recall and invited for routine screening again in 3 years' time (this is shown in Figure 11 as "RR from assessment"). Note that the y-axis of the graph starts at 90%; as more than 90% of all women screened have normal mammograms.

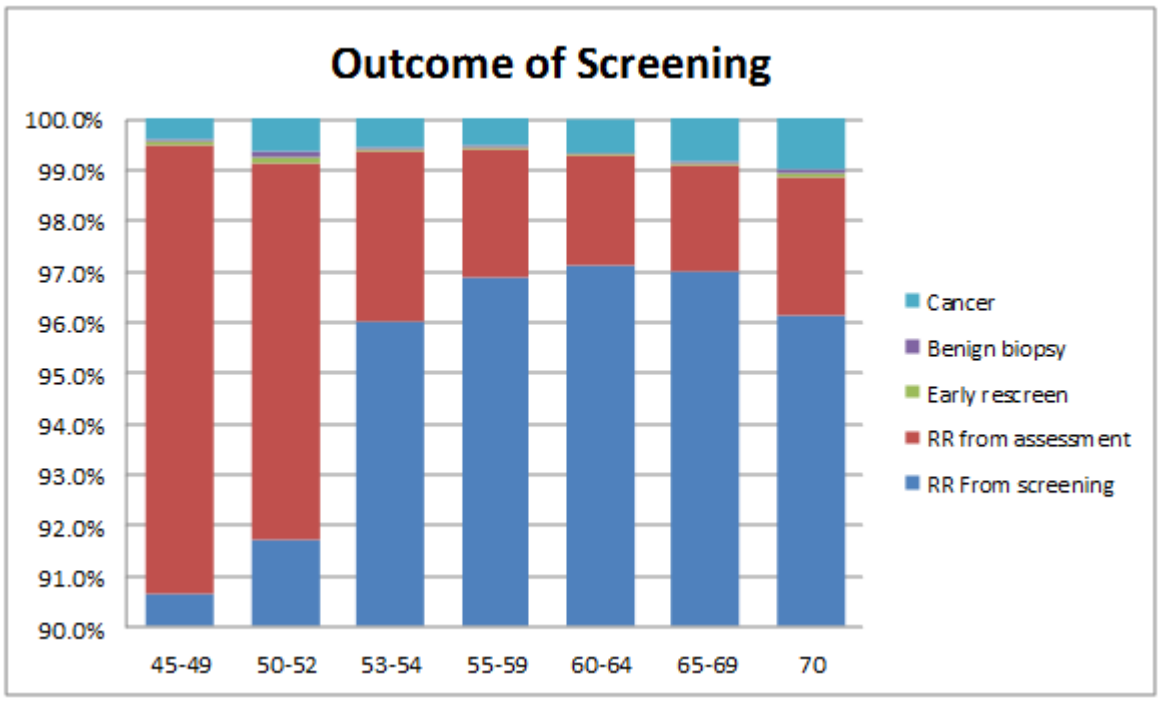


Figure 11 - Outcomes of Breast Screening by Age Band 2016/17. RR indicates 'routine recall' where women are invited for routine screening again in 3 years.

Early re-screen involves bringing a woman (who has attended an assessment clinic) back for repeat screening mammography sooner than the normal three yearly screening intervals. This occurs infrequently and these cases are monitored and reviewed.

Preoperative Diagnosis Rate

99.4% of women with invasive cancers detected by screening had the diagnosis confirmed before surgery.

The preoperative diagnosis rate measures the percentage of screen detected cancers where the diagnosis was established prior to surgery. Diagnosis before surgery is made by taking a biopsy at the assessment clinic.

Some women need to have a surgical biopsy (i.e. a biopsy taken during surgery).

This can be because the diagnosis is difficult to establish. The minimum standard for invasive cancers is that ≥90% of cancers should be diagnosed before surgery, with a target of ≥95%. All units exceeded both these minimum and target standards in 2016/17, with overall regional performance being 99.4%.

Figure 12 shows each unit's performance over a 4 year period.

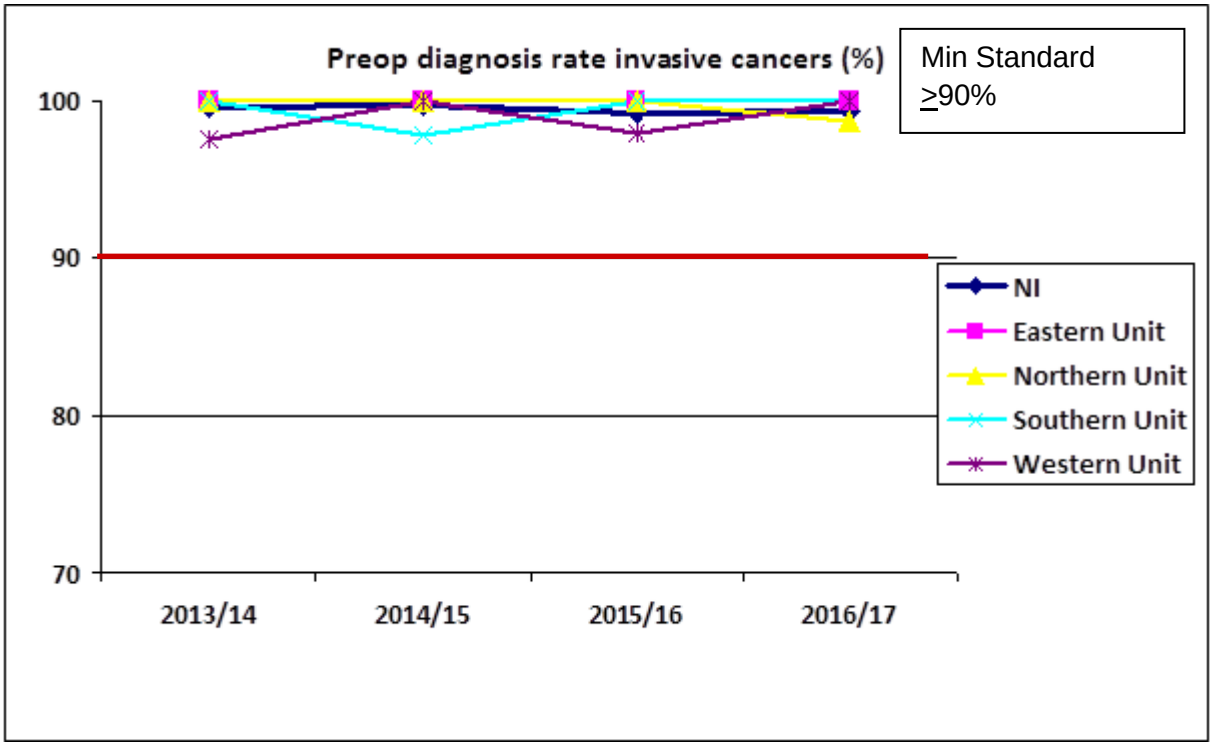


Figure 12 - Preoperative diagnosis for invasive cancers rate by unit and for Northern Ireland from 2013/14 to 2016/17 - standard ≥90%

Number of cancers detected

373 invasive cancers were detected in 2016/17. Of these, 208 were small (i.e. less than 15mm in diameter).

466 cancers were detected in 2016/17. Of these:

- 373 were invasive cancers
- 89 were ductal carcinomas in situ (DCIS)
- 2 were micro invasive cancers
- 2 were invasive status not known

A proportion of cases of DCIS will become invasive. It is not possible to identify which will / will not become invasive; therefore all women diagnosed with DCIS are offered treatment.

The total cancer detection rate for the 50-70 age group in 2016/17 was 6.8 per 1000 women. The comparative figure for England was 8.2 per 1000 women (Figure 13).

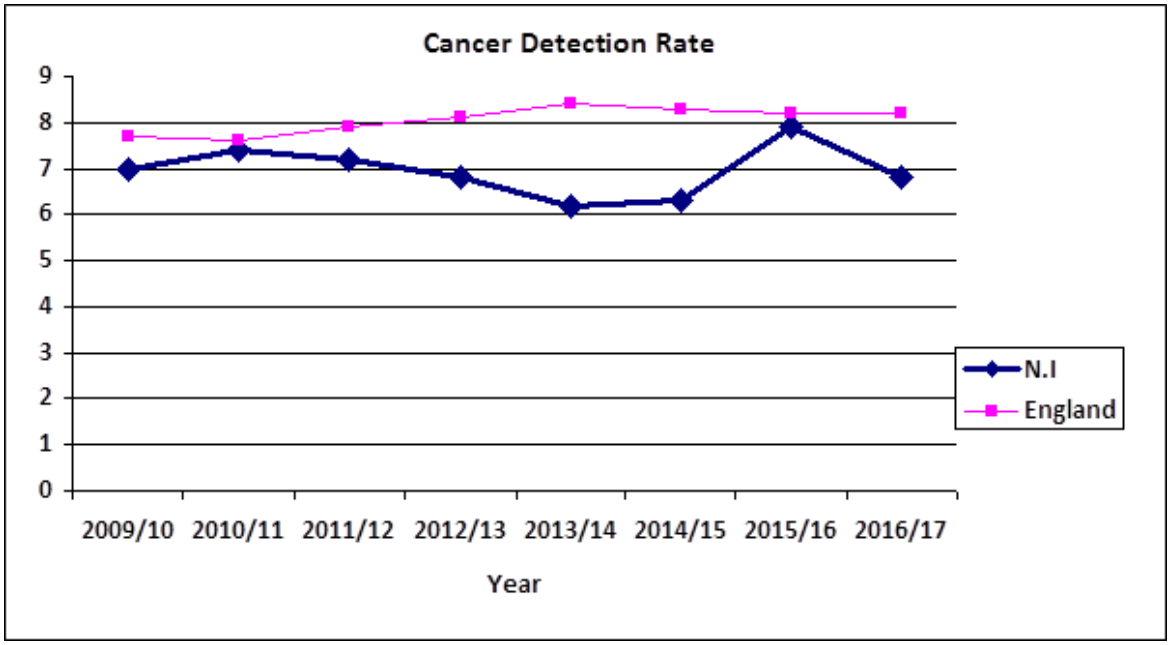


Figure 13 - Total cancer detection rate (per 1000) for Northern Ireland and England from 2009/10 to 2016/17

Invasive Cancer Detection Rate

This measure is the number of invasive cancers detected per 1,000 eligible women who were invited and screened.

5.7 per 1,000 women screened for the first time (aged under 53) were diagnosed with an invasive breast cancer. The figure for women attending for subsequent screening tests was 5.1 per 1,000.

Prevalent Screen

The minimum national standard for the invasive cancer detection rate in 2016/17 was ≥3.6 per 1,000 women for the prevalent (first) screen; with a target rate of ≥5.1 per 1,000 women screened.

Over a 6 year period the Northern Ireland rate has been consistently above, and therefore achieved, the minimum standard (Figure 14). The rate for Northern Ireland was 5.7 per 1,000 women screened, compared to 5.9 per 1,000 in England. All units exceeded the standard in 2016/17. These figures tend to fluctuate from year to year due to the very small numbers involved.

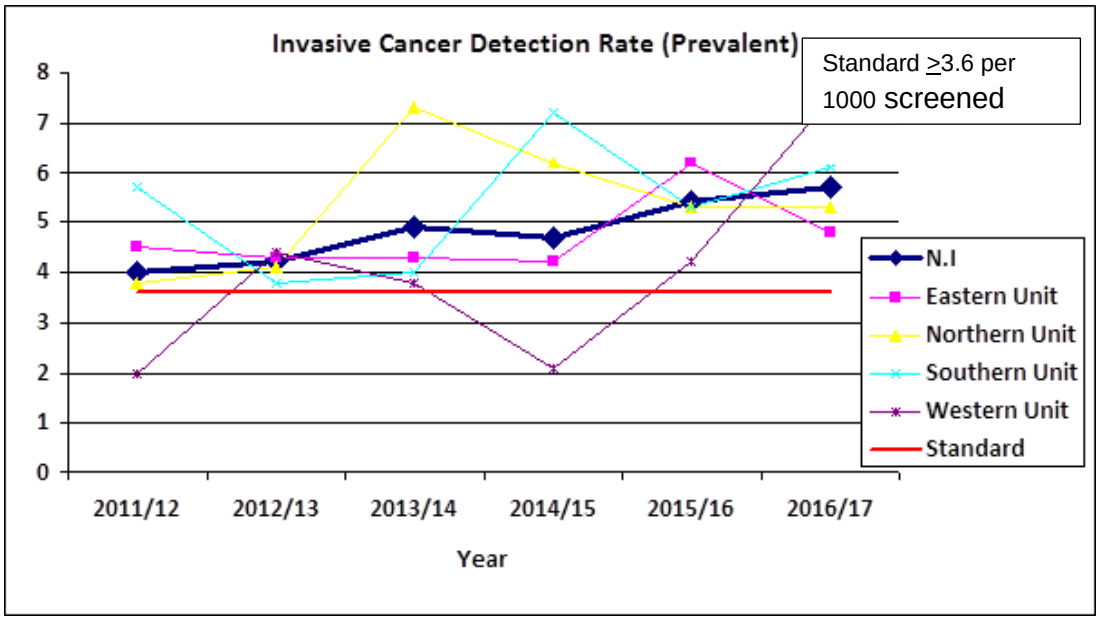


Figure 14 - Invasive cancer detection rate for the prevalent (first) screen by unit and for Northern Ireland, 2011/12 to 2016/17 -Standard ≥3.6 per 1000

The prevalent invasive cancer detection rates for each Breast Screening Unit in 2016/17 are shown again in Figure 15 with associated confidence intervals, which are wide due to the small number of invasive cancers detected. Although all units exceeded the minimum standard for prevalent cancer detection rates these were not significantly greater (as indicated by confidence intervals (CIs) crossing the standard line) apart from the Western Unit.

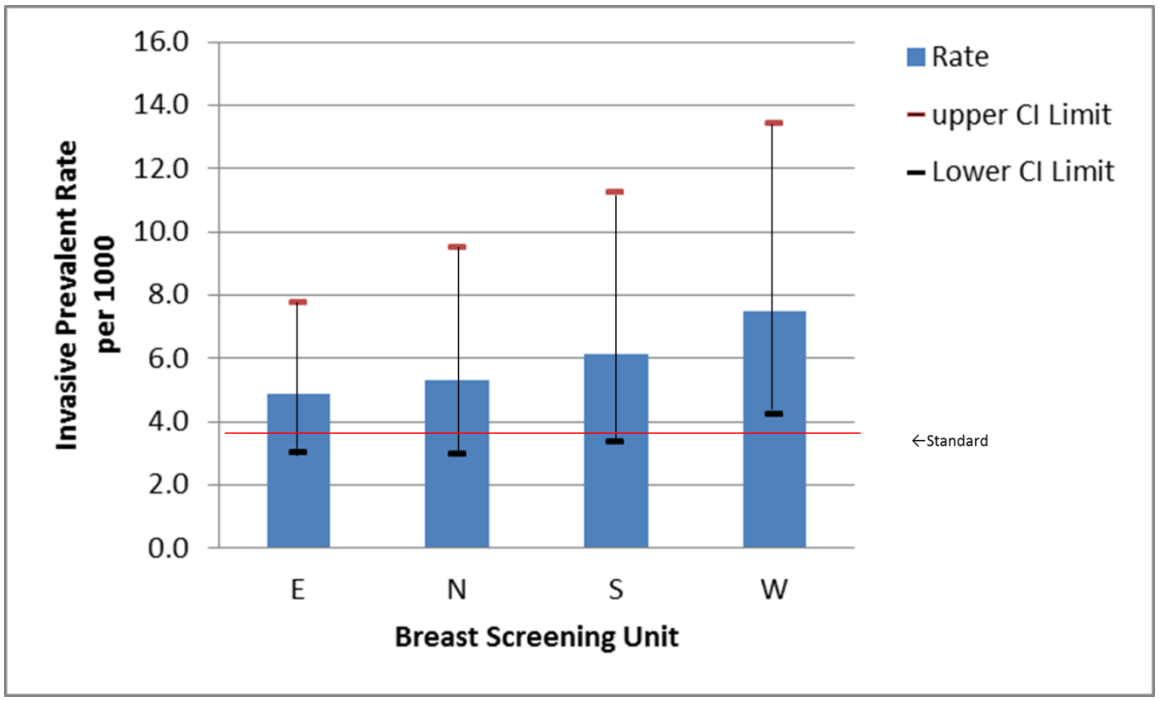


Figure 15 - Prevalent invasive cancer detection rate by unit with 95% Confidence Intervals (CIs) 2016/17

Incident Screen

The minimum national standard for the invasive cancer detection rate in 2016/17 was ≥4.1 per 1,000 women for incident (subsequent) screens; with a target of ≥5.7 per 1,000 women screened.

Each unit met the standard in 2016/17 (Figure 16). The Northern Ireland rate was 5.1 per 1000; the comparative English rate was 6.2 per 1,000.

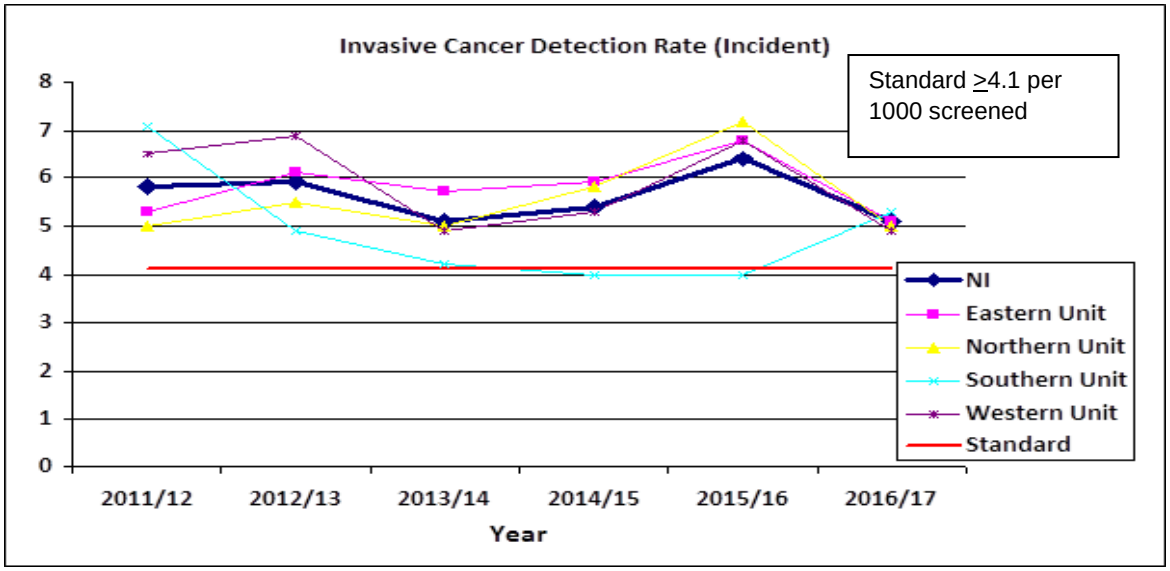


Figure 16 - Invasive cancer detection rates (incident screen) for women aged 50-70 by unit & for Northern Ireland 2011/12—2016/17

The 2016/17 rates are displayed again in Figure 17, with associated confidence intervals, which again are wide due to the small number of invasive cancers detected. Although all units exceeded the minimum standard for incident invasive cancer detection rates these were not significantly greater (as indicated by CIs crossing the standard line) (Figure 17).

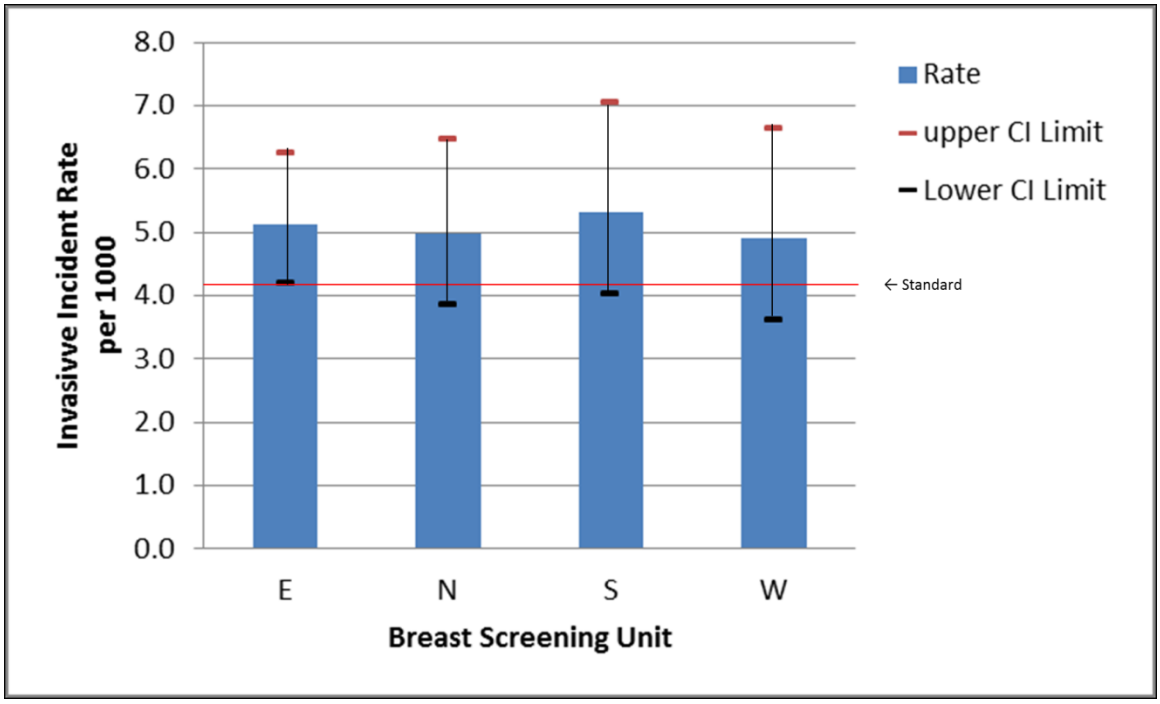


Figure 17 - Incident invasive cancer detection rate by unit with 95% Confidence Intervals (CIs) 2016/17

Small Invasive Cancers

The main aim of breast screening is to detect small invasive breast cancers, at an early stage in their natural history, when treatment is more likely to reduce the risk of death from the disease. Small cancers are defined as less than 15 mm in their maximum diameter.

2.9 per 1,000 women screened for the first time (aged < 53 yrs) had a small invasive cancer. The figure for women attending for subsequent screening was also 2.9 per 1,000.

Prevalent

Figure 18 shows the small invasive cancer detection rates for the prevalent (first) screen over a six year period. Rates naturally tend to fluctuate from year to year due to small numbers. The Northern Ireland programme exceeded both the standard and the target in 2016/17 with a figure of 2.9 per 1,000 women screened (minimum standard ≥2.0 per 1,000; target ≥2.8 per 1,000). The figure for England was 2.8 per 1,000.

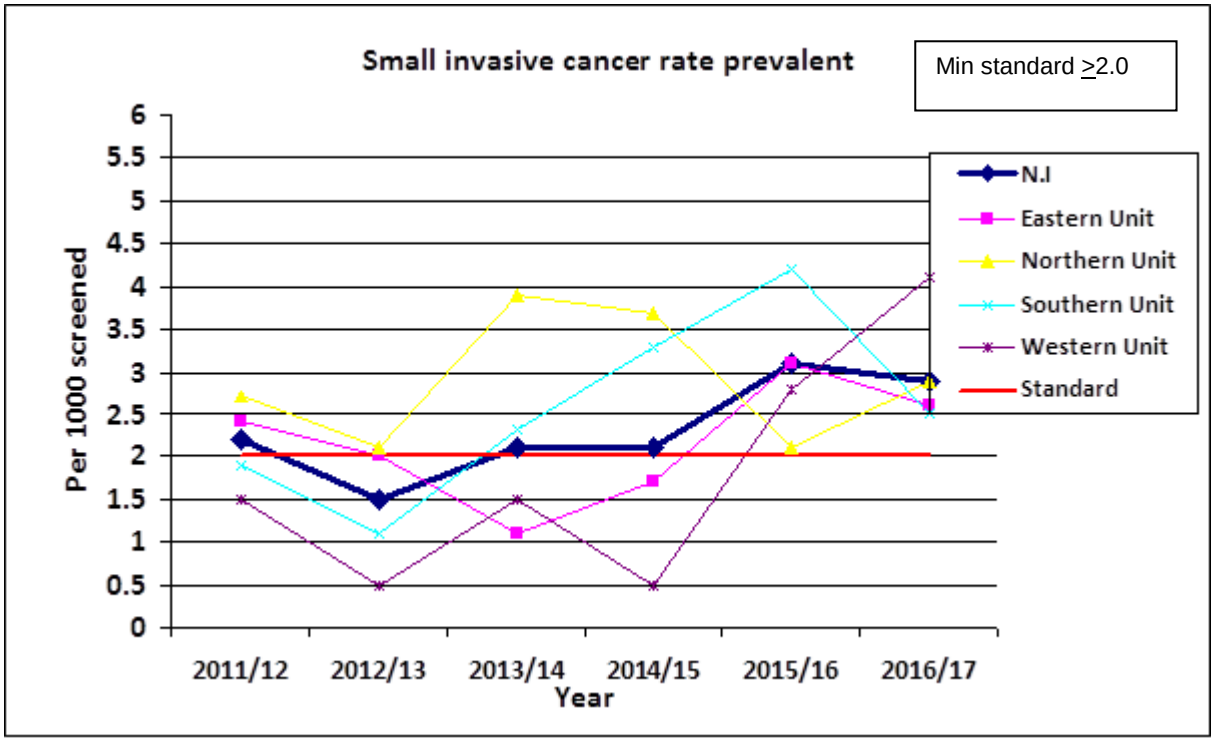


Figure 18 - Small invasive cancer detection rate (prevalent screen) by unit and for N.I 2011/12 – 2016/17

Figure 19 shows the small invasive cancer detection rate for the prevalent screen for each Breast Screening Unit in 2016/17, with associated confidence intervals. The red line is the minimum standard of 2.0 per 1,000 women screened. Although all units exceeded the minimum standard for small invasive prevalent cancer rates these were not significantly greater (as indicated by CIs crossing the standard line) (Figure 19).

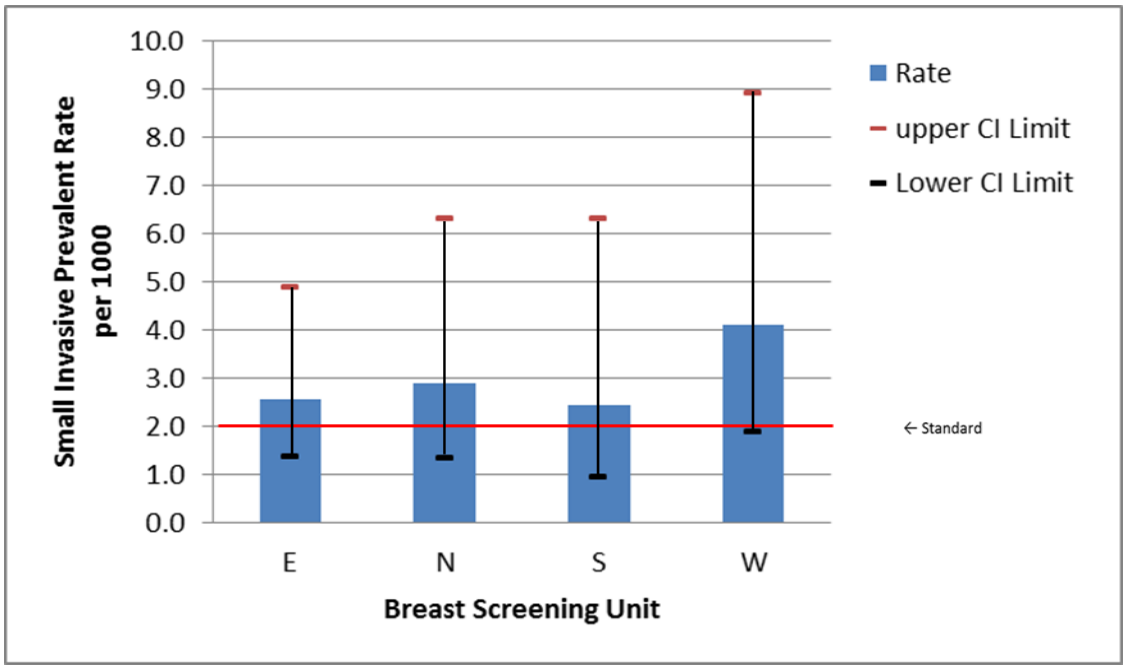


Figure 19 - Prevalent small invasive cancer detection rate by unit with confidence intervals 2016/17

Incident

The small invasive cancer rate for the incident (subsequent) screens is shown in Figure 20. The Northern Ireland programme with a rate of 2.9 per 1,000 exceeded the minimum standard of ≥2.3 per 1,000. The comparative figure for England was 3.3 per 1,000.

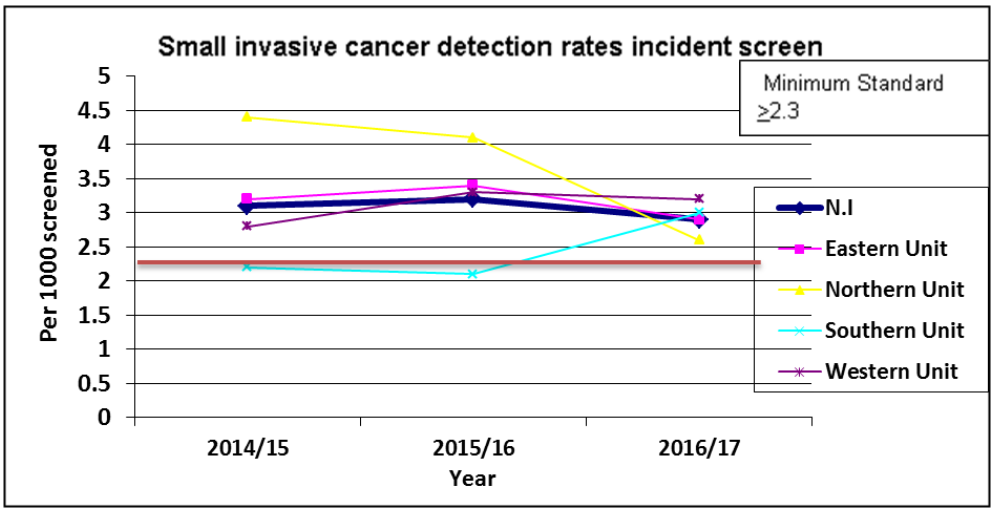


Figure 20 - Small invasive cancer detection rates (incident screen) for women aged 50-70 by unit & for NI 2014/2015—2016/17

Figure 21 shows the small invasive cancer detection rate for the incident screen for each Breast Screening Unit in 2016/17 with associated confidence intervals. The red line is the minimum standard of 2.3 per 1,000 women screened. Although all units exceeded the minimum standard for small invasive incident cancer rates these were not significantly greater (as indicated by CIs crossing the standard line) (Figure 21).

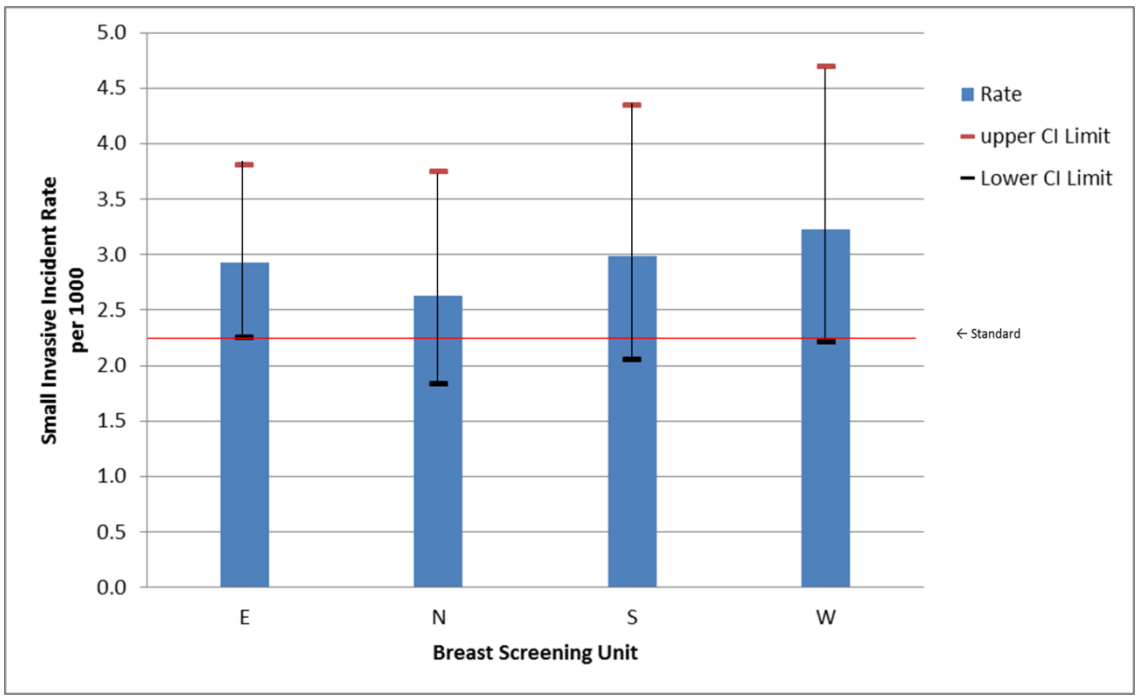


Figure 21 - Incident small invasive cancer detection rate by unit with confidence intervals 2016/17

Treatment of Invasive Cancers

Of the 373 invasive cancers detected by the Northern Ireland Breast Screening Programme in 2016/17, 309 (82.8%) were treated using breast conserving surgery, while 62 (16.6%) were treated by mastectomy. A small number (<5) had no surgery. This can be due to patient choice or because the patient is too unwell for surgery. Figure 22 shows the proportion of women treated by different methods in Northern Ireland over the past 4 years.

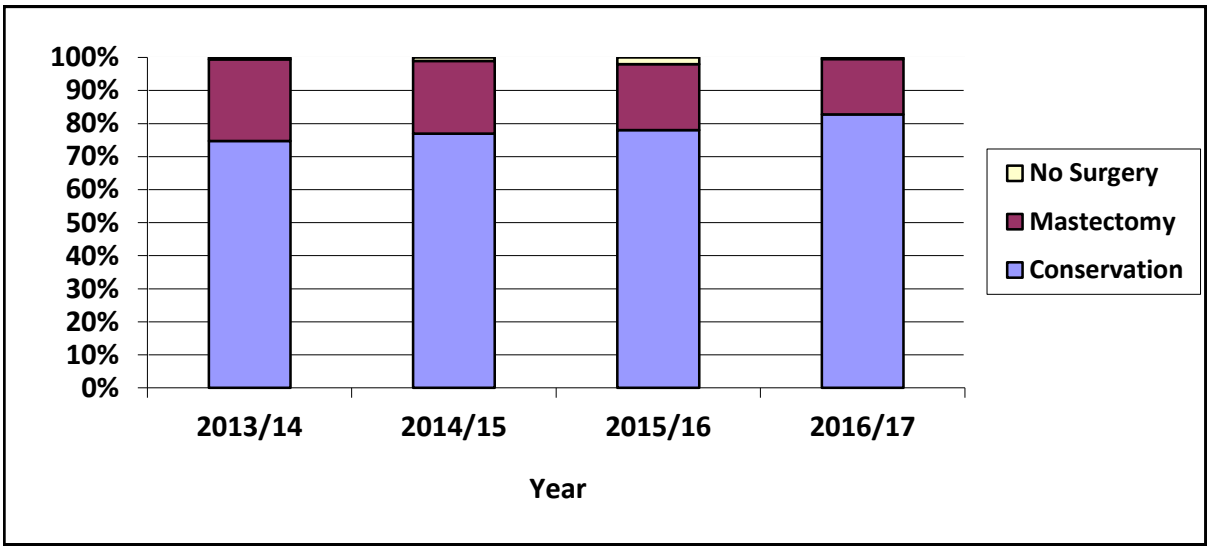


Figure 22: Treatment of invasive cancers for Northern Ireland, 2013/14 – 2016/17

The proportion of women receiving breast conserving surgery in Northern Ireland (Figure 22) compares well with the combined figures for programmes in England, Wales and Northern Ireland (Table 4).

Table 4 - Average figures for Breast Conserving Surgery and Mastectomy for England, Wales and Northern Ireland (From Annual ABS Audit Reports)[15]

	2013/2014	2014/2015	2015/2016	2016/17
Breast Conserving Surgery	78%	78%	79%	88%
Mastectomy	20%	20%	18%	17%

Benign Biopsy Rates

The proportion of women who had a surgical operation for what turned out to be benign disease was 1.2 per 1,000 screened for the prevalent (first) screen and 0.4 for the incident (subsequent) screen.

The Benign Biopsy rate is a measure of the number of women per 1,000 women screened who had surgery for benign breast disease. This, ideally, should be as low as possible. However, with some lesions (e.g. fibro-adenomas) the patient may choose to have surgery to remove a lump, even though it has been diagnosed as benign at the assessment clinic. Radial scars (a star shaped thickening of breast tissue which shows up on mammograms) are removed due to their association with tubular carcinoma of the breast; even though they are intrinsically benign.

The benign biopsy rates for the prevalent (first) and incident (subsequent) screening rounds over a six year period are shown in Figures 23 and 24. For the prevalent screen, the rate was 1.2 per 1000 in 2016/17 in Northern Ireland, which met the standard of <1.5. For the incident screen, the rate was 0.4 per 1000, which met the target of <1.0.

[15] The total for a column may be more than 100% as sometimes one patient can be recorded twice if they initially have breast conserving surgery but then proceed to a completion mastectomy if the pathology dictates.

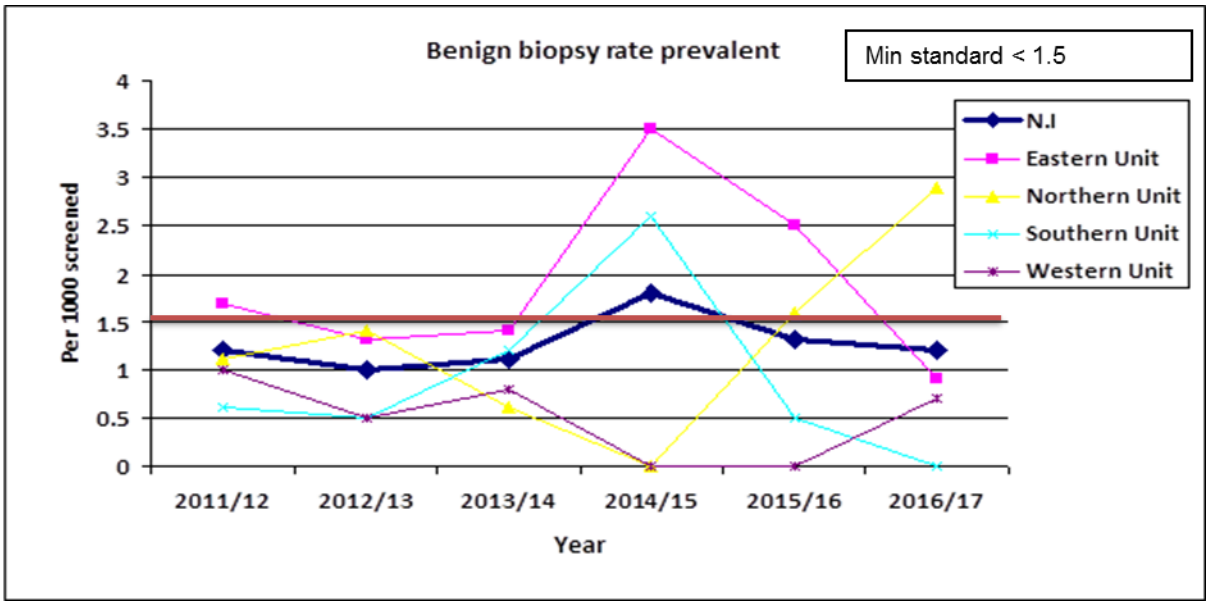


Figure 23 - Benign biopsy rate for the prevalent (first screen) 2011/12-2016/17

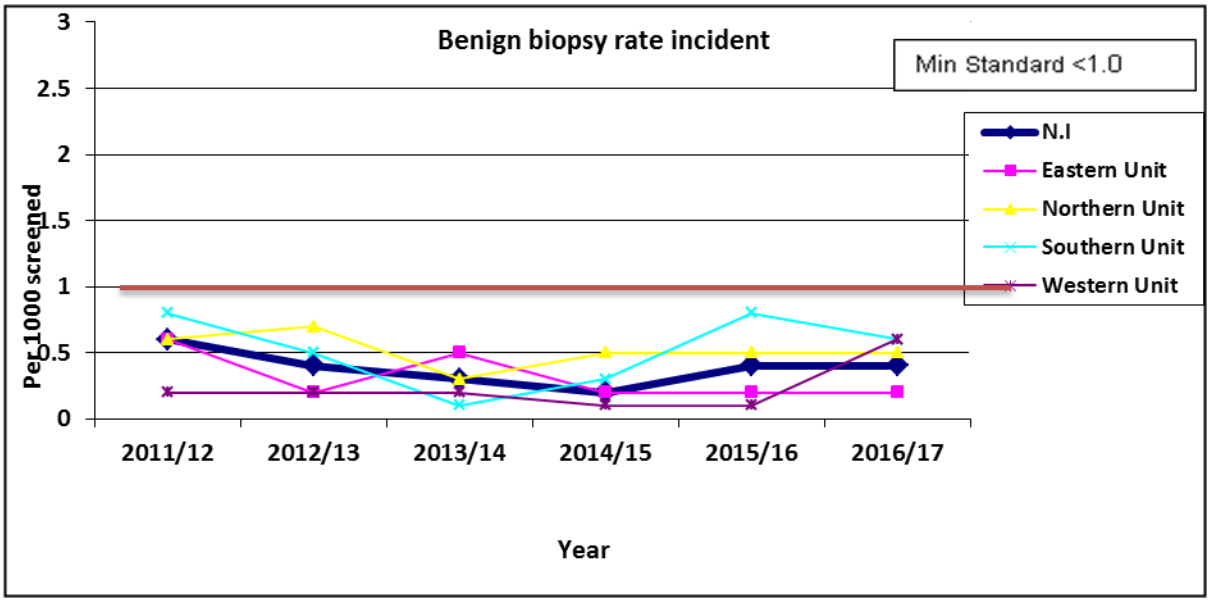


Figure 24 - Benign biopsy rate for the incident (subsequent screens) 2014/15-2016/17 in women aged 50 – 70 - minimum standard <1.0

Screening Round Length

98.2% of women were offered an appointment for mammography screening within 36 months of their previous normal screen.

The screening round length is the interval between each offered invitation for screening mammography. Measurement of screening round length provides an indicator of the efficiency with which a screening programme is managed. The long-term effectiveness of the programme is dependent on women in the target age group continuing to be screened at regular intervals.

The UK minimum standard for round length in the year 2016/17 was ≥90%. In Northern Ireland, following discussion at the Interval Cancer Workshop on 15 October 2015, it was agreed to move to a standard of 100% for round length, as a potential way to reduce the number of interval cancers in the third year. The standard has since been revised to ≥90%, in line with new PHE guidance.

Figure 25 shows the percentage of women screened within 36 months, by quarter, for the year 2016/17. The standard in place at the time in Northern Ireland was 100%. The overall Northern Ireland figure for round length ≤36 months in 2016/17 was 98.2%. This achieved the UK standard, but not the 100% standard adopted by the Northern Ireland programme.

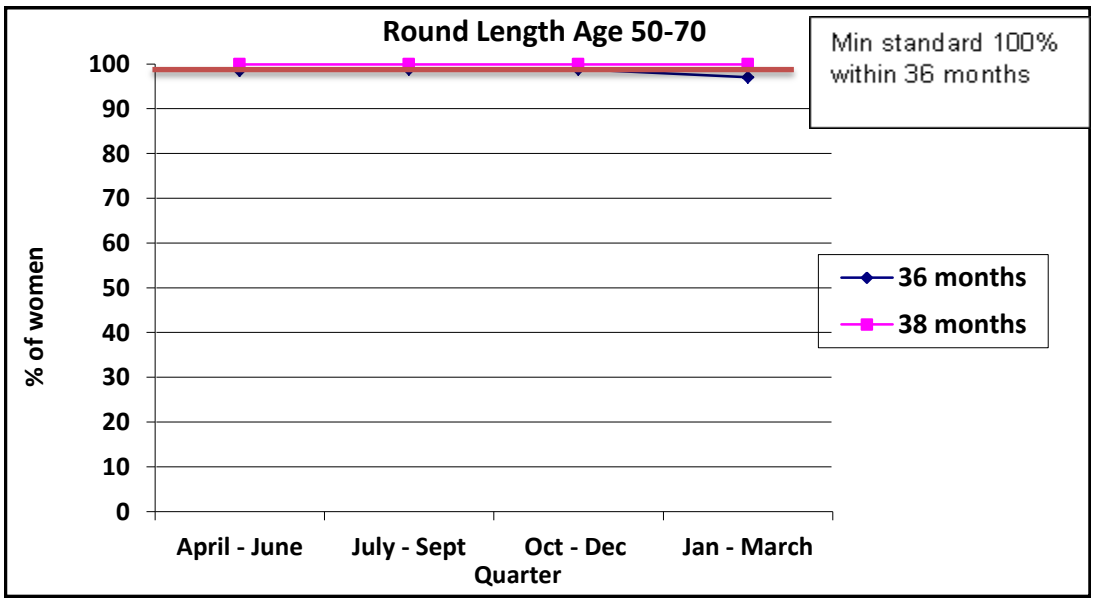


Figure 25: Screening round length by quarter for Northern Ireland, 2016/17

Figure 26 shows the round length for Northern Ireland over the period 2012/13 to 2016/17.

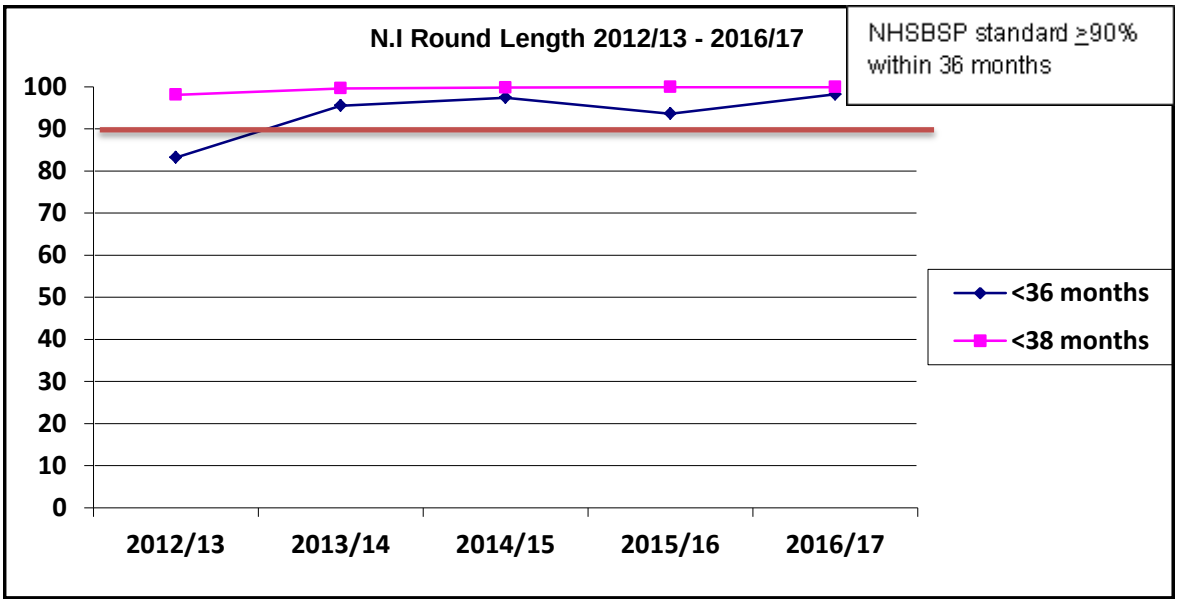


Figure 26 - Northern Ireland round length 2012/13 to 2016/17

Medical Physics: X-ray equipment performance standards

Each of the mammography x-ray machines meets the national standards for image quality and radiation dose.

The x-ray equipment base in the NI Breast Screening Programme has been fully digital since 2014. Digital equipment has a number of advantages over analogue units, including better imaging of dense breasts in younger women and a lower radiation dose for all women.

Image quality standards are high in mammography due to the need to detect very small, low contrast cancers. The performance of the x-ray equipment is assured through a rigorous QA programme. This includes testing carried out on a daily, weekly and monthly basis by the centre radiographers and on a six monthly basis by scientific staff from the NI Regional Medical Physics Service.

Equipment performance standards for mammography equipment are specified by the NHSBSP (BSP Standards 5 and 6) and cover;

- Image quality via detectability of low contrast large and small-sized details;
- Radiation dose via Mean Glandular Dose to the standard breast.

All the x-ray equipment in the NI BSP meets the national standards.

The equipment used for further assessment exposures includes Digital Breast Tomosynthesis – an advanced x-ray imaging technology which provides three-dimensional imaging of the breast. This functionality is also tested following the regime described above. National standards do not currently exist for this technology; however, the equipment used in the NI BSP meets the current suggested levels for image quality and radiation dose.

Ultrasound imaging equipment used in the Breast Screening Programme also undergoes performance testing meeting the requirements of NHSBSP Publication 70 ‘Guidance Notes for the Acquisition and Testing of Ultrasound Scanners for use in the NHS Breast Screening Programme’. This includes testing carried out on a weekly and monthly basis by the centre radiographers, and on a six monthly basis Medical Physics staff.

Specialist scientific advice relating to imaging equipment performance is provided by the NI Regional Medical Physics Service.

4 - The Northern Ireland Higher Risk Breast Surveillance Screening Programme

The Higher Risk Breast Surveillance Screening Programme commenced in April 2013. This programme offers breast surveillance screening to women who are at a significantly higher risk of breast cancer (defined as ×8 the normal risk and higher). **Appendix 3** gives an overview of the guidelines for inclusion in this programme.

This regional service is provided at a specialist imaging unit in Antrim Area Hospital in the Northern HSC Trust. Women in the programme may be offered annual mammography, MRI or both, depending on their age and the reason for referral.

The Higher Risk Breast Surveillance Screening Programme is subject to Quality Assurance (QA) procedures. The programme is included in the QA Visits to the Northern HSC Trust Breast Screening Unit and in internal QA undertaken by the Northern HSC Trust.

The QA Lead for Breast Screening chairs a six monthly meeting of the Coordinating Group for the Surveillance Screening Programme for Women at Higher Risk of Breast Cancer. This group includes representation from all HSC Trusts and from all disciplines involved in the delivery of the Higher Risk Breast Surveillance Screening Programme. In addition, a representative from BRCA Link NI was involved in establishing the surveillance screening programme and now sits on the Co-ordinating Group. Table 5 shows summary statistics for the Higher Risk Breast Surveillance Screening Programme. Recall rate (8.6%) met the minimum standard (<10%)[16].

Table 5: Statistics for Higher Risk Surveillance Screening Programme, 2016/17

Number of women invited	479
Number of women screened	372
Uptake[17]	77.7%
Cancer detection rate	21.5%
Recall rate	8.6%

[16] Technical guidance for MRI for the surveillance of Women at Higher Risk of Developing Breast Cancer. NHSBSP 68, March 2012.
[17] Uptake based on denominator of all women invited in-year and the numerator is all women who attended in-year including those screened out of area.

5 - Promoting Informed Choice

While the overall uptake of breast screening in Northern Ireland is high, there are areas and subpopulations of women with much lower uptake. This can be due to organisational and community issues in addition to individual factors, including personal choice.

The PHA, in partnership with other stakeholders, continued to work in 2016/17 to ensure that all eligible women can make an informed choice about attending for breast screening and that the service is as accessible as possible.

Key actions in 2016/17 included:

- **Regional Group on Promoting Informed Choice in Breast Screening.** This group is chaired by the PHA and has representation from Breast Screening Unit and Trust Health Promotion team members. The remit is to identify opportunities to promote informed choice in the Northern Ireland Breast Screening Programme, with a particular focus on women from disadvantaged communities, women who have learning/physical/sensory disabilities, women from minority ethnic groups, older women and other women considered to have special needs); to identify and share good practice; and to advise on the provision of information to the public and health care professionals.

- **Inclusion of Promoting Informed Choice meetings in the QA Visits to Breast Screening Units.** Since May 2014, the PHA has included standalone meetings related to Promoting Informed Choice in Breast Screening in its 3-yearly QA Visits to Breast Screening Units. A dedicated chapter on promoting informed choice is included in each QA visit report.

- **Working with the Women's Resource and Development Agency (WRDA).** In 2015, the PHA commissioned the WRDA, a local not-for-profit organisation, to raise awareness of the Breast, Cervical and Bowel Cancer screening programmes and promote informed choice among individuals from communities and populations who historically have a low uptake of cancer screening compared with the rest of the population. The aim of the WRDA's programme of work is to provide enough information to enable individuals to

make an informed decision about participating in cancer screening programmes. In 2016/17, WRDA:

  - Delivered 162 Educational Awareness Sessions on the Breast, Cervical and Bowel Cancer screening programmes to targeted service user groups throughout Northern Ireland.
  - Recruited and trained 30 peer facilitators to deliver the Educational Awareness Sessions in communities throughout Northern Ireland.
  - Attended 19 Health Awareness Events to provide information on cancer screening.

- Working with HSC Trusts to ensure that comprehensive, up to date, screening information is available on their **Trust websites**.

- **Analysis of breast screening uptake by deprivation.** In 2016, the PHA Health Intelligence Team produced a paper on behalf of the Northern Ireland Breast Screening Programme, analysing the uptake of breast screening in Northern Ireland by the deprivation quintile of the super output area in which the women live. Within individual Trusts, the super output areas with the lowest uptake of screening were identified. The paper was shared with each Breast Screening Unit and with members of the Quality Assurance Subcommittees which advise on delivery of the Breast Screening Programme in Northern Ireland. Units will use the paper to identify areas in which to focus efforts at promoting informed choice in breast screening.

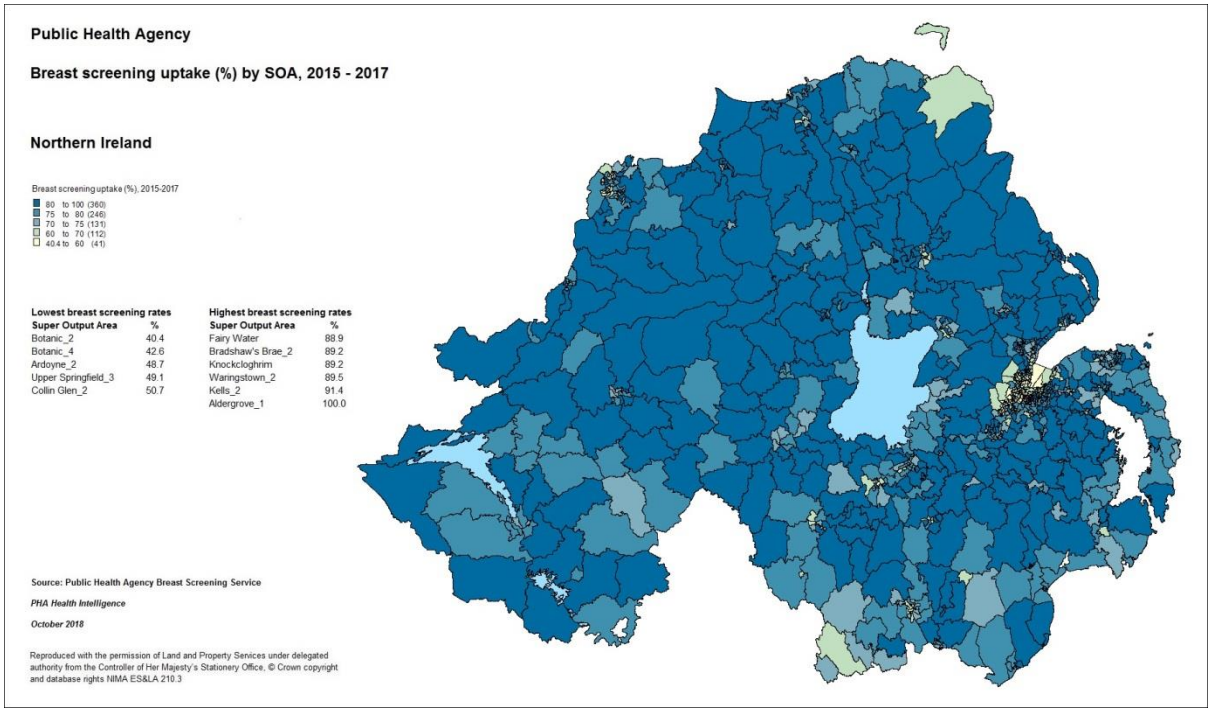


Figure 27: Breast screening uptake (%) by SOA - 2015 -2017

6 - Governance and Accountability

Quality Assurance Programme

The core purpose of the quality assurance programme for Breast Screening is to monitor, maintain and improve upon minimum standards of service, performance and quality across all elements of the breast screening programme.

The details of the aims and structures for this have been included in a QA structures document and agreed by the QA Committee.

The Governance and Accountability structure is as described in the following diagram.

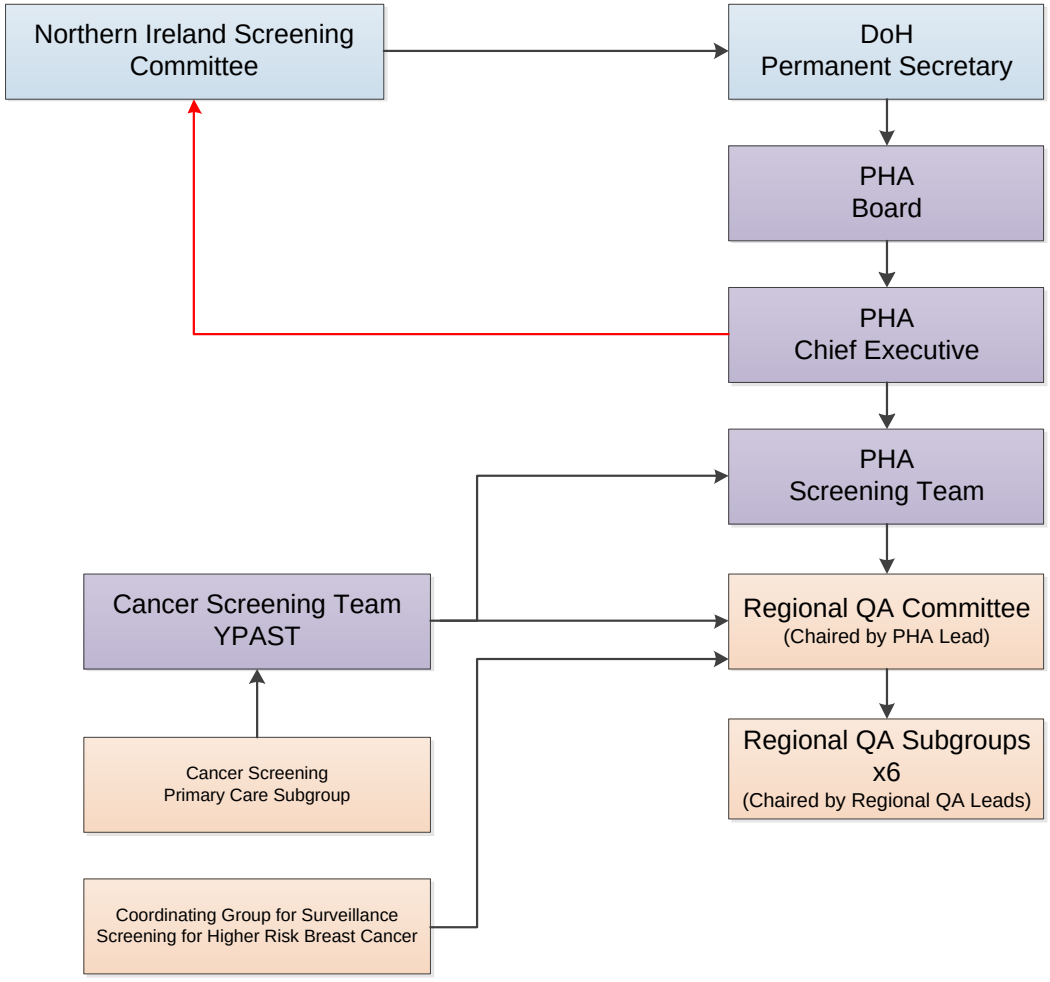


Figure 27 – Governance and accountability structure

7 - Appendices

APPENDIX 1 – Consolidated Guidance on Standards for the NHS Breast Screening Programme 50-70 (In place until July 2017)

Summary of KC62 source tables and age groups to be used in the calculation of standards (50-70)

Objective	Criteria	Calculation	Minimum Standard	Target
1. To maximise the number of eligible women who attend for screening	The percentage of eligible women who attend for screening	Tables: A, B, C1, C2 Age: 50-70	≥70% of invited women to attend for screening	80%
2. To maximise the number of cancers detected	(a) The rate of invasive cancers detected in eligible women invited and screened	Table: A Age: 50-52	Prevalent Screen ≥3.6 per 1,000	Prevalent Screen ≥5.1 per 1,000
		Table: C1 Age: 53-70	Incident screen ≥4.1 per 1,000	Incident screen ≥5.7 per 1,000
	(b) The rate of cancers detected which are in situ carcinoma	Table: A Age: 50-52	Prevalent screen ≥0.5 per 1,000	
		Table: C1 Age: 53-70	Incident screen ≥0.6 per 1,000	
	(c) SDR	Tables: A and B Age: 50-70	Prevalent screen ≥1.0	Prevalent screen ≥1.4
		Table: C1 Age: 50-70	Incident screen ≥1.0	Incident screen ≥1.4
		Tables: A, B, C1 Age: 50-70	Overall ≥1.0	Overall ≥1.4
3. To maximise the number of small invasive cancers detected	The rate of invasive cancers less than 15 mm in diameter detected in eligible women invited and screened	Table: A Age: 50-52	Prevalent screen ≥2.0 per 1,000	Prevalent screen ≥2.8 per 1,000
		Table: C1 Age: 53-70	Incident screen ≥2.3 per 1,000	Incident screen ≥3.1 per 1,000
7. To minimise the number of women screened who are referred for further tests	(a) The percentage of women who are referred for assessment	Table: A Age: 50-52	Prevalent screen <10%	Prevalent screen <7%
		Table: C1 Age: 53-70	Incident screen <7%	Incident screen <5%
	(b) The percentage of women screened who are placed on short-term recall	Table: T Age: 50-70	<0.25%	<0.12%
8. To ensure that the majority of cancers, both palpable and impalpable, receive a nonoperative tissue diagnosis of cancer	The percentage of women who have a non-operative diagnosis of cancer by cytology or needle histology after a maximum of two visits	Table: T Age: 50-70	≥85%	≥90%
9. To minimise the number of unnecessary operative procedures	The rate of benign biopsies	Table: A Age: 50-52	Prevalent screen <1.5 per 1,000	Prevalent screen <1.0 per 1,000
		Table: C1 Age: 53-70	Incident screen <1.0 per 1,000	Incident screen <0.75 per 1,000

APPENDIX 2 - KC62 Data 2016/17 for women aged 50-70

Northern Ireland Breast Screening Service

KC62 Data 2016/17

Activity Data		Invited	Screened	Assessed	Early Recall	Benign	Total Cancers	DCIS	Inv. Ca	Inv. Ca < 15mm
All Ages	Prevalent (A&B)	23502	12540	1152	13	13	90	20	70	37
	Incident (C1&C2)	60599	52143	1517	17	26	346	64	280	159
	Early recalls	27	27	25	1	0	0	0	0	0
	Self/GP referrals	0	2411	111	1	1	30	7	23	12
	Total	**84128**	**67121**	**2805**	**32**	**40**	**466**	**91**	**373**	**208**
50-70	Prevalent (A:50-52 only)	11674	8671	806	11	10	63	14	49	25
	Incident (C1:53-70 only)	52832	47579	1325	16	19	299	55	242	139
	Early recalls	26	26	24	1	0	0	0	0	0
	Self/GP referrals	0	847	48	1	0	11	2	9	4
	Total	**64532**	**57123**	**2203**	**29**	**29**	**373**	**71**	**300**	**168**

Performance against National Standards					National Standards	
Routine Screen Women aged 50 - 70		**2014/15**	**2015/16**	**2016/17**	**Minimum**	**Target**
Uptake %	Prevalent (A)	73.7	74.7	74.3	≥70%	80%
	Incident (C1)	89.9	89.7	90.1		
	Overall (A-C2)	75.3	76.1	77.1		
Technical recall/repeats%	Overall	1.8	2.3	2.2	<3%	<2%
Recall to Assessment %	Prevalent	8.3	7.9	9.3	<10%	<7%
	Incident	2.5	2.6	2.8	<7%	<5%
Early Recall %	Overall	0.04	0.05	0.05	<0.25%	≤0.12%
Benign open biopsy rate per 1000 women	Prevalent	1.8	1.3	1.2	<1.5	<1.0
	Incident	0.2	0.4	0.4	<1.0	<0.75
DCIS per 1000 women screened	Prevalent	1.4	2.0	1.6	≥0.5	NA
	Incident	0.7	1.2	1.2	≥0.6	NA
Invasive cancers per 1000 women screened	Prevalent	4.7	5.4	5.7	≥3.6	≥5.1
	Incident	5.4	6.4	5.1	≥4.1	≥5.7
Invasive cancers <15mm per 1000 women screened	Prevalent	2.1	3.1	2.9	≥2.0	≥2.8
	Incident	3.1	3.2	2.9	≥2.3	≥3.1
Non-operative diagnosis of invasive cancer by needle histology after a maximum of two attempts	Overall	99.7	99.3	99.4	≥90%	≥95%
Non-operative diagnosis of non-invasive cancer by needle histology after a maximum of two attempts	Overall	86.3	87.2	91.7	≥85%	≥90%
Standardised Detection Ratios Invasive cancers (annual - all sizes)	Prevalent	1.2	1.4	1.4	≥1.00	≥1.4
	Incident	1.3	1.5	1.2		
	Overall	1.3	1.5	1.3		
Standardised Detection Ratios Invasive cancers < 15mm (3 yr average)	Overall	1.1	1.2	1.2	≥1.0	≥1.4
Rolling three year Standardised Detection Ratios Invasive cancers (all sizes)	Prevalent	1.2	1.3	1.4	≥1.0	≥1.4
	Incident	1.3	1.4	1.4		
	Overall	1.3	1.3	1.4		
Round Length ≤ 36 months	Overall	97.4	93.6	98.2	≥100% first offered appts within 36 months	100%
≤ 38 months	Overall	99.8	99.9	99.9		
Screening to Results - (Date of screen)	Overall	97.4	96.8	98.8	≥90% within 2 weeks	100%
Screening to Assessment (Offered)	Overall	94.4	94.3	85.9	≥100% within 3 weeks	100%
Screening to Assessment (Attended appointment)	Overall	86.2	87.2	78.8	≥90% within 3 weeks	100%

Belfast Health & Social Care Trust Breast Screening Service

KC62 Data 2016/17

Activity Data		Invited	Screened	Assessed	Early Recall	Benign	Total Cancers	DCIS	Inv. Ca	Inv. Ca < 15mm
All Ages	Prevalent (A&B)	10100	5045	583	10	6	34	11	23	12
	Incident (C1&C2)	23912	20549	556	7	4	140	24	115	66
	Early recalls	11	11	11	0	0	0	0	0	0
	Self/GP referrals	0	998	48	0	0	14	3	11	4
	Total	**34023**	**26603**	**1198**	**17**	**10**	**188**	**38**	**149**	**82**
50-70	Prevalent (A:50-52 only)	4901	3506	405	8	3	25	8	17	9
	Incident (C1:53-70 only)	20773	18759	475	7	3	115	18	96	55
	Early recalls	11	11	11	0	0	0	0	0	0
	Self/GP referrals	0	338	21	0	0	5	1	4	1
	Total	**25685**	**22614**	**912**	**15**	**6**	**145**	**27**	**117**	**65**

Performance against National Standards					National Standards	
Routine Screen Women aged 50 - 70		**2014/15**	**2015/16**	**2016/17**	**Minimum**	**Target**
Uptake %	Prevalent (A)	69.2	71.9	71.5	≥70%	80%
	Incident (C1)	90.0	89.7	90.3		
	Overall (A-C2)	72.3	73.3	75.4		
Technical recall/repeats%	Overall	2.1	2.3	2.5	<3%	<2%
Recall to Assessment %	Prevalent	10.9	9.9	11.6	<10%	<7%
	Incident	2.4	2.5	2.5	<7%	<5%
Early Recall %	Overall	0.06	0.05	0.06	<0.25%	≤0.12%
Benign open biopsy rate per 1000 women	Prevalent	3.5	2.5	0.9	<1.5	<1.0
	Incident	0.2	0.2	0.2	<1.0	<0.75
DCIS per 1000 women screened	Prevalent	1.4	2.2	2.3	≥0.5	NA
	Incident	0.8	1.6	1.0	≥0.6	NA
Invasive cancers per 1000 women screened	Prevalent	4.2	6.2	4.8	≥3.6	≥5.1
	Incident	5.9	6.8	5.1	≥4.1	≥5.7
Invasive cancers <15mm per 1000 women screened	Prevalent	1.7	3.1	2.6	≥2.0	≥2.8
	Incident	3.2	3.4	2.9	≥2.3	≥3.1
Non-operative diagnosis of invasive cancer by needle histology after a maximum of two attempts	Overall	100.0	99.4	99.3	≥90%	≥95%
Non-operative diagnosis of non-invasive cancer by needle histology after a maximum of two attempts	Overall	90.5	88.6	91.4	≥85%	≥90%
Standardised Detection Ratios Invasive cancers (annual - all sizes)	Prevalent	1.3	1.7	1.1	≥1.00	≥1.4
	Incident	1.4	1.7	1.2		
	Overall	1.4	1.7	1.2		
Standardised Detection Ratios Invasive cancers < 15mm (3 yr average)	Overall	1.3	1.3	1.3	≥1.0	≥1.4
Rolling three year Standardised Detection Ratios Invasive cancers (all sizes)	Prevalent	1.2	1.4	1.3	≥1.0	≥1.4
	Incident	1.4	1.5	1.4		
	Overall	1.4	1.5	1.4		
Round Length ≤ 36 months	Overall	99.0	98.6	97.2	≥100% first offered appts within 36 months	100%
≤ 38 months	Overall	99.8	99.9	99.9		
Screening to Results - (Date of screen)	Overall	99.0	99.6	99.3	≥90% within 2 weeks	100%
Screening to Assessment (DoFOA)	Overall	93.3	96.7	87.7	≥100% within 3 weeks	100%
Screening to Assessment (Attended appointment)	Overall	87.2	90.3	79.2	≥90% within 3 weeks	100%

Northern Health & Social Care Trust Breast Screening Service

KC62 Data 2016/17

Activity Data		Invited	Screened	Assessed	Early Recall	Benign	Total Cancers	DCIS	Inv. Ca	Inv. Ca < 15mm
All Ages	Prevalent (A&B)	4857	2911	287	1	6	18	4	14	8
	Incident (C1&C2)	14243	12443	422	6	10	87	20	66	34
	Early recalls	6	6	4	0	0	0	0	0	0
	Self/GP referrals	0	529	23	1	1	2	1	1	0
	Total	**19106**	**15889**	**736**	**8**	**17**	**107**	**25**	**81**	**42**
50-70	Prevalent (A:50-52 only)	2599	2070	215	1	6	14	3	11	6
	Incident (C1:53-70 only)	12584	11424	375	6	6	77	19	57	30
	Early recalls	6	6	4	0	0	0	0	0	0
	Self/GP referrals	0	157	9	1	0	0	0	0	0
	Total	**15189**	**13657**	**603**	**8**	**12**	**91**	**22**	**68**	**36**

Performance against National Standards					National Standards	
Routine Screen Women aged 50 - 70		**2014/15**	**2015/16**	**2016/17**	**Minimum**	**Target**
Uptake %	Prevalent (A)	79.3	76.9	79.6	≥70%	80%
	Incident (C1)	92.0	90.3	90.8		
	Overall (A-C2)	80.2	79.5	80.6		
Technical recall/repeats%	Overall	1.2	2.5	2.2	<3%	<2%
Recall to Assessment %	Prevalent	9.8	9.7	10.4	<10%	<7%
	Incident	3.8	3.4	3.3	<7%	<5%
Early Recall %	Overall	0.02	0.04	0.05	<0.25%	≤0.12%
Benign open biopsy rate per 1000 women	Prevalent	0.0	1.6	2.9	<1.5	<1.0
	Incident	0.5	0.5	0.5	<1.0	<0.75
DCIS per 1000 women screened	Prevalent	0.6	0.5	1.4	≥0.5	NA
	Incident	0.7	1.2	1.7	≥0.6	NA
Invasive cancers per 1000 women screened	Prevalent	6.2	5.3	5.3	≥3.6	≥5.1
	Incident	5.8	7.2	5.0	≥4.1	≥5.7
Invasive cancers <15mm per 1000 women screened	Prevalent	3.7	2.1	2.9	≥2.0	≥2.8
	Incident	4.4	4.1	2.6	≥2.3	≥3.1
Non-operative diagnosis of invasive cancer by needle histology after a maximum of two attempts	Overall	100.0	100.0	98.7	≥90%	≥95%
Non-operative diagnosis of non-invasive cancer by needle histology after a maximum of two attempts	Overall	83.3	78.6	91.3	≥85%	≥90%
Standardised Detection Ratios Invasive cancers (annual - all sizes)	Prevalent	1.8	1.4	1.2	≥1.00	≥1.4
	Incident	1.5	1.7	1.2		
	Overall	1.5	1.6	1.2		
Standardised Detection Ratios Invasive cancers < 15mm (3 yr average)	Overall	1.6	1.7	1.5	≥1.0	≥1.4
Rolling three year Standardised Detection Ratios Invasive cancers (all sizes)	Prevalent	1.6	1.7	1.5	≥1.0	≥1.4
	Incident	1.3	1.4	1.4		
	Overall	1.4	1.5	1.4		
Round Length ≤ 36 months	Overall	97.6	95.9	98.8	≥100% first offered appts within 36 months	100%
≤ 38 months	Overall	99.9	99.6	99.9		
Screening to Results - (Date of screen)	Overall	98.7	99.5	99.3	≥90% within 2 weeks	100%
Screening to Assessment (DoFOA)	Overall	93.7	93.5	94.5	≥100% within 3 weeks	100%
Screening to Assessment (Attended appointment)	Overall	87.4	88.9	87.7	≥90% within 3 weeks	100%

Southern Health & Social Care Trust Breast Screening Service

KC62 Data 2016/17

Activity Data		Invited	Screened	Assessed	Early Recall	Benign	Total Cancers	DCIS	Inv. Ca	Inv. Ca < 15mm
All Ages	Prevalent (A&B)	4405	2362	182	0	0	16	1	15	8
	Incident (C1&C2)	11581	9887	366	0	5	59	7	52	29
	Early recalls	0	0	0	0	0	0	0	0	0
	Self/GP referrals	0	488	29	0	0	10	2	8	5
	Total	**15986**	**12737**	**577**	**0**	**5**	**85**	**10**	**75**	**42**
50-70	Prevalent (A:50-52 only)	2193	1630	122	0	0	10	0	10	4
	Incident (C1:53-70 only)	10124	9033	324	0	5	55	7	48	27
	Early recalls	0	0	0	0	0	0	0	0	0
	Self/GP referrals	0	186	13	0	0	4	1	3	1
	Total	**12317**	**10849**	**459**	**0**	**5**	**69**	**8**	**61**	**32**

Performance against National Standards					National Standards	
Routine Screen Women aged 50 - 70		**2014/15**	**2015/16**	**2016/17**	**Minimum**	**Target**
Uptake %	Prevalent (A)	74.2	75.3	74.3	≥70%	80%
	Incident (C1)	86.7	88.8	89.2		
	Overall (A-C2)	74.2	75.6	76.8		
Technical recall/repeats%	Overall	1.7	1.8	2.0	<3%	<2%
Recall to Assessment %	Prevalent	7.8	7.2	7.5	<10%	<7%
	Incident	2.5	3.2	3.6	<7%	<5%
Early Recall %	Overall	0.00	0.01	0.00	<0.25%	≤0.12%
Benign open biopsy rate per 1000 women	Prevalent	2.6	0.5	0.0	<1.5	<1.0
	Incident	0.3	0.8	0.6	<1.0	<0.75
DCIS per 1000 women screened	Prevalent	0.0	2.7	0.0	≥0.5	NA
	Incident	0.6	0.9	0.8	≥0.6	NA
Invasive cancers per 1000 women screened	Prevalent	7.2	5.3	6.1	≥3.6	≥5.1
	Incident	4.0	4.0	5.3	≥4.1	≥5.7
Invasive cancers <15mm per 1000 women screened	Prevalent	3.3	4.2	2.5	≥2.0	≥2.8
	Incident	2.2	2.1	3.0	≥2.3	≥3.1
Non-operative diagnosis of invasive cancer by needle histology after a maximum of two attempts	Overall	97.8	100.0	100.0	≥90%	≥95%
Non-operative diagnosis of non-invasive cancer by needle histology after a maximum of two attempts	Overall	83.3	81.3	88.9	≥85%	≥90%
Standardised Detection Ratios Invasive cancers (annual - all sizes)	Prevalent	1.3	1.1	1.7	≥1.00	≥1.4
	Incident	1.0	1.0	1.3		
	Overall	1.0	1.0	1.4		
Standardised Detection Ratios Invasive cancers < 15mm (3 yr average)	Overall	1.0	1.0	1.1	≥1.0	≥1.4
Rolling three year Standardised Detection Ratios Invasive cancers (all sizes)	Prevalent	1.2	1.2	1.4	≥1.0	≥1.4
	Incident	1.1	1.0	1.1		
	Overall	1.1	1.0	1.1		
Round Length ≤ 36 months	Overall	99.0	99.0	99.2	≥100% first offered appts within 36 months	100%
≤ 38 months	Overall	99.8	99.9	99.9		
Screening to Results - (Date of screen)	Overall	98.5	98.7	99.2	≥90% within 2 weeks	100%
Screening to Assessment (DoFOA)	Overall	94.9	90.6	73.1	≥100% within 3 weeks	100%
Screening to Assessment (Attended appointment)	Overall	85.5	81.7	59.7	≥90% within 3 weeks	100%

Western Health & Social Care Trust Breast Screening Service
KC62 Data 2016/17

Activity Data		Invited	Screened	Assessed	Early Recall	Benign	Total Cancers	DCIS	Inv. Ca	Inv. Ca < 15mm
All Ages	Prevalent (A&B)	4140	2222	100	2	1	22	4	18	9
	Incident (C1&C2)	10863	9264	173	4	7	60	13	47	30
	Early recalls	10	10	10	1	0	0	0	0	0
	Self/GP referrals	0	396	11	0	0	4	1	3	3
	Total	**15013**	**11892**	**294**	**7**	**8**	**86**	**18**	**68**	**42**
50-70	Prevalent (A:50-52 only)	1981	1465	64	2	1	14	3	11	6
	Incident (C1:53-70 only)	9351	8363	151	3	5	52	11	41	27
	Early recalls	9	9	9	1	0	0	0	0	0
	Self/GP referrals	0	166	5	0	0	2	0	2	2
	Total	**11341**	**10003**	**229**	**6**	**6**	**68**	**14**	**54**	**35**

Performance against National Standards					National Standards	
Routine Screen Women aged 50 - 70		**2014/15**	**2015/16**	**2016/17**	**Minimum**	**Target**
Uptake %	Prevalent (A)	76.2	77.0	74.0	≥70%	80%
	Incident (C1)	90.5	90.0	89.4		
	Overall (A-C2)	77.8	78.2	76.8		
Technical recall/repeats%	Overall	1.7	2.5	1.8	<3%	<2%
Recall to Assessment %	Prevalent	3.2	4.1	4.4	<10%	<7%
	Incident	1.7	1.7	1.8	<7%	<5%
Early Recall %	Overall	0.04	0.08	0.06	<0.25%	≤0.12%
Benign open biopsy rate per 1000 women	Prevalent	0.0	0.0	0.7	<1.5	<1.0
	Incident	0.1	0.1	0.6	<1.0	<0.75
DCIS per 1000 women screened	Prevalent	3.2	2.3	2.0	≥0.5	NA
	Incident	0.6	1.1	1.3	≥0.6	NA
Invasive cancers per 1000 women screened	Prevalent	2.1	4.2	7.5	≥3.6	≥5.1
	Incident	5.3	6.8	4.9	≥4.1	≥5.7
Invasive cancers <15mm per 1000 women screened	Prevalent	0.5	2.8	4.1	≥2.0	≥2.8
	Incident	2.8	3.3	3.2	≥2.3	≥3.1
Non-operative diagnosis of invasive cancer by needle histology after a maximum of two attempts	Overall	100.0	98.0	100.0	≥90%	≥95%
Non-operative diagnosis of non-invasive cancer by needle histology after a maximum of two attempts	Overall	83.3	95.0	94.1	≥85%	≥90%
Standardised Detection Ratios Invasive cancers (annual - all sizes)	Prevalent	0.5	1.4	2.2	≥1.00	≥1.4
	Incident	1.3	1.6	1.2		
	Overall	1.1	1.6	1.4		
Standardised Detection Ratios Invasive cancers < 15mm (3 yr average)	Overall	1.1	1.2	1.3	≥1.0	≥1.4
Rolling three year Standardised Detection Ratios Invasive cancers (all sizes)	Prevalent	0.9	1.0	1.3	≥1.0	≥1.4
	Incident	1.4	1.4	1.4		
	Overall	1.3	1.3	1.4		
Round Length ≤ 36 months	Overall	93.3	79.9	98.5	≥100% first offered appts within 36 months	100%
≤ 38 months	Overall	99.6	89.6	99.9		
Screening to Results - (Date of screen)	Overall	92.7	88.9	96.6	≥90% within 2 weeks	100%
Screening to Assessment (DoFOA)	Overall	91.3	94.3	99.3	≥100% within 3 weeks	100%
Screening to Assessment (Attended appointment)	Overall	81.1	83.4	92.6	≥90% within 3 weeks	100%

APPENDIX 3 – High Risk Surveillance Protocol for the NHSBSP

Ref	Risk	Age	Surveillance Protocol	Frequency	Notes
1	a) BRCA 1 or b) BRCA 2 carrier or c) Not tested, equivalent high risk	20-29 30-39 40-49 50+	not applicable MRI MRI + Mammography Mammography ± MRI	 Annual Annual Annual	 Review MRI annually on basis of background density
2	TP53 (Li-Fraumeni)	20-29 30-39 40-49 50+	MRI MRI MRI +Mammography Mammography± MRI	Annual Annual Annual Annual	 Review MRI annually on basis of background density
3a	Ataxia-Telangiectasia homozygotes	25+	MRI	Annual	No mammography
3b	Ataxia-Telangiectasia heterozygotes	40-50 50+	Mammography Mammography	18 monthly Routine screening (3 yearly)	Routine screening from 50
4	Supradiaphragmatic radiotherapy: irradiated below age 25 years	25-39 40-50 50+	MRI MRI +/- Mammography Mammography	Annual Annual Routine screening (3 yearly)	Surveillance commences at 25 or 8 years after first irradiation, whichever is the later

Policy for short term recalls:

5a	Repeat MRI < 6		If recall is within 6 weeks of the

	weeks		original assessment then it should be part of the same episode
5b	Repeat MRI > 6 weeks		If recall is after 6 weeks then should be logged as a short term recall episode. If recall then usually it would be at 6 months.

HSC Public Health Agency

item 11

Title of Meeting	PHA Board Meeting
Date	20 June 2019
Title of paper	MOU between the Department of Health, PHA and SBNI
Reference	PHA/05/06/19
Prepared by	Rosemary Taylor
Lead Director	Ed McClean
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to seek approval of the Memorandum of Understanding between the Department of Health, PHA and the Safeguarding Board for Northern Ireland.

2 Background Information

The Safeguarding Board for Northern Ireland (SBNI) was established in 2011 as an unincorporated statutory partnership. The PHA was identified as the corporate host for the SBNI, as set out in the Regulations made under the SBNI Act, and more fully in the Memorandum of Understanding (MOU) between the DoH, PHA and SBNI dated 11 September 2012.

3 Key Issues

Following a period of extensive engagement between the DoH, SBNI and PHA, the attached revised MOU has been agreed. Wording has been revised and updated throughout the MOU. The main changes in the document relate to:

- Greater clarity regarding the 'SBNI Central Support Team', as PHA staff;
- Line management of the most senior SBNI Central Support Team staff through a designated PHA officer (Director of Nursing);
- A new section on procurement added;
- SBNI to come under PHA SIRO and PDG arrangements for information governance, and PHA to co-ordinate FOI requests for SBNI;

- Complaints relating to the work of the SBNI to be dealt with through the normal PHA complaints procedure;

The MOU will be kept under review, especially in light of the review of the HSC structures.

4 Next Steps

Following approval the MOU will be signed by the PHA Chief Executive and returned to the Department of Health to be signed by the SBNI Chair and the Permanent Secretary. The final version will be incorporated into the PHA Management Statement and Financial Memorandum.

MEMORANDUM OF UNDERSTANDING

BETWEEN

THE DEPARTMENT OF HEALTH,

THE PUBLIC HEALTH AGENCY

AND

THE SAFEGUARDING BOARD FOR NORTHERN IRELAND

XX May 2019

CONTENTS

INTRODUCTION

1. The Safeguarding Board for Northern Ireland is a partnership of 27 members whose common purpose is to help safeguard and promote the welfare of children and young people in Northern Ireland and protect them as far as possible from all forms of neglect and abuse. The partnership is chaired by a person independent of the member agencies, and receives corporate support from the Regional Agency for Public Health and Social Well-being (PHA) to facilitate the operation of the partnership.

2. This Memorandum of Understanding (MoU) is a tri-lateral agreement between the Department of Health (the Department), the Regional Agency for Public Health and Social Well-being (hereafter referred to as the Public Health Agency (PHA)) and the Safeguarding Board for Northern Ireland (SBNI). This MoU replaces the MoU dated September 2012 between the Department, the PHA and the SBNI. It takes account of the findings and recommendations of the SBNI Review Report (the 'Jay Report'), accepted by the Minister of Health and published in August 2016. It also takes account of a subsequent review of the SBNI staffing and hosting arrangements completed in December 2016.

PURPOSE OF THIS MOU

3. This MoU specifies the roles, responsibilities and obligations of the Department and the PHA in relation to the SBNI. It also sets out how the SBNI will relate to the PHA and the Department in accountability terms. A full description of the statutory objective, functions and duties of the SBNI is set out in separate guidance[1] to the SBNI. They are summarised below.

4. As the corporate host, the PHA will either provide or secure the necessary corporate governance structures, accommodation, financial management, IT, HR and legal services, necessary to meet the staffing, accommodation and running

[1] SBNI Guidance is currently under review.

of the SBNI. The PHA will also employ the staff supporting the SBNI (The SBNI Central Support Team). This will enable the SBNI to effectively function within the resources made available to it by the Department and SBNI members.

5. The majority of the 'corporate host' services will be provided to the SBNI on the same basis as they are available to all PHA staff. However, where the SBNI requires services above and beyond those provided by the PHA's Service Level Agreement with the Business Services Organisation, the additional costs will be covered by the SBNI. In particular the SBNI will cover the costs for its Equality Unit support (because the SBNI is required to register with the Equality Commission), and its accommodation (including equipment, telephone rental and calls and other office running costs). The Chair of the SBNI and the SBNI Central Support Team will comply with PHA policies and procedures relating to corporate hosting services and functions.

6. This MoU does not affect existing statutory functions nor amend any other policies or agreements relating to the activities of the PHA or the SBNI. It is not a legally binding document; it is not a contract between partners, nor is it intended to cover every aspect of the relationship between the three parties. Each signatory agrees to work together within the framework outlined in this MoU.

The SBNI

7. The SBNI was established under the Safeguarding Board Act (NI) 2011 (SBNI Act) [2] as an unincorporated statutory partnership. It is sponsored by the Department. The SBNI is a multi-disciplinary interagency partnership, chaired independently from its members, and its statutory objective is to coordinate and ensure the effectiveness of what is done by each person or body represented on the SBNI (its members) for the purposes of safeguarding and promoting the welfare of children and young people in Northern Ireland. The statutory functions of the SBNI are:

[2] The SBNI Act is available at: http://www.legislation.gov.uk/nia/2011/7/contents

i. to develop policies and procedures for safeguarding and promoting the welfare of children in Northern Ireland;
ii. to promote an awareness of the need to safeguard and promote the welfare of children;
iii. to keep under review the effectiveness of what is done by members to safeguard and promote the welfare of children;
iv. to undertake case management reviews without discretion in such circumstances as may be prescribed;
v. to review such information as may be prescribed in relation to deaths of children in NI;
vi. to advise the Regional Health and Social Care Board and Local Commissioning Groups in relation to safeguarding and promoting the welfare of children:
    i. as soon as reasonably practicable after receipt of a request for advice; and
    ii. on such other occasions as the SBNI thinks appropriate.
vii. to promote communication between the SBNI and children and young people; and
viii. to make arrangements for consultation and discussion in relation to safeguarding and promoting the welfare of children.

The PHA

8. The PHA was established under section 12(1) of the Health and Social Care (Reform) Act (Northern Ireland) 2009 and is an Arm's Length Body (ALB) of the Department of Health. It delivers a range of health functions including:

    i. health and social wellbeing improvement;
    ii. health protection;
    iii. public health support to commissioning and policy development; and
    iv. HSC research and development.

    In addition, PHA is a member of the SBNI under section 1(3) of the SBNI Act.

9. In accordance with Regulations[3] made under the SBNI Act, the PHA is required to:

   i. Employ and appoint staff to support the operation of the SBNI;

   ii. Provide office and other accommodation to staff appointed to support the SBNI; and

   iii. Make arrangements for the upkeep of that accommodation.

PHA Corporate Host Functions

10. The PHA will act as corporate host to the SBNI. The staff it employs to support the SBNI (The SBNI Central Support Team) will have access to the full range of corporate services available to any employee of the PHA. Some of these services will be provided by the Health and Social Care Board or the Business Services Organisation under Service Level Agreement with the PHA. The SBNI Central Support Team is required to adhere to corporate policies and procedures of the PHA and their performance will be managed in accordance with the performance management arrangements of the PHA.

11. The PHA will provide the SBNI with the following:

- PHA staff who will act as the SBNI Central Support Team;
- accommodation and office facilities; and
- access to a range of corporate services: HR, training, finance, IT, legal, equality proofing and advice and support in connection with complaints handling and information management.

12. The PHA will assume line management responsibility for the most senior members of SBNI staff. It is a matter for the CEO of the PHA to decide where within the PHA line management responsibility will sit, and to nominate a PHA

[3] The Safeguarding Board for Northern Ireland (Membership, Procedure, Functions and Committee) Regulations (Northern Ireland) 2012 are available at: http://www.legislation.gov.uk/nisr/2012/324/contents/made

official with sufficient seniority to act as line manager to the most senior SBNI members of staff.

13. The nominated PHA official and the SBNI Chair must establish formal arrangements to:
    - agree the performance objectives of the most senior staff;
    - be kept informed of achievements against agreed objectives; and
    - with the support of corporate HR, address any performance issues arising relating to any member of SBNI staff.

14. The nominated PHA official will also act as the link between the SBNI Central Support Team and PHA Corporate Services. This will require the individual to keep corporate hosting arrangements under review and to work with the SBNI Chair to address any issues arising relating to corporate hosting. Any issues that cannot be resolved between the Chair and the nominated PHA official should be brought to the attention of the Chief Executive of the PHA. If necessary, the Chief Executive of the PHA will bring any unresolved issues to the attention of the Director of Family and Children's Policy in the Department.

15. The PHA is a member agency of the SBNI and, in that role, must fulfil the duties ascribed to all member agencies, including the specific duty to cooperate under section 10 of the SBNI Act. The PHA must also play its role in the exercise of the SBNI's statutory functions and the delivery of its statutory objective. However, the PHA is not accountable for the overall performance of the SBNI in terms of its statutory objective, functions and duties.

16. While the financial allocation to support the operation of the SBNI is made to the PHA by the Department of Health, decisions relating to the use of the allocation in support of strategic and annual business plan objectives are a matter for the SBNI under the guidance and leadership of the Chair of the SBNI. However, the PHA will ensure that all expenditure mandated by the SBNI fully complies with financial legislation, policy and procedures. In addition, if the PHA is of the view that additional resources are required to effectively provide corporate support to

the SBNI, this should be brought to the attention of the Department through the PHA sponsor branch.

The Department

17. On behalf of the Northern Ireland Executive, the Department sponsors and will provide funding to support the operation of the SBNI on an annual basis. Funding allocations will be made through the PHA. Expectations in connection with the funding allocation to the SBNI through the PHA are set out below (see Financial Management). On behalf of the Executive, the Department will continue to set the policy and legislative frameworks within which the SBNI operates and provide guidance as necessary. It will hold the SBNI to account for the exercise of its statutory objective, functions and duties through the Chair of the SBNI. It will hold the PHA to account for its corporate hosting role through the PHA Chief Executive. See Assurance and Accountability Arrangements below.

ASSURANCE AND ACCOUNTABILITY ARRANGEMENTS

PHA Corporate Host Responsibilities

18. The relationship between the PHA and the Department, and the framework within which the PHA operates as an ALB of the Department is specified in the Management Statement and Financial Memorandum (MSFM)[4] in place between these bodies. The MSFM makes reference to the PHA's corporate hosting responsibilities to the SBNI, acknowledging that the PHA is accountable to the Department for the discharge of its corporate host obligations to the SBNI. However, the PHA is not accountable for how the SBNI discharges its statutory objective, functions and duties.

19. As an unincorporated statutory partnership, the SBNI will not have a separate MSFM. A copy of this MoU will be appended to the MSFM of the PHA and these

[4] MSFM for PHA was reviewed and signed off in October 2018 (HE1/18/227679)

arrangements should be reflected in any future update to the Department's Framework Document[5].

20. The Chair of the SBNI and the PHA nominated official may be asked by the Department to attend a relevant section of the PHA/Department Accounting Officer-led assurance and accountability meetings if there are particular SBNI corporate host issues which require discussion. The CEO of the PHA will be advised in advance of the attendance of the Chair of the SBNI.

21. If requested, the SBNI Chair and/or the PHA nominated official will attend meetings of the PHA Governance and Audit Committee in relation to matters of relevance to the Committee arising from corporate hosting responsibilities/functions.

SBNI Statutory Objective, Functions and Duties

22. The SBNI, through the Chair, will account directly to the Department for the exercise of its statutory objective, functions and duties. In accordance with guidance issued by the Department, the SBNI will develop a Strategic Plan and Annual Business Plans and in accordance with section 6 of the Safeguarding Board Act (Northern Ireland) 2011 will produce an annual report. See Performance against Objectives below.

23. Every 4 years, the SBNI, through the Chair, will submit to the Department a draft strategic plan covering the planned priorities, strategic aims and objectives for the next 4 years. It will set out how the SBNI will deliver on its statutory objective, functions and statutory duties. The plan will be subject to Departmental approval and will be supported by annual Business Plans.

24. In January each year, the SBNI, through the Chair, will provide the Department with a draft Business Plan for the year ahead (April to March). It will include key

[5] https://www.health-ni.gov.uk/publications/dhssps-framework-document-september-2011

actions, supported by measures of success/expected outcomes, to be undertaken in the year ahead and will include financial information.

25. By August each year, the SBNI, through the Chair, will provide the Department with a draft annual report for the previous year.

26. The PHA, as corporate host for the SBNI, has no responsibility for the development of the SBNI Strategic and Business Plans, their review or approval. However as a core member of the SBNI, the PHA will contribute fully to the development of the SBNI's Strategic and Business Plans.

27. The Chair of the SBNI will formally meet with the Department's Director of Family and Children's Policy twice each year. The PHA nominated official may be asked to attend if there are particular SBNI corporate host issues which require discussion. In February, the agenda will include the discussion and agreement of the SBNI's Business Plan for the year ahead. In August, the agenda will include discussion and acceptance of the annual report. The attendance by others at the meeting will be agreed by the Chair of the SBNI and the Department's Director. These meetings will be minuted by the Department.

Performance Against Objectives

28. As indicated in paragraph 23, the SBNI is required to submit to the Department a draft 4-year Strategic Plan. The plan will reflect the SBNI priorities, strategic aims and objectives. It will set out how the SBNI will deliver on its statutory objective, functions and statutory duties. The plan will be subject to Departmental approval and will be supported by an annual Business Plan.

Declaration of Assurance to the PHA

29. The Chair of the SBNI must provide a declaration of assurance to the PHA, confirming (or otherwise) that:
    - The SBNI Central Support Team has adhered to all relevant PHA policies and procedures;

- The resources allocated to the SBNI by the Department have been deployed in full to further the objectives/priorities of the SBNI identified in its Strategic Plan and supporting Business Plans;
- Any unused resources have been flagged to the PHA within a reasonable timescale.

30. The declaration of assurance will inform the PHA mid-year and year-end Assurance Statement and Governance Statement to the Department. In circumstances where the Chair cannot provide an assurance to the PHA in connection with any of the above, an explanation must be provided in the declaration.

FINANCIAL MANAGEMENT

31. As an unincorporated statutory partnership, the SBNI is unable to hold its own funds. It receives funds from the Department via the PHA and may receive funding from other sources. Any financial allocation from sources other than the Department must be declared to the PHA and must be held by the PHA.

32. The PHA will receive an annual financial allocation from the Department to enable the SBNI to meet its statutory objective, functions and duties. This funding will provide for both running costs including the staff, accommodation and services provided by the PHA and the programme activity agreed by the SBNI and included in its annual Business Plan.

33. Prior to the approval of the SBNI Business Plans, the Department will consult with the Chief Executive of the PHA to confirm that in his/her role as Accounting Officer there are no financial issues that may impact on either the content or delivery of the SBNI plans. Where plans are subject to change after approval, the Department will further consult the Chief Executive of the PHA if this is deemed necessary.

34. The PHA will not use funds allocated for the SBNI for any other purpose. Any request for additional resources in respect of the SBNI must be referred to the Department. The PHA Accounting Officer will be advised of all requests and approvals of additional resources and expenditure, as he/she will be held accountable for this expenditure.

35. Details of the SBNI's financial allocations and expenditure will be included within the PHA Annual Accounts. The PHA must be satisfied that the level of detail fully accounts for all SBNI financial allocations.

36. The Chair of the SBNI and the SBNI Central Support Team will comply with PHA Standing Financial Instructions (SFI) and all other financial policies and procedures of the PHA.

37. Responsibility for the proper management of financial allocations to the SBNI, from all sources, falls to the Chief Executive of the PHA as Accounting Officer.

PROCUREMENT

38. The SBNI will comply with HSC procurement regulations and processes as set out in the PHA Standing Orders and SFI and other relevant policies and procedures. Goods and Services will be procured by the SBNI Central Support Team in line with the normal HSC policies and procedures, as specified in PHA Standing Orders and SFI, or through BSO PALS where this is required.

39. SBNI will work with PHA in respect of any social care procurements it is undertaking and these will be included on the PHA Social Care Procurement Plan. They will be taken forward by the SBNI Central Support Team with access to the full range of guidance and advice from BSO PALS Social Care Procurement Unit (over threshold) and PHA staff (under threshold).

GOVERNANCE

Risk Registers

40. The SBNI must maintain its own internal Risk Register. It must inform the Department of risks identified in relation to the exercise of its statutory objective, functions and duties or the delivery of its Strategic Plan and/or Business Plan. It must inform the PHA of risks identified that relate to corporate hosting arrangements. The PHA must determine if any such risks should be included in its Risk Register and/or identified to the Department.

Business Continuity Plan

41. The Chair of the SBNI will nominate a member of the SBNI Central Support Team to liaise with the PHA in connection with Business Continuity Planning arrangements to ensure the continued functioning of the SBNI in the event of disruption to normal business.

Internal Audit

42. The SBNI will be included within the PHA annual Internal Audit work plan in respect of those areas relating to the PHA corporate host functions. The SBNI will provide Management Responses to relevant draft audit findings or recommendations and will designate a senior member of the SBNI Central Support Team to undertake this function. Responses must be provided to Internal Audit within required timescales to enable it to finalise the report for submission to the PHA Governance and Audit Committee, in compliance with the standard Internal Audit reporting procedures of the HSC. Where it considers it necessary, the Department will establish separate audit arrangements for those areas for which the SBNI provides assurance directly to the Department.

Information Management

43. The remit of the PHA Personal Data Guardian (PDG) and Senior Information Risk Owner (SIRO) encompasses the SBNI in respect of records generated by or held by the SBNI Central Support Team in pursuance of SBNI business. The SBNI will designate a senior member of the SBNI Central Support Team as Information Asset Owner (IAO) who will be responsible for ensuring that information is managed appropriately and for providing assurances to the SBNI via the Chair and the PHA. The IAO will participate in the PHA's Information Governance Steering Group.

44. The SBNI Central Support Team will comply with all the PHA Information Governance policies and procedures. PHA will provide advice and guidance.

45. Freedom of Information (FOI) requests relating to the work of the SBNI will be dealt with in accordance with PHA FOI policies and procedures. On receipt of a relevant FOI request by the PHA Information Governance Team, it will be forwarded to the SBNI IAO, who will identify the relevant SBNI information handler. The response will be issued through the PHA, based on the SBNI information provided, PHA Information Governance advice and approval of the SBNI IAO.

Complaints Handling

46. Complaints relating to the work of the SBNI, will be dealt with through the normal PHA complaints procedure. SBNI staff will provide the necessary information and input to respond to the complaint. The PHA, and where appropriate, the Department, will provide advice and guidance.

47. The Chair of the SBNI will inform the Permanent Secretary of the Department of any complaints about the SBNI accepted by the NI Public Services Ombudsman for investigation and about the SBNI's proposed response to any subsequent recommendations from the Ombudsman.

48. The Chair of the SBNI will inform the PHA nominated official of any matters arising from complaints relating to any member of the SBNI Central Support Team.

Alerts

49. The Chair of the SBNI must alert:
    - the Department in a timely manner of any matter which he/she considers would adversely impact the delivery of the SBNI's statutory objective, functions, duties or reputation or the reputation of the Department;
    - the PHA in a timely manner of any matter which would adversely impact the functions or reputation of the PHA.

50. The PHA must alert:
    - the Chair of the SBNI and the Department in a timely manner of any matter which it considers would adversely impact the reputation of the SBNI.
    - the Department in a timely manner of any matter arising from its SBNI corporate host responsibilities/functions, which would adversely impact the delivery of PHA functions or reputation or the reputation of the Department.

LEGAL SERVICES

51. The Departmental Solicitor's Office will provide legal services for matters relating to the SBNI's statutory objective, functions and duties. The PHA will secure legal services from the BSO Directorate of Legal Services for those matters relevant to the PHA's corporate hosting responsibilities/functions.

ACCOMMODATION AND EQUIPMENT

52. The PHA will provide agreed office accommodation, and standard office equipment for specific use by the SBNI Central Support Team and Chair of the

SBNI. The costs of accommodation, (including equipment, telephone rental and calls, and other office running costs) will be covered by the SBNI management and administration budget. The SBNI may secure alternative accommodation, for example, as currently at the HSC Leadership premises, covering the total cost from the SBNI management and administration budget. In these instances the SBNI will comply with the normal approval mechanisms as set out by DoH Assets and Estate Management Branch.

HUMAN RESOURCES

53. With the exception of the Chair of the SBNI and Lay Members, who are publicly appointed by the Department, SBNI Central Support Team staff are employees of the PHA assigned specifically to support the SBNI. The creation of new posts within the SBNI Central Support Team will require the prior approval of the Department. The SBNI Central Support Team staff should not be utilised elsewhere in the PHA without formal agreement with the Department.

Management of SBNI Central Support Team Staff

54. The relationship between the PHA and the SBNI will be one of partnership and collaboration, ensuring appropriate working relationships and support for SBNI Central Support Team staff.

55. The SBNI Central Support Team staff, as employees of the PHA, will be subject to the same policies and procedures as other PHA staff, including leave and attendance, complaints, grievances, discipline and whistle blowing.

56. A line management structure must exist within the SBNI Central Support Team. The PHA nominated official must assure him/herself that the structure is sufficiently robust and bring any concerns about the structure to the attention of the Chair of the SBNI. Any unresolved concerns must be brought to the attention of the Department. The arrangements for approving staff leave requests as they relate to the most senior members of SBNI Central Support Team must be agreed by the Chair of the SBNI and the PHA nominated official. All other leave

requests will be handled in accordance with 'internal' SBNI line management arrangements.

57. The Chair of the SBNI will advise the PHA nominated official of any issues emerging in relation to SBNI Central Support Team staff and their adherence to PHA policies and procedures. Individual incidents/breaches of these policies and procedures will be managed in keeping with normal HSC good practice, PHA guidance and escalation arrangements.

Performance Appraisal

58. Annual appraisal of SBNI Central Support Team staff will be conducted against SBNI business and individual staff objectives and in line with the HSC Performance Appraisal processes operated by the PHA. Appraisal of the most senior staff of the SBNI Central Support Team will be conducted jointly by the Chair of the SBNI and the PHA nominated official. Line Managers of other Central Support Team staff will be responsible for performance appraisal/management with input from the SBNI Chair where relevant/necessary.

59. Appraisal of the performance of the SBNI Chair and Lay Members will be conducted in line with established Public Appointment arrangements.

Staff Training and Development

60. The PHA is responsible for induction training and for securing the provision of training and development of members of the SBNI Central Support Team in line with performance management agreements.

Recruitment of Staff

61. Through the BSO HR service, the PHA will secure the timely recruitment of staff to SBNI Central Support Team posts approved by the Department.

PRESENTATIONAL ISSUES

Communication and Liaison Arrangements

62. The PHA and the SBNI (through the Chair) will keep each other promptly and regularly informed about any work being undertaken or issues arising which may impact on the other, or in which the other has an interest. Both parties must keep the Department informed about any matter which is likely to be of interest to the Department or the Minister.

Media Handling and Support

63. It is anticipated that day to day media handling and planned communications outputs will be managed and delivered directly by the SBNI. Where additional support over and above day-to-day communication activities is required the SBNI, through the Chair, will consult the PHA to determine whether the PHA Communications Team can provide support and to agree the cost of that support where appropriate.

64. If the SBNI plans to conduct a media/social marketing campaign, this should be discussed and agreed with the Department, and PHA where appropriate, including how the cost of conducting the campaign will be met.

Web site

65. The SBNI Central Support Team is responsible for the ongoing maintenance of the SBNI website. The cost of maintaining and developing the SBNI website will be met from the SBNI's financial allocation.

OTHER MATTERS

Indemnity

66. The SBNI Chair and publicly appointed Lay Members will be indemnified by the Department while engaged in SBNI business, provided they have acted honestly and in good faith, and have not acted recklessly. This means that the Department will indemnify the Chair of the SBNI and publicly appointed lay members in relation to any legal costs and damages which may be awarded against them in connection with the conduct of SBNI business.

Conflicts of Interest

67. If any conflicts of interest should arise for the Chief Executive of the PHA in connection with his/her SBNI corporate hosting responsibilities/functions, the matter should be referred to the Department for resolution. Any conflicts of interest or perceived conflicts of interest, which arise for the Chair of the SBNI, must be notified to the Department immediately.

AGREEMENT AND REVIEW OF THE MEMORANDUM OF UNDERSTANDING

68. This MOU will be reviewed after one year of operation and then every three years. It will also be amended, if necessary, following any relevant changes to the policies, procedures and structures of the parties concerned. Any issues arising at any stage from the operation of the MoU, must be brought to the Department's attention by the SBNI or the PHA, as soon as practicable.

69. Agreement to this Memorandum of Understanding is given by signature of the following:

On behalf of the PHA

Ms Valerie Watts
(Interim) Chief Executive

On behalf of the SBNI

Ms Bernie McNally
SBNI Chair

On behalf of the Department of Health

Mr Richard Pengelly
Permanent Secretary

HSC Public Health Agency

item 12

Title of Meeting	PHA Board Meeting
Date	20 June 2019
Title of paper	PHA Rural Needs Act Annual Report 2018/19
Reference	PHA/06/06/19
Prepared by	Lynda Kernohan
Lead Director	Ed McClean
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to seek approval of the PHA's Rural Needs Act Annual Report for 2018/19.

2 Background Information

The Rural Needs Act (Northern Ireland) 2016 came into operation for public authorities including the PHA on 1 June 2018. Under the Act, the PHA is required to compile information on the exercise of its function under the Act and include this in its own Annual Report and in a Report submitted to the Department of Agriculture, Environment and Rural Affairs (DAERA).

3 Key Issues

During 2018/19, a total of four Rural Needs Assessments were carried out, details of which are contained in the Report.

4 Next Steps

Following approval by the Board, PHA will submit its Annual Monitoring Return to DAERA, in advance of the deadline of 14 September 2019.

The PHA will continue to ensure that the Rural Needs Act is taken into consideration as part of its work and a Report on progress in 2019/20 will be brought to the Board in June 2020.

The Rural Needs Act (Northern Ireland) 2016

The Rural Needs Act (Northern Ireland) 2016 came into operation for public authorities including the Public Health Agency (PHA) on 1 June 2018.

As a result the PHA developed and approved a Rural Needs Policy which:

- Assists staff to understand their statutory responsibilities under the Act, and provides guidance on undertaking a proportionate Rural Needs Impact Assessment as a mechanism for ensuring rural needs are appropriately taken into account.
- Sets out the steps to be taken and templates to be used when undertaking a Rural Needs Impact Assessment as well as the roles and responsibilities of those involved.
- Ensures that evidence of the consideration of the Act is produced along with the associated monitoring and reporting requirements.

To support the introduction of the new policy a number of awareness raising initiatives were undertaken, including:

- Face to Face and on-line training provided by DAERA;
- Features on the PHA intranet site, linking to the policy and templates;
- Article in PHA Staff e-zine;
- Emails to staff; and
- Protocols updated for the submission of Papers to the Agency Management Team.

As the Rural Needs Act continues to be embedded into the PHA's processes it is too early to fully understand how it has delivered better outcomes for rural dwellers. However the completion of the Rural Needs Impact Assessments has focused minds on the importance of the needs of rural dwellers, so that these are considered from an early stage in any project. In particular ensuring consultation with rural dwellers when planning services and consideration given to alternative service delivery methods where appropriate to meet their needs.

The PHA has carried out a number of Rural Needs Impact Assessments for the period 1 June 2018 – 31 March 2019. Details are included in the DAERA template, in appendix 1.

Appendix 1 – Rural Needs Annual Monitoring Return

Information to be compiled by Public Authorities under Section 3(1)(a) of the Rural Needs Act (NI) 2016.

(To be completed and included in public authorities' own annual report and submitted to DAERA for inclusion in the Rural Needs Annual Monitoring Report).

Name of Public Authority: Public Health Agency

Reporting Period: 1 June 2018 – 31 March 2019

The following information should be compiled in respect of each policy, strategy and plan which has been developed, adopted, implemented or revised and each public service which has been designed or delivered by the public authority during the reporting period.

Description of the activity undertaken by the public authority which is subject to section 1(1) of the Rural Needs Act (NI) 2016[1]	***The rural policy area(s) which the activity relates to[2].***	***Describe how the public authority has had due regard to rural needs when developing, adopting, implementing or revising the policy, strategy or plan or when designing or delivering the public service[3]***
Designing a Youth Engagement Service (YES) in Derry/Londonderry	Health & Social Care	Young people in rural areas were found to have difficulty in accessing transport that would enable them to avail of the Youth Engagement Services. This issue was addressed by the provision of outreach services within schools and community venues. Outreach work will also take place within the city however its focus will be on hard to reach young people.
Designing a Crisis De-escalation Service (to be piloted in the Belfast Health & Social Care Trust area)	N/A	The PHA has not identified the social and economic needs of people in rural areas as the service is being developed and piloted in the Belfast Health & Social Care Trust locality – which is classified as urban. The pilot will run until the end of March 2020 and if it proves successful may be rolled out to other areas within NI. If this is the case a further and more comprehensive rural needs assessment will be undertaken at that stage.

Designing a Regional Service User Support Service – for people who are in or have been through drug and alcohol treatment Services.	Cross Cutting	The service being commissioned will proactively engage with service users in rural areas to identify issues. Consideration will be given to accessibility of groups established, training and meetings, along with any other issues which are identified. The specification has been revised to include the following objectives: • Proactive engagement with service users who live in rural areas. • Identify any needs in relation to the project which are specific to rural service users, and work to address these. • Ensure rural service users are consulted on locations for regional meetings and training, with reasonable adjustments made to accommodate them. • Ensure all service users are supported to access training, meetings and other relevant events by refunding travel expenses, organizing car shares and providing transport where appropriate and reasonable.
Revising the service delivery model of the Northern Ireland Diabetic Eye Screening Programme (NIDESP)	Health and Social Care	The Key points currently being considered, in light of the responses received during the pre-consultation are; • Transport • Age • Health • Dependent Status • Availability of Services Whilst it is not possible to analyse the availability of potential fixed sites in rural areas, the majority of HSC health and wellbeing centres and community hospitals will be in larger settlement areas and are unlikely to be in rural areas and small settlements. A more detailed analysis of impact cannot be carried out until possible fixed sites/high street optometrist locations are scoped. It is recognised that accessibility of sites will need to be considered to ensure that travel to sites is minimised and that public transport links are optimised. However given that a model for service delivery has not yet been chosen, it is difficult to state the exact impact.

NOTES

1. This information should normally be contained in section 1B of the RNIA Template completed in respect of the activity.
2. This information should normally be contained in section 2D of the RNIA Template completed in respect of the activity.
3. The information contained in sections 3D, 4A & 5B of the RNIA Template should be considered when completing this section.

HSC Public Health Agency

item 13

Title of Meeting	PHA Board Meeting
Date	20 June 2019
Title of paper	Personal and Public Involvement Update
Reference	PHA/07/06/19
Prepared by	Jill Munce
Lead Director	Mary Hinds
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to provide the biannual update on PHA's Personal and Public Involvement work.

2 Background Information

To meet the PPI objectives within Outcomes 4 & 5 of the PHA Corporate Business Plan the PHA provides twice yearly updates to the Board on the progress of the PHA PPI Action Plan.

3 Key Issues

This report highlights the achievements that have been made in the last six month period. It focuses on the PPI Standards of Leadership, Governance, Opportunities and support for involvement, knowledge and skills and measuring outcomes.

4 Next Steps

The next biannual Report will be brought to the Board in December 2019.

Personal and Public Involvement (PPI)

PHA Board Update June 2019

Personal and Public Involvement – What is it?

PPI is the active and effective involvement of services users, carers and the public in health and social care services. Involvement can range from one-to-one clinical or social care interactions with service users and carers, in regard to their own health, through to more strategic engagements to assess needs, undertaking partnership working to co-design and co-produce services and influencing commissioning priorities and policy development. Under the HSC (Reform) Act (NI) 2009, PPI is a legislative requirement.

The rationale for PPI – Why do it?

People have a right to be involved in and consulted with on decisions that affect their health and social care. Meaningful Involvement helps to:

- effectively identify need;
- increase efficiency through tailoring services and agreeing priorities;
- improve quality, safety and patient experience;
- reduce complaints and SAIs;
- encourage self-responsibility for health and social well-being.

The PHA's role

In the 2012 PPI Policy Circular, the DHSSPS confirmed and assigned to the PHA, primary responsibility for the leadership of the implementation of this key policy area across the HSC system. It requires the PHA to provide the Department of Health with assurances that HSC bodies and in particular Trusts, meet their PPI Statutory and policy responsibilities. Additional responsibilities confirmed/assigned also included:

- ensuring consistency and co-ordination in approach to PPI;
- the identification and sharing of best PPI practice across HSC;
- communication and awareness raising about PPI;
- capacity building and training;
- development of the Engage website;
- monitoring of and reporting on PPI.

Standard 1. Leadership

Progressing PPI

The PPI Team continue to drive the integration of PPI into HSC culture and practice using the PPI standards as the basis for our work. We undertake this work through the:

- Regional HSC PPI Forum which the PHA co-chair with a service user/carer;
- PHA internal PPI Leads Group.

In the last six month period, work has been focused on a range of areas.

The Regional HSC PPI Forum

The Forum continues to implement the 2018-2020 PPI Action plan which is in line with the PPI Standards. Working through sub-groups, the Forum has progressed a number of areas of work to continue to embed service user and carer involvement at a strategic level across HSC. Working closely with the HSC Trusts, the Forum has been instrumental in supporting the role out of the transformation funding which includes exploring the concept of Citizen Hubs and also engaging Service User and Care Ambassador roles.

Transformation Funding

The PHA has continued to lead on the management of the administration of 'Involvement, Co-Production & Partnership Working' Transformation funding for DoH. PHA has worked closely with the DoH to ensure that the funding has been used to support ongoing enhancement of Involvement and Co-Production at a regional and Trust level. Investments have been made in the following areas.

- Regional Innovation and Infrastructure including commissioning of research into Monitoring Involvement and Co-Production Outcomes and Citizen Hub Research and funding for Involvement and Co-Production Projects.

- Regional Training and Capacity building by successfully implementation of Involvement and Co-Production training and development programmes.

- PHA staff recruitment of a Band 7 officer. This has enabled further work in key areas including remuneration for service users and carers and citizen hubs.

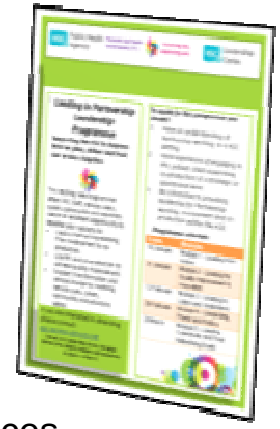
- Trust level Partnership Working Infrastructure to support the development of Involvement and Co-Production projects that would further the development of citizens hubs at a local level.

- Trust level staff recruitment of temporary Band officers.

- Development of infrastructure for Service User and Carer roles at local and regional levels. A job description has been developed and has been banded as a Band 5. Trusts continue to work with the PHA and PCC to develop a regional model for recruitment of service user and/or carer consultants.

In line with the DoH expectations, the PHA has established a monitoring process to measure the progress in each of these areas. 2019/20 'Partnership Working' funding will continue to build on the initial investments listed above.

Leading in Partnership – Leadership Programme for Involvement and Co-production



The PHA commissioned the Co-Production of the 'Leading in Partnership' leadership programme for HSC staff, service users, carers and members of the community and voluntary sector. The aim of this unique programme was to develop the necessary leadership skills to enable continuous and effective involvement of service users and carers across all levels of the HSC, whilst supporting the principles of Co-Production, Collective Leadership and Partnership Working. The first programme ran between January and March 2018 and was attended by 23 participants from across the health and social care system as well as a number of services users and carers. In 2019 the programme attracted a lot of interest and was substantially oversubscribed with 61 applications being received with 25 places allocated.

Following the success of the 2018 and 2019 programmes the DOH have funded the programme again in 2020. This was in part due to the excellent feedback for a pilot programme which indicated that it is substantially different from existing HSC leadership programmes for professional groups and management and added real value, knowledge and expertise in this critically important field.

The programme continues to:

- Develop strategic alliances across multi-disciplinary professions, service users, carers and the community & voluntary sector;
- Challenge individuals knowledge and experience of effective leadership;
- Frame effective Involvement and Co-Production leadership and professionalism in the context of current realities and challenging futures;
- Develop a relevant vision of personal leadership, positioning personal career and development plans with a wider strategic agenda;

- Develop shared inter-professional networks and build a learning community across health and social care.

The programme concluded on the 20 March 2019 with a Professional Networking Lunch and student presentations. The event was attended by 65 influential leaders from across HSC including the Permanent Secretary, Chief Nursing Officer (CNO), Deputy CNO, PHA Chair, Regional HSC PPI Forum Co-Chairs, service user and carer leaders and alumni of the programme.

Citizen Hubs

The PHA commissioned a piece of research into the concept and practice of Citizen Hubs. As part of the Transformation funding, the PHA enabled Trusts to support a number of initiatives to advance involvement, co-production and partnership working, one of which is to test, explore and develop the concept of citizen hubs.

During this period a supplier was commissioned to carry out the research and a panel / working group was established to help support the process.

The key objectives of the research were to:

1. Carry out a baseline study to identify existing partnership models.
2. Identify potential models or approaches to Citizen Hubs and how we might build / compliment on what already exists.
3. Specify the core components of what would constitute an effective Citizen's Hub.

4. Identify the pros and cons of a Citizen Hub model. Helping the HSC to understand how a Citizen Hub focussed approach would function most effectively.

A working group was established to support the process and a report has been submitted by the supplier. The report will be utilised to examine best practice models and provide recommendations for the best way forward.

Churchill Fellowship

Michelle Tennyson, Assistant Director AHPs, PPI and 10000 More Voices, completed a Churchill Fellowship. In this period, she visited Arizona and Philadelphia examining Relationship Care in order to support the delivery of her overall project – Changing the conversation with the public. Michelle has presented her early findings to a range of HSC organisations. In this period those included e.g. the Patient and Client Council, Northern Trust Locality Area Network, DOH MDT Steering Board, DOH IHRD Work stream 7 User Experience and Advocacy, Regional PPI Forum.

Michelle will write up her learning over the summer and a number of key recommendations for further enhancing the PPI approach will be developed.

Professional Advice and guidance

Strategic/Transformative

The PHA PPI team continues to provide this critical service to the wider HSC. In the last 6 months we have supported a further dozen project initiatives in terms of involvement/co-production and partnership working. The support provided varies in nature from project to project, but in the main it entails:

- The provision of professional involvement advice and guidance
- Helping to facilitate the development of an involvement plan
- Practical support in helping the project promoter to secure service user/carer participation

A few examples of this type of work are referenced below:

Involvement in Inquiry into Hyponatraemia Related Deaths (IHRD)

The PHA continued to proactively support the DoH in taking forward planning around the implementation of the recommendations from the Inquiry into Hyponatraemia Related Deaths. This is a very high profile and strategically significant programme of change and improvement for the wider HSC and it is clear the DoH have put a lot of emphasis on the need for it to be conducted in partnership with key stakeholders including our service users, carers and the wider public.

The PHA support has been achieved via the active participation of a number of colleagues on the various IHRD workstreams, but also through the partial secondment of two of our Involvement team staff to support the DoH.

The Regional Involvement Lead, Martin Quinn, and one of our senior PPI officers, Claire Fordyce, have been working with the DoH, acting as the Involvement Team for the Programme. Using their knowledge, expertise, experience and contact networks, they have:

- Supported the DoH to recruit a diverse range of service user/carer members to the Programme and provided ongoing support to facilitate their full and continued participation as partners.
- Led on the development and roll-out of an Involvement Plan for the IHRD Implementation Programme.
- Facilitated the development and roll-out of workstream specific involvement plans.
- Supported the development and ongoing roll-out of the Programme's Communication plan.
- Led on planning to support the involvement and participation of 3rd sector members.
- Contributed to the planning and delivery of the major stakeholder event held at the end of May 2019.
- Worked with the DoH and a range of partners to plan a series of engagement events, surveys, etc. during 2019 to progress further the outworking of the recommendations from the Inquiry across the workstream.
- The Implementation programme is further supported by the Executive Director of Nursing, Midwifery and Allied Health Professionals and the Assistant Director of Allied Health Professions, Personal and Public Involvement and Patient Experience who are members of workstream 7.

Encompass is a HSC wide initiative with many concepts. Key to this transformative programme is the development and delivery of an Electronic Health and Care record (EHCR) for our population. The PHA PPI team continue to work closely with the encompass team to embed Involvement and Co-Production into each of their work streams. The views of service users and carers were used to support the appointment of a provider following a regional procurement exercise in 2018.

The Unscheduled Care Reference Group for service users and carers continues to be supported by the team. As part of the transformation programme of work, a key focus for the group has been to engage with the Department of Health in the Review of Urgent and Emergency Care to ensure that the service user and carer voice is central in taking this work forward.

Review of Urgent and Emergency Care

The PHA PPI team are working closely with DoH to support their endeavour to ensure the inclusion of best practice. Involvement, Co-Production and Consultation methodology are applied to the upcoming pre and full consultation stages of the review. This is a continuation of advice and guidance which has been provided to the review team over during 2018/19.

Strategic Frailty Oversight Group - The main aim of the Group is to develop a regional approach to frailty using principles of collective leadership. Our PPI Officer will support the Group identify the role of service users and carers in the strategic direction of the HSC strategy with reference to partnership working and co design principles

Standard 2. Governance

Remuneration Framework for Service User and Carer Involvement in the HSC

In line with PPI Action Plan the PHA has been leading the programme of work to develop a recognition framework. This builds on the event on June 2018 to develop guiding principles for the establishment of a recognition framework.

A workshop took place in March 2019 to progress our thinking on matters relating to the reimbursement and remuneration of service user and carer involvement in Health and Social Care.

There was an opportunity to hear an update from Dr Jenny Sproule, PCC who had been carrying out research in this topic commissioned
by the PHA utilising Transformation funding. At the workshop we reviewed potential issues arising from this research and implications it may have for the remuneration model as set out in the co-production guide.

As part of this work we are developing guidance for people who get involved and are also on benefits. A frequent concern from those who have been participating in involvement work has been how this will affect their benefits. To address these concerns this will guide those who want to get involved to ensure their benefits are not affected.

The Leadership and Governance sub-group of the Regional Forum will continue to help drive and shape this programme of work.

Standard 3. Opportunities and Support for Involvement

PPI Communities of Practice

PHA has been providing a leading role in this Community of Practice from a PPI perspective. This community is a tri-sectoral collaboration of PPI staff, QI staff and service users and carers.

The Great Checklists were recently launched at the HSCQI Launch event at Titanic, Belfast. This event was also an opportunity to promote the new video training resource for HSC staff who are involved in involvement work (funded by the PHA through Transformation Funding).

PPI Communities of Practice presented a table at the Café Conversations in the NICON Conference 2019. This was a very successful event with lots of positive feedback on the Great checklists and the new video.

Bursary Scheme for Service Users and Carers

The PHA working with the Regional HSC PPI Forum service user and carer members, launched a bursary scheme to support service users and carers involved in strategic programmes of work in Health and Social Care (HSC). The bursary was designed to help develop service users and carers to advance their knowledge and skills to support their participation in HSC Involvement work.

The Scheme will now be reviewed in partnership with service users and carers to determine if this has been an effective mechanism to support individuals in their involvement journey in HSC and if there are opportunities to improve it should we wish to retain it moving forward.

Engage Website

The Engage website continues to support HSC staff, service users, carers and the general public, to build their knowledge and skills on involvement. Over 2000 new users have visited the website in the last six months.

Engage continues to be a central resource of information, good practice and resources on involvement, PPI and Co-Production. During this period, Engage produced a flyer to promote the use of the site. Flyers were distributed throughout all 5 Trust areas. Changes have been made to the site, such as the introduction of an Opportunities section where people can upload and access current involvement opportunities.

Shared Learning Group

The Shared Learning group is made up of a plethora of national charities as well as regional community and voluntary organisations. The purpose of the group is to promote PPI and involvement throughout the 3rd sector, in addition to sharing best practice and learning. During this period the group has revisited their terms of reference and have planned a re-launch of the forum with a view to exploring its purpose, membership and developing outcome focused actions.

Standard 4. Knowledge and Skills

Involvement and Co-Production training

In line with our responsibilities as set out in the Departmental Circular of 2012, the PHA working through the Regional HSC PPI Forum has been at the forefront of co-producing training programmes for Involvement. The Engage and Involve resource, both the hard copy taught programme, materials and the e-learning components for staff, service users and carers have been endorsed by the DoH and are recognised as the core training and development tools for Involvement.

As reported previously, the PHA has also and continues to commission specialised training for specific related areas. In the latter half of the 2018/19 a significant programme of training was undertaken to support advanced Involvement and Co-Production across the HSC, over 100 people benefited from a range of training events and programmes in the last six months. Through this we are aiming to build a cohort of staff with knowledge, expertise and experience in involvement and coproduction as we seek to build a critical mass of people to change the HSC culture to a truly person centred service.

This included:

- In-house delivery of Engage & Involve modules
- Bespoke one to one training for PHA staff
- Leading in Partnership – Leadership Programme for Involvement and Co-Production
- Developing Skills to understand and undertake consultation programme

- Bespoke facilitation skills training for PHA Health Protection team
- Citizen space and Turning point training
- Undergraduate and Postgraduate training at QUB, UU and HSC Leadership Centre
- Delivery of bespoke information sessions for a range of areas as requested.

In addition the PHA is working closely with colleagues in DoH, Clinical Education Centre (CEC) to establish best practice training and development opportunities in Co-Production and Partnership Working.

To promote a greater level of consistency across the HSC the PHA have commissioned the Patient and Client Council to recruit and provide a training and support programme for a new cohort of service users and carers. We are working closely with the PCC to ensure that the recruitment and training programme enables a greater number of people to be involved in regional and local level Involvement and Co-Production activity.

As part of the suite of training to support the development of skills and knowledge, an introduction to Citizen Space was again offered to PHA staff. The on-line platform is designed to provide a structure for on-line consultations or surveys and is now being effectively utilised by PHA for various engagement needs including the Diabetic Eye Screening consultation.

Standard 5. Measuring outcomes

PHA Monitoring

Following the PHA monitoring and audit reports in early 2018, further work has been undertaken at corporate and directorate levels to support the embedding of PPI into the culture and practice of PHA staff. Planning is underway to develop divisional Involvement and Co-Production Plans that will support in depth monitoring reports at directorate level.

External Monitoring

Previous monitoring reports were based on evidence gathered through Trust self-assessment monitoring reports, improvement visits, and additional information requested from the Trusts. The DoH advised that in 2018/19 the Trusts would complete a self- assessment form only for Involvement, whilst consideration was given to what form monitoring might take going forward, given the need to most effectively capture and learn from whatever progress was being made in terms of co-production.

This year the reports have set out the update from the Trusts against each of the recommendations made by the PHA in our previous monitoring reports. It also outlines if the Trust has 'met', 'not met' or 'partially met' the recommendations previously identified. These reports are being taken through the Forum's Monitoring Sub-Group before then being shared with PHA AMT and the DoH for their consideration.

In terms of future monitoring this will be reviewed through the sub-monitoring group with the key focus on the impact of involvement. There is recognition that further emphasis needs to be placed on what difference monitoring is making in addition to how well we are doing it.

The PHA have also engaged with a Communication Evaluation N. Ireland (CENI) to help the HSC look at the monitoring we are conducting and to inform our collective thinking about how best to assess and evaluate the impact of involvement and co-production activity moving forward.

HSC Public Health Agency

item 14

Title of Meeting	PHA Board Meeting
Date	20 June 2019
Title of paper	Corporate Monitoring Report
Reference	PHA/08/06/19
Prepared by	Rosemary Taylor, Rossa Keegan, Diane Anderson
Lead Director	Ed McClean
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to provide the PHA Board with an end of year report on the PHA Annual Business Plan 2018/19, and a mid-term report on the indicate in the PHA Corporate Plan 2017-2021.

2 Background Information

The PHA Corporate Plan 2017–2021 has five overarching outcomes:

- All children and young people have the best start in life
- All older adults are enabled to live healthier and more fulfilling lives
- All individuals and communities are equipped and enabled to live long healthy lives
- All health and wellbeing services should be safe and high quality
- Our organisation works effectively

Based on these outcomes, the Annual Business Plan was developed for 2018/19 which had 75 actions.

3 Key Issues

Of the 75 actions in the PHA Annual Business Plan 2018/19:

- 1 action has been categorised as red (significantly behind target/will not be completed)

- 12 actions have been categorised as amber (will be completed, but with slight delay)
- 62 actions have been categorised as green (on target to be achieved/already completed).

Each of the actions in the Annual Business Plan contributes to the five overarching outcomes identified in the Corporate Plan; progress against each outcome is summarised in the report.

The report on the indicators in the PHA Corporate Plan 2017-2021 is a snapshot of the most up to date data. The first page of the report provides a high level summary, of some of the key indicators against each outcome, with the detailed data (including sources) provided in the following pages.

4 Next Steps

The PHA Annual Business Plan for 2019/20 was approved by the PHA Board at its meeting on 21 March 2019. Progress against this Plan will be reported to the Board biannually.

PERFORMANCE MANAGEMENT REPORT

Monitoring of Targets Identified in

The Annual Business Plan 2018 – 2019

As at 31 March 2019

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

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

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

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

Of these 75 actions 62 have been rated green, 12 as amber and 1 as red.

Outcome	Red	Amber	Green	Total
1) All children and young people have the best start in life	0	2	8	**10**
2) All older adults are enabled to live healthier and more fulfilling lives	0	1	8	**9**
3) All individuals and communities are equipped and enabled to live long healthy lives	0	4	17	**21**
4) All health and wellbeing services should be safe and high quality	1	3	21	**25**
5) Our organisation works effectively	0	2	8	**10**
Total	**1**	**12**	**62**	**75**

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

Actions with a red RAG status.

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

Actions with an amber RAG status

1. All children and young people have the best start in life					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
4	Expand the Newborn Blood Spot Screening Programme to cover additional inborn errors of metabolism, in compliance with ministerial policy statement and advice of the UK National Screening Committee.	Tandem, mass spectrometer tendering process closed to applications on 17th April with an expected date of installation of end Sept 2019. Formal implementation project structures established.			Dr A Mairs R Doherty Draft Project Plan including planned key milestones agreed by Project Team and regional QI group prior to approval at Project Board in May 2019. Project team subgroup work progressing, including PHA working with colleagues in BSO, CHS and BHSCT (Trust Leads, Laboratory and Clinicians) to allow reporting on expanded conditions. PHA and HSCB working with the metabolic service RBHSC to prepare for implementation

1. All children and young people have the best start in life					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
5	Continue to implement the Healthy Child Healthy Future programme	The workforce issues within Health Visiting workforce have impacted the fidelity of the programme delivery. Variation in the programme delivery needs to be reduced. The Key Performance Indicators for the uptake of the HCHF have improved slightly in the last quarter. Additional resources were secured for MDTs, to improve the workforce in two areas and will improve delivery of the programme.			M Hinds D. Webb Recruitment process for the MDTs is commencing. A new approach to UK recruitment is currently being tested. .

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

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
7	Establish a minimum of 3 additional Community Pharmacy Needle and Syringe Exchange Scheme sites across NI in relation to identified need.	Two additional Community Pharmacy Needle and Syringe Exchange Scheme sites are now opened & operating in Belfast. The 3rd planned site was unable to progress due to community concerns.			Dr A Mairs Michael Owen Future delivery models for needle and syringe exchange services will be explored in 2019/20.
12	Develop healthier workplaces in the HSC and other sectors	PHA workplace health service is delivered across all 5 Trust areas by 3 providers with KPI's monitored and met. Work to retender the PHA Healthier Workplaces service in 2019 is now well underway. HSC Healthier workplaces network has secured transformation funding equivalent to 6 x Band 7 wte in each Trust and jointly for PHA/HSCB/BSO. IPT's have been approved (19/20 full year effect of £51k per project, total of £306k). Four Trusts (NHSCT, SHSCT, BHSCT and SEHSCT) have now appointed and these projects are operational.			Dr A Mairs Janet Calvert The short term nature of the transformation funding has been a challenge. WHSCT will not continue with the proposal and the joint PHA/HSCB/BSO post has not progressed. The Healthier Workplace Network are to meet on the 1st August and the transformation projects will be reviewed at this meeting. .

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
17	Introduce surveillance clinics into the Diabetic Eye Screening Programme	Funding has been allocated to BHSCT for additional staffing, training and other recurrent costs. Recruitment processes are in progress and training for surveillance examinations is ongoing. By the end of September 2018 there were 1,903 patients on the digital surveillance pathway, with 3,179 undergoing Slit Lamp Biomicroscopy examinations (Performance Report, Optomize).			Dr A Mairs R Doherty BHSCT continue to recruit staff to support full implementation and to work to establish surveillance pathways in WHSCT area.
19	Continue working with interagency partners to improve health improvement, support and self-management services for people with long term conditions to include digital information resources for people with persistent pain.	MyNI social media campaign is concluded. PHA is awaiting the outcome of a small business research initiative (SBRI) application but does not currently have the resources required to deliver the project if the application is successful.			Dr A Mairs C McMaster PHA is exploring options to resource the delivery of the project if the application is successful.

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
10	Work with HSCB to finalise a Cancer Services Indicator Framework and to publish achievement against key indicators on a rolling basis (Staff and financial resources dependent).	Cancer Service Indicators framework (CSIF) was submitted to the Department on 26 September 2017. DoH is currently considering how to align a revised service framework for cancer with the new cancer strategy which has just been commissioned.			Dr A Mairs L Herron Awaiting further guidance from DoH.
14	Continue to work with colleagues in the DoH, HSCB, HSCTs, voluntary agencies and patients to support Scheduled Care Reform.	PHA provides advice and support to the reform of scheduled care. With current staffing levels not all areas of scheduled care have input from PHA.			Dr A Mairs Dr C McMaster Prioritise area of work that require PHA input.
24	Facilitate regional learning and change within HSC as a result of The Inquiry into Hyponatraemia-related Deaths (January 2018)	Temporary Children's Nurse has been recruited however they are unable to be released by Health Protection.			M Hinds Continue to explore other options to facilitate regional learning and change within HSC

5. Our organisation works effectively

	Action from Business Plan:	Progress	Achievability (RAG) Sep	Achievability (RAG) Mar	Mitigating actions where performance is Amber / Red
1	Continue to take forward implementation of the PHA Procurement Plan	PHA continues to progress the Procurement Plan, as far as possible, within staffing resources available. Project teams have been established to take forward tender processes in relation to Suicide Prevention services (60 contracts) and Healthier Places (62 contracts); both complex areas of work that require significant planning to progress. Work has commenced to progress renewal of the drug and alcohol contracts; new tenders are due to be awarded by July 2020. A task and finish group was established to review the PHA social care procurement processes and to identify how the PHA can improve planning and management of procurement processes. The draft report is to be shared with AMT April 2019.			E McClean Rosemary Taylor / Stephen Murray The task and finish group is developing an action plan to support implementation of recommendations. The report and action plan will be shared with PHA Board for consideration early summer 2019.
7	Design and deliver a new staff intranet to support communications within the PHA	The new staff intranet has been designed, however full implementation has been delayed owing to ITS workload pressures. Testing of the revised templates is ongoing.			E McClean Stephen Wilson/Tony Sheridan Maintenance and updating of the Connect website continues in the absence of a finalised new version

Actions with a green RAG status.

1. All children and young people have the best start in life					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
1	Implement the Breastfeeding strategy through the Breastfeeding Strategy Implementation Steering Group (BSISG) and Action Plan.	Mid-term strategy review completed and published online.			Dr A Mairs Janet Calvert
2	Lead implementation and evaluation of Early Intervention Transformation Programme work streams 1 and 2.	**EITP Work Stream 2:** • Early Intervention Support Service (EISS) supported 2,177 families from August 2015 – December 2018 - 96% of cumulative target. • Recommendations from QUB research have been considered and refinements to EISS model agreed and implemented with key stakeholders. • EISS contracts currently extended for 6 months to September 2019 – further extension of contracts dependent on confirmation of funding allocation from Transformation Fund for 2019/20. • Ongoing engagement with the Outcomes Group, Children's & Young People's Strategic Partnership (CYPSP), Transformation Implementation Group and Directors of Children's Services in each Trust to consider the case for sustainability of the EISS post March 2020.			Dr A Mairs and M Hinds Amanda McLean

1. All children and young people have the best start in life

	Action from Business Plan:	Progress	Achievability (RAG) Sep	Achievability (RAG) Mar	Mitigating actions where performance is Amber / Red
		• CYPSP are convening a task group to consider the impact/effectiveness/fit of the EISS model & recommendations, including a possible funding case, for sustaining EISS post 2020 as a coherent family support option for early intervention regionally. **EITP Work Stream 1:** • Over 400 participants have completed Solihull 2 day Foundation course for midwives as of Dec 2018. • As of December 2018 4,571 mothers have participated in & completed Group Based antenatal Care & Education programmes. With a further 1,249 still participating in a programme. • All pre-school education settings have been allocated a named Health Visitor. • The 3+ Review is being offered to 60% of children attending DE funded pre-school education academic year 18/19 (100% of eligible pre-school children in NHSCT • Evaluation study of Getting Ready for Baby and Getting Ready for Toddler is on-going. QUB are due to report end of 2019. • EITP came to an end on 31st March 2019 however the Trusts are embedding the services in to universal practice.			

1. All children and young people have the best start in life

	Action from Business Plan:	Progress	Achievability (RAG) Sep	Achievability (RAG) Mar	Mitigating actions where performance is Amber / Red
3	Implement the Infant Mental Health Action Plan	PHA continues to facilitate and lead the regional Infant Mental Health Implementation Group. Key actions to date include: • Solihull Workforce Guide – produced • IMH e-bulletin: issued April 2018 and December 2018 • Launch and dissemination of PHA/NSPCC 'The Case for Infant Mental Health in NI' Policy and Evidence Report – April 2018. • Between April 2018 and March 2019 27 staff from various settings across 3 Trust localities trained to access Video Interactive Guidance (NICE recommended method of improving attachment relationship between parent and young child (0-5). All parents supported reported improved capacity to recognise and respond to needs of their babies. • From September 2018, 9 staff from CAMHS, Surestarts and Health Visiting were enabled to access M9 Infant Mental Health Diploma. All report having increased knowledge and skills in work with under 3's. • Guidance on positive mental health for parents was produced for participants in the 'Mood Matters for Families with Newborns'; 80 programmes were delivered in antenatal and community sessions to 740 expectant and new parents during 2018/19.			Dr A Mairs Maurice Meehan

1. All children and young people have the best start in life

	Action from Business Plan:	Progress	Achievability (RAG) Sep	Achievability (RAG) Mar	Mitigating actions where performance is Amber / Red
6	Enhance multi-disciplinary working within neonatal wards across each Trust area by embedding AHP support (dietetics, OT, physio, SLT)	There is now full implementation of AHP support across neonatal wards in NI with evidence of enhanced MDT working which has recently secured regional recognition at the 2018 Advancing Healthcare Awards in transforming the workforce to improve outcomes for children and their families			M Hinds M Tennyson Geraldine Teague
7	Roll out of the Regional Support for Education (RISE) model across the region	The RISE NI model has been implemented across all Trust areas with greater standardisation and enhanced integration across the health and education sector, demonstrating positive outcomes for children, enabling them to access the curriculum more effectively			M Hinds M Tennyson Geraldine Teague
8	Maintain and improve vaccination programmes for children and young people by working with HSC organisations, and delivering a PPI study to better understand barriers to vaccinate hard to reach communities such as the Roma	On-going work with HSCB on improvement of uptake in practices. 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.			Dr A Mairs Dr J Johnston
9	Achieve uptake targets for seasonal influenza vaccinations for children aged 2-4 years and the primary school programme set by DoH.	Seasonal flu vaccine programme formally ended on 31 March 2019. All primary school children offered opportunity to receive vaccine through school based programme with uptake of 76%.			Dr A Mairs Dr J Johnston

1. All children and young people have the best start in life					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		All 2-4 year olds offered opportunity through GP practices with uptake 48%. Uptakes generally same as 2017-18.			
10	Develop and promote a range of communications aimed at helping parents and carers recognise and manage issues relating to the health and wellbeing of children and young people.	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, including 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 audiences/locations and targeted social media messaging including videos.			E McClean S.Wilson

2. All older adults are enabled to live healthier and more fulfilling lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
1	Lead, in conjunction with other PHA/HSCB departments and external stakeholders, on creating a public health vision for frailty using an outcomes based approach. A frailty model will be tested that will include: • Falls • Continence • Mild Cognitive Impairment • Social Isolation	Significant progress has been made including: • A PHA/HSCB Strategic Frailty Oversight Group has been established • A regional Frailty Network has been established and launched on 28th March 2019. Evaluation of the event will examine how people will use this in their work area to improve outcomes. • Frailty Network Co-ordinator appointed • Data Analysist appointed – key to measuring outcomes / improvements secured through this programme. • Frailty prototypes underway across the region to test different frailty models. Monitoring and evaluation of the outcomes from these will be completed in 2019/20. • An expert panel for frailty has been established. Priority areas for 2019/20 have been identified and task & finish groups are being established. There will be a focus the identification and measurement of outcomes.			M Hinds E. Ross
2	Establish a regional Age Friendly Network and implement, with partners, the WHO Age Friendly Communities model in local government districts in co-operation with DFC 'Active Ageing Strategy'	N.I. Age Friendly Network has been established, with representation from all 11 Councils. Initial meetings have focused on developing a series of draft documents relating to the operation and membership of the Network e.g. guiding principles, TOR, membership and chairs			Dr A Mairs Siobhan Sweeney

2. All older adults are enabled to live healthier and more fulfilling lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		role and development of an effective information hub. Initial priorities were agreed as: • Mapping Age Friendly across NI • Development of effective information hub • Strategic and operational approach to loneliness and Isolation. • Planning for annual Age Friendly Assembly.			
3	Develop and implement a regional arts programme to enhance the wellbeing and quality of life of older people across Northern Ireland through their active engagement and increasing access to participation in high quality arts activities	In June 2018 a grant application round was opened in partnership with Arts Council NI. Approximately £140,000 was allocated to 19 projects in arts, community and voluntary groups across NI. The projects included all art forms, e.g. music, writing, circus, craft and drama. All of the projects aligned with the strategic themes of isolation and loneliness, older men, carers and area of need. In partnership with Artscare the 'Here and Now Festival' delivered 235 workshops across the five HSCTs, reaching 3,000 participants. All artists received Arts and Health Training and induction prior to facilitating the workshops. The focus of 18/19 training was best practice in delivering workshops to older frail people living with poor mental health. This was delivered in partnership with SEHSCT Occupational Therapy department.			Dr A Mairs Siobhan Sweeney

2. All older adults are enabled to live healthier and more fulfilling lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		Reported benefits: • Increased levels of social interaction • Enhanced relationships with staff and service users. • Reduced levels of anxiety • Opportunity for lifelong learning opportunities.			
5	Influence future practice and policy in the care of older people, through the launch of reports and leaflets from commissioned research in dementia and through follow-up knowledge exchange processes with key stakeholders.	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. 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.			Dr A Mairs Dr Gail Johnston Dr Janice Bailie
6	Lead work with the HSCB and Trusts to start delivering Phase Two of the Dementia EHealth and Data Analytics Pathfinder Programme for Northern Ireland including the implementation	This Programme aims to build eHealth & data analytics capacity and capability with an initial focus on dementia, through the following workstreams:			E Ritson

2. All older adults are enabled to live healthier and more fulfilling lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
	of a PatientPortal for Dementia Patients.	**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 will enable people 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). A Dementia Analytics Research User Group (DARUG) has been formed to tie together work on research, commissioning of data analytics projects and GPIP. To-date a total of 8 dementia data analytics projects have been awarded with a further 12 submissions being evaluated			

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

	Action from Business Plan:	Progress	Achievability (RAG) Sep	Achievability (RAG) Mar	Mitigating actions where performance is Amber / Red
		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. 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			

2. All older adults are enabled to live healthier and more fulfilling lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
7	Prepare for introduction of FIT testing within Bowel Cancer Screening Programme	Awaiting policy and financial decision from the DoH. A CAG has been established and continues to develop the specification for the laboratory equipment and consumables required for the introduction of FIT. A site visit to further inform the implementation was undertaken to the Scottish Bowel Screening Programme in November 2019.			Dr A Mairs T Owen
8	Continue with the vaccination programmes to protect the health of older adults such as flu and shingles.	Health protection and health improvement teams worked with local groups to increase awareness of flu and shingles vaccine for elderly individuals. Seasonal flu vaccine programme formally ended on 31 March 2019. This year those over 65 years were offered a new more effective vaccine All were offered opportunity to receive vaccine through GP practices with uptake of 70% (DoH Target). The shingles vaccine programme runs throughout the year, from 1 October to 3 September, but predominantly delivered alongside flu vaccine. Uptake for 2018-19 as of end of March 43% for 70 year olds and 45% for 78 year olds.			Dr A Mairs J Johnston

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

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
1	Continue to work with local government on the implementation of community planning	PHA continues to work with all 11 councils and their community planning partnerships. The 4 areas agreed for HSC focus in community planning (mental health and wellbeing, physical activity, early years and later years/age friendly) are clearly reflected across all 11 community plans and action plans are now being agreed developed. Action plans have been developed and implementation has begun. While these reflect the above 4 areas, they vary in detail and approach, reflecting local needs. Monitoring of actions also varies across each of the councils. OBA is being adopted across some councils and report cards are in development to help plan and monitor. The PHA continues to lead the HSC Community Planning Forum, including representation from all HSCTs and the HSCB. The Forum facilitates collective action across all the organisations and encourages alignment with MLB and PFG.			E McClean Julie Mawhinney
2	Lead and coordinate regional implementation of the Making Life Better Public Health Framework	The regional implementation arrangements for MLB have been reviewed and refreshed to reflect the changes to ADOG and the development of the draft PFG Framework as			Dr A Mairs

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		well as community planning and its processes. The creation of the MLB HSC Partnership allows oversight of the implementation of MLB enabling a consistent approach to be adopted across the HSC. Alignment with transformational work relating to Delivering Together on issues such as community development, healthy places and workplace health is also a key part of discussions. At a local level MLB has been embedded in the 11 council led Community Plans, cutting across the core themes of health and social wellbeing, regeneration and environmental sustainability. In terms of the delivery of projects a broad range of almost 120 initiatives are currently being delivered under the MLB banner, valued at £3.6m regionally. These range from partnerships with local government and other statutory partners to collaboration with a range of voluntary and community based organisations targeting interventions to stimulate sustainable improvements in health and wellbeing. Planning has commenced for a regional MLB networking event to take place in June 2019. Work is also ongoing exploring how Trusts and PHA can better collaborate to promote MLB.			Brendan Bonner

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
3	Develop and implement the actions flowing from the Transformation workstream on the expansion of community development approaches.	Tender has been awarded and the capacity building programme has commenced with the following objectives: • To establish and host an online Community Development Portal • To develop and deliver a Community Development curriculum which is relevant, accessible and evidence based. • To develop and refine the draft evaluation framework, to measure and assess the impact of the Community Development Framework, to create a Northern Ireland evidence base which will inform future development in 2019-2021. • To build sustainable resilient communities through positive collaboration mentoring of organisations/groups via the development of a community mentorship programme First of a bi-annual community development conference was held in March with over 100 attendees Capacity Building and Evaluation subgroups are currently being established to support the Implementation Board			Dr A Mairs Diane McIntyre

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
4	Lead and implement programmes which tackle poverty (including fuel, food and financial poverty) and maximise access to benefits, grants and a range of social inclusion services for vulnerable groups.	• **Tackling fuel poverty** for vulnerable target groups included the implementation of the regional PHA Keep Warm Pack Scheme (7,121 packs distributed during 2018/19) and a range of locality based work relating to energy efficiency and fuel poverty support. • **Food poverty** was addressed through support for the regional Fareshare food redistribution model as well as locality work to improve access to healthier affordable choices for those most at risk through building community capacity, skills and knowledge. At least 70 Community Food Members were registered and receiving food on a weekly basis (benefiting at least 5,900 individuals/quarter). Food was redistributed to provide at least 388,500 meals according to FSA guidelines. A pool of 25 volunteers was maintained for the Community Food Network. • **Improving incomes and benefit maximisation** for vulnerable clients was taken forward through the provision of targeted benefit entitlement advice for those with underlying health needs. Approximately 1,603 vulnerable clients were supported through the Northern and Southern locality 'Advice 4 Health' projects resulting in over			Dr A Mairs Tracey Colgan

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		£944k income/benefit maximisation. Through the BHSCT Mental Debt Advice Service approx.1000 clients received advice and help to maximise their income/benefits with a minimum of £225,000 annualised realised for these clients.			
5	Implement the multi-agency obesity prevention action plan	The PHA has continued to Implement 'A Fitter Future for All', monitoring its progress through the Regional Obesity Prevention Implementation Group. It is working with DoH to agree the next set of short term outcomes for the final phase of AFFA from 2019-2022. A wide range of programmes focusing on healthier eating, weight management and physical activity are being delivered. Of particular note in past six months: • PHA is leading the development and procurement of an early year's obesity prevention programme, which will be available in Sure Starts and in client's own home on referral from a Health Visitor, in 2019/20. • A regionally consistent Physical Activity Referral Scheme has been agreed, with phased implementation between April and June 2019.			Dr A Mairs Caroline Bloomfield

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		• Discussions are underway on the potential to restart the commercial weight management programme, in light of the poor evaluation of the 'Choose to Lose' adult weight management programme. • Implementation of the Minimum Nutritional Standards for staff and visitors in HSC facilities is underway. • 60 new schools recruited to Active School Travel programme, bringing total to 349 schools. • Daily Mile now implemented in over 220 schools.			
6	Continue to consolidate the drug and alcohol services tendered and commissioned under the New Strategic Direction on Alcohol and Drugs (NSDAD) 2011-17 and the PHA/HSCB Drug and Alcohol Commissioning framework 2013-16 including revising the framework to inform future service design and procurement.	The procured Drug and Alcohol services continue to operate well and are meeting agreed KPIs. PHA are continuing to progress the revision of the Commissioning framework 2013-16 as part of an overall re-procurement process for alcohol & drug services being taken forward in 2019/20.			Dr A Mairs Michael Owen
8	Commission and monitor uptake of stop smoking services in line with KPIs, in particular with young people, pregnant smokers and disadvantaged adults.	Stop Smoking Services continue to be commissioned across Northern Ireland with particular emphasis on pregnant smokers and their partners, disadvantaged smokers and young people.			Dr A Mairs Colette Rogers / Siobhan O'Brien

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		Smoking prevalence across NI fell to 18% of the general population in 2018/19. The new branding of stop smoking services has now been launched across all services including a new website to support smokers in their quit attempts			
9	Lead and implement a range of programmes to promote mental and emotional wellbeing and prevent suicide.	£8.7 million of services have been implemented in the last year in relation to promoting mental and emotional wellbeing and suicide prevention through community voluntary and statutory service providers including, for example: • Lifeline Service • Training - Suicide awareness & intervention skills; primary care depression awareness have been delivered to over 14,000 people • Self-harm Registry and Self Harm Intervention Project have been delivered across all 5 HSCTs • Community Capacity Building, programmes, services and small grants support; mental health promotion, therapeutic intervention. • Bereavement support & guidance including the Regional Bereaved by suicide development Project. • 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			Dr A Mairs Fiona Teague

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		alongside police officers 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. Other work includes support for rural communities, young people and the arts, stress control programmes, work with sporting bodies, clergy, prisons, LGBT communities/families, green gym/horticultural therapy and working with the Education Authority on the FLARE programme Emergency community response plans and the SD1 process for identifying & early response to emerging clusters of suicide have been evaluated with actions being developed. A regional stakeholder engagement process has begun in relation to future Protect Life services involving over 400 people.			
10	Lead on the strategic planning and commissioning of prison healthcare for Northern Ireland and co-ordinate the implementation of the joint health care and criminal justice strategy action plan which incorporates prioritising the	The Regional Commissioning/Planning Programme for Prison Healthcare and Associated Services Team for prison healthcare continues to meet monthly. The team aims to ensure people detained in prison should be 'afforded provision of or access to appropriate			M Hinds Siobhan McIntyre

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
	transformation of health care services in police custody.	services or treatment,' which are 'at least consistent in range and quality with that available to the wider community'. A '10 point plan', setting out key deliverables across 10 thematic services, has been developed. A number of deliverables will be progressed through 7 transformation projects. A nurse led pathfinder in Musgrave custody suite, funded through Transformation monies, is now in place, operationally managed by BHSCT. While evaluation of the pathfinder is still ongoing early findings recommend proceeding with the roll out of this service. A regional specification is being developed to support a tender for a HSCT to provide nurse led custody health care service across a further nine PSNI custody suites. The report is due for submission in June 2019. A number of improvement projects are also being progressed by PHA in respect of workforce development, PPI, staff training and I.T. solutions for healthcare in criminal justice. A systematic review of SAIs in prisons is underway with PHA/RQIA. In January 2019 a social prescribing pathfinder was established on the Hydebank Wood Secure College site to test uptake and improvements in health improvement initiatives for Ash House (Women's Prison). Additional funding has been approved to extend the pathfinder for a further 6			

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		months and to extend the Social prescribing Transformation project. Protocols have been developed for improved prevention and screening services for detained persons in prison for breast, cervical and bowel cancer.			
11	Monitor, co-ordinate and promote the work of recovery colleges in NI, increase opportunities for co-production, and pilot Wellbeing and Recovery Star mental health teams and recovery colleges.	Transformation funding has been secured to enhance sustainability of Recovery Colleges and evaluation of Recovery Colleges. Work has begun on Phase One of the evaluation which will be taken forward by PHA Health Intelligence. All Trusts have availed of training in Outcome Star and are using within Mental Health services.			M Hinds Briege Quinn / Deirdre McNamee
13	Award over €7m funding to support ten cross-border healthcare intervention trials in Northern Ireland and Republic of Ireland through the Cross-border Healthcare Intervention Trials in Ireland Network (CHITIN INTERREG VA) programme. Complete selection and initiation of 10 healthcare intervention trials under the CHITIN programme	HSC R&D's CHITIN programme, which received €8.8m (including 15% contribution from the DoH NI and ROI) from the EU's INTERREG VA Programme and on which the PHA is the lead partner, was officially launched in September 2018. €6,931,327 of this funding was awarded to QUB, UU, BHSCT, NUIG and RCSI in July to support 11 cross-border healthcare intervention trials.			Dr A Mairs Janice Bailie/Rhonda Campbell

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		A further 6 trials (1 QUB, 3 UU, 1 RCSI, 1 NUIG led) have commenced activity with a focus on healthy cognitive ageing with diabetes, mental illness, teenage physical inactivity, asthma and medicines management with multimorbidity. 18 General Practices/Practitioners were recruited (14 in ROI and 4 in NI) to 2 QUB led trials that commenced in Sept 2018.			
14	Provide strategic leadership and co-ordinate the Regional Learning Disability Health Care and Improvement Steering group on behalf of PHA and HSCB	A workshop was held in October to review the work of the Regional Learning Disability Health Care and Improvement Steering Group and the three sub-groups to establish a workplan for the next three to five years. Feedback from participants at the workshop will help inform the workplan and structures for implementation of a revised Action Plan and contribute to new regional model of service for Learning Disabilities. An independent review of an assessment and treatment inpatient service model for Learning Disability is due to report mid-summer 2019. The recommendations will inform the new work plan for the regional steering group.			M Hinds Briege Quinn / Deirdre McNamee
15	Lead the implementation of the Regional Palliative Care work plan	The early identification prototype phase 1 ran from June 2018 – December 2018. 46 GP practices (urban and rural) participated across NI.			M Hinds Corrina Grimes

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		There was evidence of District Nurses attending the majority of monthly palliative care meetings. The number of patients on the palliative care registers increased from 254 at the beginning of the prototype to 433 at the end of phase 1 (70% increase). Advanced care planning publication – *Your Life, Your Choices* (YLYC) has been distributed to all NI Care Homes (17k copies); A stock of Palliative Care in Partnership (PCIP) branded items are available for future Advance Care Planning (ACP) events, including PCIP banner stands for members and ACP exhibition stand; A number of public engagement events are being scheduled for year 2, including a PCIP stand at the Balmoral Show 2019.			

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
16	Lead on the development of the Promoting Good Nutrition (PGN) strategy implementation plan in the community	The PGN steering group through its sub groups has developed prevention messages and supporting materials. Screening and intervention pathways have been reviewed and updated. A workshop, hosted by CNO, was held to outline the work of the steering group as well as other nutrition projects and initiatives. Output from the workshop will feed into the review of the PGN strategy, informing future direction and priorities.			M Hinds Lynne Charlton / Corrina Grimes
18	Prepare for introduction of primary screening with Human Papillomavirus Virus (HPV) testing within the Cervical Screening Programme.	While Initial scoping work has been completed and there are ongoing discussions with UK colleagues as to appropriate pathways and algorithms, a policy decision from the DoH is awaited.			Dr A Mairs T Owen
20	Continue to lead the implementation and monitoring of eHealth and care Strategy under the objectives of • Supporting People • Using Information and Analytics • Fostering Innovation which will contribute to the development of a regional EHCR.	Telehealth - The Inhealthcare system is being used by NHSCT and SHSCT for 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. Flo text messaging service roll-out has been delayed due to issues around Information Governance - work to resolve these issues is ongoing. Telecare - A discussion document on future of Telecare has been circulated and responses			E Ritson

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		received from a variety of stakeholders. Responses are informing the work ongoing to specify and develop a replacement service. Citizen facing VC - Project team and plan of work being established to progress a number of pilot projects for virtual consultations. Feedback from pilot projects has indicated improved patient experience, reduction in travel times and quicker access to services. HSC On-Line - A-Z of health conditions published on NIDirect website, officially launched in January 2019 as 'NI Symptom Search'. This provides the public with quality, accurate, easy to read information to enable them to manage their condition appropriately and select services they need. 13,000 users access the site each month. 60% of GP practices are offering patient facing online services.			
21	Deliver new communication programmes supporting public health messaging around suicide prevention, mental health promotion, smoking cessation and cancer awareness.	The withdrawal of funding in–year for the proposed PIC programme curtailed the programme delivery plan. However in December 2018 the PHA was awarded Transformation funding to enable the delivery of a new public information campaign on AMR enabling the PHA to deploy the PHE			E McClean S Wilson

3. All individuals and communities are equipped and enabled to live long healthy lives					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		Keep Antibiotics Working campaign during Feb and Mar 2019. Approval was also given to allow a reduced programme of PIC activity for smoking cessation and mental health promotion to be delivered in the final quarter of the year. Evaluations of the programmes are currently being concluded but early results demonstrate high levels of awareness of the campaign messages amongst the targeted public audiences. A range of communication channels, including paid for advertising, were used to communicate with the public around the Lifeline 24/7 suicide prevention service and early evaluation results show that this has resulted in strong awareness levels across Northern Ireland. The Be Cancer Aware campaign programme was promoted by poster dissemination, social media messaging and an instore display partnership with Menary's retailer.			

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
1	Continue to implement the PPI Strategy and deliver training on PPI in research for researchers and members of the public and facilitate opportunities for patients and public to be involved as partners and co-designers in the research process through the promotion of the PIER (Public Involvement enhancing Research) role.	Three further training workshops for PIER members have taken place in October and December 2018 with a further event planned for June 2019. PIER members continue to be involved in a variety of activities as opportunities arise including research steering groups, funding panels, delivery of training for researchers. 18 people attended a further Building Research Partnerships (BRP) course in October in Ulster University. 2 PIER members took part in R&D's doctoral panel in January and February 2019 and external activities have included the Encompass workshops and ESRC panels in London.			Dr A Mairs Janice Bailie/Gail Johnston
2	Provide leadership, direction and guidance on involvement to the HSC including support for the Regional HSC PPI Forum and transformational work programmes.	The PHA have continued to provide leadership, direction and guidance on Involvement to the HSC, including: • Planning and supporting the Regional HSC PPI Forum meeting, the Regional HSC PPI Forum Strategic meeting and the Regional HSC PPI Service User and carer meetings. • The regional HSC PPI Action Plan has been finalised • PPI has been supported in a range of transformation projects including, Unscheduled Care, E-Health, Adult Social Care, Elective Care, Encompass, WHSCT			M Hinds Michelle Tennyson /Martin Quinn

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		LD, Recurrent Pregnancy loss, Dyspraxia, Dementia Patient Portal & App development PPI,GP Information Platform.			
3	Continue the work of the multiagency and multidisciplinary Regional Adult Dysphagia group, including work to improve awareness, identification and management of dysphagia	The initial implementation cycle of the International Dysphagia Diet Standardisation Initiative (IDDSI) descriptors has been completed across all HSC trusts. Further transition work to complete implementation and evaluate the impact on staff working under the new framework is in progress. Work is underway to develop regional training proposals and regional dysphagia checklists to support staff who work with service users with a dysphagia. Regional plans have been developed for communication of key safety messages including production of regional 'Dysphagia Aware' and 'Don't Mess with Your Meds' posters highlighting the importance of early recognition and consulting pharmacy to ensure medications are dysphagia friendly.			M Hinds Michelle Tennyson / Mary Emerson
4	Identify opportunities to establish how the AHP workforce can support primary care transformation with an initial focus on first contact physiotherapy	PHA is chairing the Regional First Contact Physio Professional Forum. Pilots are operational in WHSCT and SEHSCT. BHSCT are recruiting the physiotherapy element of MDT.			M Hinds Michelle Tennyson / Shane Breen

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
5	Lead and co-ordinate regional implementation of the District Nursing Framework and test new district nursing models of care, for a regional community nurse-led model of care prototype	The District Nursing framework was launched in early 2018 at a joint PHA/DoH conference. A District Nursing Framework Implementation Group has since been established, chaired by Mary Hinds. A number of subgroups have also been established. The neighbourhood District Nursing prototype is being tested across the Trusts.			M Hinds Rose McHugh
6	Implement the comprehensive patient and client experience programme, monitor the agreed key regional priorities for 2018/19 and continue to roll out 10,000 Voices in a range of areas e.g. Unscheduled Care and Discharge.	A range of 'Always Events' (those areas of care that are so important to patients and clients they should always happen) including noise at night, communication, family presence, mealtime matters and pain management, which were piloted during 2017/18 have been spread within each Trust in 2018/19. The 10,000 Voices programme of work continued to be rolled out during 2018/19 across a range of settings. Projects were completed in respect of experience of bereavement, adult safeguarding process and the experience of discharge. Reports make recommendations to improve patient experience and ensure services are person centred. Work is ongoing in respect of dysphagia, managing delirium and mental health services.			M Hinds

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		Three successful events titled 'everyone is an important piece of the puzzle were held regionally to promote good communication. There has been engagement with education providers to ensure that findings inform training for pre and post registration medical, nursing and Allied Health Professional staff.			
7	Continue to gain assurance on progress with regional safety and quality priorities through Quality Improvement Plans and Key Performance Indicators; and provide advice and support to Trusts on the implementation of these key priorities	Whilst there has been significant work from all organisations involved to date, it is recognised that there is a need to continue to evaluate and refine this process to ensure better quality data and improved patient experience for the year ahead and into the future. The priorities for 2018/19 were designed to support a more consistent approach to the definition and measurement of pressure ulcers, falls, NEWS and MGA at both local and regional levels across all Trusts. Work progressed to take forward the agreed work plan for all QIPs and KPIs. Workshops were held to evaluate all QIP programmes to date.			M Hinds Lynne Charlton
8	Provide a strategic role in the management of and learning from the SAI process, including leading the development of Learning Matters	A thematic review commenced September 2018 on mixed gender accommodation and is now complete; this has identified a number of key priorities for action for 2019/20.			M Hinds Lynne Charlton

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
	newsletter, development of thematic reviews and contributing to the SAI Biannual learning report.	The report will be presented to PCE/QSE June 2019. An SAI bi-annual learning report was published in October 2018. A final draft of the learning matters newsletter has been circulated to the editorial team prior to being published in May 2019. The SAI procedure is under review with input from both PHA and HSCB. HSCB/PHA have commissioned a pilot training package in using a systems analysis approach to the review of reporting and follow up of SAI's for members of review teams, DRO's and panel chairs.			
9	Continue to oversee the implementation of the Q2020 Strategy including providing advice and support to the task streams and co-ordinate the development of the Annual Quality Report.	Work progressed in relation to: • Continuing the development of Always Events within each HSC Trust with view to scaling regionally • Supporting multi-disciplinary faculty development in relation to human factors. • Developing an improvement project aimed at reducing surgical never events; a workshop held in March 2019 identified improvement priorities that, as a region, could potentially be taken forward during 2019/20.			M Hinds Lynne Charlton

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		• Continuing to promote training programmes aligned to the Attributes Framework and standardising HSC Trust level 2 and level 3 quality improvement programmes. • Supporting the development of a regional model for supporting staff involved in SAIs and other incidents, including the testing of Schwartz rounds and buddying model. The PHA led the development of the annual quality report which was launched on World Quality Day (8 November 2018), along with a video demonstrating quality improvement throughout the region.			
12	Support the implementation of the Northern Ireland Diabetes Strategic Framework through the regional diabetes network.	The PHA is leading on the introduction of a Diabetes Prevention programme for NI. This is a behaviour change programme to delay and /or prevent the onset of diabetes. The PHA is supporting the implementation of the Diabetes Strategic framework to ensure the appropriate development of services to people with diagnosed diabetes. Processes have been established in the 5 HSCTs for the new regional diabetes prevention programme in line with NICE Type 2 diabetes: prevention in people at high risk (PH38).			Dr A Mairs Dr B Farrell

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		All Trusts are receiving participant referrals electronically via clinical communication gateway (CCG) from primary care staff. The programme offers participants support with behaviour change over a 9 month period through group sessions facilitated by specialist staff trained to work as health coaches. Delivery of programmes are due to commence in all Trusts by end of May 2019.			
13	Support the stroke modernisation programme and the planned consultation on the organisation and delivery of stroke care.	The DoH led the stroke consultation that was launched in March 2019 with the PHA in a supporting role. The Stroke network is working with the 5 Trusts on quality improvement in stroke care. Two sites (RVH and SWAH) have achieved grade 'A's in the national audit SSNAP.			Dr A Mairs Dr B Farrell
15	Raise awareness & knowledge about AMR, through: • Ensuring the timely availability of intelligence about antimicrobial use, antimicrobial resistance and healthcare-associated infections in secondary care by publishing regular reports, through an integrated dashboard and monitoring progress against targets set in the commissioning plan	HI-Surv was rolled out to Trusts in April 2018 to facilitate data collection for HCAI and data visualisation, through dashboards, for HCAI, AMR and AMU. A monthly target monitoring report is issued to Trusts to facilitate monitoring progress against Trust specific targets. An evaluation was conducted in October 2018 to determine the utility of HI-Surv and ensure it is fit for purpose. A Trust stakeholder meeting is planned for June 2019 to discuss the findings			Dr A Mairs Dr M Sartaj Dr L Patterson Dr P Veal

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
	direction; and • Engaging the public and raising public awareness to help reduce inappropriate antibiotic use.	and any resulting changes to the system. The data collected in HI-Surv will be used to inform HCAI and AMU targets (in secondary care) for 2019/20. Social media led engagement activities took place during European Antibiotic Awareness Week (12 -18 Nov 2018); E Bug training for student teachers was delivered in partnership with Stranmillis University College; awareness raising of e Bug materials for teachers is ongoing; mass media campaign "Keep Antibiotics Working" delivered between December 2018 and March 2019; multiple media interviews (Radio Ulster; Cool FM); public health stand at Balmoral Show (May 2019) will focus on antibiotic resistance; infographics on good antibiotic use developed and hosted on multiple social media channels.			
16	Develop an operational plan for an Emergency Operation Centre (EOC) to support the management of an outbreak / major incident by PHA.	The operational plan has been developed and will be kept under review, particularly in respect of staffing issues.			Dr A Mairs Mary Carey
17	Working in partnership with HSCB and HSCTs, continue to support and develop cancer services nursing, including:	Non-recurrent and recurrent funding for Phase 3 (2018/19) was allocated to HSCTs. Charitable partners committed significant extra funding resource to bring forward some of the CNS posts from phases 4 and 5 within Trusts based			M Hinds Loretta Gribben

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
	• Roll out of Clinical Nurse Specialist (CNS) workforce expansion plan across NI HSC Cancer Services; • Oversee the Acute Oncology Nursing Service (AONS); and • Develop a sustainable model for Non-Medical Prescribing (NMP)	on clinical need. The implementation of CNS workforce expansion plan is ahead of expected timescale. Ongoing monitoring of Acute Oncology Nursing workforce and service delivery remains in place. In response to recent AOS Peer Review findings an AOS CRG Sub Group has been set up to explore options for AOS nursing services expansion. Non-medical prescribing model has been developed and Phase 1 implemented. An additional recurrent investment has been allocated to HSCTs to support NMP workforce expansion and Phase 2 implementation.			
18	Deliver/Commission Flu Fighters to support the delivery of flu vaccine for HSCNI workers to achieve the 40% target.	The seasonal flu vaccine programme for Trust employed Health and Social Care Workers (HSCW) ended on 31 March 2019. PHA and Trusts worked with the Flu Fighter campaign® for a second year to increase awareness of flu vaccine among HSCWs. End of season uptake increased for a second year at 35% for HSCWs (39% HCWs, 23% SCWs).			Dr A Mairs J Johnston

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
19	Lead on the development of methodology and models for the policy framework for Delivering Care Project NI for the nursing and midwifery workforce across NI.	• The September 2018 returns report that permanent and temporary staff is 4,187.09WTE (current shortfall of 706.25 WTE against the target position of 4,893.34 WTE across 143 wards to achieve Phase 1 normative staffing). • (Nb figures have been amended from previous returns to exclude staff on maternity leave and career breaks.) • Phased funding has been implemented for the staffing models for Phase 2 Emergency Department; Phase 3 District Nursing; and Phase 4 Health Visiting. • Phase 7 Primary Care and Phase 5A Mental Health papers were endorsed by CNO February and April 2019 respectively. • Phase 6 Neonatal and Phase 8 Independent Sector are all underway. • A UK Four Country plus Ireland teleconference has taken place with a commitment to establish a National network for Nurse Staffing in Care Homes.			M Hinds Siobhan McIntyre
20	Implement the GP Nursing Framework, including addressing workforce capacity within primary care settings, through the development of ANP roles; rolling out regional education and training programmes, co-design with	• The RCN were commissioned to co-ordinate events for the regional GPN network. Four network events have taken place to date in 2018/19. • Delivering Care Phase 7 has been developed which identifies the need for			M Hinds Siobhan McIntyre

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
	users, carers and communities.	additional general practice nurses and healthcare assistants to meet the increasing demand and pressures faced in general practice. 2 Federations have been identified to increase the numbers of GPNs incorporating skillmix and include an allocation for practices to undertake childhood immunisations • There are currently 15 trainee Advance Nurse Practitioners in Primary Care employed with two local GP Federations. (7 are in their 2nd year and 8 in their first year of training). When qualified, these ANPs will be a great asset to help improve GP services within NI. • Ongoing discussions are being held with the primary care steering group, DoH and OU re the initiation of OU programmes for non-registered staff • The PHA has commissioned NIPEC to undertake the competency and career pathway for GPNs which is near completion. • A total of 35 training courses have been provided attended by 414 GP nursing staff to date.			

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
21	Design and manage projects and programmes that directly impact on nursing workforce, recruitment and retention. Effective and methodical execution of nurse led initiatives including a public health focus. Plan and implement the Burdett grant across NI	A training programme tailored to meet the individual needs identified by the ward staff was developed. Staff from RETAIN Wards participated in awareness sessions on Frailty and Continence; Promotion and use of NIPEC Career Pathway; Health-promoting strategies for the ageing nursing workforce. End point data, and results from project RETAIN, presented at a celebratory event in October 2018 indicated that the project has had a significant impact on the recruitment and retention of nursing staff across the 10 wards that participated. The impact was substantial, with reductions of up to 66% in nurse vacancies in these wards. There has been improved morale across all teams and improved outcomes for patients and their families. The outcomes of the project have also influenced regional workforce initiatives including an increase of senior posts in medical and surgical wards, including the 10 wards that participated. The project ethos and approach will now be replicated in other areas within HSC Trusts and the independent sector across NI.			M Hinds Siobhan McIntyre / Gillian McCorkell

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
22	Support the DoH in undertaking a workforce analysis of the AHP professions to support the Delivering Together framework to determine the future capacity requirements of undergraduate and post graduate training numbers and the training and skills required to ensure that AHPs have the capacity and skills to support transformational reform	PHA AHP consultants have been leading workforce analysis work, on behalf of DoH, across all of the 12 AHP professions. Reviews are in process of final approval.			M Hinds Michelle Tennyson
23	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.			M Hinds Kathy Fodey
25	Implement a range of actions through the HSC Safety Forum in support of HSC Trusts and other key stakeholders to improve the safety and quality of services delivered.	• The Safety Forum is leading on a range of work in sepsis, maternity, mental health, paediatrics, NIAS turnaround times and Regional EWS. • A 2nd QI ECHO programme has been facilitated. Monthly ECHO sessions for teams in Trusts (13 teams involved) commenced April 2018, with a final sharing day in November 2018. Plans are in place for 3rd QI ECHO with District Nursing and			M Hinds

4. All health and wellbeing services should be safe and high quality					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Sep	Mar	**Mitigating actions where performance is Amber / Red**
		focus on palliative care. An initial introductory day took place at end of Feb. • Hosted and facilitated Student Selected Component on Patient Safety (12 week course ran from Feb 18 – May 18). • Hosted and facilitated annual Regional SAI event (7 June 2018). • Following final interviews for the 4th Regional Annual Safety Forum Awards in December, a winner was identified from each of the 4 categories along with an overall winner. Awards presented at event on 27 February 2019. • Continues to co-ordinate the Health Foundation's Q Programme within NI (160 members in NI). The Safety Forum organised a number of learning events: Two Data master classes (October 2018), Coaching workshop (November 2018) and Liberating Structures 2 day workshop (November 2018). Members have also been facilitated to attend a number of regional learning events.			

5. Our organisation works effectively

	Action from Business Plan:	Progress	Achievability (RAG) Sep	Achievability (RAG) Mar	Mitigating actions where performance is Amber / Red
2	Continue to facilitate and support embedding of OBA approach.	The PHA continues to further develop business planning and corporate monitoring processes to reflect an OBA approach and place a focus on the impact PHA is having through its actions. Six report cards were prepared and submitted to DoH in respect of PHA commitments under the NICS Outcomes Delivery Plan (PFG). The learning is being used to further develop and embed this approach across other areas. Work is also continuing, with local councils and other HSC organisations in particular, to develop report cards for our commitments within community planning			E McClean Rosemary Taylor
3	Review and test the PHA Business Continuity Management Plan to ensure arrangements to maintain services to a pre-defined level through a business disruption.	The BCP desk top test was undertaken 7 November 2018. The plan was updated and presented to AMT, GAC and approved by PHA board on 21/03/19. The updated version (V7) has been rolled out across the organisation.			E McClean R Taylor / Karen Braithwaite
4	Ensure appropriate Corporate and Information Governance arrangements are in place to underpin and support the Public Health Agency in undertaking its core business	Corporate and information governance arrangements continue to be maintained. A new Whistleblowing policy was approved June 2018 and awareness training provided for staff.			E McClean R Taylor / Karen Braithwaite

5. Our organisation works effectively

	Action from Business Plan:	Progress	Achievability (RAG) Sep	Achievability (RAG) Mar	Mitigating actions where performance is Amber / Red
		Information governance policies and procedures have been updated to reflect GDPR A process for providing assurances on corporate and information governance arrangements, following the cessation of Controls Assurance Standards has been implemented, and a paper confirming completion of this process has been presented to AMT and GAC early April 2019 to inform the preparation of the Governance Statement. Alongside this the PHA Assurance Framework has also been reviewed and updated.			
5	Support the Northern Ireland Public Health Research Network (NIPHRN) to identify opportunities for research in PHA priority areas through the organisation of a series of events on key topic areas bringing a wide range of stakeholders together	The NIPHRN relocated in September 2018 and is now hosted in the School of Health Sciences, Ulster University. The NIPHRN hosted a seminar with the UU School of Health Sciences, and the Institute of Public Health Ireland in December 2018 and discussed the new CMO physical activity guidelines. The network showcase event has been postponed until autumn/winter 2019 with guest speakers from the relevant research councils. Two Research Development Groups have been formed in the past 6 months.			Dr A Mairs Janice Bailie (Nicola Armstrong)

5. Our organisation works effectively

	Action from Business Plan:	Progress	Achievability (RAG) Sep	Achievability (RAG) Mar	Mitigating actions where performance is Amber / Red
6	Action recommended changes arising from the 2017-18 Consultative Review of R&D funded infrastructure	An engagement workshop to examine the restructuring of the NICRN has taken place; an action plan is in development based on the collated responses from stakeholders. As part of the UK Wide streaming of research applications a UK Local Information Pack has been finalised and released following extensive engagement and consultation activity. Within Northern Ireland research sites have initiated implementation plans for the UK wide research application system to record and track the progress of research applications. Training has been undertaken to support the users. Organisational development to prepare the community to move towards a consistent UK model to confirm capacity and capability for the site to participate in a research study has taken place.			Dr Harper Janice Bailie (Gail Johnston)
8	Continue to embed PPI into the culture and practice of the organisation through the PPI internal leads group and the roll out of PPI training for PHA staff.	The PHA PPI team continues to work with the PHA internal leads group to embed PPI into the culture and practice of the organisation. A training plan for 2018/19 was agreed by the group.			M Hinds Michelle Tennyson / Martin Quinn

5. Our organisation works effectively

	Action from Business Plan:	Progress	Achievability (RAG) Sep	Achievability (RAG) Mar	Mitigating actions where performance is Amber / Red
		• Engage & Involve modules were delivered in October and November 2018. • The "Leading in Partnership" leadership programme was delivered in the spring of 2019. • A series of CPD programmes on Involvement & Consultation were developed and commissioned from the Consultation Institute and delivered in spring 2019. • Further training for 2019 / 20 is currently being planned.			
9	Meet DoH financial, budget and reporting requirements	All deadlines in relation to Monthly monitoring to the DoH have been met and the year-end annual accounts completed.			P Cummings
10	Continue to support and develop staff during a period of organisational change, including relevant communication with staff	Updates are provided to all PHA staff by Chief Executive via email, and through Team meetings where relevant. Staff continue to have access to training and development opportunities through the HSC Leadership Centre.			V Watts

PHA Corporate Plan 2017-2021 Monitoring

Update as at May 2019

Corporate Plan Monitoring

Outcome	Description
Overall	• Gap in life expectancy between males and females • Gap between highest and lowest deprivation quintile in healthy life expectancy at birth • Healthy life expectancy at birth • Healthy life expectancy for most deprived areas • Preventable mortality
All children and young people have the best start in life	• Infant mortality rates • Proportion of mothers breastfeeding on discharge and differential between the average and most deprived • Proportion of babies born at a low birth weight • Percentage of obese children (aged 4–5) • Children (aged 0–4) registered with a dentist • Population vaccination coverage • Percentage of children who are at the appropriate stage of development in their immediate pre-school year
All older adults are enabled to live healthier and more fulfilling lives	• Life expectancy at age 65 • Percentage of older people reporting themselves to be in good health • Number of falls • Implementation of the FallSafe bundle
All individuals and communities are equipped and enabled to live long healthy lives	• Percentage of obese adults; or percentage of adults surveyed as obese and proportion in the most disadvantaged areas • Proportion of adults (aged 18+) who smoke, both in the population as a whole and the most deprived areas • Population mental and emotional wellbeing as measured on the Warwick-Edinburgh Mental Wellbeing scale (WEMWBS) • Percentage of population scoring 4 or more in the 12-item general health questionnaire (GHQ12) (signifying possible mental health problem) • Incidence of suicide, both in the population and in the most deprived areas • Alcohol-related admissions to hospital • Proportion of adults (18+) who consume alcohol above weekly sensible drinking limits • Uptake of adult screening programmes
All health and wellbeing services are safe and high quality	• Proportion of PHA projects and contracts where PPI is incorporated • Uptake of PPI training and usage of the Engage website within the PHA and across the HSC • Percentage of people who are satisfied with Health and Social Care (based on their recent contact)
Our organisation works effectively	• HSC staff satisfaction survey • Controls assurance standards • Campaign awareness and reach of press release

Corporate Plan Monitoring

The public health data reported in this update can be found in the following reports, all of which are updated on an annual basis:

- Health Inequalities Report (Department of Health) – each indicator within the NI health and social care inequalities monitoring system (HSCIMS) is examined at regional and sub-regional levels. It includes an analysis of the inequality gaps between the most and least deprived areas. Available here.
- Health Survey NI Report (Department of Health) – the Health Survey NI runs every year on a continuous basis. It covers a range of health topics that are important to the lives of people in NI today. It has run from April 2010, with separate modules for different policy areas included in different financial years. Available here.
- Core Tables supporting the Director of Public Health Annual Report (PHA) – a comprehensive review of key public health indicators. Available here.
- Children's Health in Northern Ireland Report (PHA) – breaks down indicators such as birth weight, maternal BMI, maternal smoking and breastfeeding status by various geographies and by deprivation status, as well as outlining why these aspects are important to children's health. The report includes comparative data from other UK countries and the Republic of Ireland, where available. Available here.

In addition, data can be accessed from the NINIS (NI Neighbourhood Information Service) website, available here.

This update focuses on the regional position. The sources identified above also provide demographic breakdowns, such as geography (eg Trust, local government district, district electoral area, urban/rural), gender, age and deprivation insofar as data limitations will allow.

Corporate Plan 2017-21 Indicators At a glance

Data available at outset of Corporate Plan

61.7 yrs 58.7 yrs

In 2012-14 Healthy Life Expectancy at birth was 61.7 years for women and 58.7 years for men,

14.6 12.2

In 2012-14, the HLE gap between the most and least deprived was 14.6 years for women and 12.2 years for men.

82.3 yrs 78.3 yrs

In 2012-14 Life Expectancy at birth was 82.3 years for women and 78.3 years for men.

211 deaths

In 2010-14, the age standardised preventable death rate (per 100,000 population) was 211.

6.5%

In 2015, the percentage of babies born weighing under 2,500g was 6.5%

Overall

All children and young people have the best start in life

The story so far...

60.3 yrs 59.1 yrs

In 2015-17 Healthy Life Expectancy at birth was 60.3 years for women and 59.1 years for men,

14.5 14.3

In 2015-17, the HLE gap between the most and least deprived was 14.5 years for women and 14.3 years for men.

82.3 yrs 78.5 yrs

In 2015-17 Life Expectancy at birth was 82.3 years for women and 78.5 years for men.

207 deaths

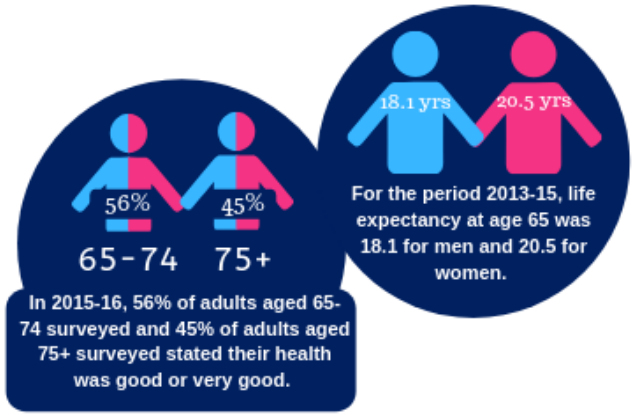
In 2013-17, the age standardised preventable death rate (per 100,000 population) was 207.

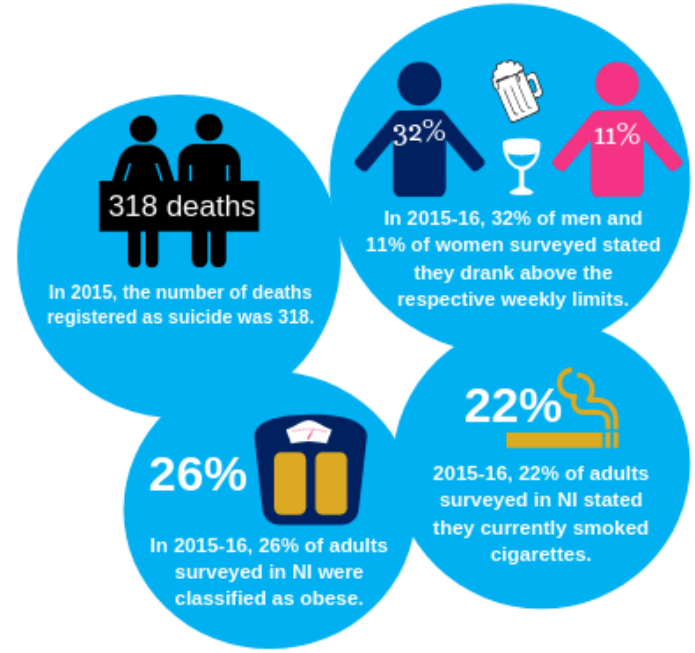
5.9%

In 2017, the percentage of babies born weighing under 2,500g was 5.9%

Corporate Plan 2017-21 Indicators At a glance

Data available at outset of Corporate Plan

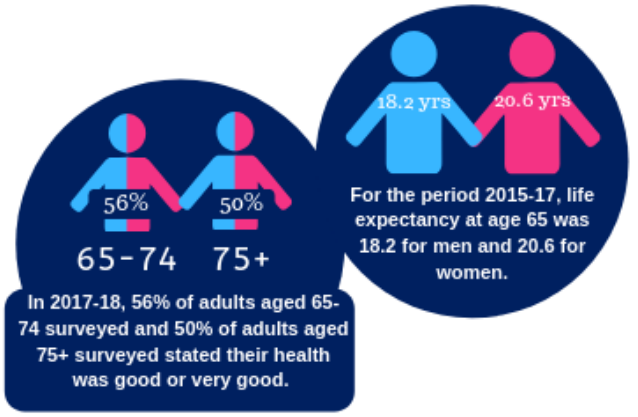


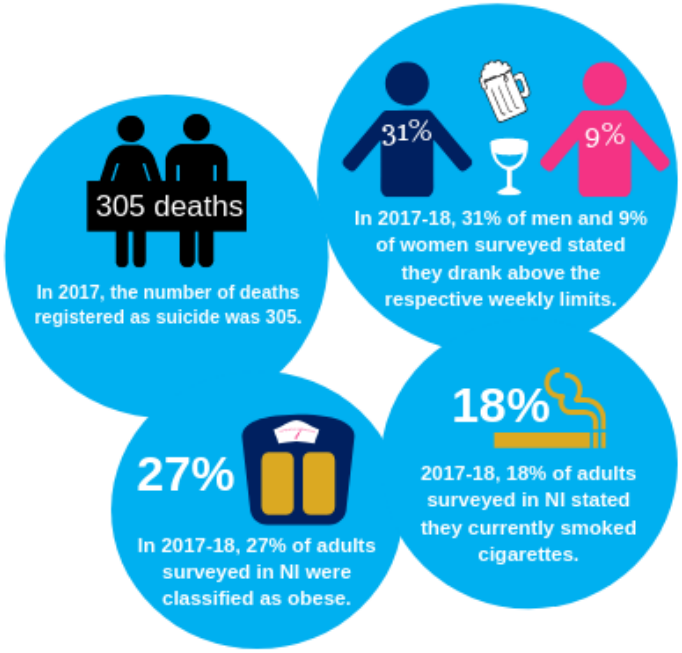


All older adults are enabled to live healthier and more fulfilling lives

All individuals and communities are equipped and enabled to live long healthy lives

The story so far...





Detailed update on indicators

Indicator	Current position (April 2019)
OUTCOME - OVERALL	
1. Gap in life expectancy between males and females Life expectancy (LE) at birth is the expected years of life at time of birth based on mortality patterns in the period in question. It is based on the average death rates over a 3 year period.	For babies born in the period 2015-17, the life expectancy gap between men and women was 3.8. The table below shows the trend over time. Since 2008-10, the gap between men and women has decreased, driven by an increase in male life expectancy. In recent years however, growth in life expectancy has stalled. This slowdown in improvement has been seen in the other countries of the UK as well as other large European Union (EU) countries. However, among the large EU countries, the UK has had the slowest rate of improvement since 2011. Public Health England (PHE) performed a detailed analysis of trends in England. The main finding was that the overall slowdown in life expectancy improvement is due to factors operating across a wide range of age groups, geographies and causes of death. PHE found it impossible to attribute the recent slowdown in improvement to any single cause and suggested that a number of factors, operating simultaneously, need to be addressed. Trends in specific causes of death by age group and geography are being produced by Health Intelligence in the PHA. A Health Intelligence Briefing on potentially avoidable or preventable premature deaths is also being undertaken.

	LE at birth		Gender gap	LE at birth most deprived		LE at birth least deprived		Deprivation gap	
	M	F		M	F	M	F	M	F
2008-10	77.0	81.4	4.4						
2009-11	77.4	81.9	4.5						
2010-12	77.7	82.1	4.4						
2011-13	78.0	82.3	4.3	73.6	79.6	81.1	83.9	7.5	4.3
2012-14	78.3	82.3	4.0	74.1	79.7	81.1	84.1	7.0	4.4
2013-15	78.3	82.3	4.0	74.3	79.6	80.8	84.1	6.5	4.5
2014-16	78.5	82.3	3.8	74.5	79.6	81.1	84.1	6.6	4.5
2015-17	78.5	82.3	3.8	74.2	79.6	81.3	84.1	7.1	4.5

See also:

- https://www.ninis2.nisra.gov.uk/public/PivotGrid.aspx?ds=9270&lh=73&yn=2008-2017&sk=134&sn=Health%20and%20Social%20Care&yearfilter=.
- https://www.health-ni.gov.uk/sites/default/files/publications/health/hscims-mlb-2018.pdf

Corporate Plan Monitoring

Indicator	Current position (April 2019)
OUTCOME - OVERALL	
2. Gap between highest and lowest deprivation quintile in healthy life expectancy at birth Healthy life expectancy (HLE) at birth is the average number of years a person can expect to live in good health. HLE provides an estimate of lifetime spent in 'very good' or 'good' health, calculated using respondents' perception of their own health according to the Health Survey NI. HLE excludes communal establishments. The NI Multiple Deprivation Measure (NIMDM 2017) is an area-based measure of deprivation in NI. It provides a way of ranking areas within NI from the most deprived to the least deprived. It can be displayed as quintiles or deciles. Each quintile contains 20% of small areas in NI and each decile 10%. For more information see https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/NIMDM17-%20with%20ns.pdf.	In 2015-17, the HLE gap between the most and least deprived quintiles was 14.3 for men and 14.5 for women. HLE estimates at deprivation quintile level are subject to a confidence interval of around +/- 1.7 years. In addition, a change in the HLE gap is only identified if the gap appears to increase/decrease and there is a significant change in HLE for the most and/or least deprived quintile OR where a clear and consistent trend is observed over 4 or more years. This means that although there has been some fluctuation year on year, there has been no notable statistical change in male and female HLE in the most and least deprived quintiles over time. However the gap is fluctuating and, whilst the use of survey data must be treated with some caution, as described in Indicator 3 there appears to be a reduction in the overall NI HLE. In addition, this is set against a background of flattening off of life expectancy growth and recent indications of increased levels of preventable mortality and higher death rates in the most deprived quintile. The table below shows the data over time. **2011-13** (M: 58.4, F: 61.6) / **2012-14** (M: 58.7, F: 61.7) / **2013-15** (M: 58.4, F: 61.0) / **2014-16** (M: 59.1, F: 60.9) / **2015-17** (M: 59.1, F: 60.3) **most deprived**: 51.3 / 53.8 / 51.2 / 53.4 / 51.1 / 53.1 / 50.6 / 52.7 / 50.2 / 51.3 **least deprived**: 63.1 / 67.8 / 63.4 / 68.0 / 63.0 / 67.5 / 64.3 / 65.7 / 64.5 / 65.8 **gap most and least deprived**: 11.8 / 14.0 / 12.2 / 14.6 / 11.9 / 14.4 / 13.7 / 13.0 / 14.3 / 14.5 See also: • https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/Measurement_Annex_PfG_2016_2021_Gap_between_highest_and_lowest_deprivation_quintile_in_healthy_life_expectancy_at_birth.pdf • https://www.health-ni.gov.uk/articles/regional-health-inequalities-statistics • https://www.health-ni.gov.uk/sites/default/files/publications/health/hscims-mlb-2018.pdf

Corporate Plan Monitoring

<table>
<tr><th>Indicator</th><th>Current position (April 2019)</th></tr>
<tr><td colspan="2">OUTCOME - OVERALL</td></tr>
<tr><td>3. Healthy life expectancy at birth

Healthy life expectancy at birth is the average number of years a person can expect to live in good health. HLE provides an estimate of lifetime spent in ‘very good’ or ‘good’ health, calculated using respondents’ perception of their own health according to the Health Survey NI. HLE excludes communal establishments.</td><td>The table below provides the NI figures since 2010-12. HLE in men has remained constant in NI, whereas HLE in women has declined. This is set against a background of flattening off of life expectancy growth and indications of increased levels of preventable mortality (see Indicator 4) and higher death rates in the most deprived quintile in recent data.

<table>
<tr><th></th><th>Male HLE</th><th>Female HLE</th></tr>
<tr><td>2010-12</td><td>58.5 years</td><td>61.6 years</td></tr>
<tr><td>2011-13</td><td>58.4 years</td><td>61.6 years</td></tr>
<tr><td>2012-14</td><td>58.7 years</td><td>61.7 years</td></tr>
<tr><td>2013-15</td><td>58.4 years</td><td>61.0 years</td></tr>
<tr><td>2014-16</td><td>59.1 years</td><td>60.9 years</td></tr>
<tr><td>2015-17</td><td>59.1 years</td><td>60.3 years</td></tr>
</table>

See https://www.nisra.gov.uk/publications/pfg-measurement-annex-healthy-life-expectancy-birth.</td></tr>
<tr><td>4. Preventable mortality

A death is deemed preventable if, in the light of understanding of the determinants of health at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided by public health interventions in the broadest sense.</td><td>In 2013-17, the age standardised preventable death rate (per 100,000 population) was 207. Whilst it is lower than that in 2010-14, this is not a statistically significant decrease. However this is set against a background of flattening off of life expectancy growth and indications of increased levels of preventable mortality and higher death rates in the most deprived quintile in recent data. The table below shows the figures over time.

<table>
<tr><th>2010-14</th><th>2011-15</th><th>2012-16</th><th>2013-17</th></tr>
<tr><td>211</td><td>207</td><td>205</td><td>207</td></tr>
</table>

See also:
• https://www.nisra.gov.uk/publications/pfg-2016-21-measurement-annex-preventable-mortality
• https://www.health-ni.gov.uk/sites/default/files/publications/health/pfg-4.pdf

Causes of death* have been categorised as preventable in line with the Office for National Statistics definition below:
• Infections: TB, Hepatitis C, HIV/AIDS.
• Neoplasms : malignant neoplasms of lip, oral cavity, pharynx, oesophagus, stomach, colon, rectum, liver, trachea, bronchus, lung, skin, breast, cervix uteri, mesothelioma
• Nutritional, endocrine & metabolic: diabetes mellitus.
• Drug use disorders: alcohol related diseases, excluding external causes, illicit drug use disorders.
• Cardiovascular diseases: ischaemic heart disease, DVT with pulmonary embolism, aortic aneurysm and dissection.
• Respiratory diseases: flu (incl swine flu), COPD.
• Unintentional injuries: transport accidents, accidental injury
• Intentional injuries: suicide & self-inflicted injuries, homicide/assault, misadventures to patients during surgical and medical care.

*age limits are applied to many of these causes. This does not mean that deaths from the selected causes for older persons are considered unavoidable or that the condition will not respond well to treatment in older people</td></tr>
</table>

Corporate Plan Monitoring

Indicator	Current position (April 2019)
OUTCOME – ALL CHILDREN AND YOUNG PEOPLE HAVE THE BEST START IN LIFE	
5. Infant mortality rates The number of infant deaths per 1,000 live births. Infant deaths refer to all deaths in the first year of life.	The infant mortality rate in NI in 2013-17 was 4.6. The table below shows how this compares with previous time periods and also the gap between most and least deprived areas. There has been no statistically notable change in the NI rate or the gap between most and least deprived quintiles.
6. Proportion of mothers breastfeeding on discharge and differential between the average and most deprived The proportion of all live births, where the HCN (Health and Care Number) of the mother is recorded, that were being breastfed on discharge from hospital. Figures include mothers' breastfeeding their child as well as using complementary feeding. For infants, evidence supports the role of breastfeeding in reducing the risk of: • ear infections • respiratory infections • gastroenteritis • bowel complications • Sudden Infant Death Syndrome • childhood leukaemia	In 2017, 47% of mothers were breastfeeding on discharge from hospital. The table below shows how this compares with previous time periods and also the gap between the average (NI) and most deprived areas. Whilst the NI proportion has remained constant since 2013, the differential has narrowed due to increases in the most deprived quintile.

Deaths per 1,000 live births	2008-12	2009-13	2010-14	2011-15	2012-16	2013-17
NI	4.7	4.3	4.6	4.5	4.5	4.6
most deprived	5.1	4.5	5.2	5.3	5.2	5.2
least deprived	4.6	4.3	4.5	4.7	4.5	4.4
gap between most & least deprived	0.5	0.2	0.7	0.6	0.7	0.8

% breast feeding on discharge	2009	2010	2011	2012	2013	2014	2015	2016	2017
NI	44	46	45	42	46	46	46	46	47
most deprived	31	33	30	28	30	32	31	32	33
% differential (NI & most deprived)	31	29	33	35	35	31	32	32	31

Corporate Plan Monitoring

Indicator	Current position (April 2019)
OUTCOME – ALL CHILDREN AND YOUNG PEOPLE HAVE THE BEST START IN LIFE	
7. Proportion of babies born at a low birth weight The proportion of all live births where the Health and Care Number (HCN) of the mother is recorded and the birth weight of the infant is less than 2,500g (5.5lb). Typically, an infant might have a lower birth weight because they were born earlier than expected (pre-term) or where growth has been restricted (small for gestational age). A birth weight below 2,500g contributes to a range of poor outcomes, including: • infant mortality • respiratory problems • infections • in later life – diabetes, high blood pressure, heart disease, obesity • possible lower life expectancy • possible lower educational achievement	In 2017, the percentage of babies born weighing under 2,500g was 5.9%, a decrease from the level in 2013 (6.3%). There has been no notable change in the deprivation gap, although there has been improvement in the most deprived quintile. The table below shows the data over time. **% low birth weight** **NI** 6.3 6.3 6.5 6.3 5.9 **most deprived** 7.6 6.9 7.3 7.0 7.1 **least deprived** 5.5 4.7 6.3 5.4 5.4 See also: • https://www.nisra.gov.uk/publications/pfg-2016-21-measurement-annex-babies-born-low-birth-weight • https://www.health-ni.gov.uk/sites/default/files/publications/health/pfg-7.pdf
8. Population vaccination coverage • Pneumococcal or pneumo jab (PCV) protects against some types of pneumococcal infection. • Rotavirus vaccine protects against rotavirus infection. • Men B vaccine protects against meningitis caused by meningococcal type B bacteria. • Hib/Men C vaccine protects against Haemophilus influenzae type & meningitis caused by meningococcal group C bacteria. • MMR vaccine protects against measles, mumps & rubella. • HPV vaccine protects against cervical cancer. • MenACWY vaccine protects against meningitis (caused by meningococcal types A, C, W & Y bacteria). • 4-in-1 pre-school booster protects against diphtheria, tetanus, whooping cough & polio.	The table below shows percentage NI vaccination uptakes over time. **2010-11 2011-12 2012-13 2013-14 2014-15 2015-16 2016-17 2017-18** **DTaP/IPV/Hib3** 97.5 97.6 97.6 97.5 96.8 97.2 97.0 96.2 **MenB** .. .. 95.8 **MenC** 97.2 97.2 97.4 N/A 97.5 98.1 95.8 .. **Rotavirus** .. .. 94.3 94.4 94.1 **PCV** 97.3 97.4 97.5 97.4 96.6 97.1 97.0 96.4 **MenC/ Hib** 95.0 95.5 95.9 96.2 95.0 95.7 95.0 94.6 **MMR1 by age 2** 92.9 93.3 95.6 96.2 95.2 95.8 94.9 94.4 **MMR1 by age 5** 96.7 96.7 97.0 97.5 96.4 97.5 97.4 96.8 **MMR2 by age 5** 91.3 91.2 90.9 92.4 93.1 93.0 92.8 92.4 **Pre School Booster** 92.9 92.9 92.2 93.4 93.8 93.6 93.3 92.9 **HPV** 88.0 89.6 91.9 92.7 92.9 90.7 89.6 84.7 **School Leavers Booster** 75.4 77.5 79.0 79.9 78.5 87.4 85.7 80.0 **Men ACWY** 78.0 86.5 85.3
9. Percentage of children who are at the appropriate stage of development in their immediate pre-school year	Data have been developed and are to be tested and assessed by the Technical Assessment Panel.

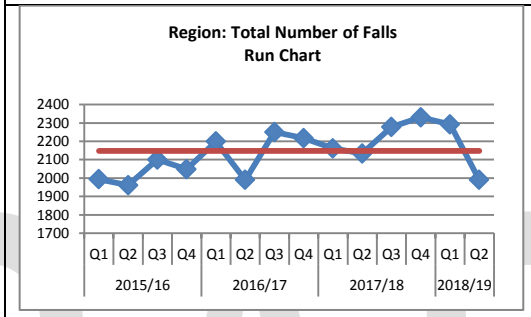
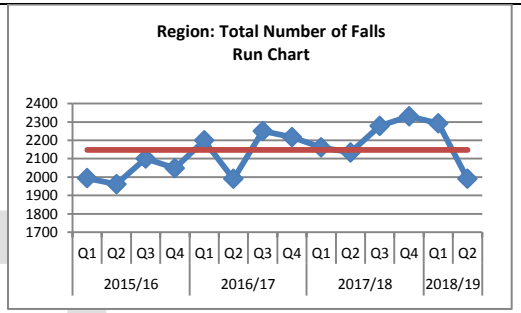
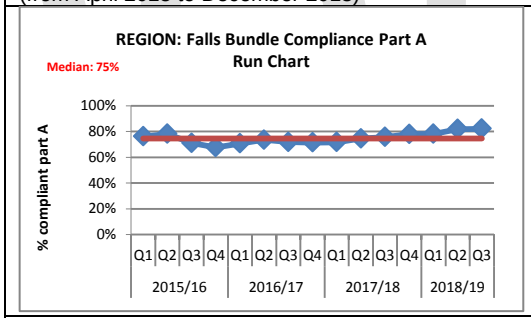
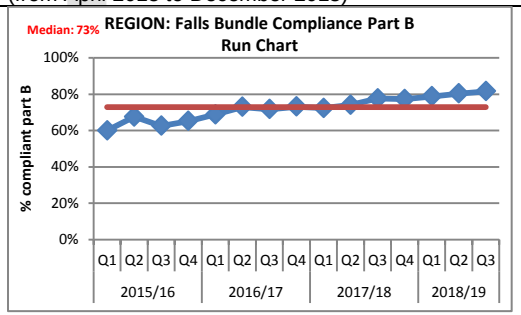
Corporate Plan Monitoring

Indicator	Current position (April 2019)
OUTCOME – ALL OLDER ADULTS ARE ENABLED TO LIVE HEALTHIER AND MORE FULFILLING LIVES	
10. Life expectancy at age 65 The expected years of life at age 65 based on mortality patterns in the period in question. It is based on the average death rates over a three year period.	For the period 2015-17, life expectancy at age 65 was 18.2 for men and 20.6 for women. The table below shows the data over time. Overall, life expectancy at age 65 has increased for men and stayed constant for women since 2008-10. This has resulted in a decrease in the gap between men and women. However male life expectancy at age 65 has plateaued since 2012-14. The inequality gaps between the most and least deprived quintiles for male and female life expectancies at age 65 showed no notable change. However this is set against a background of flattening off of life expectancy growth and indications of increased levels of preventable mortality and higher death rates in the most deprived quintile in recent data.
11. Percentage of older people reporting themselves to be in good health Self-reported health has been included in the Health Survey NI since it began in 2010. Survey respondents are asked: *How is your health in general, would you say it was?:* • *Very good* • *Good* • *Fair* • *Bad* • *Very bad* This indicator measures the proportion of those aged 65 and above who state their general health is good or very good.	In 2017-18, 56% of adults aged 65-74 surveyed and 50% of adults aged 75+ surveyed stated their health was good or very good. The table below shows the trend over time for these age groups, along with the NI average (all ages) for comparison. Both age groups, and particularly the 75+ group, fall short of the overall result for NI (all ages). There has been some fluctuation over time, but no statistically significant change.

	LE at age 65		Gender gap	LE at age 65 most deprived		LE at age 65 least deprived		Deprivation gap	
	M	F		M	F	M	F	M	F
2008-10	17.3	20.1	2.8						
2009-11	17.6	20.3	2.7						
2010-12	17.8	20.5	2.7						
2011-13	17.9	20.5	2.6	16.6	19.2	19.4	21.5	2.8	2.3
2012-14	18.1	20.5	2.4	16.6	19.2	19.4	21.6	2.8	2.4
2013-15	18.1	20.5	2.4	16.7	19.2	19.3	21.6	2.6	2.4
2014-16	18.3	20.6	2.3	16.5	19.2	19.4	21.5	2.9	2.4
2015-17	18.2	20.6	2.4	16.4	19.2	19.4	21.5	3.0	2.3

% self-reported good/very good health	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18 (conf int)
aged 65-74	59%	55%	56%	58%	56%	56%	60%	56% (52.0-60.3)
aged 75+	45%	48%	46%	58%	46%	45%	47%	50% (45.2-54.8)
all ages	73%	73%	72%	73%	72%	70%	73%	70% (68.8-71.9)

Corporate Plan Monitoring

Indicator	Current position (April 2019)	
12. Number of falls	The graph below show the total number of all falls per 1,000 occupied bed days (from April 2015 to October 2018)	The graph below show the total number of falls per 1,000 occupied bed days (from April 2015 to October 2018) which resulted in harm of a moderate/major/catastrophic nature.
		
	Regionally, there is fluctuation in the total number of all falls; there has been a reduction in the number of falls which resulted in harm of a moderate/major/catastrophic nature, particularly over the past 2 years, which demonstrates the impact of the measures which have been introduced over the past 3 years. The PHA/HSCB is continuing to work with Trusts to evaluate current processes and plan for improvements.	
13. Implementation of the FallSafe bundle	The graph below show compliance with Part A of the bundle (from April 2015 to December 2018)	The graph below show compliance with Part B of the bundle (from April 2015 to December 2018)
		
	During 2016/17 and 2017/18 the PHA worked closely with HSCB and HSC Trusts to implement and spread the Royal College of Physicians 'Fallsafe' bundle, an evidence based collection of interventions proven to reduce falls; in inpatient settings. Trusts measure compliance with Part A & Part B of the bundle and report to the PHA and HSCB on a quarterly basis. Regional compliance with both bundles has been 80% for the last 3 quarters (from 1st April 2018 - 31st December 2018). Both parts of the bundle have been spread to 100% total within the adult inpatients areas wards for each Trust.	

Corporate Plan Monitoring

Indicator	Current position (April 2019)
OUTCOME – ALL INDIVIDUALS AND COMMUNITIES ARE EQUIPPED AND ENABLED TO LIVE LONG HEALTHY LIVES	
14. Percentage of obese adults; or percentage of adults surveyed as obese & proportion in the most disadvantaged areas Obesity levels are estimated using the Body Mass Index (BMI). This is a widely used indicator of body fat levels. It is calculated by dividing an individual's weight in kilograms by the square of their height in metres. In adults a BMI of 30kg/m^2 or above is considered obese. BMI measurement has been included in the Health Survey NI since it began in 2010. Adults are classified as those aged 16 and above.	In 2017-18, 27% of adults surveyed in NI were classified as obese. The table below shows the trend over time and the deprivation gap. There have been significant increases in the obesity levels for NI and the least deprived quintile since 2010-11/2011-12. The obesity level in the most deprived quintile has not changed significantly over the same time period.
15. Proportion of adults (aged 16+) who smoke, both in the population and the most deprived areas Smoking status has been included in the Health Survey NI since it began in 2010. Survey respondents are asked: *Do you smoke cigarettes at all nowadays?*	In 2017/18, 18% of adults surveyed in NI stated they currently smoked cigarettes. The table below shows the trend over time and the deprivation gap. There have been significant decreases in the smoking levels for NI and the most deprived quintile since 2010-11/2011-12. The smoking level for the least deprived quintile has also decreased significantly over the same time period, but has plateaued since 2012-13.

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18 (conf int)
NI	23%	23%	25%	24%	25%	26%	27%	27% (25.0-28.6)
most deprived	26%	25%	31%	26%	28%	28%	26%	30% (25.5-35.0)
least deprived	19%	19%	21%	22%	19%	24%	25%	24% (20.1-27.8)

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18 (conf int)
NI	24%	25%	24%	22%	22%	22%	20%	18% (17.1-19.8)
most deprived	39%	39%	37%	34%	36%	36%	32%	30% (26.8-34.2)
least deprived	14%	18%	12%	12%	12%	13%	11%	11% (8.8-13.7)

Corporate Plan Monitoring

Indicator	Current position (April 2019)
OUTCOME – ALL INDIVIDUALS AND COMMUNITIES ARE EQUIPPED AND ENABLED TO LIVE LONG HEALTHY LIVES	
16. Population mental and emotional wellbeing as measured on the Warwick-Edinburgh Mental Wellbeing scale (WEMWBS) The WEMWBS is used to measure mental health and wellbeing. It asks people to indicate how often they have felt a certain way, such as feeling optimistic, feeling relaxed, thinking clearly, feeling confident and feeling cheerful. A score then is assigned (minimum 14 and maximum 70). The higher the score, the better the level of mental wellbeing. WEMWBS has been included in the Health Survey NI in most of the years since it began.	In 2017-18, the average WEMWBS score for adults surveyed in NI was 51.4. The table below shows the trend over time and the deprivation gap. The 2017-18 average NI score is significantly higher (ie improved) compared to scores in 2010-11 to 2014-15. **2010-11 / 2011-12 / 2013-14 / 2014-15 / 2016-17 / 2017-18 (conf int)** **NI**: 49.6 / 50.4 / 50.9 / 50.7 / 51.2 / 51.4 (51.0-51.8) **most deprived**: 47.3 / 47.9 / 49.2 / 48.3 / 48.8 / 50.0 (49.0-51.0) **least deprived**: 50.8 / 51.7 / 52.5 / 51.5 / 52.0 / 52.5 (51.8-53.3)
17. Percentage of population scoring 4 or more in the General Health Questionnaire (GHQ12) (signifying possible mental health problem). The General Health Questionnaire (GHQ) is a screening tool designed to detect the possibility of psychiatric morbidity in the general population. The questionnaire contains 12 questions about recent general levels of happiness, depression, anxiety and sleep disturbance. An overall score of between 0 and 12 is constructed, with a score of 4 or more being classified as a respondent with a possible psychiatric disorder, referred to as a 'high GHQ12 score'. GHQ12 has been included in the Health Survey NI in most of the years since it began.	In 2017-18, 18% of adults surveyed in NI had a GHQ12 score of 4 or more. The table below shows the trend over time and the deprivation gap. The 2017-18 level in NI is significantly lower (ie improved) compared to that in 2010-11. **2010-11 / 2011-12 / 2013-14 / 2014-15 / 2015-16 / 2016-17 / 2017-18 (conf int)** **NI**: 20% / 19% / 19% / 19% / 19% / 17% / 18% (16.4-19.2) **most deprived**: 28% / 27% / 26% / 30% / 27% / 27% / 22% (18.8-26.1) **least deprived**: 16% / 16% / 13% / 15% / 13% / 14% / 15% (12.5-18.4)
18. Incidence of suicide, both in the population and the most deprived areas Suicide deaths in NI are classified using the UK definition which includes deaths from Self-inflicted Injury as well as Events of Undetermined Intent.	In 2015-17, the crude suicide rate (per 100,000 of the population) was 16.5. The table below shows the trend over time and the gap between most and least deprived areas. The NI trend has been increasing and the gap between the most and least deprived quintiles has increased since 2012-14, driven by the increasing trend in the most deprived quintile. **2011-13 / 2012-14 / 2013-15 / 2014-16 / 2015-17** **NI**: 15.9 / 15.5 / 16.1 / 15.9 / 16.5 **most deprived**: 29.9 / 27.2 / 27.3 / 29.6 / 32.3 **least deprived**: 9.3 / 9.2 / 8.8 / 8.9 / 9.0 See also: https://www.nisra.gov.uk/publications/suicide-statistics

Corporate Plan Monitoring

Indicator	Current position (April 2019)
OUTCOME – ALL INDIVIDUALS AND COMMUNITIES ARE EQUIPPED AND ENABLED TO LIVE LONG HEALTHY LIVES	
19. Alcohol-related admissions to hospital Standardised Admission Rate (SAR) due to alcohol related causes is a comparison of alcohol related admission rates in an area with that in NI as a whole. It takes account of the different age-sex profiles in different areas. Alcohol related admissions are classified using the ICD-10 codes set out in Table A3 of the Regional NI Health & Social Care Inequalities Monitoring Report http://www.dhsspsni.gov.uk/hscims-2014-bulletin.pdf.	In 2015/16 – 2017/18, the standardised rate for alcohol related admissions (per 100,000 of the population) was 691. The table below shows the trend over time and the gap between most and least deprived quintiles. There has been no statistically notable change in the NI level over time. **2011/12-2013/14:** NI 694; most deprived 1,567; least deprived 301 **2012/13-2014/15:** NI 719; most deprived 1,600; least deprived 318 **2013/14-2015/16:** NI 728; most deprived 1,595; least deprived 335 **2014/15-2016/17:** NI 721; most deprived 1,577; least deprived 341 **2015/16-2017/18:** NI 691; most deprived 1491; least deprived 340
20. Proportion of adults (18+) who consume alcohol above weekly sensible drinking limits for women and men The Department of Health recommendation for regular drinking is not to exceed 14 units per week, or men and women. . A question on drinking above and below weekly limits has been been included in 5 Health Surveys NI since it began in 2010.	In 2017-18, 31% of men and 9% of women surveyed stated they drank above the respective weekly limits. The table below shows the trend over time for both sexes. More men than women drink over the recommended weekly limit. There have been significant decreases over time for both men and women. **2010-11:** drink in excess of the Department of Health's weekly drinking limits - Male 37%; drink in excess of the Department of Health's weekly drinking limits - Female 15% **2011-12:** drink in excess of the Department of Health's weekly drinking limits - Male 36%; drink in excess of the Department of Health's weekly drinking limits - Female 13% **2013-14:** drink in excess of the Department of Health's weekly drinking limits - Male 32%; drink in excess of the Department of Health's weekly drinking limits - Female 12% **2015-16:** drink in excess of the Department of Health's weekly drinking limits - Male 32%; drink in excess of the Department of Health's weekly drinking limits - Female 11% **2017-18 (conf int):** drink in excess of the Department of Health's weekly drinking limits - Male 31% (28.7-33.7); drink in excess of the Department of Health's weekly drinking limits - Female 9% (7.9-10.5)
21. Uptake of adult screening programmes There are 4 adult screening programmes in NI: • AAA (Acute Abdominal Aneurysm) screening - available for all men aged >65. Uptake targets are: (1) Acceptable ≥ 75%, (2) Achievable ≥ 85%. • Bowel cancer screening - available to men & women aged between 60-74 (every 2 years). Uptake targets are: (1) Acceptable ≥ 52%, (2) Achievable ≥ 60%. • Breast cancer screening - all women aged between 50-70 (every 3 years). Uptake targets are: (1) Acceptable ≥ 70%, (2) Achievable ≥ 80%. • Cervical cancer screening - available to women aged between 25 - 64 (every 3 years for 25-49 and every 5 years for 50-64). Uptake target is Acceptable ≥ 80%.	The table below shows screening uptakes over time. **2014-15:** AAA 83.1; Bowel 57.1; Cervical 77.1 **2015-16:** AAA 83.8; Bowel 59.8; Cervical 77.2 **2016-17:** AAA 84.1; Bowel 59.4; Cervical 76.8 **2017-18:** AAA 83.3; Bowel 61.3; Cervical 76.4 **2012/13-2014/15:** Breast 75.3 **2013/14-2015/16:** Breast 76.1 **2014/15-2016/17:** Breast 76.3 **2015/16-2017/18:** Breast 76.2 The AAA screening programme exceeded its Acceptable target across all the years. The Bowel cancer screening programme exceeded its Acceptable target across all the years and exceeded the higher Achievable target in 2017-18. The Breast cancer screening programme exceeded its Acceptable target across all the years. The Cervical cancer screening programme has not met its Acceptable target since 2014-15.

Corporate Plan Monitoring

Indicator	Current position (April 2019)
OUTCOME – ALL HEALTH AND WELLBEING SERVICES ARE SAFE AND HIGH QUALITY	
22. Proportion of PHA projects & contracts where PPI is incorporated	**Proportion of PHA projects & Contracts where PPI is incorporated** PHA Business plan • The PHA business plan 2016/17 contained 81 objectives, 18 of these did not require PPI (due to the nature of the objective). • Of the 63 remaining objectives 94% undertook a range of PPI initiatives. The remaining 6% plan to include PPI to achieve the objective. • An additional 6 PHA led PPI projects were identified via the Internal Monitoring which took place in 2017/18 to support regional clinical and strategic leadership across HSC. Contracts The PHA has a system in place to ensure that all contracts awarded include PPI. In 2019/20 the PHA will conduct a further review of PPI activity across the PHA, again linked to corporate and business objectives. In addition a programme will commence to develop an Involvement and Co- Production Action Plan for each division within the PHA to build on the culture of operational PPI that has grown within the PHA.
23. Uptake of PPI training & usage of the Engage website within the PHA and across the HSC	The PHA continues to work to help facilitate meeting the increasing demand for general and specialised training programmes to support Involvement and Co- Production within the PHA and across the HSC. The existing DoH endorsed Engage & Involve programme remains the HSC wide main training provision. In addition, the PHA PPI team have added a range of specialist programmes to meet the needs of staff and the HSC. PHA • 1/3 of PHA staff has undertaken the Engage & Involve e-learning module • 40 staff have undertaken Engage & Involve modules which are delivered twice a year within the PHA • The PHA PPI team provide one to one and team bespoke training and support for project based work. • Staff across the PHA have availed of specialist training programmes including, Involvement and Co-Production Leadership Programme, Developing Skills Programme, Understanding and Undertaking Consultations. HSC wide • 2018 data suggests that 2431 staff across HSC Trusts have undertaken PPI training at Trust level (we are still working with Trusts to agree a monitoring mechanism) this includes, e-learning and Engage & Involve taught modules. Speciality programmes To date 48 participants have undertaken the Leading in Partnership – Leadership Programme for Involvement and Co-Production, the programme is scheduled to run again in September 2019/20. An additional 36 attended training to support developing skills and understanding and undertaking consultation. In addition to these the PHA PPI team has continued to deliver professional advice and guidance to 81 individual

Corporate Plan Monitoring

Indicator	Current position (April 2019)
	projects between April 2017 and April 2019. The Engage website continues to support HSC staff, service users, carers and the general public, to build their knowledge and skills on involvement. Over 2000 new users have visited the website in the last six months. Engage continues to be a central resource of information, good practice and resources on involvement, PPI and Co-Production. During this period, Engage produced a flyer to promote the use of the site. Flyers were distributed throughout all 5 Trust areas. Changes have been made to the site, such as the introduction of an Opportunities section where people can upload and access current involvement opportunities.
24. Percentage of people who are satisfied with health and social care (based on their recent contact)	No data available beyond baseline. The Patient Experience Score for 2017 (baseline year) was 83, where 0-25 = poor/very poor; 75-100 = good/very good.
OUTCOME – OUR ORGANISATION WORKS EFFECTIVELY	
25. HSC staff satisfaction survey	The HSC Staff Satisfaction Survey was conducted April 2019. Results are not yet available.
26. Controls assurance standards	Controls Assurance Standards ceased with effect from 1 April 2018. Assurance is now provided primarily through the PHA Assurance Framework.
27. Campaign awareness & reach of press release	4 campaigns were implemented in the final 4 months of 2018/19. These included - AMR, Smoking cessation, Mental Health and FAST. Evaluation results are due for Mental Health and FAST. **Smoking campaign evaluation top line results** Smoking campaign focused on encouraging smokers to make a quit attempt highlighting the benefits of using the smoking cessation services. The campaign programme involved a short 3 wk burst of activity during March 2019. Sample size: 475 (smokers (n=338), recent quitters – quit in the last 3 months (n=137)) High level of campaign exposure (74%). TV (49%) greatest exposure *[radio, 40%: outdoor, 44%: online, 32%]* All respondents shown the advertising and most agree the campaign would encourage them to: • Think positively about the stop smoking service (68%) • Use the stop smoking service if quitting in future (63%) • Think about stopping smoking (60%) • Do at least one of the above (73%)

Corporate Plan Monitoring

Indicator	Current position (April 2019)
	Awareness of Stop Smoking Service • 77% had heard of the Stop Smoking Service. Recent quitters higher awareness (92%) • 42% could recall Stop Smoking Service logo • Positive response to the Stop Smoking Service among those aware of the service agreeing the service has: ü Helped thousands of smokers to quit (74%) ü Increases your chances of quitting smoking (68%) ü You are up to 4 times more likely to quit if you use the service (63%) **AMR campaign evaluation – topline results** The PHE AMR campaign was extended into Northern Ireland for an 8 week period beginning Christmas Eve with the aim of alerting the public to the risk of antibitioic resistance with the aim of reducing patient's expectations for antibiotics to be prescribed. Sample 1000 adults aged 16 and over pre and post campaign Spontaneous awareness has increased 20 percentage points with 55% of respondents seeing/hearing something in the last 6-8 weeks about antibiotics/AMR versus 35% pre-campaign. Total prompted campaign awareness was very high - 84% (TV 76%, radio 46%, outdoor and press 47%) Campaign has also been successful in being thought provoking (93% very/somewhat thought provoking); believable (97% very/somewhat believable) and relevant (80% very/somewhat relevant). (All respondents) Respondents were asked in a situation where they feel unwell and think they need an antibiotic but GP says they do not need them, how likely would you be to ask for them. Positive shifts pre and post campaign - 83% (71% pre –campaign) said they would be very/quite unlikely to ask for antibiotics and 12% (22% pre campaign) very/quite likely to ask for them.