HSC Public Health Agency

agenda

Title of Meeting	123rd Meeting of the Public Health Agency Board
Date	18 June 2020 at 1.30pm
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

standing items

1 1.30	Welcome and apologies		Chair
2 1.30	Declaration of Interests		Chair
3 1.30	Minute of Previous Meeting held on 21 May 2020		Chair
4 1.35	Matters Arising		Chair
5 1.40	Chair's Business		Chair
6 1.45	Chief Executive's Business		Chief Executive
7 1.55	Finance Update - PHA Draft Budget 2020/21	**PHA/01/06/20**	Mr Cummings

items for noting

8 2.05	Update on PHD Response to COVID-19	**PHA/02/06/20**	Professor van Woerden
9 2.25	Update on Contact Tracing Programme	**PHA/03/06/20**	Chief Executive
10 2.40	Update on Vaccination Programme - Northern Ireland Seasonal Influenza Vaccination Programme Planning for 2020-21 - COVID-19 vaccine and potential implication for seasonal influenza programme 2020	**PHA/04/06/20**	Professor van Woerden

11 PPI Update Report **PHA/05/06/20** Mr Morton
2.45

closing items

12 Any Other Business
3.00

13 Details of next meeting:

Tuesday 7 July 2020 at 1.30pm (Special Board Meeting)

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

HSC Public Health Agency

minutes

Title of Meeting	122nd Meeting of the Public Health Agency Board
Date	21 May 2020 at 1.30pm
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

Present

Mr Andrew Dougal	-	Chair
Mrs Olive MacLeod	-	Interim Chief Executive
Mr Edmond McClean	-	Interim Deputy Chief Executive / Director of Operations
Mr Rodney Morton	-	Director of Nursing and Allied Health Professionals
	-	*(via video link)*
Professor Hugo van Woerden	-	Director of Public Health
Alderman William Ashe	-	Non-Executive Director (*via video link*)
Mr John-Patrick Clayton	-	Non-Executive Director (*via video link*)
Ms Deepa Mann-Kler	-	Non-Executive Director (*via video link*)
Alderman Paul Porter	-	Non-Executive Director (*via video link*)
Professor Nichola Rooney	-	Non-Executive Director (*via video link*)
Mr Joseph Stewart	-	Non-Executive Director (*via video link*)

In Attendance

Mr Paul Cummings	-	Director of Finance, HSCB
Ms Marie Roulston	-	Director of Social Care and Children, HSCB *(via video link)*
Ms Jenny Redman	-	Boardroom Apprentice *(via telephone link)*
Mr Robert Graham	-	Secretariat
Mr Stephen Wilson	-	Assistant Director, Communications and Knowledge Management

Apologies

Dr Aideen Keaney	-	Director of Quality Improvement

49/20	**Item 1 – Welcome and Apologies**
49/20.1	The Chair welcomed everyone to the meeting. Apologies were noted from Dr Aideen Keaney.
49/20.2	The Chair advised members that he and the Chief Executive would have to leave the meeting at approximately 2:30pm to meet with the Minister and that he has asked Mr Stewart to chair the meeting during this

period.

50/20 **Item 2 – Declaration of Interests**

50/20.1 The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.

51/20 **Item 3 – Minutes of previous meetings**

51/20.1 The minutes of the Board meeting held on 23 April 2020, were approved as an accurate record of that meeting.

51/20.2 The notes of the Board briefing held on 6 May 2020 were approved as an accurate record of that meeting.

52/20 **Item 4 – Matters Arising**

52/20.1 There were no matters arising.

53/20 **Item 5 – Chair's Business**

53/20.1 The Chair expressed concern that a large number of individuals do not do well on ventilators. In fact, he said there is evidence indicating that between 30 and 40% of individuals with COVID-19 who are treated on ventilators do not survive. He added that the President of the Faculty of Intensive Care Medicine had indicated that continuous positive airways pressure (CPAP) may be an appropriate and less invasive form of treatment for some individuals with COVID-19. Mr Morton said that additional CPAP machines were procured and utilised as part of the response to the pandemic. Mr Cummings added that he has commissioned a report to look at the use of different treatments to see which is most appropriate.

53/20.2 The Chair suggested that many people stayed at home too long before admitting themselves to hospital. Mr Cummings agreed that this was certainly a factor at the start of the outbreak, but the messaging now is that people should go to a COVID-19 centre as soon as possible. The Chair worried that individuals might leave it too late and would not be eligible for CPAP. Mr Morton gave an assurance that this was not the case.

54/20 **Item 6 – Chief Executive's Business**

54/20.1 The Interim Chief Executive said that the staff of the PHA continue to remain very busy dealing with the pandemic, but also starting to plan for the recovery phase. She said that work is ongoing to look at how to make the office environment safer for staff returning with enhanced cleaning taking place and a one-way system on the staircases introduced.

54/20.2 Ms Mann-Kler asked if there were any particular concerns about staff health and wellbeing. The Interim Chief Executive said that the senior staff have been taking most of the workload and need to take a proper break. She advised that work is starting to ramp up in terms of contact tracing, and that there will be a presentation later in the meeting on Health Improvement initiatives. Ms Roulston added that there is a staff health and wellbeing group that has been set up by Ms Michelle Tennyson, which is receiving feedback from staff on a range of issues. The Chair asked what happens to that feedback.

54/20.3 Mr Clayton said that he had a concern about how social distancing will be managed within the office, and noted that there will be staff who will continue to have childcare responsibilities. The Interim Chief Executive advised that Dr Keaney is leading a piece of work to overhaul the working environment on the 4th floor which will help cleaning staff carry out more in-depth cleaning. She said that there are increased amounts of hand gels and sanitisers throughout the building, but she acknowledged that there remain some concerns regarding the canteen. She said that correspondence has been sent to all staff keeping them up to date on what has been happening.

54/20.4 Alderman Porter said that it is important to keep the messaging positive as this has been a difficult time for people.

55/20 Item 7 – Finance Report

55/20.1 Mr Cummings presented the final Finance Report for 2019/20 and said that PHA had ended the year within the ±0.25% tolerance with a surplus of £115k. He said that Trust expenditure had remained largely in line with previous years, but there had been a slight overspend in programme expenditure offset against the underspend in the management and administration budget. He said that the capital expenditure had matched the budget, and although there was a slight dip towards the end of the year, the prompt payment performance remained high.

55/20.2 The Chair congratulated Mr Cummings and his colleagues for this very successful outcome.

55/20.3 Mr Stewart echoed the views of the Chair. He noted that some of the payments had not been able to be made on time due to terms and conditions of contracts not being met.

55/20.4 The Chair asked if any unallocated expenditure could be used to finance a media campaign. Mr McClean said that this was possible, but it would have to fit within the wider framework of other campaigns. He advised that PHA has received its allocation letter for 2020/21 and will be bringing a financial strategy to the Board based on this allocation.

55/20.5 Alderman Ashe also expressed his thanks to Mr Cummings and his

team for their work in not only achieving a break-even position, but completing the work on time given competing priorities.

55/20.6 The Board noted the Finance Report.

56/20 Item 8 – Update from Chair of Governance and Audit Committee

56/20.1 Mr Stewart advised that the Governance and Audit Committee had met on 20th May and that the main papers considered, namely the draft Annual Report and Governance Statement, had been considered in the confidential session of the meeting.

56/20.2 Mr Stewart said that the Committee had expressed concern about receiving an updated corporate risk register, and that it has been agreed that a special meeting of the Committee will be convened within the next 2/3 weeks following completion of the latest review. He highlighted particular issues that should feature on the risk register, including reputational damage and resilience.

56/20.3 The Board noted the update from the Chair of the Governance and Audit Committee.

57/20 Item 9 – Update on COVID-19

Distinct Role of PHA in the COVID-19 Crisis

57/20.1 Professor van Woerden said that there is a clear statutory role for PHA in terms of improving the health of the population.

57/20.2 Professor van Woerden said that work is now commencing that PHA is assisting with in terms of getting treatments programmes, which had been stood down during the pandemic, back up and running.

Survey of a Sample of the Northern Ireland Population

57/20.3 The Chair said that there is a need to establish a baseline on the incidence of COVID-19 and carry out a random survey of a sample of the Northern Ireland population. Professor van Woerden said that there is currently a telephone survey of up to 1,000 people a week that can help come up with a symptoms perspective. He added that the ONS is also doing a survey, but not a Northern Ireland-specific one.

57/20.4 Professor van Woerden said that two antibody tests have now been approved. He added that as part of the Research and Development work, there are studies taking place in conjunction with the Republic of Ireland with some protocols being developed. He advised that left over samples from hospitals are being tested. The Chair remarked that this was a very positive development.

57/20.5 Mr Clayton said that he had seen some information suggesting that the

overall death rate is currently higher when COVID-19 deaths are taken out of figures, and asked if this is being looked at. Professor van Woerden acknowledged that there is a risk of this with services being reduced, and also with people not seeking help. He said that studies are carried out on excess deaths during the flu season, and that a similar exercise is being conducted in relation to COVID-19. The Chair recalled that a letter had been received from Northern Ireland Chest Heart & Stroke expressing concern to the interim Chief Executive that individuals potentially with heart attacks and strokes were reluctant to call 999 and that it had suggested there should be a further run of the FAST campaign.

Testing in Northern Ireland

57/20.6 Professor van Woerden said that testing is a huge project, but Northern Ireland has carried out more tests per capita than other parts of the UK. He advised that testing has been expanded in care homes, and anyone who is over the age of 5 and is symptomatic can be tested. He assured members that there is no shortage of testing capacity in hospitals.

57/20.7 The Chair asked when all care homes will be tested. Professor van Woerden explained that if more than one resident in a care home tests positive, then all residents are staff are tested. He said that a rolling programme of testing will be done across all care homes on a priority basis, in conjunction with HSC Trusts and the Northern Ireland Ambulance Service (NIAS). Mr Morton clarified that the Trusts will undertake the majority of the work, with NIAS helping out.

57/20.8 Professor Rooney asked about PHA's role in infection prevention control and giving guidance. Mr Morton explained that as part of their normal duties in any outbreak the PHA health protection team supports care homes and provides infection prevention control advice. He added that as part of a wider programme, the PHA, with the HSCB, worked with Trusts to ensure that there was sufficient PPE. Professor Rooney asked if PHA was reactive in giving its advice. The Interim Chief Executive said that the health protection service is available 365 days a year. She said that Mr Morton and Ms Roulston worked together to develop a programme of support for every care home and that Northern Ireland was more proactive than any part of the UK in this work. She added that working with Trusts and RQIA, additional staff and advice were provided to care homes and she commended the work that was done.

57/20.9 Mr Clayton noted the involvement of Trusts and NIAS in testing, but he asked what PHA's role was in this area specifically. He also asked about the frequency of testing. Professor van Woerden explained that one of PHA's Assistant Directors, Dr Brid Farrell, is leading the advisory group for the Department of Health in regard to testing. He said that there is a dynamic approach in terms of testing in homes.

57/20.10 Alderman Porter asked if PHA was working to link with political parties to

ensure they are clear as to what PHA's role is. Mr Wilson said that there is a plan in place for engagement with all political parties to ensure they are brought up to speed on the main issues and are clear as to PHA's role. He noted that the work of PHA is not only focused on health protection. The Chair noted that there had been a request from the Health Committee to all health organisations in order to supply information in a more timely manner.

57/20.11 Ms Mann-Kler asked whether emergency departments have any concerns in relation to testing. Professor van Woerden acknowledged that reassurance is important, but the tests are far from perfect, but the quality is improving. He noted that at present the tests are picking up about 80% so that means for the other 20% there are false negatives. He said that there continues to be good co-operation between the different parties looking at testing, but he felt that this will continue to be a pressure point. Mr Cummings added that there is an issue about supply of reagents for testing.

57/20.12 The Chair said that there is a challenge in terms of knowing where to direct and target testing. Professor van Woerden noted that tests can give a false positive and a false negative, and that in any system priority has to be given to ensure that those who are highest priority can get access to tests. Mr Stewart asked who is assessing the quality of the laboratories carrying out the testing. Professor van Woerden advised that all laboratories take part in a national quality assurance programme, which is a combination of self-assessment and a site visit. He added that for the UK, Colindale is recognised as the best in the UK. However he assured members that there are clear quality standards in regard to testing, wherever it takes place.

<u>Tracing</u>

57/20.13 The Interim Chief Executive reminded members that the PHA had set up a pilot contact tracing service, but now the next phase of this work is being put in place in preparation of the lifting of lockdown restrictions. She advised that there has been a significant number of people volunteering to assist, but it would be impossible to train 700 people. She said that presently PHA is dealing with up to 50 positive cases a day, but it is difficult to contact trace many of them due to not being able to obtain contact telephone numbers, but a workaround is being looked at.

57/20.14 The Interim Chief Executive explained that the new service will run for a minimum of 1 year, and there will be three tiers. She said the bottom tier will be a call centre where people who do not wish to use an app can speak to a call handler. She went on to say that the middle tier will consist of nurses and health protection officers who are skilled in contact tracing. She said that PHA has contacted a number of nurses on Trust banks, and have also offered contracts to two environmental health staff.

57/20.15 The Interim Chief Executive outlined that it was envisaged that this middle tier service will have up to 30 people working 12 hours a day, 7 days a week at a location still to be finalised, but possibly in Ballymena. She added that the team will be led by a doctor and there will also be the capacity to undertake analytics of the data gathered.

57/20.16 The Interim Chief Executive advised that there is a steering group leading this work with a robust project structure including a risk register and an action log, and that there are workstreams on HR, finance and communications. She said that the PID for this work is with the Minister and he is expected to make an announcement shortly on this work.

57/20.17 Ms Mann-Kler asked whether equality considerations are being taken into account. The Interim Chief Executive advised that the group and met with the Human Rights Commissioner, and would also be meeting with the Equality Commissioner. She added that there is also representation from the Patient Client Council on the group, as it is acknowledged that it will be important to get to those "hard to reach" groups.

57/20.18 Professor Rooney asked who is involved in the group. The Interim Chief Executive advised that it is being chaired by the former Deputy Chief Medical Officer, Dr Liz Mitchell. Professor Rooney asked about the HR input. The Interim Chief Executive explained that HR are helping to expedite the recruitment process as the team needs to be in place quickly.

57/20.19 Mr Stewart said that it is important that the Board is sighted on this work and asked how the decision was made that PHA was to lead on this. The Interim Chief Executive advised that PHA has always carried out contact tracing as it is a health protection function. Professor van Woerden said that this type of work would be done on a routine basis in tracking infections such as TB, so it was understandable that the Department asked PHA to lead.

57/20.20 The Interim Chief Executive explained that of the 3 tiers, 2 will be managed internally, while the call centre tier will be managed by NI Direct. He added that the Chief Medical Officer is very actively involved in this process and that the steering group is providing effective oversight. She understand that the Board wishes to see more detail, and she agreed to share this when it becomes available.

At this point the Chair and Interim Chief Executive stepped out of the meeting.

<u>Nursing/Care Homes</u>

57/20.21 Mr Morton advised members that the PHA and HSCB have developed a

model to assist care homes and that the key elements of this work are around the prevention of infection, wraparound care and providing additional support in terms of staff. He added that this work is being monitored by a steering group but also by the Chief Nursing Officer and Chief Social Services Officer as well as by Mrs Mary Hinds and Ms Patricia Donnelly who have been asked to provide independent scrutiny to the process. He said that he would be happy to share the paper that has been produced together with the action plan.

57/20.22 Ms Mann-Kler noted that the PHA had recently attended the Northern Ireland Assembly Health Committee and there had been questions asked regarding care homes. She asked whether there was a robust audit trail in terms of the governance of PHA's remit in this area. Professor van Woerden explained that the elderly are in a vulnerable group, and PHA has worked from the outset on dealing with vulnerable groups including not only elderly in care homes, but people in shared accommodation and supported living as well as homeless people. He also highlighted risks in shared living establishments where groups of people live together and there are large numbers of people coming in and out. Therefore, he noted that while care homes were not specified, PHA has been working from the outset on assisting a range of vulnerable people in different settings.

57/20.23 Ms Mann-Kler asked about PPE and if there are sufficient quantities and if the single use policy remains in place. Mr Morton acknowledged that PPE remains tight for all sectors, but he informed members that he is part of a group that has completed a modelling exercise to look at PPE demand over the next year. He said that this model will be used to inform future procurements to ensure that there is an accurate and consistent supply. He added that the model includes supply for the independent sector.

57/20.24 In relation to PPE in care homes, Mr Morton said that he was not aware of any concerns and that the Trusts are taking the lead in terms of providing support to care homes. He acknowledged that the issue of single use PPE is a complex one, and that his team has produced a paper on the repurposing and reuse of PPE in line with effective decontamination procedures. He said that there will be further work looking at sessional use in certain types of environments. He explained that if it is not possible to maintain social distancing, then there is an expectation that PPE will be changed each time there is interaction with a patient.

57/20.25 Professor Rooney asked whether PHA is monitoring COVID-19 among groups with complex needs and intellectual disability. Mr Morton said that within PHA and HSCB there is a cellular structure, and this ensures that all vulnerable groups are picked up. He said that there has been a lot of work undertaken in mental health hospitals and community hospitals, and that Mrs Mary Hinds and Ms Patricia Donnelly are also looking at this area as part of their remit.

57/20.26 Mr Morton said that he, and Professor van Woerden, are working on a new infection prevention control framework which should be finalised in the coming weeks. Ms Roulston added that she has weekly telecalls with Directors across all 5 Trusts to get an overview of current work, and that there is a structure in place.

57/20.27 Professor Rooney said that she was seeking to clarify PHA's role in terms of infection control. Mr Morton assured members that PHA is working with HSCB in this area. He advised that PHA has a specific health protection role for all members of the community, irrespective of location, but for commissioned services this responsibility lies with the Trusts. He said that PHA's role is to monitor any infection outbreaks and ensure that they are dealt with. He noted that it is a complex landscape as some providers and public sector, while others are in the private sector.

57/20.28 Mr Clayton said that he would hope to see an improvement based on the additional measures that are being put in place. He asked about PPE and, declaring an interest as a UNISON representative, he passed on concerns about the failure of certain types of respirator masks. He said that data from Trusts in this are unclear. Mr Morton explained that there are different types and grades of FFP3 respirator masks and it is not uncommon for these to fail a FIT test. However, he said that there should be an opportunity to be tested for another type of mask. He acknowledged that this could become challenging if the number of options is reduced, but that he is undertaking a piece of work looking at the failure rate of certain products to ensure that these particular products are not being bought in large volumes. He emphasised that it is the Trusts' responsibility to ensure staff get tested for an alternative type of mask.

57/20.29 Mr Clayton asked for an update on the independent sector. Mr Morton said that the Trusts are helping independent sector providers.

57/20.30 Professor van Woerden noted that Northern Ireland is procuring face masks from international manufacturers who are using local templates.

57/20.31 Mr Morton said that there is beginning to be a flattening of the curve and that the trend is now not an upward one, but he conceded that there are homes with complex needs. He said that going forward there will need to be further work to improve infection prevention control, with enhanced cleaning, but there will be a challenge in managing footfall. He said that there will be a need to maintain the highest standards possible in order to protect the most vulnerable citizens.

57/20.32 Professor van Woerden delivered a short presentation to members. He began by showing how the number of confirmed outbreaks in care homes has decreased in recent weeks and how the interventions by PHA and HSCB have helped to reduce the number of cases. He

showed an age pyramid which highlighted that the highest number of deaths from COVID-19 has been in the older age categories. In summary, he said that there has been significant spread of COVID-19 in nursing homes, which was expected, but that the curve is beginning to flatten. In general terms, he said that there is a delicate balance to be met in terms of the lockdown as there is a risk of inadvertently causing ill health while trying to prevent harm.

At this point Mr Morton and Ms Roulston left the meeting.

Post Lockdown

During this section the Chair and Interim Chief Executive returned to the meeting.

57/20.33 Mr Stewart welcomed Mr Séamus Mullan to the meeting and invited him to give his presentation.

57/20.34 Mr Mullan gave members an overview of the work that the Health Improvement team has been involved in with other stakeholders. He advised that each Local Council has its own emergency response team and there is a member of PHA Health Improvement staff on each of these groups. He added that PHA is also working with the Department for Communities.

57/20.35 Mr Mullan advised that PHA has over 500 contracts with community and voluntary sector organisations and that a demand and capacity analysis of the services provided by these contracts has shown that overall demand for services has either increased or stayed the same. He said that undertaking this exercise gives PHA intelligence as to where an increase in demand can be anticipated. He added that where resources have been stood down, this allows for a direct intervention to ensure that additional funding can be reinvested In other areas.

57/20.36 Mr Mullan reminded members that this is Mental Health Awareness week, and PHA, as the organisation responsible for the Lifeline contract, has been monitoring the number of calls to the Lifeline service, and there has been a slight increase in previous weeks after a dramatic decline. He showcased the work of the Multi Agency Triage Team (MATT) that is working within the South Eastern Trust area which is a service available to those people contact 999 and require emotional support. He added that the service also helps to reduce the number of attendances at emergency departments for people in crisis. He noted that there has had to be a change in how that service is being delivered due to social distancing measures so more work is being delivered online, and he is hoping that this type of model could be rolled out more widely.

57/20.37 Mr Mullan said that the PHA provides direct interventions into the community and voluntary sector and highlighted the CLARE project which helps deliver parcels and support to those who cannot leave their

homes due to COVID-19. He said that PHA has worked with the Department of Agriculture and the Department for Infrastructure in its role as an influencer/agenda setter. He referenced the Farm Families Project and initiatives to improve physical activity.

57/20.38 In response to a comment from Alderman Porter about PHA's work in the area of mental health, Mr Mullan said that PHA is working at a policy level and has had a direct input. He added that the PHA is also part of the Protect Life Implementation Group which will be meeting soon, and PHA has an explicit role vis-à-vis the implementation of Protect Life 2. He advised that PHA will be investing up to £8m per annum on Protect Life 2 activities across Northern Ireland,

57/20.39 Ms Mann-Kler asked if PHA is taking advantage of the opportunities presented by COVID-19 as the work of the Agency is gaining greater profile exposure than previously. Mr Mullan said that there are an increased number of blogs being prepared and one blog published recently on infant mental health had a very high number of hits. He said that PHA is also working with regional organisations to capture any learning and what the important issues are for the community. Mr McClean said that much of the focus of politicians recently has been on waiting lists, and he expressed concern about how PHA can distil any learning and experience, but at the same time put greater emphasis on its core roles of prevention and improvement. He said that there is now the opportunity to make a greater case for resources for improving and protecting health.

Communications

57/20.40 Mr Wilson informed members that over the last few months the communications team in PHA has been working beyond full capacity dealing with issues relating to COVID-19. He gave members of some of the work that the team has been involved in, and what its current priorities are.

57/20.41 Mr Wilson explained that the PHA communications teams works alongside its counterparts in HSCB and the Department of Health to ensure that there is an integrated approach across all areas. He noted that the primary focus has been on health protection, but there has been work taking place across other parts of the organisation and he referenced in particular work going on within health Improvement. He added that the campaigns team has been working with the Executive Office in terms of managing the rollout of key messages and PHA provides advice on the public health content. He said that the publications team also works to supply the various needs across the sector.

57/20.42 Mr Wilson noted the reference already made by Mr Mullan on the blog which appears on social media 3 times per week. He advised that PHA has revamped its corporate website and is looking at develop a new

corporate site.

57/20.43 Mr Wilson said that one of the big successes for PHA has been its social media work with Facebook posts over the last 28 days reaching almost 30 million people, with 1.35 million engagements and 3.3 million video views. He said that the number of Facebook followers has increased by over 40,000. He added that PHA's tweets have had similar levels of engagement and that there has been a similar increase in the number of Twitter followers. He noted that in terms of how this stacks up against other public sector organisations, he said that PHA has had some of the highest performing social media posts across the UK, with one post being second only behind the Prime Minister's daily briefing.

57/20.44 Mr Wilson said that the challenge for PHA now is how to go forward and optimise this. He said that it would not have been possible for PHA to do this without the help of colleagues providing appropriate messaging.

57/20.45 The Chair commended Mr Wilson and his team for their phenomenal work.

57/20.46 Ms Mann-Kler also congratulated the team and said that having timely transparent communication is critical and the levels of engagement on social media have been outstanding. She agreed that there is now a need to build on that momentum, and she was pleased to note the joined-up nature of the messaging, which will be important as we move out of lockdown.

57/20.47 The Chair noted that due to time constraints, it had not been possible to cover all of the items on the agenda, but he asked that if members had any specific issues they wished to raise to contact him in the first instance. He thanked the Directors for their continuing efforts in this work.

58/20 Item 10 – Any Other Business

58/20.1 There was no other business.

59/20 Item 11 – Details of Next Meeting

Thursday 18 June 2020 at 1:30pm

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

Signed by Chair:

Date:

Public Health Agency

2020-21 Draft Budget

For Approval

PHA Draft Budget 2020-21

Introduction

This paper sets out the total resources which the PHA has available in 2020-21. 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 2020-21 is set out in the table below.

Source of Funding	£m
Department of Health allocation	102.710
Assumed allocation for the Safeguarding Board (SBNI)	0.659
Other assumed allocations for Administration (incl. Clincial Excellence Awards, NIMDTA trainees funding, etc.)	1.161
Assumed income (from secondments etc.)	0.702
Total Resources Available	**105.232**

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.

Service Developments Funded in 2020-21

The opening allocation letter from DoH included additional recurrent funding for service developments amounting to £3.9m, as set out below:

	£m
Demography	0.365
Non-Pay Inflation	1.253
Drugs & Alcohol projects	0.741
Protect Life 2 Self Harm	0.300
Bowel Screening - FIT	0.200
Immunisation Pressures	0.300
Cell-based Quadrivlent Flu	0.650
Other pressures	0.118
Total additional funding	**3.927**

In light of current pressures linked to COVID-19 it is likely that some of these developments will experience some delay in implementation. While this is difficult to quantify, it is expected there will be approximately £0.3m of in-year slippage which will be re-prioritised as the year progresses.

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 2020-21.

Recommendation

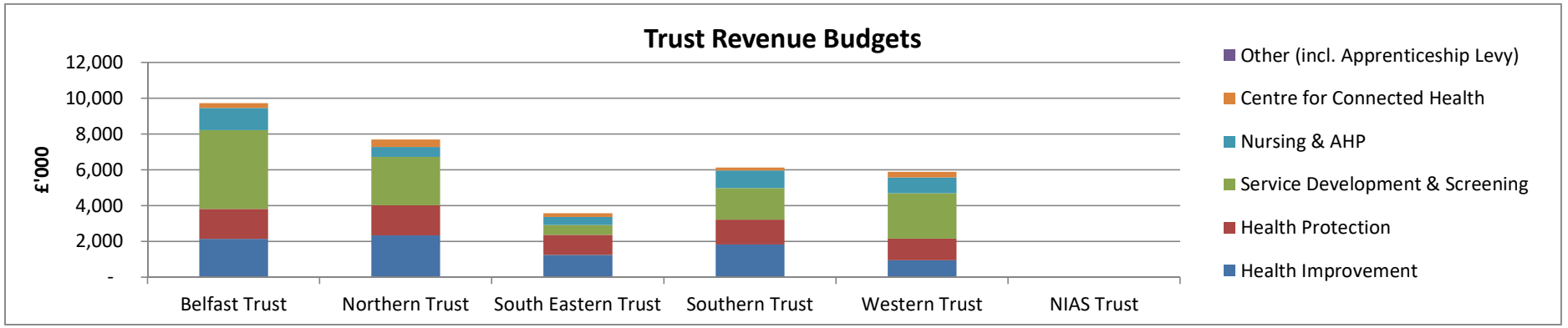
This Draft Budget is recommended to the Board for approval.

Public Health Agency
2020-21 Budget

		Programme		Ringfenced Funds	Mgt & Admin	Total
		Trust	PHA Direct			
		£'000	£'000	£'000	£'000	£'000
Revenue Funding	*Page*					
Trust Allocations	*3*	33,012	-	-	-	**33,012**
PHA Direct Programme *	*4*	-	49,818	244	-	**50,062**
PHA Administration	*6*	-	-	-	22,158	**22,158**
Total Budget		33,012	49,818	244	22,158	**105,232**
Capital Funding	*Page*					
Research & Development	*5*	7,826	4,174	-	-	**12,000**

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

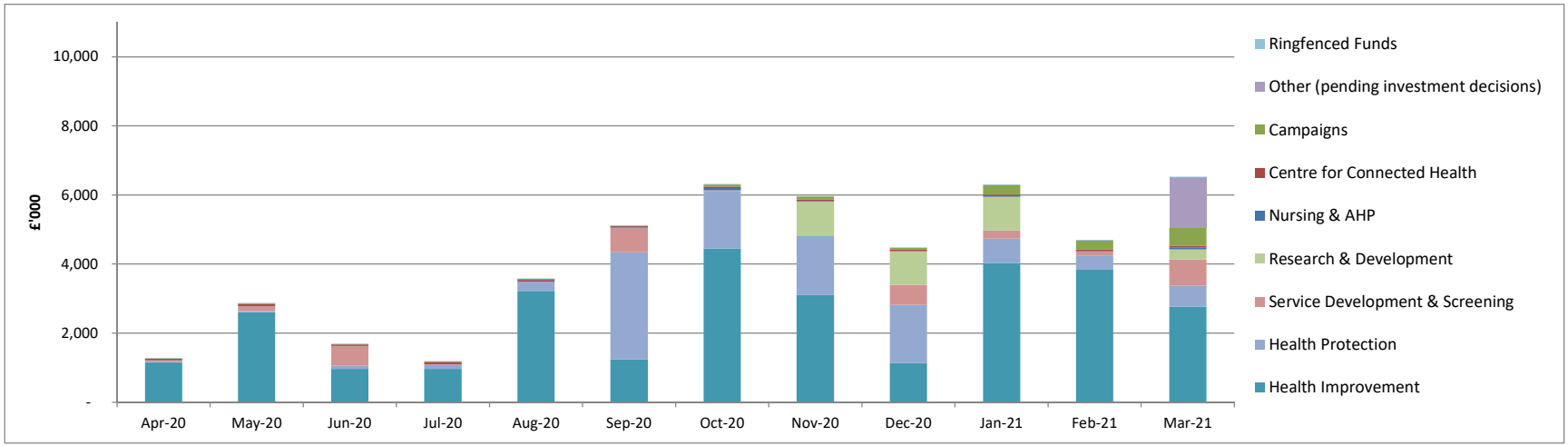
Trust Programme
2020-21 Budget



	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	2,142	2,346	1,252	1,831	961	-	**8,532**
Health Protection	1,670	1,684	1,119	1,392	1,207	-	**7,073**
Service Development & Screening	4,408	2,702	555	1,751	2,538	-	**11,954**
Nursing & AHP	1,241	544	446	990	868	-	**4,089**
Centre for Connected Health	261	418	202	162	323	-	**1,365**
Other (*incl. Apprenticeship Levy*)						-	**-**
Total Revenue funding	**9,723**	**7,693**	**3,574**	**6,126**	**5,896**	**-**	**33,012**

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
2020-21 Budget



Revenue Budget	Apr-20 £'000	May-20 £'000	Jun-20 £'000	Jul-20 £'000	Aug-20 £'000	Sep-20 £'000	Oct-20 £'000	Nov-20 £'000	Dec-20 £'000	Jan-21 £'000	Feb-21 £'000	Mar-21 £'000	Total £'000
Health Improvement	1,153	2,608	963	967	3,220	1,244	4,447	3,104	1,136	4,028	3,832	2,766	**29,469**
Health Protection	17	35	96	111	249	3,094	1,669	1,709	1,685	706	420	609	**10,399**
Service Development & Screening	38	139	561	22	11	704	22	19	575	238	105	759	**3,193**
Research & Development	-	-	-	-	-	-	-	970	970	980	-	290	**3,211**
Campaigns	3	6	4	3	2	3	54	91	46	281	266	518	**1,277**
Nursing & AHP	11	22	11	26	40	10	64	17	10	10	14	60	**295**
Centre for Connected Health	43	43	43	43	43	43	43	43	43	43	43	43	**515**
Other (pending investment decisions)	-	-	-	-	-	-	-	-	-	-	-	1,458	**1,458**
Total Revenue Budget	**1,265**	**2,854**	**1,678**	**1,172**	**3,565**	**5,099**	**6,298**	**5,953**	**4,464**	**6,286**	**4,679**	**6,503**	**49,818**
Ringfenced Budgets													
EITP Trauma Informed Practice	20	20	20	20	20	20	20	20	20	20	20	24	**244**
Ringfenced Funds	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**24**	**244**

The budgets and profiles are shown after adjusting for retractions and new allocations in the Allocation Letter from DoH. Price Inflation has been applied to the respective budgets. 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 relates to the EITP project managed by the Safeguarding Board.

Public Health Agency
2020-21 Capital Allocation

	Annual Budget Programme		
	Trust £'000	**PHA Direct £'000**	**Total £'000**
Capital Funding			
R&D Expenditure - Trusts	7,826	-	**7,826**
R&D Expenditure - PHA Direct	-	4,174	**4,174**
Total	7,826	4,174	**12,000**

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 £12.0m for this activity in 2020-21, of which approximately £8m relates to Research & Development projects in Trusts.

PHA Administration
2020-21 Budget

	Nursing & AHP £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Salaries	4,023	2,809	11,935	316	348	444	**19,875**
Goods & Services	166	1,307	407	54	58	291	**2,283**
Total Administration Budget	**4,189**	**4,117**	**12,342**	**370**	**406**	**735**	**22,158**

This Administration budget includes funding allocated from the Department of Health for 2020-21 (£19.8m), assumed allocations for the Safeguarding Board (£0.7m) and medical trainee posts funded by NIMDTA (£0.5m), and also income from secondments to other HSC organisations (£0.7m).

HSC Public Health Agency

item 8

Title of Meeting	PHA Board Meeting
Date	18 June 2020
Title of paper	Update on PHD response to COVID-19
Reference	PHA/02/06/20
Prepared by	Stephen Bergin, Gerry Waldron, Brid Farrell, Julie Mawhinney
Lead Director	Hugo Van Woerden
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

This report provides an updated position regarding the main domains of COVID-related work being undertaken within the directorate from 1 May-31 May.
Six priority areas encompass the following referenced domains of work:

1. Epidemiological Plan - *enhancing surveillance, developing early alert systems*
2. Contact Tracing – *early identification of clusters, outbreak control, protecting the wider community*
3. Care Homes – *protecting the vulnerable*
4. Testing – *enhancing capacity encompassing: diagnostic, outbreak control, surveillance; strategic planning (ie. new tests/testing approaches)*
5. Service Development – *restoration of services; planning for potential future surge*
6. Health Improvement – *facilitating community recover, fostering resilience*

2 Background Information

PHD has a lead role in the response to COVID-19 but also in a number of key areas of work that have either continued throughout the response to COVID-19 or now need to restart following a pause.

The attached document s– the Directorate Overview and Progress Update May 2020 – are produced on a weekly and monthly basis respectively to provide an updated position on the current progress and priorities of the Public Health Directorate (PHD) as at 3 June 2020.

3 Next Steps

In summary, we will continue to progress our key priorities as outlined but our immediate next steps are to:

- Continue to ensure an appropriate level of testing capacity
- Complete the contact tracing pilot (first stage)and move into the second stage - the longer term operational plans
- Plan, prepare and begin to restart paused services as appropriate
- Review and implement recovery plans
- Begin preparations and implementation for the resilient phase

COVID-19: AN UPDATE REPORT FOR MAY 2020

INTRODUCTION

This report provides an updated position regarding the main domains of COVID-related work being undertaken within the directorate from 1 May-31 May (this is the third monthly report: previous reports covered the March and April periods).

Six priority areas encompass the above referenced domains of work:

1. Epidemiological Plan - *enhancing surveillance, developing early alert systems*
2. Contact Tracing – *early identification of clusters, outbreak control, protecting the wider community*
3. Care Homes – *protecting the vulnerable*
4. Testing – *enhancing capacity encompassing: diagnostic, outbreak control, surveillance; strategic planning (ie. new tests/testing approaches)*
5. Service Development – *restoration of services; planning for potential future surge*
6. Health Improvement – *facilitating community recover, fostering resilience*

Progress against each priority area, during May, is reviewed in the following sections.

WHERE WE ARE NOW - WHERE WE PLAN TO GO

The anticipated phases (of the pandemic) are set out below - having shifted from phase 3, we are now actively engaged in Recovery and Resilience development. In parallel, we are now planning for a resumption of '*business as usual*' within the HSC, albeit within the context of COVID-19.

	DESCRIPTION	ACTIONS REQUIRED
PHASE 1 Jan-Feb	Preparedness Containment	*This phase has passed*
PHASE 2 March	Community spread	*This phase has passed*
PHASE 3 April-May	'Peak Surge' - develop resilience	*This phase has passed*
PHASE 4 May-Sept	**Recovery**	**Active phase** Aim: take forward recovery plans across the HSC encompassing both primary/secondary care
PHASE 5 June-Dec	**Resilience**	**Active phase** Early alert systems developed, Robust contact tracing and community surveillance, Communicating with the public – behaviours and wider community VIGILANCE

1. Epidemiological Plan

The aim of the Epidemiological Plan, through the effective use of information and data, is to identify trends and patterns that, in turn, have the potential to influence policy, practice and recommendations for the HSC (and potentially other government departments). Of crucial importance, epidemiological data has the potential to provide an early alert system, even before sufficient numbers of clinical cases present to services. This data may also have important secondary purposes, for example, at risk population sub groups and providing more effective treatment.

The accompanying schematic (Annex A) provides an overview of the various stakeholder contributions.

Having identified the key epidemiological data sources, along with their respective operating systems, the next stage of this process is to establish the effective infrastructure within which these source/systems can operate, at an aggregate/regional level. Adele Graham, former PHA head of health intelligence, is assisting with this process. Once the infrastructure has been established, phase two of this work will begin, ie. to understand the critical epidemiological information with the potential to provide the above referenced early alert system.

Individual objectives of the plan are to inform:

1. A better understanding of the epidemiology of COVID disease by time-person-place through descriptive, analytical methods and using surveillance information from across the health sector (led by PHA Health Protection Surveillance);
2. Local modelling, both shorter term HSC surge activity and longer term monitoring of public health interventions (social distancing / restrictive movement etc. within the NI Modelling Group);
3. The development of public communication plan and universal / targeted public health interventions that protect most vulnerable (led by PHA Health Improvement / Communications);
4. Service planning in primary and secondary care and provide early notifications of surge activity (PHA Service Development / HSCB acute services and HSCB Integrated Care);
5. Provide relevant data to the Expert Advisory Testing Group;
6. Provide data to assist with the investigation and management of clusters and outbreaks, ie. contact tracing;
7. Guide future decisions on social distancing and potential ‘lockdown’;
8. COVID research and development towards gaps identified (PHA R&D).

Other progress includes links made with ONS regarding their survey, the daily feeds from the e-symptomology apps are now being received and the behavioural change group has developed a number of proposals. The laboratory seroprevalence study (Cell 6) has had good progress on the residual sample work, with the first cohorts ready to be tested from Belfast Trust by QUB and Western Trust by UU. Availability of Roche test kits has now made it possible to test in parallel with both kits. Work continues towards a proposal on the way forward for a population antibody seroprevalence study in NI.

2. Contact Tracing

The PHA Health Protection Service, in terms of the next phase of pandemic planning, has developed a regional, large scale contact tracing system, operating in three steps:

Step 1 - Case: Identify contacts and advise on social isolation.
Step 2 - Contacts: Identify links to individual cases, seek testing if symptomatic and advise on social isolation where necessary.
Step 3 - Control: Identify clusters and take action to prevent further community spread.

Phase 1 of this project, as a pilot commenced on the 27th April. The focus for May has been on planning for substantive regional service, ie. Phase 2. This is progressing the longer term operational plan for the service: from 19 May, contact tracing has been undertaken for all confirmed positive cases of COVID-19. From this date up to Saturday 6th June 480 telephone encounters with cases have taken place, with 721 contacts of these cases successfully traced.

Testing is now available to everyone in N.Ireland (aged over five with symptoms); this forms an important part of the contact tracing programme. The number of staff required each day within the service is customised in line with workload – this is primarily dictated by the number of positive cases per day. Sufficient staff have been trained and currently the service is able to meet demand

Over the coming months, active surveillance mechanisms will improve given the significantly higher COVID testing capacity within the region. This is a key element of the overall public health response to the pandemic. As referenced in the preceding section (Epi Plan), enhanced testing combined with active surveillance and population monitoring, can potentially provide an early alert (sentinel) system regarding an imminent secondary wave and/or dense population clusters.

3. Care Homes

Given the individual vulnerabilities of residents, care homes have become one of the main priority areas during the COVID pandemic: they are a particularly high risk because of the shared communal environments and the potential for spread attributable to asymptomatic, yet infected, staff.

Since March 2020, over 170 homes with respiratory outbreaks (both COVID and non COVID) have been supported by the PHA duty room: by way of comparison (in terms of scale/magnitude), there were 8 outbreaks of flu in care homes during the whole of 2018/19.

In response to these outbreaks, the PHA initiated well-established mechanisms, supporting care homes with specific outbreak control advice and guidance, in parallel to Trusts providing nursing and infection control support.

The PHA duty room continues to be the first point of contact for care homes on suspicion of an outbreak. Every suspected outbreak is risk assessed and recommendations are made on testing within the home (residents and staff) and on reducing the risk of further spread. Care homes submit daily updates to the duty room. These are reviewed and further telephone follow up and advice continues to be provided.

In addition to the above health protection input, public health consultants have been heavily involved in the development and implementation of the joint PHA / HSCB care home surge plan. Coordinated by an internal multidisciplinary team, they are applying evidence-based practice to help ensure appropriate medical/nursing care is provided within homes. Recommendations to reduce transmission within homes is being taken forward through enhanced infection prevention and control measures, along with the application of best practice and learning (from across the region) based upon experience acquired from care homes to date.

Daily surveillance figures on outbreaks within care homes are issued by the surveillance team and a weekly update report is shared with the Department and other key partners. On direction from the Department, care homes provide a single daily update to RQIA which provides information on a range of key variables about how care homes services are coping with the impact of COVID. This information is then shared with the HSCB, PHA, Trusts, RQIA and Department. A public health consultant has established a group of representatives from each of these organisations to:

- Agree principles for sharing and using data
- Develop detailed case definitions for use by care homes
- Establish a process for cross organisation data quality assurance and improvement
- Address information governance and data protection requirements
- Develop dashboards for key variables
- Seek feedback from care homes on the process

The PHA is also overseeing implementation of Department guidance regarding COVID testing care homes: a consultant in public health, along with other directorate staff (temporarily redeployed from the child health information team), have been working closely with all Trusts and NIAS to ensure all homes with outbreaks have been tested and followed up in line with the policy. In addition, they are working with laboratories, Trusts and the regional Pathology Network to ensure testing samples are labelled correctly. They are also working closely with BSO to establish data flows and make sure information can be accessed from the data warehouse. This will help ensure up to date information is available on the course of outbreaks, with both individual care home data produced from the laboratory system and also up to date regional surveillance information.

4. Testing

The PHA, working with partners including within the Department of Health, HSC Trusts, NI Pathology Network and universities, aims to develop a Northern Ireland

approach to COVID-19 testing and to oversee and coordinate its implementation. A key aim to date has been to rapidly expand testing capacity, to meet potential demand in the population. Key actions in testing include:

- Increasing the laboratory capacity to test patients, vulnerable groups and front line staff within HSC laboratories.
- Working with the Department of Health and Social Care in England and other partners to deliver National Initiative testing for key workers and symptomatic people in the community
- Providing tests to allow surveillance of COVID-19.
- Participation in research programmes to identify robust and rapid diagnostics
- Linking with colleagues in England, Scotland and Wales to explore how testing can be increased on a UK basis.
- Chairing and contributing to the Expert Testing Advisory Group in the Department of Health, NI.
- Coordination and contribution to population seroprevalence studies
- Exploration of and roll out of antibody testing

Throughout May, key considerations have included determining the appropriate level of test capacity, across the wider HSC sector, to encompass for the following purposes:

1. Individual diagnostic testing (both primary/secondary care, and occupational health)
2. Outbreak control and contact tracing
3. Population surveillance (including research).

Four national initiative testing centres are in place – Belfast, Derry, Craigavon Enniskillen (from 28 May). Testing available for key workers and symptomatic members of the public on the 18th May 2020.

Mobile testing units (MTUs) are also to be introduced. The first of these has been introduced in the final week of May in Omagh and a further 3 will be deployed over the May-June period. Testing is also available through the home testing route via the digital platform.

Satellite testing of care home residents and staff in asymptomatic care homes has also been introduced with drop off / pick up support from MTU's as additional support for this service.

In addition, further consideration is being given to 'walkthrough' testing sites in urban areas where there is low car ownership.

Lab capacity now available in RVL, NIBTS (Via RVL), NHSCT, SHSCT and WHSCT and the Consortium between universities, AFBI and ALMAC is exploring how they might increase their capacity. AFBI lab has now opened.

The total regional HSC Laboratory covid-19 swab testing capacity per day on 22 May 2020 was **1,642 tests per day** (based on average daily figure for BHSCT, AFBI and WHSCT).

Up to 1000+ tests/day are available via national initiative testing. Electronic transfer of results now in place and data being mapped and will be made available to NIECR in due course.

5. Service Development:

During the peak period of the pandemic (and the weeks running up to this time), public health consultants within the Service Development division of the directorate led on regional work to enhance surge capacity across the wider HSC system. Their input was particularly important in helping to ensure appropriate capacity, in particular, within the secondary care system and that potentially limited resources were prioritised effectively (and also ethically).

The input of the Service Development division therefore had a key enabling function to facilitate the maximum operational effectiveness of the wider HSC response. This included facilitating evidence based practice, e.g. liaison with national networks (sharing best practice), identifying end-to-end care pathways, guidance from clinical networks, etc. Going forward, evidence based and subject matter expertise will be a key component of the wider COVID endeavour. This will not just be in clinical management terms but also population and predictive modelling.

Public health consultants have continued to work jointly with HSCB, Trusts and other stakeholders, to ensure that:

1. HSC providers have appropriately scaled services available to diagnose and treat the needs of patients with COVID-19 disease in the population. This work is wide-ranging, including provision of epidemiological expertise to support the DoH modelling group, liaison with the 4-nations specialist commissioning teams, participation in clinical network planning, working through extant commissioning groups and clinical liaison. Services covered range from neonatal and obstetric care, through to local services, specialist hospital services and palliative care.
2. Staff availability, supplies of equipment and consumables to treat COVID-19 patients are sufficient to meet need. This includes development, monitoring and refinement of the critical care surge plan, equipment needs for invasive and non-invasive ventilation, assuring oxygen site capability and supply, bed capacity, and monitoring anaesthetic and critical care drugs and fluids which are in short supply worldwide.
3. Staff treating patients who have, or may have, COVID-19 are adequately protected in the course of their work, and themselves do not pass the condition to patients. This links to the work of PPE and Testing workstreams.
4. Services for people who have non-COVID-19 conditions continue where it is safe and feasible for them to do so. This includes participation in agreeing regional policy on service prioritisation to restore services, including screening, cancer care and neurosurgery. This work is also considering the safe provision of

elective services against a background of ongoing levels of COVID-19 in the community and in secondary care sites and the possibility of a second wave.

PHA is also supporting de-escalation and the planning for the resumption of some services, redefining COVID and non-COVID sites and service and condition prioritisation. Progress includes:

- Developing plan for a level of de-escalation and to support resumption of other areas of work while acknowledging the potential for a second wave. Monitoring of key medications used in critical care and anaesthetics is also underway.
- General acute - Planning is underway to recommence some high priority elective services against a background of rising general unscheduled care presentations. Work has also commenced on redefining COVID and non-COVID sites, service and condition prioritisation and testing protocols for both staff and elective patients.
- Care Homes - A clinical care pathway for use in care homes is being finalised. Testing of care home residents and staff in outbreaks prior to the change in testing policy on 24th April is being co-ordinated via PHA/Trusts and NIAS. Testing of "clean" (ie no outbreaks ever) care homes is co-ordinated via national initiative.
- Oncology/haematology - Working to agree prioritisation for red flag surgery by site, locally and regionally
- Respiratory - NICE and NHS England community, primary and secondary care respiratory guidance continues to be shared with HSCTs and primary care colleagues as it emerges. Working group of community respiratory HOSAR teams, RQIA and PHA to strengthen oxygen prescribing governance in care homes met 11 May 2015 and reported 15 May 2020. RAG rated monitoring of BOC community oxygen supply stocks in place and offered to HSC Silver for inclusion in its reporting matrix.

The input of the Service Development division has had a key enabling function to facilitate the maximum operational effectiveness of the wider HSC response. More detail on these actions is included in annex B.

6.. Health Improvement Surge Plan - Resilience and Recovery

From a Public Health perspective and Health Improvement in particular, the impact on health behaviours and lifestyles and the wider determinants of health will be of a significant influence in terms of how future services are designed and procured/commissioned.

The directorate's Health Improvement division has a long track record of helping people and communities during very testing times; these approaches now need to be re-visited and scaled up for the necessary COVID19 response, particularly within a cross-government and multi-sectoral approach (including the community and voluntary sectors). Cognisant of this, a resilience and recovery plan has been developed by the Health Improvement division.

This plan identifies key actions in the short to medium term, assuming there will be a further surge(s) in COVID19 but also set the foundations for longer term actions that focus on community base resilience and recovery approaches. The medium terms approach, anticipated from January 2021, aims to address the long-term health and social wellbeing of the pandemic, as well as moving to restore normal improvement functions. Almost complete, the Plan covers a total of 548 contracts in place with statutory and non-statutory contractors across a range of Making Life Better priority work areas. It also provides a demand and capacity assessment across thematic areas to help prioritise the activity required to address impact of COVID-19 across resilience and recovery phases.

Example of high level issues requiring repurposed activity include:

- **Stop Smoking Services NI** - Face to Face services and CO monitoring currently on hold. Access to NRT via Pharmacy being negotiated with Pharmacy/ HSCB/CPNI. Remodelling elements of Stop Smoking Services underway to provide support via telephone instead of face to face. Public Health Messaging in development. Website updated in light of COVID-19.
- **Protect Life 2 Implementation** – Continue to work with partners and stakeholders to implement the PL2 strategy. Priority is to maintain current service delivery where possible and look at innovative ways to engage stakeholders that will help design future services.
- **Drugs and Alcohol** -Ensure additional D&A capacity redirected to sustaining current Needle & Syringe Exchange Scheme (NSES) and Take Home Naloxone (THN) services (including contingency planning / implementation) and DAMIS. Ensure continued delivery of existing D&A Low Threshold services.
- **Early Years Obesity** - Contract recently agreed for delivery of HENRY programme across NI immediately prior to COVID-19. Delivery mechanism requires face to face contact therefor programme on hold until lockdown measures are relaxed. Preparatory work for rolling out training to health visitors across NI still able to progress therefore resources focussed in concluding this aspect of plan.
- **Early Years Early Intervention Support Service** – PHA commissioned services currently supporting 650 families annually who are facing problems at early stage and need early intervention and family support. Public Health Agency asked by DH to develop a new integrated service model and has demonstrated considerable success and will be particularly relevant in supporting the public health implications of disruption and pressure on families in COVID-19 context.
- **Physical Activity** -Community Active Travel Programmes on hold and capacity repurposed to linking in with Planning Service and DFI to identify opportunities to accelerate shift in modal transport and increased availability of road space as a result of reduced motor traffic during pandemic.
- **Later Years** – delivery of Age Friendly strategy under review due to delivery mechanism. Age Friendly officers to be repurposed to alternative communications strategy to prevent frailty by providing clear public health information.

The consequences of the pandemic, for society, will be multi-faceted and potentially very severe for some vulnerable groups (e.g. the elderly, those who are homeless and socio-economically disadvantaged). The impact will not only be material but with potentially emotional and in some cases with even psychological consequences.

The Health Improvement division, using tried/tested means will adapt to the consequences of COVID upon the population. They, including colleagues within Trust HI teams, will work in partnership with other government agencies and also the community/voluntary sectors. Community based action, undertaken at scale, will be necessary – particularly as incomes deteriorate and/other sequelae kick-in, such as within the housing/rental sectors. While much of this is predictable, there will no doubt be other unforeseen consequences, which have yet to realise/consider.

An internal Health Improvement Business Continuity team has also been established within the Division and a clear action plan put in place to ensure consistency of delivery and reporting within HI. The Business Continuity Group has been tasked with documenting and capturing the learning from the health improvement contribution to the Covid-19 response. Weekly report produced, highlighting the key progress, learning and issues/gaps in relation to the ten cells and groups which Health Improvement staff are involved in, namely: Knowledge Management, Covid General Business, Contract Management, Stakeholder Engagement/Partner Liaison, Resilience and Recovery, Staff Health and Wellbeing, Surge Planning, Health Improvement Messaging, EOC, and Business Continuity.

Health Improvement are also involved in the Mental Health & Emotional Wellbeing COVID-19 Surge Cell. This surge cell will consider the range of psychological and mental health needs emerging; identify appropriate responses to meet anticipated and emerging needs; and mobilise and coordinate the resources required to support the psychological and wellbeing needs of all those impacted by the pandemic and promote recovery in its aftermath.

NEXT STEPS AND CONCLUSION

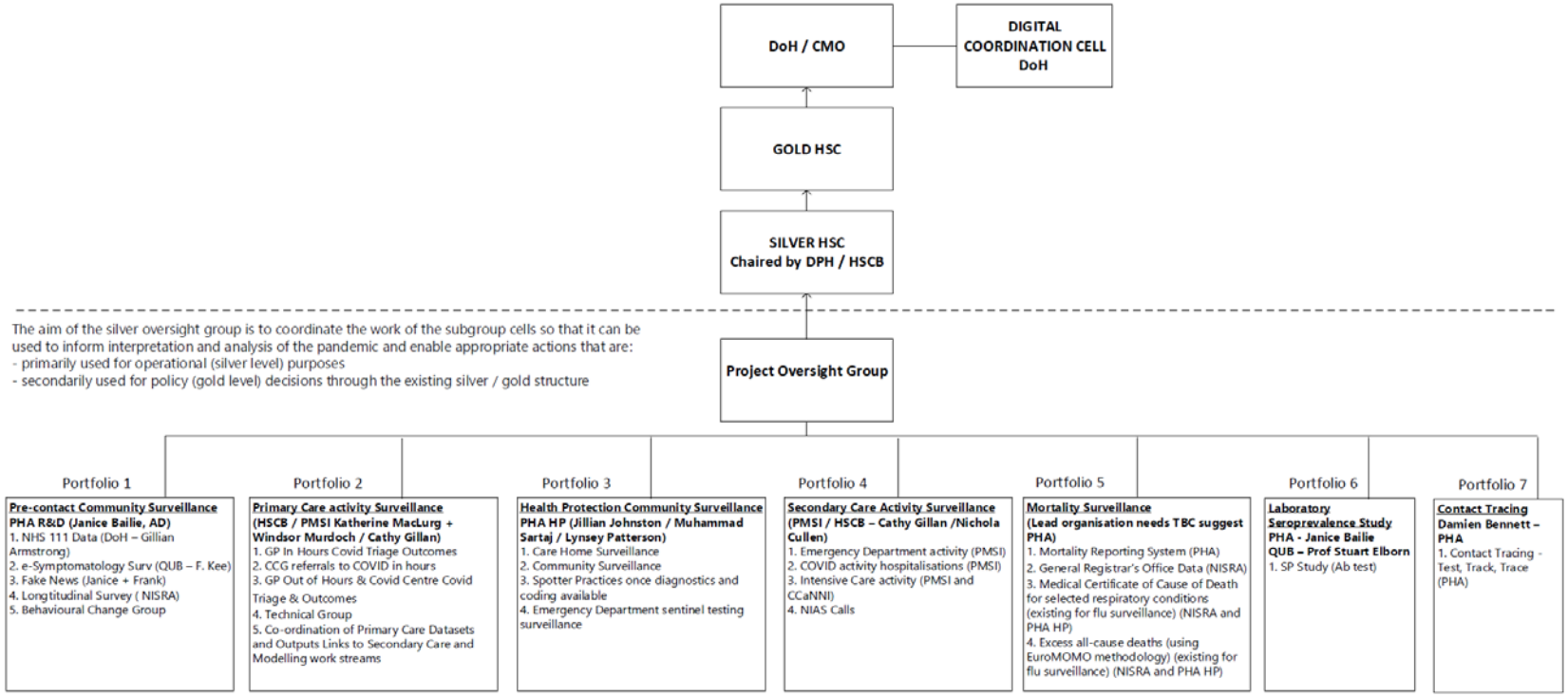
We continue to work and plan within a rapidly changing context and as we look to the next phase, we will continue to review the strategic approach we have taken as outlined.

In summary, we will continue to progress our key priorities as outlined but our immediate next steps are to:

- Continue to ensure an appropriate level of testing capacity
- Complete the contact tracing pilot (first stage)and move into the second stage - the longer term operational plans
- Plan, prepare and begin to restart paused services as appropriate
- Review and implement recovery plans
- Begin preparations and implementation for the resilient phase

This report will be updated for 01.07.20

EPIDEMIOLOGY DATA STRUCTURE



The outputs of the subgroup cells are used for:

1. To inform understanding of the epidemiology of COVID disease by time-person-place through descriptive, analytical methods and using surveillance information from across the health sector (lead is PHA Health Protection Surveillance)
2. To inform local modeling, both shorter term HSC surge activity and longer term monitoring of public health interventions (social distancing/ restrictive movement etc.) (Lead is NI Modeling Group)
3. To inform development of public communication plan and universal / targeted public health interventions that protect most vulnerable (Lead is all in PHA - specifically Health Improvement / Communications)
4. To inform service planning in primary and secondary care and provide early notifications of surge activity (Lead is PHA Service Development / HSCB acute services and HSCB Integrated Care)
5. To inform monitoring of the NI testing strategy (Lead is Expert Advisory Testing Group)
6. To inform and monitor public health action and control measures on the ground in the investigation and management of cases clusters and outbreaks
7. To inform future decisions on lifting restrictive movements - through contact tracing activities on the ground
8. To direct the COVID research and development agenda towards gaps identified (PHA R&D)

Annex B: Service Development

The input of the Service Development division has had a key enabling function to facilitate the maximum operational effectiveness of the wider HSC response. This included facilitating evidence based practice, eg. liaison with national networks (sharing best practice), identifying end-to-end care pathways, guidance from clinical networks, etc. Going forward, evidence based and subject matter expertise will be a key component of the wider COVID endeavour. This will not just be in clinical management terms but also population and predictive modelling.

Public health consultants have continued to work jointly with HSCB, Trusts and other stakeholders

More specifically during the response to COVID-19, service development consultant staff have also facilitated the development of resilience in services including ICU, critical care and renal services. More detail included below.

Critical Care

Regional surge plan Formally agreed by Trusts and GOLD. Approval from GOLD to plan for a level of de-escalation to support resumption of other areas of work acknowledging potential for second wave. Need to consider options for additional critical care capacity to recognise admissions due to COVID-19 which will be on-going. Critical care medications Work continues under this group to monitor 10-12 key medications used in critical care and anaesthetics, as well as CRRT consumables.

Nephrology

Monitoring of the impact of COVID on nephrology services via engagement with clinical and service leads on a regular basis. Interface between critical care and renal being explored due to small number of patients with COVID requiring IHD rather than CRRT. Examination of commissioned provision for acute dialysis also underway in relation to this issue.

Palliative Care

DNACPR Development of DNACPR and Advance Care Planning materials including a single regional DNACPR form has been requested from Gold via Silver. Implementation plan awaiting sign-off.

General Acute

Acute sector recovery planning Planning underway to recommence some high priority elective services against a background of rising general USC presentations. Work commencing to support DoH & HSCB on redefining COVID and non-COVID sites, service and condition prioritisation and testing protocols for both staff and elective patients. Clinical networks are being reconvened to debrief, gather learning and inform future planning for service recovery and future strategic direction post COVID 19.

Care Homes

Care homes Planning for oxygen requirements in care homes during COVID surge completed through interagency Community Oxygen Supply Working Group (COSWG). A clinical care pathway for use in care homes being finalised. Testing of care home residents and staff in outbreaks pre change in testing policy on 24th April is being co-ordinated via PHA/Trusts and NIAS. Testing of "clean" (ie no outbreaks ever) care homes to be co-ordinated via national initiative.

Oncology / Haematology

Red flag surgery Working to agree prioritisation for red flag surgery by site, locally and regionally

SACT Working to agree planning / prioritisation for SACT for haem / oncology and radiotherapy

Paediatrics

Working with Paeds network re: oversight of capacity impact of and progression through surge plan. Paper re amendment to the Surge plan to permit de-escalation approved by GOLD.

Maternity

Sharing national guidance, implementing remote monitoring for hypertension and planning for NI input into national COVID audits.

Ophthalmology

Work ongoing includes working with trusts to maintain services e.g. retinopathy of prematurity, prioritising time sensitive interventions eg macular disease and cataract WLI.

Respiratory

NICE and NHS England community, primary and secondary care respiratory guidance continues to be shared with HSCTs and primary care colleagues as it emerges. Working group of community respiratory HOSAR teams, RQIA and PHA to strengthen oxygen prescribing governance in care homes met 11 May 2015 and reported 15 May 2020 .

Sexual Health

Following closure of some and reductions in the availability of other HSCT Genitourinary Medicine (GUM) and Sexual and Reproductive Health (SRH) clinics, the extension of an on line sexually transmitted infections (STIs) testing and safeguarding pilot beyond the end of March 2020 and inclusion of online sexual health advice and contraceptive services provision to improve access for NI residents during the COVID 19 pandemic restrictions will be included in June monitoring

Radiology

Radiology BHSCT progressing well with rollout of work stations and provision of VPN to enable remote reporting. Regional radiology contingency plan finalised and sent to Acute Surge Cell.

Knowledge management cell

New Learning Community Subgroup being developed to identify key learning / improvements in ways of working/ things that are not working and to avoid repeating in future.

Prisons

Working with SET and prison service to ensure joined up response. Sharing of PHE guidance

Modelling and Record Linkage

Working with Virology to refine bed utilisation information and with Trusts to agree a standard system incorporating greater clinical detail to both refine regional modelling & strengthen operational forecasting / service monitoring
Models and projections being updated as the situation progresses
A record linkage study is ongoing to link notifications of COVID 19 and hospital data.

Non Covid Work

As we prepare for the second wave of COVID 19, the Service Development Directorate is also getting re-involved with in diverse areas including:

- Specialist Commissioning Team and service improvement
- Work with Networks/named secondary care services (Pathology, Cancer, Trauma, Cardiac, diabetes, stroke, critical care)
- Supporting HSCB on elective care reform
- ECR/IFR Panel
- SAIs/DROs/identification of regional learning
- Subfertility services
- Leading consultant workforce planning at the request of DoH via DPH
- NICE TA and CG implementation
- Supporting neurology review and lookback
- DoH Breast cancer needs assessment
- Mental Health
- Prisons
- Maternity needs assessment

HSC Public Health Agency

PHD Overview

3 June 2020

This plan sets out the current focus of the Directorate of Public Health and its priorities over the coming month.

CONTENTS

INTRODUCTION 3
DIRECTORATE LEVEL COVID PRIORITIES 4
Summary Table 5
Priority Areas 6
NOTABLE DIVISIONAL BUSINESS 21
LONGER TERM PRIORITIES 32
Work Requests 35

INTRODUCTION

This report will be updated on a weekly basis for DPH with the headlines available to CMO.

A full more detailed report will be collated on a monthly basis for DPH and onwards to CMO but initial drafts will make use of the information submitted through this template.

RAG Status

The RAG Status is defined as follows

GREEN	Underway and working to expected timescales
AMBER	Delayed start or may not meet expected timescales
RED	Will not meet expected timescales

Process

Updates will be collated through Planning and Project Managers and Project Managers but should be signed off by Leads before submission.

- Section 1 should be completed on a weekly basis
- Section 2 should be reviewed on a weekly basis and updated as required
- Section 3 should be reviewed monthly (for the first weekly return of every month) and a reminder of this will be provided when it is required

Weekly updates should be provided by close of business on Tuesday so a full weekly update can be provided to DPH in advance of IMT and AMT (on Thursday)

DIRECTORATE LEVEL COVID PRIORITIES

There are five key priorities relating to the impact of COVD-19 and two additional, more overarching priorities that must be considered as we look to resuming 'normal' business and to ensure staff wellbeing and resilience in a period of intense working.

1. Epidemiological Plan (Stephen, Conal)
2. Health Protection Forward Planning (Gerry, Jackie, Mary) (to include updates on the steering group)
3. Service Development and Surge (Brid, Diane)
4. Testing (Brid, Sinead)
5. Health Improvement (Brendan)

- Resuming normal business
- Staffing and resilience

The following chart provides an overview of their current phase and status. More detail is provided in the succeeding pages.

Summary Table

	PHASE3:PEAK/SURGE		PHASE 4: RECOVERY				PHASE 5: RESILIENT		
	April	**May**	**June**	**July**	**August**	**September**	**Oct**	**Nov**	**Dec**
EPI Plan - Stephen Bergin	PHASE 1 – identify epidemiological key sources – establish infrastructure / key contacts		PHASE 2 – understand the critical epidemiological info sources with potential to provide an early alert system		Phase 3 – produce reliable and informative information, including at locality level, to provide an early alert system (epidemiology) – running routine reports				
HP Forward Planning – Contact Tracing – Gerry Waldron and Jackie Hyland	PHASE 1 – setting up and preparation		PHASE 2 – development of a regional service			PHASE 3– regional service fully established, delivering full Contract Tracing functionality at scale regionally			
Surge/Service Development – Brid Farrell	PHASE 1 – reflecting on lessons learned to date		PHASE 2 – preparing for potential 2nd wave – both primary and secondary care services				PHASE 3 – resilient services established and in place (equipment, PPE, personnel)		
Testing – Brid Farrell	PHASE 1 - determining the appropriate level of capacity, across the wider HSC sector, to encompass for: diagnostic testing (both primary/ secondary care, and Occ Health) outbreak control and contact tracing. Establish surveillance systems for care homes, ED and spotter practices. Approaches to seroprevalence agreed. Implement the national initiative for testing		PHASE 2 – surveillance systems in place: primary and community care (nursing/care homes) Antibody testing prioritisation framework				PHASE 3 – capacity to test at regional scale in the event of 2nd pandemic		
Health Improvement – Resilience and Recovery Plan Brendan Bonner	PHASE 1 – developing community focused resilience; recovery plan developed		PHASE 2 – review recovery and resilience (multi-agency) plans				PHASE 3 – initiate collaboration with interagency partners and Service Providers		
PH Normal Business Hugo and Stephen									

Priority Areas

1. Epidemiological Plan

Priority Area	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
Epidemiological Plan	Stephen		R&D update Pre-contact community surveillance cell (Cell 1) - NHS111 data – Access to this data was requested by Ian Young's modelling group, who are interested in the potential to monitor the calls for any upturn in cases following the release of lockdown measures. Some changes have been requested in the information being collected and these are being progressed in discussion with the digital cell. - E-symptomatology – Daily feeds are being provided into the epidemiology group from the Apps. - Social Media scanning - A meeting of the full social media group took place on Friday 27th May. A series of feeds that provide information of interest to Public Health Directorate and PHA communications were discussed and will be provided as a summary report going forward. Some additional detail will be agreed with Paul McWilliams from the modelling group to ensure the relevant feeds are providing the information that is needed to inform modelling activity. - ONS survey – A useful call with representatives of DHSC and ONS on Thursday 28th May, revealed that HMT is willing to provide full funding cover for this study to go ahead in Northern Ireland (as well as the other devolved nations). Their initial proposal was to survey 1000 households per month in NI	

Priority Area	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
			for 12 months, swabbing each household member, and offering one household member the opportunity to provide a blood sample for antibody serology testing. All logistical issues around sample processing and testing to be handled by ONS, with testing completed in Oxford, and analysis of data can be done within NI. There is room for negotiation around the sample numbers given our assumed low prevalence rates, to ensure that the study provides the required answers for NI. A provisional start date of week beginning 29 June was agreed assuming there are no issues. This should give us a good basis for a measure of population seroprevalence in NI and the possibility of comparison with RoI, who are planning to start their study mid-June. The RoI study will take blood samples for antibody testing only, in two centres Dublin & Sligo (high and low prevalence areas), with repeat testing at two further time periods over 1 year. A further meeting of the seroprevalence group will take place on 3.6.20 to discuss the sampling frame for the ONS study. Initial data from England suggest an infection rate of 0.25%. A call is also being set up for Ian Young and Frank Kee with the modelling team in University of Manchester to advise of their methodology around the calculation of R from the data collected so far. A paper is to be preared for the Expert Testing Group on 5.6.20 with recommendations for the way forward. - Behavioural change group Sub-group has created some proposals from the submitted suggestions and these were agreed at last week's meeting and are being progressed in consultation with the Department. Other suggestions from	

Priority Area	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
			- PHA and Board colleagues will also be further considered. Laboratory seroprevalence study (Cell 6) Good progress on the residual sample work, with the first cohorts ready to be tested from Belfast Trust by QUB and Western Trust by UU. Availability of Roche test kits has now made it possible to test in parallel with both kits. This group is also overseeing the ONS survey work described above. An additional proposal for antibody seroprevalence testing in HCW and care homes is in preparation and will need to be rapidly developed, as the first batch of Roche test kits has a short remaining shelf life of one month. This group will meet for the second time on 3.6.20.	

2. Health Protection Forward Planning

Priority Area	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
Health Protection Forward Planning	Gerry	GREEN	**Contact tracing** - pilot commenced Health Protection Froward Planning Steering group being established The PHA Health Protection Service, in terms of the next phase of pandemic planning, is developing a regional rapid, large scale system operating in three steps: • Step 1 - Case: Identify contacts and advise on social isolation. • Step 2 - Contacts: Identify links to case, seek testing if symptomatic and advise on social isolation. • Step 3 - Control: Identify clusters and take action to prevent further spread (see process map in Appendix 1). Phase 1 of this project commenced on the 27th April for 4-6 weeks. This is the emergency response phase which will focus on the following; Reducing the spread of infection and save lives by rapidly identifying and closing down chains of transmission of COVID-19 by: • Setting up a regional, rapid, large scale system of contact tracing using staff from outside of the health protection function that could be trained and working to a protocol, the objectives of which (long and short term) are to: o risk assess- and assessment of the level of risk based on exposure. o risk manage-identification of required interventions to manage the risk. o communications- vital part of public health incidents. Communications will be delivered based on who needs to be	

Priority Area	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
			informed, co-ordination of public communications, the provision of advice and guidance and direct communications with health care providers as determined by the nature of the incident and risk to population health. **Surveillance -** Spotter practice prevalence testing – letters gone out practices should be submitting from today (28/04/2020) Care Home prevalence study – preliminary results to be presented to Expert Testing group today. ED Study – proceeding Staff generally coping well despite being overstretched by response to COVID. Some resilience needs to be built into the system and engagement of former colleagues who are willing to return to work would be appreciated. HR processes should be encouraged to expedite. **Care homes** – existing work continues, ie. outbreak control/incident management and infection control advice issued via the PH Duty Room and HP consultant. PHD contributing to wider PHA/HSCB group with regional oversight: group meeting weekly, with PHD representation; also internal IMT group encompassing PH, Nursing and Social care. Note additions inputs via cross reference to: - Surveillance / sero prevalence monitoring (see above sub-section) - Service Development: sub-section (3) under 'oxygen' and 'respiratory'.	

3. Service Development and Surge

Priority Area	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
Service Development and Surge	Brid	GREEN	**Critical Care** Regional surge plan Formally agreed by Trusts and GOLD. Approval from GOLD to plan for a level of de-escalation to support resumption of other areas of work acknowledging potential for second wave. Need to consider options for additional critical care capacity to recognise admissions due to COVID-19 which will be on-going. Critical care medications Work continues under this group to monitor 10-12 key medications used in critical care and anaesthetics, as well as CRRT consumables. **Nephrology** Monitoring of the impact of COVID on nephrology services via engagement with clinical and service leads on a regular basis. Interface between critical care and renal being explored due to small number of patients with COVID requiring IHD rather than CRRT. Examination of commissioned provision for acute dialysis also underway in relation to this issue. **Palliative Care** DNACPR Development of DNACPR and Advance Care Planning materials including a single regional DNACPR form has been requested from Gold via Silver. Implementation plan awaiting sign-off. **General Acute** Acute sector recovery planning Planning underway to recommence some high priority elective services against a background of rising general USC presentations. Work commencing to support DoH & HSCB on redefining COVID and non-COVID sites, service and	`

Priority Area	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
			condition prioritisation and testing protocols for both staff and elective patients. Clinical networks are being reconvened to debrief, gather learning and inform future planning for service recovery and future strategic direction post COVID 19. **Care Homes** Care homes Planning for oxygen requirements in care homes during COVID surge completed through interagency Community Oxygen Supply Working Group (COSWG). A clinical care pathway for use in care homes being finalised. Testing of care home residents and staff in outbreaks pre change in testing policy on 24th April is being co-ordinated via PHA/Trusts and NIAS. Testing of "clean" (ie no outbreaks ever) care homes to be co-ordinated via national initiative. **Oncology / Haematology** Red flag surgery Working to agree prioritisation for red flag surgery by site, locally and regionally SACT Working to agree planning / prioritisation for SACT for haem / oncology and radiotherapy **Paediatrics** Working with Paeds network re: oversight of capacity impact of and progression through surge plan. Paper re amendment to the Surge plan to permit de-escalation approved by GOLD. **Maternity** Sharing national guidance, implementing remote monitoring for hypertension and planning for NI input into national COVID audits. **Ophthalmology** Work ongoing includes working with trusts to maintain services e.g.	

Priority Area	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
			retinopathy of prematurity, prioritising time sensitive interventions and cataract WLI. **Respiratory** NICE and NHS England community, primary and secondary care respiratory guidance continues to be shared with HSCTs and primary care colleagues as it emerges. Working group of community respiratory HOSAR teams, RQIA and PHA to strengthen oxygen prescribing governance in care homes met 11 May 2015 and reported 15 May 2020 . RAG rated monitoring of BOC community oxygen supply stocks in place and offered to HSC Silver for inclusion in its reporting matrix. **Sexual Health** Following closure of some and reductions in the availability of other HSCT Genitourinary Medicine (GUM) and Sexual and Reproductive Health (SRH) clinics, the extension of an on line sexually transmitted infections (STIs) testing and safeguarding pilot beyond the end of March 2020 and inclusion of online sexual health advice and contraceptive services provision to improve access for NI residents during the COVID 19 pandemic restrictions will be included in June monitoring.. **Radiology** Radiology BHSCT progressing well with rollout of work stations and provision of VPN to enable remote reporting. Regional radiology contingency plan finalised and sent to Acute Surge Cell. **Knowledge management cell** New Learning Community Subgroup being developed to identify key learning / improvements in ways of working/ things that are not	

Priority Area	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
			working and to avoid repeating in future. **Prisons** Working with SET and prison service to ensure joined up response. Sharing of PHE guidance **Modelling** Provision of epidemiological support to the DoH regional modelling group. Working with Virology to refine bed utilisation information and with Trusts to agree a standard system incorporating greater clinical detail to both refine regional modelling & strengthen operational forecasting / service monitoring Models and projections being updated as the situation progresses.	

4. Testing

Priority Area	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
Testing	Brid	GREEN	Three national initiative testing centres are in place – Belfast, Derry, Craigavon with a fourth site in Enniskillen to open 27th test day. Full opening 28th. Testing also available through home testing route on a first come first served basis via the digital platform. Testing available to key workers and symptomatic members of the public since the 18th May 2020. Mobile testing units (MTUs) are to be introduced with the first being deployed this week in Omagh and a further 3 to be deployed in May / June. Satellite testing of care home residents and staff in asymptomatic care homes being introduced with drop off / pick up support from MTU's as additional support for this service. Meeting next week to consider introduction of 'walkthrough' testing sites in urban areas with low car ownership. Electronic transfer of results now in place and data being mapped and made available to NIECR in near future. Lab capacity now in RVL, NIBTS (Via RVL), NHSCT, SHSCT and WHSCT. Consortium between universities, AFBI and ALMAC	

Priority Area	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
			exploring increasing further capacity. AFBI lab has now opened. The total regional HSC Laboratory covid-19 swab testing capacity per day on 22 May 2020 was **1,642 tests per day** (based on average daily figure for BHSCT, AFBI and WHSCT). A further 1000+ tests/day are available via national initiative testing.	

5. Health Improvement Surge

Priority Area	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
Health Improvement Surge Plan	Brendan	GREEN	**Sustaining the Operational Function of the Division** A Business Continuity team which was established within the Division had a clear action plan is in place to ensure consistency of delivery and reporting within HI. The Business Continuity Group has been tasked with documenting and capturing the learning from the health improvement contribution to the Covid-19 response. As we move to a process of recommencing routine business in a "new normal" this group will be formally stood down with effect from 10 June. Development of Health Improvement Surge and Forward Plan almost complete. Plan covers total of 500 contracts in place with statutory and non-statutory contractors across a range of Making Life Better priority work areas. Demand and capacity assessment completed across all 500 contracts and informs action plan to prioritise activity required to address impact of COVID-19 across resilience and recovery phases. Example of high level issues requiring repurposed activity include: • **Stop Smoking Services NI** - Face to Face services and CO monitoring currently on hold. Access to NRT via Pharmacy being negotiated with Pharmacy/ HSCB/CPNI. Remodelling elements of Stop Smoking Services included in commissioning plan to DoH. Public Health Messaging in development. Website updated in light of COVID-19. • **Workplace health and wellbeing** – work ongoing to roll-out	Stop Smoking

Priority Area	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
			newly commissioned 'Work Well, Live Well' programme which is the PHA Workplace health commissioned service. This service will take on additional importance this year in assisting workplaces to address health and wellbeing of staff as workplaces return to a deal with a new normal in society. • **Protect Life 2 Implementation** – Continue to work with partners and stakeholders to implement the PL2 strategy. Priority is to maintain current service delivery where possible and look at innovative ways to engage stakeholders that will help design future services. • **Drugs and Alcohol** -Ensure additional D&A capacity redirected to sustaining current Needle & Syringe Exchange Scheme (NSES) and Take Home Naloxone (THN) services (including contingency planning / implementation) and DAMIS. Ensure continued delivery of existing D&A Low Threshold services. • **Early Years Obesity** - Contract recently agreed for delivery of HENRY programme across NI immediately prior to COVID-19. . Preparatory work for rolling out training to health visitors across NI progressing in advance of lockdown measures being lifted to ensure programme is ready for implementation. **Early Years Early Intervention Support Service** – PHA commissioned services currently supporting 650 families annually who are facing problems at early stage and need early intervention and family support. Public Health Agency asked by DH to develop a new integrated service model and has demonstrated considerable success and will be particularly relevant in supporting the public health implications	Services had been escalated to Silver previously as provision had decreased – services being reactivated therefore no further issues

Priority Area	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
			of disruption and pressure on families in COVID-19 context. • **Physical Activity** -Community Active Travel Programmes on hold and capacity repurposed to linking in with Planning Service and DFI to identify opportunities to accelerate shift in modal transport and increased availability of road space as a result of reduced motor traffic during pandemic. • **Later Years** – delivery of Age Friendly strategy under review due to delivery mechanism. Age Friendly officers to be repurposed to alternative communications strategy to prevent frailty by providing clear public health information. **Health Improvement role in the new Silver Cell – MENTAL HEALTH & EMOTIONAL WELLBEING COVID 19 SURGE CELL.** Health Improvement are involved in this cell This surge cell will consider the range of psychological and mental health needs emerging; identify appropriate responses to meet anticipated and emerging needs; and mobilise and coordinate the resources required to support the psychological and wellbeing needs of all those impacted by the pandemic and promote recovery in its aftermath. There will also be sub-cells from this group that will look at the public messaging for mental and emotional being and also an impact cell that will involve health intelligence. Work has now commenced on the development of this cell or a more formal process for planning in the future, initial planning work has commenced with HSCB on the future role for the group. In addition to the routine Comms/PR work that HI have been actively engaged in during the pandemic, leading on the development of	

Priority Area	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
			series of Blogs to help the public access insights and become better informed and knowledgeable about Covid-19 and to nudge behaviours such as support for the response by Health & Social Care and other partners; reducing fear / panic, misinformation; support with public health advice; and taking some positive steps about sustaining and improving population wellbeing. Blogs to date over 20 publications reaching over 20,000 individuals have included: • Deaths data and reporting • Contact Tracing • Volunteering (aligned to Volunteer Week) • Mental Health (aligned to MH Awareness Week)	

Staffing wellbeing and resilience

The staff health and wellbeing group has put in place a number of measures for staff across the office sites and a SharePoint holds the various guidance and information that has been produced.

A return to the office and the need to protect and prepare staff for this must also be considered corporately in line with guidance once released from BSO and agreed at AMT.

NOTABLE DIVISIONAL BUSINESS

This tables notes additional divisional priorities that do nott directly relate to the COVID 19 response but are impacted by or must continue during the response period.

Health Protection

Division	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
Health Protection	Gerry		Immunisation (detail to follow)	

Service Development

Division	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
Service Development	Brid		Work involving service development and the health intelligence divisions is underway to examine the unintended consequences in service and population health terms of the Covid-19 surge. Work to agree a phased de-escalation of critical care capacity is needed to permit selected high priority elective procedures to recommence. This will take into account complexity of maintaining streams for Covid-19 positive, Suspect and Non-Covid-19 cases. SD division will support forthcoming work to explore additional options for acute inpatient ward bed expansion in the event of a second Covid-19 wave The impact of COVID 19 on care homes is now at a critical point in the pandemic response. Service Development is supporting the regional group on care homes and leading on the development of a clinical care pathway to support care homes during pandemic. SD Division will support DoH & HSCB in coordinating a regional approach to restarting elective non-COVID-19 work, with an emphasis on cancer diagnosis and treatment. As PHA and Trust staff capacity allows, high priority service planning and improvement work which was paused since	

Division	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
			February 2020 will begin a phased restart.	
Service Development	Brid	amber	Development of exit strategy for transformation projects in collaboration with HSCB	To be agreed
Service Development	Christine, Deborah, Stephen Wilson and Linda McRandle	green	Small Business Research Initiative (SBRI) for online pain management resource development PHASE 1 nearing completion; planning for PHASE 2 commenced	none
Service Development	Christine and Deborah	amber	Healthy Living Centre Alliance Pain Management Support Programmes delivery, monitoring, evaluation and planning	Delivery suspended but evaluation and planning ongoing
Service Development	Christine and Wendy	amber	Completion of Long Term Ventilation in Community Settings Action Plan with integration of learning from COVID 19	Delayed but will progress during summer
Service Development	Christine	amber	Completion of HSCT Interstitial Lung Diseases Specialist Services IPTs for infrastructure funding	Delayed but nearing completion and no need to escalate

Screening

Division	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
Screening - overall	Stephen	Amber	Most population screening programmes paused 25/03/20. Maintaining only time-critical programmes, ie. newborn and antenatal bloodspot and hearing screening along with: - Higher risk breast screening - Diabetic eye screening for pregnant women - Tests for non-routine cervical screening All other routine screening are paused.	To review end May
Screening – Individual programmes	Tracy	Amber	Diabetic eye: Paused. Newly diagnosed, routine and surveillance screening invitations and clinics paused from week beginning 23 March 2020. Screening continues to be offered to pregnant women only. All image reading has been completed and referrals to ophthalmology have been triaged to identify any requiring emergency follow up.	

Division	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
	Sinéad		Breast: Breast Screening Programme was formally paused on 24 March 2020. However, Southern Trust made the decision to pause their invitations on 16 March. Western Trust paused screening on one of their two mobile units on 16 March, due to lack of toilet facilities as the Lakeland Forum had closed. Higher Risk Breast Screening continues but there is no out of area screening option provided. All screening is at the Northern Trust higher risk unit. Uptake has decreased during the pandemic with women electing to cancel or not to attend.	
	Tracy		Bowel: Paused. Screening invitations paused from week beginning 23 March 2020. Completed kits continue to be received and reported by the screening lab but these are now in very small numbers. Results letters continue to be issued for these. No pre-assessments, screening colonoscopy or CTC investigations have been undertaken from the above date	
	Damien		Cervical: All invites for March and April (usually sent in the middle of the month in a batch) have been paused. Women who have already been invited may seek to attend their GP for screening, Samples from women who have already had a smear taken should be processed and managed as usual. Non-CSP samples should continue to be processed (e.g. symptomatic women). Women referred by GPs should be appropriately managed. Women with symptoms should be	

Division	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
			managed and referred as appropriate. Women currently managed by Colposcopy should continue to be managed in this manner. Note: Although there had been plans to try and facilitate those who were short term laboratory or colposcopy repeats it was decided not to pursue invites for this group as: • Colleagues in Scotland and Wales confirmed that all cervical screening invitations (including short term recalls) were paused. • The drop off in attendance from mid-March suggests women would be unlikely to attend. • GPs would be unlikely to facilitate smears. • BSO would have difficulty undertaking effective prioritising within the repeat groups. As all invites (routine and non-routine) had been paused from mid-March to investigate this further, this will not have any impact on the workload of GPs, laboratories or colposcopy services.	

Division	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
	Adrian		AAA: Paused. No screening and no surveillance of men with small or medium sized AAA diagnosed by the screening programme. There has also been an impact on 10 men referred with large AAAs to the Specialist Vascular Team for potential surgical intervention. All 10 are on hold for further treatment, but 9 have had their outpatient appointment; all 10 men have had their CT scans. Currently, in line with Vascular Society Guidelines (issued in light of Covid-19 pandemic), none of these men have been treated as their AAAs are less than 7cm.	
	Adrian	Green	Infectious Diseases in Pregnancy: Programme continuing. May be delay in screening for some women due to isolation precautions. Also if hepatology services are depleted due to staff relocation to assist with on COVID 19 wards there may be a delay in the review appointments for the hepatitis B positive women meaning we may not meet the current standard of 6 week review.	
	Adrian	Amber	Newborn hearing: Programme continuing on basis of contingency protocol which seeks to maximise the numbers of babies who complete screening prior to discharge from hospital. No outpatient screening is being offered.	Normally 70% of screening is completed before discharge from maternity unit, with 30% completed at outpatient clinics. Screeners are attempting to complete screening before
	Adrian	Green	Newborn blood spot:	

Division	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
			Programme continuing. Any delayed or declined due to Covid-19 being monitored.	discharge. This is facilitated by the temporary closure of the stand-alone Midwife Led Units and the pause in home births. For those unable to complete screening at present (e.g. babies who move into Northern Ireland during this time or who are discharged before offer) their details are recorded and they will be offered screening at a later date

Health Improvement

Division	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
Health Improvement	Brendan		**Protect Life 2 Implementation** – Substantial work has taken place in the last 10 weeks to ensure PL2 work continues. Where possible services have continued to be provided. Additional support/information has been made available to the public and those individuals working in local communities to ensure they are supported. With ongoing messaging taking place. Work is well underway to reconfigure services to the changing needs in local communities arising from COVID-19 in relation to psychological wellbeing and recovery. This will potentially impact on the future service design Next meeting of the Regional Steering Group, Chaired by CMO is due to take place at the end of June 2020.	Work is underway to look at the mental health and emotional wellbeing impact of COVID-19 on communities. This work will link closely with the new Silver Cell on this issue.
			PHA and HSCB support for Department of Education to establish a resourced Emotional Wellbeing Framework for schools and youth service. In support of MLB and the role of Education to establish an integrated model that supports an early help, support and intervention focus on children's emotional health and wellbeing needs. This will support prevention and early intervention as well as clarification of the existing referral pathways for those who may require more intensive support. (Indicative DE budget £5m). A Draft AMT paper to be signed off by PHMT	DE have requested PHA and HSCB AD/Director level involvement in Department of Finance Innovation Lab in May- need to ensure support and input. PHA staff member currently supporting the Framework development group.

Division	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
			Maintaining current and continuity of service provision in regards to Needle Exchange (NSES), Take Home Naloxone (THN) and DAMIS.	Reconfigure NSES and THN to meet COVID-19 guidance including training.
			Working with the Councils on their response to "Voluntary & Community Sector Emergencies Leadership Group – Planning for Recovery and Renewal".	A copy of the action plan will be with PHMT in the coming week.
			Testing for vulnerable and socially disadvantages communities –working at developing links to vulnerable groups to support the roll out of future community based testing centres/access points.	Plans are at an early stage but we will explore links with local government, community and voluntary groups and how we can utilise existing contract arrangements to broaden the scope of reach to groups.

HSC R&D

Division	Lead	RAG	Update	Mitigating Actions and/or Issues for Escalation
HSC R&D	Janice		• Prioritised national clinical trials and other funded research on COVID-19, through HSC R&D funded infrastructure (Northern Ireland Clinical Research Networks (NICRN), Northern Ireland Clinical Research Facility (NICRF), and Northern Ireland Clinical Trials Unit (NICTU). Dissemination of information on these studies to HSC, Department and broader audiences • Providing advice and support on research ethics and governance issues through the 4 nations research policy group and local research governance infrastructure – with particular attention on fast-tracking COVID-19 studies • Continue to work on local and research governance issues through the HSC Approval change programme • Approval of Statement of Activities Cost Attribution Template (SoECAT) for studies to all UK funders led from Northern Ireland • Issuing and managing a COVID-19 funding call • Providing a STAC function for PHA – responding to queries as required • Management of ongoing funded awards • Continue to implement the PPI Strategy and engage with the PPI community & PIER (Public Involvement Enhancing Research).	

LONGER TERM PRIORITIES

Set out by division, the following priorities are the focus of each division over the coming 3-6 months. This information is reviewed on a monthly basis.

The following information sets out the agreed priorities within each division on 29 April 2020. The priorities listed below are subject to change as work evolves and information becomes more available.

Health Protection

- Staff wellbeing
- The need to build resilience into the system
- Spotter practice prevalence testing
- Care Home prevalence study – preliminary results to be presented to Expert Testing group today.
- ED Study – proceeding
- Staff generally coping well despite being overstretched by response to COVID. Some resilience needs to be built into the system and engagement of former colleagues who are willing to return to work would be appreciated. HR processes should be encouraged to expedite.

Service Development

- Staff recovery following a period of very intense working.
- Working with PHA Nursing, HSCB, RQIA and HP colleagues to ensure the services provided to care home residents in homes where there are cases of Covid-19 are safe and sustainable.
- Working with HSCB, Trusts, CCaNNI to ensure controlled de-escalation of critical care capacity and a managed reintroduction of elective diagnostic and treatment services, while remaining ready to escalate again if there is a second wave.

- Providing input and supporting any learning events at organisational / regional level - ? collation of divisional learning to date would be important to capture for next phase
- Mapping of capacity available to work on non-COVID work – this will be dictated by what capacity is required on an on-going basis to manage / monitor surge which is one of the top 5 priorities.
- Prioritisation of the non-COVID work across the division – this probably requires the most discussion. Some of it will be influenced by the areas of work which HSCB also views as priority given that we rarely operate without HSCB colleagues.
- Making sure children's services are re-started while maintaining some of the good things that have happened as a result of covid, ensuring children are not disadvantaged and developing and implementing the mitigation plan we are developing with paeds network.

Screening

- Restart paused screening programmes

Health Improvement

- Continued services and support inter-agency planning on wide variety of HSWI Themes including Protect Life, Drugs and Alcohol, Early Years, Later Years, Smoking Cessation, Home Accident Prevention. Physical Activity, Obesity prevention, Homelessness and Community Development.
- Procurement currently suspended but Protect Life/Mental Health, Early Years, Drugs and Alcohol, Community Development and Sexual Health thematic contracts and investments all priority areas and COVID-19 context will be key in progression once situation can allow procurement schedule and wider consideration with stakeholders.
- Surge Plan review and Plan
- Maintaining payments to C&V sector to ensure staffing levels remain to support vulnerable clients and regional COVID-19 response and support for Department of Communities Vulnerable Groups Hubs
- Providing support and relevant capacity to PHA Divisional COVID-19 planning and implementation across Cells including Contract Tracing.

HSC R&D Division

- Participating in UK wide and leading local groups on delivering the research governance agenda especially in terms of the evolving changes and requirements due to the COVID 19 situation with particular attention on fast-tracking COVID-19 studies
- Providing ongoing maintenance of the Science & Technology Action Cell (STAC) function for PHA
- Supporting the function of and access to the Administrative Data Research Centre, Honest Broker Service & Health Data Research UK (HDRUK) for HSC research purposes especially in light of COVID 19 and the implications with data and data access
- Supporting the function of and access to the Administrative Data Research Centre, Honest Broker Service & Health Data Research UK (HDRUK) for HSC research purposes especially in light of COVID 19 and the implications with data and data access
- Support research training opportunities for HSC benefits: as well as our routine schemes we have a COVID 19 Rapid Response Call open at present and are also joint funding lots of COVID related studies under our Opportunity and Needs Led schemes.
- Supporting current funded researchers who have been called back to the front line and how this impacts their current research project.
- Support researchers to compete successfully for R&D funding, locally, nationally and internationally – work is ongoing to encourage and support ongoing applications to the many other funding streams. As well as support development of research
- Continue to implement the PPI Strategy and to engage with the PPI community and involving our PIER (Public Involvement Enhancing Research) panel in all aspects of our work where possible, including as Patient and Public reviewers for our funding call.
- Continued engagement with Industry and other relevant stakeholders in our routine business and for COVID related studies
- Financial monitoring, returns and processing of invoices are ongoing to ensure the Division reaches financial breakeven, regular liaising with DoH, our finance colleagues and all internal and external stakeholders
- Continued team meetings, one to one's and regular updates to ensure the health and wellbeing of all staff working remotely and to ensure everyone has sufficient work and support especially during these unknown times

Work Requests

The following table should be used to highlight any large work requests for band 8 and above within the Public Health Directorate.

This form should be used for larger work requests (e.g. those that require more than one week of commitment) or those requests that the line manager deems as requiring approval.

Please note these guidelines may change as the process embeds.

Work Request	From (contact and dept/ organisation)	Detail of task (problem, expected outputs) and what will be required (resource, time, staff)	Exit Strategy – actions required on completion	Recommendation (agree/disagree)	Staff to be involved
Join new sub-group of Laboratory Community Surveillance group	Expert Testing Group	The sub-group will report via the laboratory community surveillance group to the expert testing group on antibody seroprevalence, firstly on a proposal to take forward antibody testing for COVID-19 in healthcare workers and care homes. The group must progress this urgently as the first batch of kits received has a very short shelf life remaining of 1 month.	Strategy for antibody testing of full population developed in partnership with the Expert Testing Group	Agree	Janice Bailie and 1 other from R&D PM team
Review Guidance for Estate Agents & Property Market	Department for the Economy – Taskforce	In the light of COVID19 and supporting steps to get the economy back up and running, PHA have been asked to review guidance for Estate Agents/property market	This is a task and finish exercise to be done over 2 weeks prior to 8 June easement	Agree	Brendan Bonner
Review of Strategic	Ed McClean and Marie Roulston	Based on the learning from the MH Silver Cell work is required to	The strategy will set in place a	Agree	Fiona Teague Brendan Bonner

Direction for the Commissioning for Mental Health and Emotional Wellbeing		reconfigure how we commission mental health and emotional wellbeing support in order to address the impact of COVID19. This will include redesign of MATT, Lifeline, SHIP services etc	new way of working for the future		

HSC Public Health Agency

item 9

Title of Meeting	PHA Board Meeting
Date	18 June 2020
Title of paper	Update on Contact Tracing Programme
Reference	PHA/03/06/20
Prepared by	Olive MacLeod
Lead Director	Olive MacLeod
Recommendation	For **Approval** ☐ For **Noting** ☒

Purpose

The purpose of this paper is to update the PHA Board on the Contact Tracing Programme

Background

On Monday 27 April, the Public Health Agency began a pilot programme of contact tracing for a sample of people who had received positive tests for Covid -19. There are around 80 trained staff who work on a rota to contact the person who has tested positive; identify those people with whom they have had contact and may therefore be at risk of developing the disease; and in turn contacting them to advise them on the appropriate next steps. These staff have mostly been redeployed from within the Health Service to support the work and we are grateful for their ongoing commitment as we move from the pilot phase to a long term service.

On 1 May CMO wrote to Dr Elizabeth Mitchell and Alistair Findlay requesting that they chair a Steering Group (CTSG) tasked with overseeing the implementation of a Contact Tracing and Advisory Service for Northern Ireland. The Public Health Agency (PHA) was requested to operationalise the service – the scope of which includes requirements to:

- Encompass traditional contact tracing elements as well as new technology-enabled elements;
- Identify 80% of contacts of cases within 48 hours of the onset of symptoms;
- Provide information to all contacts on symptoms to be aware of in the next 14 days along with information on what to do if such symptoms develop;
- Risk assess the need for self-isolation and provide appropriate advice;

- Actively follow up on high risk cases and passively follow up on low risk cases;
- Offer rapid and seamless access to testing if appropriate; and
- Identify and follow up on vulnerable citizens.

Strategic Context and Governance

The overall strategic context for the service is set out in the DoH "Test, Trace & Protect" strategy published on 1 June. CMO has established an Oversight Board for all elements of the strategy and a number of workstreams have been established from the Steering Group to operationalise the tracing programme.

As Accounting Officer I maintain overall responsibility for the PHA elements of the programme and I have seconded a colleague to act as Programme Lead and provide the necessary assurance to me on its progress.

Current Position

From Monday 18 May the Agency has been contacting everyone who has tested positive for the virus and undertaking the contact tracing process. Northern Ireland is the first part of the UK to have this service established and operational.

As of 10/6/20
Cases added to the contact tracing database since start of scheme (post pilot) – 363
Number of **cases** with successful telephone encounters since start of scheme (post pilot) – 300
Number of **cases** with unsuccessful telephone encounters since start of scheme (post pilot) – 71 (includes queue and carry over from pilot)
Number of **contacts** identified since start of scheme (post pilot) – 565
Number of **contacts** with successful telephone encounters since start of scheme (post pilot) – 510
Number of **contacts** with unsuccessful telephone encounters since start of scheme (post pilot) – 58
Average number of contacts identified per case since start of scheme (post pilot) – **1.88**

Future Delivery Model
There are three discrete but linked elements in the delivery model for the overall service:

- A digital, largely self-contained, suite of products that align with each other – the symptom checker app, a proximity app, an online test booking platform and a self-service contact tracing website.
- A call centre – essentially operating as a proxy for those citizens who cannot or do not wish to use the digital products. Call handlers will have back office access to the digital platforms and will provide information on various aspects of the service.
- A back office contact tracing service. This is a larger scale version of the service previously run in pilot by the PHA. It will operate on two different levels depending on the complexity of the contacts. The operating model is described below.

The PHA Service operates on two levels:

- Professionals (such as nurses and EHOs) and trained contact tracers for the majority of cases; and
- Health Protection Consultants for those cases where contacts are complex.

The pilot scheme was running on the basis of actively contacting a sample of those people who had a confirmed positive test result. The process is triggered by receipt of positive virology results to the centre and is outbound only – there is no function for citizens to contact the centre. Going forward (and from 18 May) the PHA has been operating on the basis of tracing the contacts of all people who have received a positive CV19 test result.

Presently there are round 30 positive tests each day in NI. These are referred to as "index cases". Each index case has a very small number of contacts – between three and seven. This is because of generally good adherence to the current restrictions in place. As restrictions lift, citizens will have more sustained contact with each other in daily life – at work, at home, travelling and at leisure. In parallel, testing capacity is increasing and now in NI all citizens aged over five years with symptoms of CV19 are eligible for a test.

The CV19 Contact Tracing and Advisory service will be required until a vaccine is developed or there is sufficient herd immunity in order that the disease may be controlled. This is likely to be at least two years. Whilst contact tracing is part of our remit in general health protection, the scale required for the management of CV19 requires a discrete operation.

Progress

We have commenced recruitment for the professional contact tracers to staff the operation. Interest in the role was high with almost 200 applicants. We will shortly advertise for a range of staff to enhance our analytical capacity. We have secured premises in County Hall, Ballymena which allow us to have safe working for a large cohort of staff.

We have also advertised for additional public health consultants to provide medical advice and clinical leadership in the centre. Additionally we have secured some of the administrative support required and are currently scoping what more is needed. The HSC Leadership Centre has agreed to second a dedicated trainer to us to support the centre.

Flexibility

Case numbers at present are small and manageable. As access to testing has expanded and the number of contacts increases as restrictions lift we will require a core of staff operating the centre. Our workforce planning model is based on the ability to flex staff should the numbers increase or decrease substantially. Essentially we will have a core of staff in the centre covering a 12-hour weekday period as well as weekends (this may not be 12-hour opening hours). We will retain other staff on an "on call "or bank basis to support additional capacity should it be

needed. Should less capacity be required, the staff will be redeployed to other health protection functions associated with the management of the outbreak (such as health surveillance).

I have written to the original cohort of HSC staff that worked with us and asked that those who are interested remain on our bank should we need them in future. I have also secured the services of around 20 experienced nurses who are already on Trust banks to work in the centre should there be a delay in recruiting our permanent staff. These nurses are currently undergoing training and will also work in the centre on a rota basis to ensure their skills are kept up to date.

This approach gives us flexibility to meet increased or decreased demands on the service. Other work is underway in respect of ensuring information governance is robust and effective as this is an area of considerable public and political interest. We have also established strong links with the Department's Digital Health & Social Care programme which not only supports the work of the contact tracing but has enhanced the progress of digital developments to support our other functions.

Engagement

We are conscious of the considerable public, political and media interest in the overall programme – although some individual elements such as the proximity app attract more attention. A communication and engagement workstream has been established and engagement with a range of stakeholders has commenced. You will have seen some of the recent print and broadcast media coverage of the programme - which has been positive.

Next Steps

This is a challenging area of work which has required significant input from a range of PHA staff working at pace. There are multiple relationships with other stakeholders across the Department, wider public sector, HSC and private sector. It is a credit to our staff that they have navigated these and the various risks and challenges that have arisen. If the Board is in agreement, I recommend that further updates are provided via my Chief Executive Brief to future meetings.

HSC Public Health Agency

item 10

Title of Meeting	PHA Board Meeting
Date	18 June 2020
Title of paper	Update on Vaccination Programme
Reference	PHA/04/06/20
Prepared by	David Irwin, Jillian Johnston; Louise Flanagan
Lead Director	Hugo Van Woerden
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to update the Board on the following two papers:

- Northern Ireland Seasonal Influenza Vaccination Programme Planning for 2020-21
- COVID-19 vaccine and potential implication for seasonal influenza programme 2020

2 Background Information

Northern Ireland Seasonal Influenza Vaccination Programme Planning for 2020-21

Northern Ireland has a well-established seasonal influenza vaccination programme delivery system. In line with UK expectation the programme for 2020-21 season is to be enhanced.

In preparation the Chief Medical Officer is holding the following NI influenza vaccine planning meetings:

- The schools programme – Tuesday 9th June 2020 2pm
- The GP based programme –Tuesday 16th June 2020 2pm; and
- Vaccination of Health and Social Care Workers - Thursday 18th June 10am

Context post COVID-19 pandemic

Planning is underway with UK and local programme board meetings, as a consequence of the COVID-19 pandemic, this year's planning cycle will need to take account of a number of factors, including:

- Increased challenge and complexity in light of social distancing measures
- An expectation that "demand" for influenza vaccination in eligible groups is likely to increase
- a requirement by DH to increase uptake to 95% across all eligible groups
- In line with JCVI and other UK policy recommendations, DH announced introducing universal vaccine to all children in School Year 8 (11-12 year olds)
- Currently DHSC policy seeks to increase the eligibility criteria amongst the adult flu vaccine programme, subject to procurement of additional flu vaccine

As a result there is a need to consider alternative evidence-based modes of delivery.

COVID-19 vaccine and potential implication for seasonal influenza programme 2020

A UK COVID-19 Vaccine Programme Board has been established to prepare for the delivery of a CVOID-19 vaccine should one become available. A Northern Ireland specific COVID-19 Planning Board is also being established.

Implications

It is paramount that routine vaccination uptake is maintained – primary care and Trusts to ensure they apportion appropriate resources to achieve this. A co-injection of COVID-19 and influenza vaccines is to be determined by JCVI – this has potential for multiple vaccination visits to be needed to complete courses 2 for COVID-19 1 for influenza.

Time frame

The earliest completion of Phase III trial is August 2020, so the earliest start date for a COVID-19 programme is the start of October 2020.

Target population

This will be the UK population with priority groups if the vaccine is in short supply. The priority groups will be the same as for influenza and high risk groups for severe illness (50+ years, "shielding")

3 Next Steps

As outlined in the attached papers.

COVID-19 vaccine and potential implication for seasonal influenza programme 2020

8th June 2020

Summary

Introduction

A UK COVID-19 Vaccine Programme Board has been established to prepare for the delivery of a CVOID-19 vaccine should one become available.

Northern Ireland specific COVID-19 Planning Board also being established.

Implications

Paramount routine vaccination uptake maintained – primary care and Trusts to ensure they apportion appropriate resources to achieve this.

Co-injection of COVID-19 and influenza vaccines to be determined by JCVI – potential for multiple vaccination visits needed to complete courses 2 for COVID-19 1 for influenza.

Time frame

Earliest completion phase III trial August 2020, earliest start date COVID-19 programme start Oct 2020.

Target population

UK population, priority groups if vaccine in short supply: as for influenza + high risk groups for severe illness (50+ years, “shielding”)

Storage & distribution

Manufacturer level -70^{o}C and three months shelf live after thawing and storage 6-8^{o}C.

Multi dose vials with risks of wastage, and hygiene/sterility concerns.

Security needs for storage sites.

Schedule

2 doses 28 days apart.

Workforce

Need to increase across HSCB (PHA, BSO, Trusts and Primary Care).

Programme Board is considering the need for non-vaccination trained staff (who will have to follow newly developed protocols and administer COVID-19 vaccine).

Existing staff will also be required to provide training, advisory and supervisory activities for these new “vaccinators”.

Delivery to HCWs will be via existing OH and possibly expanded communist pharmacist routes (but these will already be under pressure to deliver planned enhanced influenza vaccine programme).

Similar concerns for non-Trust employed staff receiving via their OH / standard arrangements.

Public information materials

New public information materials will need to be developed and produced.

New Patient Group Directions will need to be produced.

New training materials will have to be produced.

Vaccine coverage surveillance

Data capture for new vaccine to determine coverage, patient specific to record who has received doses, side-effects/adverse reactions, may include a seroprevalence study

Need for:

Increased staff numbers – training, indemnity, salary/payments. (May require a limited domestic service for those shielding who can't be transported to a drive through/centre). Domiciliary service mooted for care homes.

Facilities for enhanced cold chain: -70^{0}C storage for long-term and 2-8^{0}C for shorter term storage before use. New vaccine fridges needed for each local administration centre

Dose sparing syringes

Sharps bins

Additional PPE (as determined)

Consideration of methods of delivery – drive through (as with COVID-19 testing) or other possible models (also discussed for influenza) – community pharmacy, drive through, leisure centres other community facilities capable of holding vaccination teams and addressing social distancing needs – capacity estimates will be essential for planning.

Introduction

In Northern Ireland, Department of Health (DH) delivers policy, sets the strategic direction and secures regional funding for all vaccination programmes. Decisions are based on evidence and recommendations from the United Kingdom Joint Committee of Vaccinations and Immunisations (JCVI). On 7th May 2020, an extraordinary JCVI meeting on COVID-19 was held with NI representation (PHA) and a DH observer in attendance. The purpose of the meeting was to provide initial early advice to help inform panning assumptions for a COVID-19 vaccination strategy with the focus on advising who might be prioritised to receive the vaccine, assuming there is a safe and effective vaccine, and based on potential timelines of availability and quantity.

Since the JCVI meeting, a national COVID-19 programme board has been established chaired by PHE, and with PHA and DH (NI) membership. DH is progressing planning in line with national plans and the request is to plan for an early case scenario start date of autumn 2020. Should a COVID-19 vaccine indeed become available for autumn 2020 delivery this will require significant additional resource across all Health and Social Care organisations in Northern Ireland and would have implications for the delivery of the seasonal flu vaccine programme as outlined in this paper.

Implications

The following issues have been raised that may have a significant impact of influenza vaccine delivery in the coming season:

- Paramount concern is for everyone to be up-to-date with their recommended planned vaccinations as part of our routine national vaccination programmes. it is therefore important the primary care and Trust resources are maintained to ensure that the childhood, school and other adults vaccine programmes continue to be delivered

- If co-injection at the same time as influenza is not an option, DHSC has stated that COVID-19 should be prioritised over influenza although it is unclear if this is also a JCVI recommendation. At this stage, DH (NI) has not stated any priority although it is likely that they would wish to be in line with the UK. If this is the case, people may need to come back for flu jab until evidence from JCVI is available around co-injections.

- **Possible time frame:** Earliest date for completion of phase III is end of August 2020 (for any vaccine), and at latest by mid-2021 – programme likely to last for, at least, 6 months.

- **Target Population**: As per JCVI, and taking account the fact that a vaccine is currently not developed, the recommended target population for a COVID-19 vaccine is to offer to those at greatest risk first:
    - all over 50-year olds/"shielding" (possible reason for proposed extension of flu vaccine to this group)
    - Current influenza 'at risk' groups
    - All health and social care workers
    - Involved armed forces personnel/police/other key workers

  Children's programme unlikely at this stage

- **Storage and distribution: current recommendations for s**torage at manufacturer level have stated -70^{0}C which is significantly lower than currently seen with other vaccines). Once defrosted possible 3 months stability at 2-8^{0}C. Multi-dose vial presentations is also the assumption, certainly as the start of the planning, which presents issues over hygiene/sterility and additional time factors in delivery to patients. Security arrangements for central storage sites for vaccine.

- **Vaccine schedule:** current plans are for a two doses (28 days apart) COVID-19 vaccine schedule. Policy clarification will need to be sought on whether two doses should be held for the first priority groups or single doses more widely administered with the assumption / hope that there will be new and ongoing deliveries

- **Workforce across public health (PHA), commissioning (HSCB), trusts and primary care:** will need to increase across the HSC to deliver COVID-19 (and influenza vaccination) to both public eligible groups and Health and Social Care Workers (HSCWs).

    - The following list considers those who may be employed to carry out this urgent programme for public eligible groups:
        - Health care assistants
        - Retired health care professionals
        - Army personnel
        - Non-clinical based medical students

- Non-clinical based nursing students

  - The Programme Board is considering the need for non-vaccination trained staff (who will have to follow newly developed protocols and administer COVID-19 vaccine). However, even if this will spare the existing staff for national programmes, there will still be calls upon their time for training, advisory and possibly supervisory activities. If JCVI determine that both COVID-19 and Influenza co-injections can be given then unless similar arrangements are put in place for influenza vaccine demands upon trained staff will increase.

  - Current expectation is that the vaccination of Trust employed Health and Social Care Workers can be maintained in the usual way through Trusts Occupational Health services although demand is likely to be high and workforce will need to be resourced to deliver

  - Non-Trust employed Social Care Workers will also continue to be offered vaccination in the usual way, through either their employer schemes or the long-standing SLA between DH and Trust Occupational Health Services. However, this delivery model would require significant resourcing and consideration of alternate models may be preferable e.g. via community pharmacies.

- **Public information (publications, website and social media), promotion, health professional resource and training:** new regional materials for the public, HSCW and professionals delivering the vaccine will need to be developed, including Patient Group Direction (PGD). Training will need to be carried out which has historically been done by PHA immunisation staff. If new / non-professional vaccinating staff are to be considered in delivering then protocols to administer COVID-19 vaccine will need to be developed. if this will call on existing staff for national programmes time for training, advisory and possibly supervisory activities.

- **Vaccine Coverage Surveillance:** Data capture for new vaccine to determine coverage, patient specific records who has received doses, side-effects/adverse reactions, may include a seroprevalence study.

Need for:

Increased staff numbers – training, indemnity, salary/payments. (May require a limited domestic service for those shielding who can't be transported to a drive through/centre). Domiciliary service mooted for care homes.

Facilities for enhanced cold chain: -70^{0}C storage for long-term and 2-8^{0}C for shorter term storage before use. New vaccine fridges needed for each local administration centre

Dose sparing syringes

Sharps bins

Additional PPE (as determined)

Methods of delivery:

Drive through (as with COVID-19 testing) or

Other possible models (also discussed for influenza) – community pharmacy, drive through, leisure centres other community facilities capable of holding vaccination teams and addressing social distancing needs – capacity estimates will be essential for planning.

Northern Ireland Seasonal Influenza Vaccination Programme Planning for 2020-21

8th June 2020

Summary

Introduction

Northern Ireland has a well-established seasonal influenza vaccination programme delivery system. In line with UK expectation the programme for 2020-21 season is to be enhanced.

In preparation the CMO is holding the following NI influenza vaccine planning meetings:

- The schools programme – Tuesday 9th June 2020 2pm
- The GP based programme –Tuesday 16th June 2020 2pm; and
- Vaccination of Health and Social Care Workers - Thursday 18th June 10am

Context post COVID-19 pandemic

Planning is underway with UK and local programme board meetings, as a consequence of the COVID-19 pandemic, this year's planning cycle will need to take account of a number of factors, including:

- Increased challenge and complexity in light of social distancing measures
- An expectation that "demand" for influenza vaccination in eligible groups is likely to increase
- a requirement by DH to increase uptake to 95% across all eligible groups
- In line with JCVI and other UK policy recommendations, DH announced introducing universal vaccine to all children in School Year 8 (11-12 year olds)
- Currently DHSC policy seeks to increase the eligibility criteria amongst the adult flu vaccine programme, subject to procurement of additional flu vaccine

As a result there is a need to consider alternative evidence-based modes of delivery.

Children's Programme Delivery

Additional vaccine stock acquired to increase uptake in previous target population to 95% (existing business case for 85% uptake) has been further increased by the extension to children entering their first year of secondary school.

Unclear if this signals government intent to extend the target population in the under 18's each year by vaccinating those offered it in the previous year's programme.

Adults Programme Delivery

DHSC has procured a significant increased supply of influenza vaccine – planned to increase coverage to those aged between 50-64 years of age. Following this procurement, no additional supply is accessible to the UK and a decision is awaited from ministers in DHSC on potential sharing of stock with the Devolved Administrations. The supply does not appear to be sufficient to cover the England 50-64 age range and other options for vaccine deployment are under consideration.

To date, this information remains Official Sensitive.

NIGPC believes that GPs can address the existing target population, but are concerned over the additional demands required for an extended 50-64 year cohort (potentially doubling the target population).

Given the desired increased target attainment and the impact of managing COVID-19 during the forthcoming influenza vaccination season the Department of Health, PHA, Integrated Care and School Nursing services are regularly meeting to discuss the delivery of vaccination to the Northern Irish population. Other approaches to achieving delivery and improved access to the vaccine are also being considered.

Planning for the possible delivery of COVID-19 vaccine to the whole NI population with priority given to those in the same target groups as influenza vaccine are also underway.

To date, maternity services in Northern Ireland have not administered the flu vaccine due to staffing capacity issues.

Increasing uptake to 95% within this target population (ignoring the possible extended cohort) will require a significant increase in funding as each administered vaccine attracts a fee of approximately (£10) with a potential doubling of funding for this payment stream.

HSCW Programme Delivery

Historically HSCW uptake has been lower than other region in the UK.

Improvement is dependent on additional resource both for public health to provide dedicated and targeted support and for Trusts to delivery to an increasing work force. This becomes more acute with the potential introduction of a COVID-19 vaccine. Financial resource and engagement of Trust senior staff is needed to support an increase in uptake.

Public Health Delivery

Unfortunately as a consequence of COVID-19, the staff commitment to immunisation within the Health Protection Team has been curtailed, adding to the burden of the staff continuing to provide support this programme.

Vaccine uptake surveillance (currently delivered by the HP surveillance respiratory team) does not have the capacity to deliver both the ongoing COVID-19 surveillance activities as well as their usual flu work plan. This has been exacerbated by the absence of the surveillance officer who collates uptake figures (currently on maternity leave) to date this post has not been back-filled.

A table outlining the additional requirements for PHA responsibilities is included in the main text of the report (Table 1).

Appendix 1 details the PHA Health Protection Responsibilities for Seasonal Flu Vaccine Programme delivery

Appendix 2 provides a summary of the Annual Cycle of the Seasonal Flu Programme

Appendix 3 provides details of the Seasonal Influenza Vaccine Programme Schedule, mode of delivery and vaccine procurement

Introduction

In Northern Ireland, the Department of Health (DH) delivers policy, sets the strategic direction and secures regional funding for the seasonal flu vaccination programme. Decisions are based on evidence and recommendations from the UK Joint Committee of Vaccinations and Immunisations (JCVI). During the summer DH issues the annual CMO policy letter, '*seasonal flu vaccine programme*' to Health and Social Care organisations. This sets out policy arrangements for preparations and management of the programme.

In addition to DH, Public Health Agency (PHA), Health and Social Care Board (HSCB) and Health and Social Care Trusts (HSCTs) are separately accountable for their own responsibilities in delivering vaccination programmes. PHA and HSCB work with Trusts, Primary Care and other providers in the operational aspects of the response to flu, including delivering the flu vaccine programme, as outlined, the '*PHA / HSCB Flu Plan*'. Within the PHA, the Health Protection Immunisation Team provides regional oversight and coordination of flu vaccine delivery, as well as other direct responsibilities as outlined in appendix 1.

In Northern Ireland, the mode of delivery for flu vaccine is mainly by Primary Care. Trust service providers also deliver flu vaccine to specific groups, via school nurses, occupational health services and district nursing services. Commissioning of primary care vaccine programmes is the responsibility of the HSCB Integrated Care Directorate via the GMS Contract. Commissioning of Trust service providers is either by DH (Occupational Health Services) or PHA Nursing Directorate for nursing services including school nursing, community child health and district nursing. Last year, HSCB Integrated Care Pharmacy Directorate, with support from the PHA HP Immunisation Team, commissioned a pilot offering flu vaccine to Health and Social Care Workers (HSCWs) in community pharmacies. The PHA HP Immunisation Team supports the commissioning process, has oversight and monitors the vaccination financial budget to HSCB.

In preparation for the 2020-21 flu vaccine programme, the CMO is holding the following regional influenza vaccine planning meetings:

- The schools programme – Tuesday 9th June 2020 at 2pm

- The GP based programme –Tuesday 16th June 2020 at 2pm; and
- Vaccination of frontline Health and Social Care Workers - Thursday 18th June at 10am

2020-21 planning in the context of the COVID-19 pandemic

Planning for the 2020-21 seasonal flu vaccine programme is now underway and will follow the usual planning programme as previous years (outlined in Appendix 2 and 3). However, as a consequence of the COVID-19 pandemic, this year's planning cycle will need to take account of a number of factors, including:

- Increased challenge and complexity for service providers to deliver the flu vaccine programme, in light of social distancing measures
- An expectation that "demand" for influenza vaccination in eligible groups is likely to increase
- a requirement by DH for service providers to increase uptake to 95% across all eligible groups
- In line with JCVI and other UK policy recommendations, on 5th June 2020 DH announced a change the childhood vaccine programme policy – introducing universal vaccine to all children in School Year 8 (11-12 year olds)
- In line with DHSC policy, DH may potentially increase the eligibility criteria amongst the adult flu vaccine programme, subject to procurement of additional flu vaccine

As a result there is a need to consider alternative evidence-based modes of delivery, such as drive-through services, alternative service providers and / or mass vaccination campaigns, all of which require additional resources, expanded and adapted plans as outlined in this document.

Additional requirements for Flu Vaccine Planning

Children's Programme Delivery

On 4th June 2020, the Minster approved procurement of additional LAIV vaccine (60,000 doses). It has been agreed that the additional stock will be used to achieve an uptake target of 95% across all childhood age groups, compared to the existing DH target of 75%, as well as to introduce for the first time universal vaccinations of all School Year 8 children.

Not only is this a significant increase in uptake from last year but, the added complication of social distancing: arranging appointment slots to address this; and the use of PPE for administering will increase the time taken to vaccinate target groups with a need for additional resources (staff, materials etc.). It is understood that the DH Ministerial submission is also seeking to request additional financial resource to enable this but this is still being worked up by DH and PHA Nursing colleagues.

The existing business case for the school programme is commissioned to deliver vaccines to 85% of P1-P7. Prior to COVID-19, PHA Immunisation Team carried out a review of the flu vaccine schools programme since introduction (2013/14) and had identified a resource requirement of one FTE B5 public health nurse per Trust. Since 2019-20 this has been on the PHA Finance cost pressure list. Further additional resource to deliver the COVID-19 additionality will need to be agreed and approved by Department of Health as soon as possible to enable school nurse teams to start recruitment of new school nurse staff.

It is unclear whether this is for the current year only or the means by which DH plans to implement the JCVI recommendation that the programme should be extended to all children aged two to less than seventeen years old, by incrementally adding in each year those who have in the previous year received the influenza vaccination at school.

Adults Programme Delivery

In preparation for this year flu programme, DHSC in England have sought to procure additional injectable vaccines to (1) achieve a target of 95% in existing eligible groups and (2) potentially broaden the offer of vaccine to other groups. To date, they have secured some, but not all their preferred volume, and there are no policy plans on who they plan to offer the vaccine too. Options discussed have been: universally to all those in the 50-64 age range; to household contacts of all eligible groups; or household contacts of those advised to “shield” in response to COVID-19 . To date, this information remains Official Sensitive and has not been indicated in the national influenza season letter for England. We and the other Devolved Administrations are awaiting a ministerial decision on access to supplies from the DHSC for the 50-64 year extension cohort (no alternative supplies are available).

Regarding delivery to the normal cohorts NIGPC believes that GPs can address this group, but there are concerns should this be extended to the 50-64 year cohort (supplies becoming available) how a potential doubling of the target population could be addressed.

Given the desired increased target attainment and the impact of managing COVID-19 during the forthcoming influenza vaccination season the Department of Health, PHA, Integrated Care and School Nursing services are regularly meeting to discuss the delivery of vaccination to the Northern Irish population. Other approaches to achieving delivery and improved access to the vaccine are also being considered. A successful pilot of community pharmacy seasonal influenza vaccination was undertaken last year in Northern Ireland and PHA would like to see this scheme being rolled out more widely across the country, potentially improving access for those within target cohorts (especially those who would normally be expected to rely on an occupation health service – health and social care staff).

Currently a number of models are under consideration, including drive through, or use of a large currently redundant building (e.g. leisure centres) which would facilitate appointment systems, social distancing while waiting, and a one way systems for access and egress.

In addition to the seasonal influenza vaccination programme for 2020, there are also plans underway to deliver COVID-19 vaccination to the same cohort groups covered by seasonal influenza vaccination (prioritised until supplies are available to cover the whole of the UK population) potentially from September/October 2020, successful trials and licencing permitting.

To date, maternity services in Northern Ireland have not administered the flu vaccine due to staffing capacity issues.

Increasing uptake to 95% within this target population (ignoring the possible extended cohort) will require a significant increase in funding as each administered vaccine attracts a fee of approximately (£10) with a potential doubling of funding for this payment stream.

HSCW Programme Delivery

Historically HSCW uptake has been lower than other region in the UK. Whilst there have been improvements over the previous 3-4 years, the ability to improve further is dependent on additional resource both for public health to provide dedicated and targeted support and for Trusts to delivery to an increasing work force. This becomes more acute with the potential introduction of a COVID-19 vaccine. Financial resource and engagement of Trust senior staff is needed to support an increase in uptake.

Public Health Delivery (public, professional resources and surveillance uptake)

The PHA Health Protection Immunisation Team consists of one HP consultant, 2 part time B7 immunisation nurses and 1 FT B4 project officer. Unfortunately as a consequence of COVID-19, the immunisation nurses have been unable to provide any commitment to vaccine programme and the project officer has been on long-term sick since mid-April 2020.

Similarly, vaccine uptake surveillance is currently delivered by the HP surveillance respiratory team, who does not have the capacity to deliver both the ongoing COVID-19 surveillance activities as well as their usual flu work plan. Added to which,

the B6 surveillance officer that collates uptake figures is on maternity leave and to date has not been replaced.

The following table outlines the additional requirements for PHA responsibilities.

Table 1: Additional PHA requirements for Influenza vaccine delivery

Area (organisation responsible)	Current	Additional resource requirement as a consequence of COVID-19 requirement out with COVID-19 needs
Vaccine Procurement (BSO PaLS and RPPhS on behalf of PHA)	PHA is responsible for the regional procurement of injectable flu vaccines and holds a Wholesale Dealer Authorisation (WDA) Licence. An SLA is place with the Regional Procurement Pharmacy Service (RPPhS), Northern Trust (£60K recurrent) to manage the procurement process and ongoing pharmaceutical expertise. The procurement of injectable flu vaccines completed in April 2020, with the following type and volume of vaccines ordered: • 265,000 aTIV (75% target) • 265,000 QIVc (75% target, 50% HCW) DH is responsible for engaging with the national procurement of the childhood flu vaccine (LAIV). This year (**pre-COVID-**	**Pharmacist within PHA** Whilst PHA holds a WDA Licence there is no pharmacy resource to provide the expertise and requirement for WDA which is currently held by HP Consultant Additional resource will need to be factored in to manage the logistics of increased number of deliveries to schools to manage the expanded schools programme **Expanded Pharmacist roles within RPhPS** To manage the logistics of increased number of deliveries to schools to manage the expanded schools programme

	19) 200,000 doses of LAIV were secured to enable 85% uptake target plus the additional 60K announced on 4th June	
Coordination of flu vaccine storage and distribution logistics (PHA and RPPhS)	PHA is responsible for commissioning the regional storage and distribution of flu vaccines and holds a contract with Movianto NI (£120K recurrent). As part of the SLA, RPPhS coordinate the receipt of delivery arrangements with the manufacturers/suppliers, the contract management with Movianto and ongoing pharmaceutical expertise during the season.	**Expanded Pharmacist roles within RPhPS** Following the last 2 flu season years, where there were flu vaccine shortages and delays, there has been increasing recognition of a gap in the logistical management of storage and distribution between Movianto and PHA. The gaps already recognised become more acute in light of COVID-19 It would be better for the Northern Trust to have additional staffing as part of their contract to ensure effective liaison with storage capacity within the trust and the distribution to end users (GPs, school nursing services and community pharmacies should the successful pilot be extended across NI). **Capacity within Movianto** Following the last 2 flu season years, it has been increasing apparent that the current Movianto contract has limited flexibility to be able to deal with unforeseen consequence in the flu programme (delays etc.). This is likely to be more acute as a result of COVID-19 and recently we have become aware that

		Movianto have withdrawn their contract with Belfast and Southern Trust pharmacy departments to distribute childhood vaccines suggesting that they have concerns about their ability to deliver.
Publications (PHA)	• Develop public & HSCW hard copy leaflets and posters • Development of professional factsheets, training slides, on line videos • Procurement of print and distribution	**Dedicated Immunisation Nurse and programme manager required for the PHA Immunisation Team** This staff resource is already limited and due to increased number of leaflets and distribution points required, and new leaflet information on social distancing etc. it will become more acute.
Health Professional training	• Face to face training school nurses • +/- GP federation groups • +/- Trust on request Sept - Mar:	**Dedicated Immunisation Nurse and programme manager required for the PHA Immunisation Team** As above More training will be required given the expanded and new changes to the programmes
Communication Plan / Promotion (PHA Comms)	Press releases / social media throughout season	**Dedicated Immunisation Nurse and programme manager required for the PHA Immunisation Team** To enable consultant time to be freed up to engage with Comms and provide target messages via better engagement with PHA Health Improvement teams
PGDs and ongoing pharmacy expertise	HSCB Integrated Care are responsible for PGDs but these are developed jointly by immunisation nurses.	**Dedicated Immunisation Nurse and programme manager required for the PHA Immunisation Team PLUS Pharmacist within PHA**

		PGD/ cold chain incidents Support expansion of community pharmacy delivery
Surveillance uptake data	The HP respiratory surveillance team are responsible for delivery flu activity surveillance throughout the year and vaccine uptake of the schools, GP and HSCW programmes to Trust and NI level.	**Dedicated surveillance staff for flu vaccine uptake surveillance** To deliver uptake at NI, Trust and individual practice level. AND To deliver new practice level analyses of uptake. **Uptake rates for influenza (and other) vaccine in individual GP practices is not made available to PHA** – only Trust wide rates are available. We suspect that this year (and we expect going forward) the DH will be seeking information on uptake rates at a practice level (for influenza and potentially other vaccinations) – to enable identification of those practices which are doing well and those which are not – to facilitate sharing of best practice approaches, targeted education activities, or even if necessary, enabling an alternative means of vaccination for patients in poorly performing practices.

Appendix 1: PHA Health Protection Responsibilities for Seasonal Flu Vaccine Programme delivery

1. Regional strategic oversight and coordination
2. Technical expertise and support for policy makers, commissioners and providers
3. Planning and implementation of new / change to the programme
4. Regional procurement of injectable flu vaccines (the Live Attenuated Intra-nasal vaccine (LAIV) is procured nationally by PHE)
5. Supporting health professional delivery of programmes –ensuring health professionals have appropriate knowledge and resources to deliver the programmes, through development of guidance, training tools and delivery, development of Patient Group Directions
6. Public information – raising awareness and promoting vaccinations, through information leaflets, maintaining the PHA website, social media and the media.
7. Surveillance – providing ongoing systematic surveillance of vaccine uptake and influenza activity.
8. Quality improvement - a role in implementing interventions to improve vaccination uptake and address health inequalities.
9. Outbreak and significant incidents - investigation and management of all vaccine-preventable disease outbreaks and other vaccine-related incidents

Appendix 2: Summary of the Annual Cycle of the Seasonal Flu Programme

January–March

- The vaccination programme for the current season should be complete although late vaccination may be continuing particularly for pregnant women.
- JCVI may issue additional guidance.
- WHO announces the virus strains selected for the next season's flu vaccine for the northern hemisphere
- Manufacturers can only start the process of creating the vaccine for use in the autumn once WHO has recommended the strains to be included in the vaccine. This happens in February, leaving a limited time for manufacture before the vaccination campaign starts usually in late September. Manufacturers may not be able to respond to unexpected demands for vaccine at short notice, or to allow for changes/mutations to the strains that may be identified later in the year.
- PHA work with BSO Procurement and Logistical Services (PaLS) and Regional Procurement Pharmacy Services (RPhPS) to secure sufficient supplies of injectable flu vaccine for the coming season

April–June

- Vaccine supply issues are monitored
- Leaflets are planned, drafted and tested
- Training materials are planned.
- Liaison with DH on policy issues.
- Public information and media work is planned; briefs and materials drafted.

July–September

- DH issue vaccine policy letter, including guidance about vaccine uptake data collections
- Trusts, GP practices and pharmacists begin communications activities to promote uptake of the vaccine among eligible groups.
- GP practices contact their eligible patients and invite them to attend for vaccination.
- Deliveries of vaccine to GP practices start from mid-late September.
- Leaflets are printed and distributed.
- Training for practices and Trusts is completed.

October–March:

- Deliveries of vaccine continue according to manufacturers' production processes.

- GPs and Trusts vaccinate eligible patients, with majority of vaccination complete by the end of November, and complete uptake monitoring returns.
- Uptake surveillance shared with DH and other HSC organisations monthly for the following groups:
  - people aged 65 and over
  - people aged under 65 with a clinical “at-risk” condition
  - all pregnant women
  - children aged 2-4 years old and children in primary 1-7
  - frontline health and social care workers

March

- Official end of season
- End of season uptake published

Appendix 3: Seasonal Influenza Vaccine Programme Schedule, mode of delivery and vaccine procurement

	Eligible Group	Mode of Delivery	Vaccine Procured
Children's Flu Programme	• 6 months - 2 years (risk groups) on 31 August 2020	GP	QIVe
	• 2-4 years (universal)	GP	LAIV
	• 4-11 years (primary school – universal	Trust School Nurses	LAIV
	• 11-18 years (risk groups)	GP	LAIV
Adult Flu Programme	• aged 65 years and over	GP	aTIV
	• 18 - 64 years in clinical risk groups	GP	QIVc
	• Pregnant women	GP	QIVc
	• Long-stay residential care homes	GP /Trust District Nurses	aTIV / QIVc
	• Close contact immunocompromised	GP	aTIV / QIVc
	• Carers	GP	aTIV / QIVc
Health and Social Care Worker Flu Programme	• Trust-employed Health and Social Care workers	Trust Occupational Health / Community Pharmacy (pilot 2019-20)	QIVc (all including those 65+)
	• Non Trust-employed Health and Social Care workers (i.e. employed by a registered residential care/nursing home, registered domiciliary care provider, or a voluntary managed hospice provider)	Number of options: SLA with Trust Occupational Health/ Employer schemes/ Community Pharmacy (pilot 2019-20)	QIVc (all including 65+)

HSC Public Health Agency

item 11

Title of Meeting	PHA Board Meeting
Date	18 June 2020
Title of paper	Personal and Public Involvement Update
Reference	PHA/05/06/20
Prepared by	Martin Quinn
Lead Director	Rodney Morton
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.

The PHA has lead responsibility for the implementation of PPI Policy across the HSC. In the main, the PHA manages these responsibilities by working in partnership with other HSC bodies and service users and carers through the Regional HSC PPI Forum.

In a time of significant change, Transformation and the challenges brought about by the COVID-19 pandemic, the PHA PPI Team has been very proactive and adaptable in supporting the system in regards to Involvement, Co-Production and genuine Partnership Working, as well as supporting our collective endeavours on work related to addressing the Coronavirus challenges.

4 Next Steps

The next biannual Report will be brought to the Board in December 2020.

HSC Public Health Agency

Personal and Public Involvement (PPI)

PHA Board Update June 2020

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

PPI & the PHA's Role

PPI is the active and effective involvement of services users, carers and the public in health and social care services. People have a right to be involved in and consulted with on decisions that affect their health and social care. Under the HSC (Reform) Act (NI) 2009, PPI is a legislative requirement.

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.

Background to Update Report & COVID 19 Impact:

This report covers the period from January to the start of June 2020. It gives an overview of the progress made against the PHA PPI Action Plan including how we have discharged our leadership responsibilities in Involvement across the HSC system. The report is structured in an agreed format, using the Departmentally approved Involvement Standards, upon which the PHA & Trust Involvement Action Plans are based.

Of particular note in this period is the impact of the COVID 19 pandemic, with the consequent implications for PPI and progress against plans laid down in advance of the emerging crisis. Like much of the system, COVID 19 had a huge impact on what we have been able to do, anticipated timelines, how we work and what we focussed our energies on. Much of the planned work was slowed down, put on hold, or not possible to progress because of the restrictions placed on society, but time not used in taking forward our pans was put to good use in other ways.

The PPI staff team redirected much of our time, expertise, skills and experience to support the collective effort to combat the COVID 19 virus.

Members of the team have:

- Served on the Communications and Knowledge Management Cells;
- Covered EOC rotas
- Been trained in Contact Tracing
- Covered Contact Tracing rotas
- Served on the PHA/HSCB & BSO Health & Well-Being Group

- Contributed to and provided professional involvement advice and guidance to projects and discreet pieces of work connected to the HSC response to COVID 19, or which have been trying to operate in an environment hugely changed by it.

Beyond this, the team have also been talking to Involvement Experts, Academics, HSC staff, service users, carers and other stakeholders, about how we collectively, might facilitate effective involvement in this “new norm”, where social distancing is common place, where technology is being much more widely utilised to enable communication and interaction.

Information and resources to support this way of working have been sourced, promoted and disseminated and the team have commenced work on the development of guidance which draws upon best practice and which we hope to make available to the system for use by the summer.

Standard 1. Leadership

The Regional HSC PPI Forum

The Forum held a meeting on 2nd March in Mossley Mill, Newtownabbey. It was co-chaired by Michelle Tennyson, Assistant Director of AHPs, PPI and PCE and Don Harley, a service user and carer member. During this period, a number of areas of work have been taken forward and progressed in line with the PPI Standards.

At the meeting, the HSC Trust PPI Leads presented a joint up-date on theTransformation funding to progress 'Involvement, co-production and partnership working. This joint presentation highlighted how dedicated support can enhance the involvement of service users and carers across HSC. The PHA continues to lead the Forum to progress regional work including the Recognition Framework, the Consultation Scheme Template and the Training sub-group which is jointly chaired by PHA and PCC.

An overview of the hugely successful Involve Fest week (lead by Bronach McMonagle Senior PPI Officer) was presented at the Forum meeting. Forum members themselves were active in the planning, management, delivery and participation of the Involvement Festival. Feedback from members was very positive as the week helped to highlight, celebrate and share learning and recognise the impact of involvement, co-production and partnership working on people's health and social well-being.

Members agreed that a key action for the Regional PPI Forum will be to commence the development of the next PPI Action Plan for 2021 onwards.

PHA PPI Internal Leads Group

As part of the ongoing PPI Internal leads group, we have been reviewing the internal monitoring process and considering how PPI might be included in the corporate monitoring arrangements moving forward. As a Group we have identified aligning the reporting of PPI to the Performance Management Report.

The meeting in March was postponed due to staffs' commitment to Covid-19 but we hope to continue in the Autumn.

Transformation Funding

The PHA has successfully led the management of the administration of 'Involvement, Co-Production & Partnership Working' Transformation funding for DoH. In the past six months the PHA has worked closely with the DoH to ensure that the funding of circa £500,000 has been used to support ongoing enhancement of Involvement , Co-Production and Partnership Working at a Regional and Trust level. A full financial report has been shared with DoH Transformation and Finance Departments. In addition, project evaluations were developed for all funding allocated with summary reports on the impact of Transformation projects, presented by HSC Trust Leads at the Regional Forum meeting. Final

evaluation reports are anticipated in the coming month. The PHA remains in discussion with the DoH in regards to the outworking and potential continuation of a number of these initiatives.

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

In 2019/20 the PHA commissioned two further cohorts of the successful 'Leading in Partnership' leadership programme. Over 100 have now undertaken the programme, including HSC staff, service users, carers and members of the community and voluntary sector. The programme continues to be in demand, with each programme being over-subscribed with 80 applications received for the January 2020 intake alone.

January 2020 Cohort – COVID-19

Due to the outbreak of COVID-19 the final day of the January 2020 programme and the Ministerial Networking and Celebration event scheduled were postponed. The PHA PPI Training Lead, Roisin Kelly, under the leadership of Michelle Tennyson is working with the HSC Leadership Centre to complete the programme, exploring the use of digital and virtual learning techniques that will support these interactive sessions.

This is a unique programme that is building 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 programme is effectively:

- Developing strategic alliances across multi-disciplinary professions, service users, carers and the community & voluntary sector;
- Challenging individuals knowledge and experience of effective leadership;
- Framing effective Involvement and Co-Production leadership and professionalism in the context of current realities and challenging futures;
- Developing a consistent vision of personal leadership, positioning personal career and development plans with a wider strategic agenda;
- Developing inter-professional networks and build a learning community across health and social care.

Professional Advice and Guidance

The PHA PPI team provides a vast range of professional advice and guidance across all sectors of the HSC. This is a critical service which has seen a considerable growth in the last six months. 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
- Professional involvement advice and guidance during the implementation of the work

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

- **Inquiry into Hyponatraemia Related Deaths (IHRD) Implementation Programme**

The PHA continues to proactively support the DoH in taking forward planning around the implementation of the recommendations from the Inquiry into Hyponatraemia Related Deaths. Two members of the PPI Team Claire Fordyce and James McLaughlin are seconded to the Department to progress the Involvement element of this work with oversight provided by the PHA's Regional PPI Lead, Martin Quinn.

The Hyponatraemia Implementation Programme is a model of co-production at the regional policy level. The programme is delivered via a series of Workstreams and sub-groups and the Involvement Team work closely with these to take forward and support the implementation of their Involvement Plans.

Work has continued to support each of the Workstreams to advance and implement their Involvement Plans. During this period, Claire has led on work to:

- Support staff to identify how to effectively and meaningfully involve service users, carers and families when a SAI takes place;
- Engage service users and carers to develop guidance on Openness for individuals using HSC services;

- Start planning on how to effectively involve the public in the development of an Independent Medical Examiner for Northern Ireland;
- Develop a consultation plan for the proposed Duty of Candour.

- **Review of Urgent and Emergency Care**

The PHA continues to work with DoH to support their endeavours to ensure the inclusion of best practice in Involvement, Co-Production and Partnership based approaches in respect of the upcoming pre and full consultation stages of the review. In addition to work previously reported on, we have facilitated the undertaking of research and the delivery of two regional workshops, in Belfast and Omagh, with 140 service user, carer, community and voluntary sector representatives in attendance.

At the outbreak of COVID-19 a final Involvement report was being developed to include the findings from the Involvement and Co-Production activities undertaken. Additional planning was also being progressed for the next stages of the Involvement and Consultation.

- **WHSCT Pathfinder**

The PHA PPI team have continued to provide input and advice to the WHSCT Pathfinder team and its work at the invitation and request of the WHSCT Chief Executive Dr Anne Kilgallen. In addition the Pathfinder project has been partnering with the PHA in respect of the research that we are taking forward in respect of the development of Involvement Outcome Indicators.

- **PHA, Protect Life - Suicide Prevention Strategy - Phase 2**

The PPI team has been an integral part of the development of an Involvement plan for the PHA's Phase 2 of the Protect Life, Suicide prevention strategy which lays out the involvement objectives for the consultation and implementation stage of the strategy. In more recent times the PHA has provided advice and guidance in terms of amending the plan in light of restrictions implemented due to Covid-19 pandemic.

2. Governance

Remuneration Framework for Service User and Carer Involvement in the HSC

The PHA's Senior PPI Officer Jill Munce, has been leading an extensive programme of work in the last 18 months to consider the development of a 'Recognition Framework' which looks at issues surrounding reimbursement of out of pocket expenses for service user and carers. It has also included work on the subject of potential payment or recompense for service user and carer time, input and expertise in certain circumstances, in line with the direction of travel set out in the DoH Co-Production Guide.

The final draft of the Regional Guidance and Procedures for the Reimbursement of Expenses for Service Users and Carers was presented at the most recent Forum meeting for subsequent submission to the Department for their consideration. There is some further work required regarding recompense which the PHA had been taking forward via a core working group with membership from the PCC, HSC Trusts and Service Users and Carers. Due to COVID 19, this work was delayed, but plans are in place to re-ignite this final push required to complete the paper for DoH information and consideration.

UK Standards for Public Involvement – Better public involvement for better health and social care research

As reported in the last update, these standards were designed on a UK, 4 Nation basis, to improve the quality and consistency of public involvement in research. They were launched on Monday 18th November at Malone House, Belfast, to coincide with Involve Fest.

The PHA were a key partner in this initiative, with our own involvement standards being an inspiration and acting as a pathfinder for this 4 Nation collaborative.

Within the last number of months, work has been taking place under the newly formed National Institute Health Research, Centre for Engagement and Dissemination to promote and embed these standards across the UK. The PHA's regional PPI Lead, Martin Quinn has collaborated with Involvement Leads from the other Nations to jointly author articles which are going forward for consideration for inclusion in a number of Research and Medical Journals and Publications.

Personal and Public Involvement Regional Guides

The PPI Guides have been developed to provide advice and support for involvement across HSC, with quite a number having been completed and widely disseminated. The COVID 19 pandemic has however highlighted the need to have others ways of engaging, involving and co-producing with people that does not rely on the traditional methods where physical face to face interaction is either not permitted or is severely restricted. To support initial involvement via on-line video conferencing, a

‘Guide to participating in a video conference’ has been developed by the PPI Team. This helps users to link into PEXIP (the video conference technology) and also supports good practice of hosting meetings on-line. Further guides are planned where social distancing is in place and restrictions remain for meetings or larger gatherings.

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.

Following the success of the GREAT checklists, this has been developed further into an online learning resource called ‘Making Improvement GREAT’.

The PPI Community of Practice attended the QI conference in February at Dublin castle to display their GREAT work.

Multi-Disciplinary Teams (MDTs)

The Primary Care MDT's main purpose is to focus on prevention and early intervention, on population health and on activating individuals to proactively manage their own health and wellbeing.

There are currently 5 MDT's running across 5 GP Federations with the aim to establish 17 MDT's across Northern Ireland. GP Federations are made up GP practices that provide primary care services to patients within their geographical range. The team are currently supporting both the Derry and Down federation to introduce involvement and partnership working to embed PPI into their practice at both a front line and strategic level.

The team has provided strategic oversight in terms of professional advice and guidance. In the first phase, professional involvement advice has been provided directly to the respective primary care MDT's as they seek to embrace active and meaningful involvement with service users / carers.

The team is helping to develop a bottom up approach to ensure PPI is embedded at both a localised and strategic level to allow for a truly person centred approach to be adopted.

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. Engage continues to be a central resource of information, good practice and resources on involvement, PPI and Co-Production. During this period, Engage has made a number of adjustments to its site to ensure it is easily navigated by service users / carers and staff. Plans have also been explored to re-develop the opportunities section of Engage.

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 reporting period, a number of networking engagements have taken place to encourage membership to the group. Meetings are currently put on hold until the restrictions as a result of COVID 19 are lifted.

Standard 4. Knowledge and Skills

Training

The PHA has successfully provided a range of relevant training opportunities for HSC Staff, Service Users, Carers, Community and Voluntary Sector colleagues.

In the last six months approximately 150 people have availed of training initiatives delivered and commissioned by the PHA. This included:

- Leading in Partnership – Leadership Programme for Involvement and Co-Production
- Developing Skills to understand and undertake consultation x1
- Delivery of Facilitation Skills training x 2
- Bespoke one to one training for PHA staff
- 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.

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.

Further training and development was planned for 2020, this would have included an Executive level briefing session, but this was postponed due to COVID-19.

Through this we are aiming to build a cohort of people with knowledge, expertise and experience in involvement and co-production as we seek to build a critical mass of people to change the HSC culture to a truly person centred service.

Standard 5. Measuring outcomes

PHA Internal PPI Monitoring

Further work has been undertaken at corporate and directorate levels to support the embedding of PPI into the culture and practice of PHA staff. This year we have been reviewing the internal monitoring process to consider how PPI might be included in the corporate monitoring arrangements moving forward. The template has been aligned to the reporting of the Performance Management Report and had started to be completed by Directorates with support from the PHA PPI Team prior to Covid-19.

Commissioning of Research – Involvement Outcomes Framework

The PHA commissioned research to develop an Outcomes Based accountability framework for assessing the impact of involvement and co-production in health and social care. The objective is to measure the impact that involvement and co-production makes to service users and carers and the difference it potentially may make to population outcomes in the draft Programme for Government Indicators.

A user guide has also been developed as part of this work to cover the core common outcomes of involvement, co-production and partnership working that may apply across Health and Social Care at different levels. It is hoped that this work will be concluded over the summer and will help inform plans for external monitoring going forward.