HSC Public Health Agency

agenda

Title of Meeting	122nd Meeting of the Public Health Agency Board
Date	21 May 2020 at 1.45pm
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

standing items

1 1.45	Welcome and apologies		Chair
2 1.45	Declaration of Interests		Chair
3 1.45	Minute of Previous Meeting held on 23 April 2020 Note of Board Briefing held on 6 May 2020		Chair
4 1.45	Matters Arising		Chair
5 1.45	Chair's Business		Chair
6 1.50	Chief Executive's Business		Chief Executive
7 2.00	Finance Report	**PHA/01/05/20**	Mr Cummings

committee updates

8 2.05	Update from Chair of Governance and Audit Committee		Mr Stewart

items for noting

9 2.15	Update on COVID-19		All Directors

a) Distinct role of PHA in the COVID-19 Crisis
b) Survey of a sample of the Northern Ireland population - power for that study
c) Testing in Northern Ireland – logistics – numbers – timescales and targets
d) Tracing – quality standards – volumes

and timescales

e) Trends in data

f) Nursing/Care Homes
   - PHA role
   - PHA accountabilities and responsibilities
   - Risks/Governance/Assurance and controls

g) Post Lockdown
   - PHA roles and responsibilities public behaviours

h) Communications

i) Covid-19 PHA Lessons Learnt to prepare for waves 2 and 3?

j) Mental health during Covid-19 and post lockdown

closing items

10 Any Other Business
2.55

11 Details of next meeting:

Thursday 18 June 2020 at 1.30pm

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

HSC Public Health Agency

minutes

Title of Meeting	121st Meeting of the Public Health Agency Board
Date	23 April 2020 at 1.30pm
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

Present

Mr Andrew Dougal	-	Chair (*via video link*)
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

Dr Aideen Keaney	-	Director of Quality Improvement
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

Apologies

None

39/20	**Item 1 – Welcome and Apologies**
39/20.1	The Chair welcomed everyone to the meeting. There were no apologies.
39/20.2	The Chair proposed that Item 8 was moved up the agenda as Professor van Woerden had another meeting to attend.

40/20 Item 2 – Declaration of Interests

40/20.1 The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.

41/20 Item 3 – Minutes of previous meetings

41/20.1 The minutes of the Board meeting held on 19 March 2020, were approved as an accurate record of that meeting.

41/20.2 The minutes of the extraordinary meeting held on 10 April 2020 were approved as an accurate record of that meeting.

41/20.3 Alderman Ashe asked that it be placed on record his appreciation that queries raised by members had been responded to by officers outside of the Board meeting.

42/20 Item 4 – Matters Arising

42/20.1 There were no matters arising.

43/20 Item 8 – Update on COVID-19: Duties specific to PHA

43/20.1 Professor van Woerden began by giving members a short update presentation. He highlighted a graph showing that Northern Ireland's death rate is much lower than other countries, and he showed how the number of admissions to hospitals and the occupancy rates of ICU beds are beginning to decrease. He informed members that a contact management programme has been initiated. He finished by noting the increase in the number of care homes where there has been an outbreak.

43/20.2 The Chair asked about the current testing strategy, and in particular antigen testing. Professor van Woerden advised that the current antigen test is not specific or reliable. In response to a question regarding random sampling, he said that Northern Ireland is working towards this, but due to a range of methodological issues, it may take up to 8 weeks before this is fully operational. Ms Mann-Kler asked about maximising testing for HSC staff. Professor van Woerden advised that there is currently no staff waiting to be tested. In terms of wider testing of the Northern Ireland population, he said that wider scale testing is being ramped up so that each individual diagnosed with COVID-19 would be tested, as well as their contacts resulting in thousands of tests being carried out. The Chair noted that if Northern Ireland were to carry out a proportionate volume of testing to that in England, this would equate to 3,300 tests per day.

43/20.3 Mr Clayton asked about testing in care homes. He noted that the number of outbreaks in care homes is increasing and asked what approaches were being considered to step up testing. Professor van

Woerden acknowledged that there is huge pressure on staff who work in these facilities, and that they are at higher risk, but he assured members that there is extensive testing, with options being looked at such as mobile testing, or testing being carried out by community nurses or GPs going to individual's homes. Mr Clayton asked about the potential collaborative working with the Republic of Ireland. Professor van Woerden said that there have been discussions, particularly about antibody testing.

43/20.4 Alderman Ashe asked about staff in care homes who may be self-isolating, as this may require homes to upscale. Professor van Woerden said that each Trust would have a resilience plan in place.

43/20.5 Alderman Porter asked if staff are reluctant to work in care homes if there is an outbreak. He also asked about the testing strategy and why there was a change from the earlier contact tracing approach. Professor van Woerden noted that there had been significant media interest in the area of contact tracing, but he said that Northern Ireland's approach had worked well to date. In relation to care homes, he said that all homes will have an outbreak plan, and that there is support being provided to the homes by the Health Protection team in PHA. He explained that the approach used would see individuals who are at higher risk being shielded with reduced access to visitors. He acknowledged that there is likely to be an increase in the number of care homes affected.

43/20.6 Professor Rooney noted that care homes have their own plans, but she asked whether these has been developed based on advice from PHA, and has PHA given specific advice in relation to how admissions should be managed. Professor van Woerden said that PHA would assist homes, and added that patients are being tested prior to admission. Mr Morton explained that all homes will have an infection prevention control manual, which they would be expected to implement, and that PHA would provide guidance. Professor Rooney said that she would be concerned as whether PHA had a statutory responsibility in this area. The Interim Chief Executive advised that there are standards, and that these would inspected and monitored by RQIA. She clarified that it is the responsibility of the homes to have a plan, and PHA's role is to support them. Mr Morton said that, alongside HSCB, PHA is working on three key strategies – prevention, mitigation and service continuity. Ms Roulston added that there had been a very useful workshop on this area held on Monday with a further meeting taking place tomorrow.

43/20.7 Ms Mann-Kler asked about PPE for care home staff, and PHA's guidance in this area. Mr Morton explained that Trusts are supplying care homes with PPE, but he acknowledged that stock levels are under severe pressure. He added that the Department of Health has asked him to look at reprocessing, recycling and reuse of PPE in the context of PHE guidance, but he stated that both the Chief Medical Officer and Chief Nursing Officer are clear that the policy in Northern Ireland is that PPE should not be re-used. He advised that the group that he is part of

will consider the circumstances under which such a decision could be taken. Mr Clayton asked what those circumstances would be, and a timeline for when this may be the case. Mr Morton said that the current strategy is focused on ensuring that there is sufficient PPE, and that any change is this strategy would be based within the context of best practice and evidence. He advised that visors can be decontaminated and reused. He added that a timeline would be predicated on how long the current stocks last.

43/20.8 When asked about the resilience and wellbeing of PHA staff, the Interim Chief Executive advised that the senior staff have been working hard since January on this crisis and that there was discussion this morning regarding the need to put in rotas for 5-day working out of 7 days and for ensuring that there are deputy arrangements in place so that senior staff can have time off without being interrupted. She added that this will be necessary given that this type of working is likely to continue for the next 18 months/2 years.

43/20.9 Ms Mann-Kler said that she is deeply concerned about the workload, and she expressed her thanks to the Executive Directors for the work they have done so far. She acknowledged their input to the Health Committee session last week, and asked if there was anything the Board could do. The Interim Chief Executive thanked Ms Mann-Kler for acknowledging the workload, and said that as a team the Directors are working well together, but a robust plan is needed to ensure that they can take their leave.

43/20.10 Professor Rooney said that a regional wellbeing framework has been produced and asked whether PHA is ensuring that its staff can avail of this. Ms Roulston advised that Ms Michelle Tennyson has been involved in work to support the resilience of staff in both HSCB and PHA.

43/20.11 The Interim Chief Executive said that there is a challenge for PHA in terms of the data that is being produced on a daily basis and dealing with queries from the Minister, his Special Advisor and the Permanent Secretary on a daily basis. Mr McClean said that the increased scrutiny of both HSCB and PHA is proving challenging to the resilience of staff. Mr Cummings added that at the moment there is a requirement to quickly turn around business cases.

43/20.12 Mr Cummings suggested that as the Directors of the PHA are also required to attend meeting of the HSCB Board, perhaps a joint briefing would be more beneficial. Mr Stewart acknowledged that staff are becoming tired, but he felt that a joint briefing with HSCB Board members would not be appropriate given the different statutory remits. He also expressed concern about the pressure to produce business cases at speed and sought assurance that the PHA had a proper paper trail in place to know who authorised these. Mr Cummings assured members that the proper processes are being followed, but this was

more of an issue for HSCB. Mr Stewart responded saying that there should be clarity in terms of why certain decisions were made and who was involved. Mr Cummings said that HSCB and PHA ensures that for any decisions that require to be made, the proper people are in the room and that the two organisations continue to have joint senior management team meetings even though there are 2 Chairs and 2 Chief Executives. Mr McClean added that where required in the development of a proposal PHA professional staff will assist, and that boundaries will not get in the way.

43/20.13 The Chair asked about contact tracing. Professor van Woerden reported that there is an advisory group which is chaired by Dr Brid Farrell, and that an operational planning document has been approved. The Chair asked when this group would report. Professor van Woerden said that the group reports directly to the Chief Medical Officer. The Chair asked about targets. Professor van Woerden advised that the group is covering a huge remit across Northern Ireland, looking at different types of tests and tests in different settings. He added that there is a research project ongoing in care homes and in the community to look at patterns of the disease, and there is also engagement with the private sector with organisations like Randox and Deloitte.

43/20.14 The Chair said that the public should be more aware of this work and he cited an article where Professor John Newton, testing czar, stated that there is currently no reliable antibody test on the market.

43/20.15 Ms Mann-Kler asked about the strategy on contact tracing, both at the present time, and post-lockdown. She said that she assumed that PHA was leading on this, and is making use of digital technologies and the MOU with the Republic of Ireland. Professor van Woerden said that this is a complex landscape and is led across the UK by central Government. He said that at the early stages of the pandemic, contact tracing was used extensively but a decision was taken not to continue this. However he added that PHA is starting to undertake tracing in the context of an outbreak to monitor the pattern of spread. He advised that a centre is being set up by Microsoft and that there is a group that has been established with a view to a pilot being initiated on 27 April.

43/20.16 Mr Clayton asked if PHA is staffing the pilot, and if it has the capacity to do so. Professor van Woerden said that in the early stages it will be staffed internally, but in response to a query from the Chair, he added that in the longer term there will be inputs from environmental health officers as well as recently graduated nursing and medical students. Alderman Porter sought assurance that all the decisions that are currently being taken are clinically-led rather than political. Professor van Woerden assured members that the testing strategy being taken forward is the appropriate one.

43/20.17 The Chair asked about what health preconditions could be given to reducing lockdown restrictions. Professor van Woerden said that this

would be determined by central Government.

43/20.18 Ms Mann-Kler asked if PHA has sight of the latest post-lockdown public health strategy as this would be an area of particular concern. The Interim Chief Executive said that the Department of Health has already begun to plan for this, and will share its thinking with the PHA. Alderman Porter felt that from a mental health perspective and issues such as the opening of parks etc., that PHA would be involved in these discussions.

43/20.19 Ms Roulston said that, in terms of Professor Rooney's earlier comment regarding a regional framework for mental health resilience and support, there is a group being chaired by Dr Tony Stevens which will look at how HSC engages with the community and engages staff. Professor Rooney sought assurance that PHA is gathering intelligence from a range of sources to determine the regional picture, and whether people are presenting to services. Mr McClean advised that he had spoken to Mr Brendan Bonner regarding Lifeline and other community-based services, and that there is no discernible increase to the number of suicides. He added that post-pandemic, there will be an impact on the services that PHA commissions and it is something that PHA is anticipating. Professor van Woerden noted that there has been an increase in terms of the incidence of domestic violence, and a reduction in the number of safeguarding referrals. Professor Rooney said that there has been an increase in the number of calls to Childline. Mr Stewart said that post pandemic a major issue could be that of bereavement with families having been denied the opportunity to grieve in the traditional manner and enquired whether the Agency had plans to veer funds to support services or to bid from additional funding.

43/20.20 Alderman Porter asked whether there was research being done to look at the impact that lockdown is having, and in particular where people may not want to leave their homes, and he asked what the tipping point is if lockdown is in place for too long. Professor van Woerden advised that Dr Janice Bailie, Research and Development Division, PHA, has set up a behavioural research group to look at some of these issues, and he added that the Chief Medical Officer has also expressed concern regarding the short, medium and long term impacts on mental health.

43/20.21 Mr McClean said that in relation to the point made by Mr Stewart, PHA is providing stability to its providers and giving them as much flexibility as possible during this pandemic phase. He said that Mr Brendan Bonner and his team are working on a post-pandemic response plan and that this will link with Making Life Better.

43/20.22 Ms Mann-Kler noted that at today's Health Committee update, the appointment of a Mental Health champion was announced, and that historically mental health is an area that has been under resourced and understaffed.

43/20.23 Ms Mann-Kler said that communications are very important during this time, and she would welcome an update on the key messages that PHA will be promoting going forward and an assurance that these will reach all levels of the community. Mr McClean agreed that this could be an area which could be discussed in more detail at the next meeting as there is a large amount of work going on, and he agreed to share that with members.

44/20 Item 5 – Chair's Business

44/20.1 The Chair said that he had circulated his business in advance of the meeting. He asked whether there was a limit in terms of the number of COVID-19 tests that can be carried out per day. Professor van Woerden said there are ongoing efforts to scale up the number of tests being undertaken daily, but he assured members that there was no backlog of patients or staff waiting to be tested. In response to a question from the Chair, he stated that laboratory capacity was no longer an issue.

45/20 Item 6 – Chief Executive's Business

45/20.1 The Interim Chief Executive said that the work relating to COVID-19 is dominating the work of PHA staff, but there is a need to start to plan for when there is a return to normal business. She acknowledged that there have been challenges for PHA in terms of the surveillance data that is being produced, and she has made it clear what PHA's responsibility is in this area. She stated that definitive data regarding deaths come from death certificates, and that there can be a delay of up to 5 days in this information becoming available. The Chair said that he did not see the benefit in generating these data on a daily basis, and that weekly data would be more meaningful. He also emphasised that the publication of daily statistics gives a daily opportunity for the press to publish stories which unnecessarily cause anxiety in the community, then when the weekly figures are finally produced they state that these are much greater than the statistics provided by PHA.

45/20.2 Ms Mann-Kler noted that there are a lot of pressures falling on the Executive Directors and she asked whether this is continuing to accelerate, or are there signs that it is beginning to ease off. The Interim Chief Executive reiterated that the biggest issue remains the data, but that the Minister's Special Advisor has been invited to a meeting so as he can obtain an oversight of what PHA's role in this area is.

46/20 Item 7 – Governance in Emergency

46/20.1 Mr McClean said that the correspondence received from the Department of Health confirmed that a number of regular year-end meetings were being stood down, but the timescales remain in place for the production of the Annual Report and Accounts for 2019/20, together with the Governance Statement. He suggested that this year's PHA Annual

Report may be a "lighter touch" Report. Mr Cummings said that he is currently working through the detail of this with the auditors, and in response to a question from Mr Stewart, he assured members that his team will ensure that an accurate set of accounts is produced that will be audited before being brought to the PHA Board.

46/20.2 Mr McClean moved on to discuss the PHA's Business Continuity Plan, and he advised that this is reported on twice a week and regularly kept under review. He advised that there is a comprehensive system of reporting from all of the cells which support HSC Silver, and that this is also being kept under review. He added that thought is being given to what lies ahead as PHA's day to day work still needs to be dealt with, and that this week the weekly Agency Management Team meetings have been reinstated.

46/20.3 Mr Clayton noted the comment that PHA is having to adapt as things change, and he asked whether there is enough staff to deal with this, and if many staff are on sick leave or self-isolating. Mr McClean advised that PHA does have a number of staff who have underlying health conditions and a small number of staff who may need to be redeployed, but he said that the only area where PHA may require additional support is in the field of project management, but that support has been obtained through the Leadership Centre.

46/20.4 Professor Rooney said that when there is the opportunity, she would welcome the reflections of the new Interim Chief Executive on how the current working arrangements with PHA and HSCB are working. Mrs MacLeod agreed to consider this.

46/20.5 Mr McClean explained that there is the need for PHA to ensure that it maintains a focus on "business as usual", and considers all anticipated risks, for example ensuring that vaccination programmes are continuing, and that people still continue to attend emergency departments when required, and that safeguarding referrals are being made. He said that PHA is also mindful of its contracts with the community and voluntary sector, and giving those organisations a degree of flexibility, but ensuring that core activities are maintained.

46/20.6 The Chair recorded thanks to members for their participation. He particularly acknowledged the herculean demands being placed on the senior team during this extended period. He also asked that sincere thanks be conveyed from the Non-Executive Directors to all staff for their enduring commitment.

46/20.7 Alderman Porter asked whether PHA is giving advice to Councils. Mr McClean explained that Mr Brendan Bonner has been linking with SOLACE. He said that there was a challenge for PHA in that it was being expected to make decisions across all sectors, instead of providing advice and guidance.

46/20.8 Ms Mann-Kler noted that today's agenda focused solely on COVID-19, and whether there were any other reports that should continue to be brought to the Board. Mr Cummings said that the monthly Finance Reports will continue to be brought, but there would not have been a report brought to the April meeting in any case.

46/20.9 Ms Mann-Kler said that she did not feel that a monthly meeting was sufficient, and asked whether members could receive a weekly update or a short report, but without wishing to place additional demands on the Executive Directors. Alderman Porter said that the Executive Directors should determine the frequency of any updates. Mr Stewart said that he agreed with both members, but felt there should be an opportunity for Non-Executives to highlight any issues or concerns they have. It was agreed that Mr McClean and Mr Cummings would facilitate an update meeting, and that if other Executive Directors were available to contribute they could do so. Mr Clayton suggested that any issues identified by Non-Executives should be sent in advance.

46/20.10 The Chair asked that Non-Executive Directors should e-mail him with any issues which they wished to be raised, or alternatively they could contact him by telephone. He undertook to then communicate with Executive Directors.

47/20 Item 9 – Any Other Business

47/20.1 There was no other business.

48/20 Item 10 – Details of Next Meeting

Thursday 21 May 2020 at 1:30pm

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

Signed by Chair:

Date:

HSC Public Health Agency

minutes

Title of Meeting	Public Health Agency Board Briefing
Date	6 May 2020 at 11am
Venue	12/22 Linenhall Street, Belfast

Present

Mr Andrew Dougal	-	Chair (*via video link*)
Mrs Olive MacLeod	-	Interim Chief Executive
Mr Edmond McClean	-	Interim Deputy Chief Executive / Director of Operations
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 Robert Graham	-	Secretariat

Apologies

Ms Jenny Redman	-	Boardroom Apprentice

1 Item 1 – Welcome and Apologies

1.1 In the absence of the Chair, who joined later in the meeting, Mr Stewart welcomed everyone to the meeting.

2 Item 2 – Clarification of Roles

2.1 Mr McClean advised that the current gold/silver/bronze arrangements involving the Department/PHA/HSCB/HSC Trusts remain in place and that within the HSCB and PHA there is a number of cells leading on specific areas of work. He noted that the area of care homes has come under increased scrutiny and that the Minister and the Chief Medical Officer have taken a particular personal interest. Other current issues he noted include testing capacity and PPE. He advised members that there had been no particular concerns emanating from the review of the gold/silver/bronze arrangements carried out by Liz Mitchell and Alistair Finlay at the request of the Chief Medical Officer.

2.2 Mr McClean said that the arrangements have become more bedded down, but he added that PHA also needs to focus on other areas such as wellbeing and giving consideration to the transition out of this current situation into a more normal environment, before a potential second phase of the pandemic.

2.3 The Interim Chief Executive said that a lot of time has been spent over the last 2 weeks on care homes, and now there is a focus on contact tracing. She advised that a Contact Tracing Steering Group has been established by the Chief Medical Officer. She noted that there is a contact tracing pilot set up in Linenhall Street but the aim is to have a larger programme up and running by next week. She added that the Steering Group is meeting 3 times per week, and is looking at a range of options, including a call centre model. She explained that any contact tracing programme will need to be in place for at least 2 years. She cautioned that if the aim of the programme is to contact all those who are symptomatic, rather than only people who are positive, then more staff will be required to work on the programme.

2.4 Mr McClean said that for the next phase of the programme, it is not clear yet what the expectation is, but that this programme will be the responsibility of PHA.

2.5 Ms Mann-Kler asked about risk. Mrs MacLeod said that there is a risk register for this programme. She said that the biggest risk is that the programme will not start on time. She noted that in other parts of the UK, and in the Republic of Ireland, this work is being introduced in a phased approach.

2.6 Alderman Porter said that if we don't have the necessary materials, that is the biggest risk. The Interim Chief Executive said that in relation to nursing homes, there are established processes for ordering PPE through their commissioning Trust. She added that Mr Rodney Morton has said that there is no shortage in PPE, but she acknowledged that the guidance is constantly changing and it is difficult for the homes to keep up.

2.7 The Interim Chief Executive said that PHA is tracking all homes where there is an outbreak, and that the numbers are stabilising. She said if a resident has respiratory problems, then they are swabbed. Professor Rooney said that there is a lot of stress and anxiety in the nursing homes sector, and she is working on a group to develop resources in the area of bereavement. She noted that there is an increased focus in this area.

2.8 Mr Stewart thanked the Interim Chief Executive and Mr McClean for the update, and he said that the biggest risk for PHA is keeping a handle on everything. The Interim Chief Executive said that she had advised the Chief Medical Officer that PHA is working flat out, but will ensure that it takes the time it needs to get the contact tracing programme up and running properly.

2.9 The Chair expressed concern about a previous negative and damaging experience with using a call centre. The Interim Chief Executive said that the Steering Group will be considering bids from call centres, and that quality assurance will be an area of focus. The Chair said that it is important that there

is professional training by staff of the PHA itself. Mr Clayton said that he was assured to hear that this is being kept within PHA, but he cautioned that outsourcing could lead to reputational damage, especially during these times when issues such as social distancing in the workplace need to be borne in mind. Mr McClean acknowledged that there are challenges.

2.10 Ms Mann-Kler asked about governance and ensuring there is a proper audit trail. The Interim Chief Executive that in addition to the Corporate Risk Register, there is a separate risk register for the contact tracing project, but that this is owned by the Steering Group and that the Chief Medical Officer is the Senior Responsible Owner.

3 Item 3 – Data Collection

3.1 Mr Stewart said that he wished to be assured that there were no implications or negative comments about the PHA following the letter received by the Permanent Secretary from the Chief Executive of the Statistics Authority (UK). The Interim Chief Executive advised that PHA prepares a weekly flu bulletin, and that following the onset of COVID it moved to producing daily report, but the Department moved to produce its own dashboard. She explained that when deaths were reported to PHA, they may have been deaths that had occurred up to a month previously, hence the figures did not tally with those of the Department, but she said that the data from NISRA are the most reliable. She assured members that the information that PHA has is correct and there was no failure on its part. She said that PHA will continue to receive data, but it use these data to assist with its surveillance function.

4 Item 4 – Testing

4.1 Mr Clayton asked that if the capacity for testing is going to increase, how will this link with the contact tracing work. The Interim Chief Executive said that testing will increase to about 3,000 tests per day, and that Dr Brid Farrell is leading on a testing strategy based on the latest SAGE advice.

4.2 The Chair asked if there will be targets for testing and logistics. The Interim Chief Executive said that this will all be dealt with by the testing cell, but she pointed that only half of the current laboratory capacity is being utilised. She added that if a decision is made to test all of those individuals who are symptomatic then this will increase the number of tests required. She advised that there is an app that is being piloted on the Isle of Wight, and that if that technology is going to be used in Northern Ireland, then the contact tracing group will work with the technology cell.

4.3 The Interim Chief Executive noted that the number of cases is decreasing, but she hoped that when the restrictions are lifted that people will continue to adhere to social distancing.

5 Item 5 – Tracing

5.1 This was covered until Item 2 above.

6 Item 6 – Monitoring Trends

6.1 Mr McClean said that HSCB has the main role in dealing with nursing homes, but PHA has been carrying out work in terms of outbreak control. The Interim Chief Executive said that there had been a call for Trust staff to assist in nursing homes, and some Trusts have fared better than others in this regard.

6.2 The Chair asked whether any residents from homes had been transferred to critical care beds in hospitals. The Interim Chief Executive said that this would be a decision for a GP.

6.3 Mr Clayton noted a report which reported that 60% of COVID-related deaths were in care homes, and that there continues to be a high number of cases. He asked about the pressures on staff and what measures PHA could put in place to contain the spread. The Interim Chief Executive said that PHA is coping. She advised that in the height of the flu season, PHA would be supporting up to 100/120 homes, and present it is supporting approximately 100, some with residents with respiratory issues, and other with COVID issues. She said that the team in PHA is coping, but there has been some additional capacity brought in.

6.4 The Interim Chief Executive explained when the numbers of COVID-19 cases in homes were starting to increase a meeting was set up with Trusts and the Department, and that each Trust was asked to produce a plan for each home in its area. She said that Mr Morton and his team are now monitoring the outworking of these plans. Mr McClean added that a small number of homes needed more support from Trusts, but the situation is beginning to stabilise. The Interim Chief Executive said that Trusts highlight any issues through their daily SITREPs to Silver, and that RQIA is also monitoring the situation and carrying out inspections.

6.5 Ms Mann-Kler asked about testing in homes. The Interim Chief Executive explained that if there is one symptomatic person in a home then that individual is isolated and tested, but if there are 2 or more, then all residents and staff are tested. She added that any individuals being admitted to homes have to have had a negative test result, but she noted that may homes are closed to admissions to protect their residents.

7 Item 7 – Inequalities

7.1 The Interim Chief Executive said that there is work ongoing within Health Improvement looking at health inequalities. She said that there is a representative from the Patient Client Council on the contact tracing steering group, as the group is mindful that it will be important to engage with those "hard to reach" groups.

7.2 Mr McClean said that there have been no issues in terms of deciding on eligibility of ventilators in terms or age or ethnicity. He noted that there is something about the physical ability and wellness of an individual to cope with the aftermath of being on a ventilator. He agreed that inequalities are going to

be an important focus of work going forward as there will inevitably be a greater impact economically on lower socio-economic groups. He said that PHA will be working with the Department in terms of a system-wide response which has a population health focus.

7.3 Mr Clayton said that he has a concern about the economic impact. He noted that in England there is work to look at the impact on different socio-economic groups. He asked whether COVID has affected everyone equally. Mr McClean said that PHA is monitoring the data, but is not seeing any evidence of any particular differences between groups. He noted that there are more men than women who have died, and that respiratory issues such as obesity and smoking may also be factors.

7.4 Alderman Porter noted that at the outset the message from central Government was about staying at home, but now there has been a reassurance that leaving home is safer, and how that will change of message will impact on people's mental health. Mr McClean said that that particular concern will be picked up as part of the next phase of the communications strategy, and that PHA is beginning to look at its key messages for the coming weeks and months. Professor Rooney agreed that messaging is important, and that PHA has a role to play in dealing with the effects of the aftermath, but that any decisions taken need to be informed by science. Mr McClean said that PHA is working with the Department for Communities, SOLACE and the community and voluntary sector to ensure that there is alignment in messaging, looking at a timeframe of over the next 18 months. Alderman Porter highlighted concerns about education assistants not wishing to go back into classrooms. Mr McClean said that PHA will be working with the Department for Education, as part of it work with different groups to get key messages out.

8 Item 8 – PPE

8.1 Mr Clayton raised a concern about PPE. He said that across hospitals the message is that there is enough PPE, but that varies across care homes and domiciliary care, but his concern related to the reuse of PPE and he asked for an update on that. Mr McClean said that he would need to raise this with Mr Morton and come back to Mr Clayton on this.

9 Item 9 – Any Other Business

9.1 There was no other business.

10 Item 10 – Details of Next Meeting

Thursday 21 May 2020 at 1:30pm

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

Signed by Chair:

Date:

Public Health Agency

Public Health Agency

Finance Report

2019-20

Month 12 - March 2020

PHA Financial Report - Executive Summary

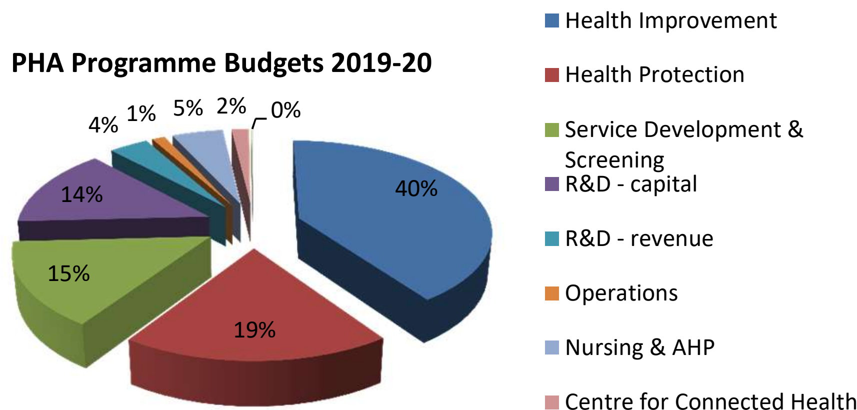
Year End Financial Position (page 2)

At the end of the year PHA is underspent against its budget by approximately £0.1m. All figures in this report are draft, subject to any final year-end audit adjustments. This underspend is primarily caused by underspends on Administration budgets across the Agency, offset by planned overspends on PHA Direct Programme budgets.

Budget managers are to be commended for their close review of their budget positions throughout the year, and in particular in the approach to year-end, which has enabled the PHA to meet its

Programme Budgets (pages 3&4)

The chart below illustrates how the Programme budget is broken down across the main areas of expenditure.

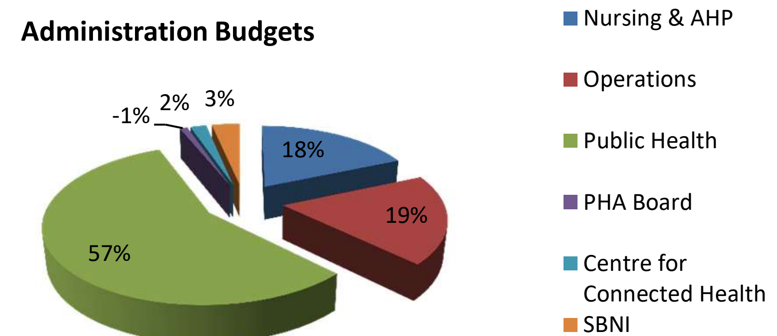


Administration Budgets (page 5)

Approximately half of the Administration budget relates to the Directorate of Public Health, as shown in the chart below.

A significant number of vacant posts remain within PHA, and this is creating slippage on the Administration budget.

Management is proactively working to fill vacant posts and to ensure business needs continue to be met.



Public Health Agency
2019-20 Summary Position - March 2020

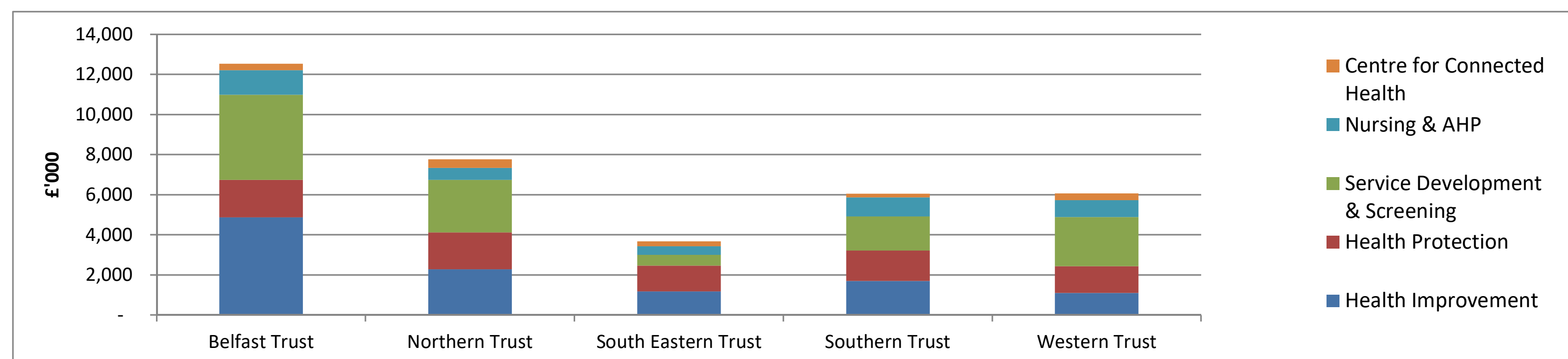
	Programme		Annual Budget Ringfenced	Mgt & Admin	Total
	Trust	**PHA Direct**	**Trust & Direct**		
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Available Resources					
Departmental Revenue Allocation	36,958	42,870	9,552	20,921	**110,300**
Revenue Income from Other Sources	-	116	-	730	**846**
Total Available Resources	36,958	42,986	9,552	21,652	**111,147**
Expenditure					
Trusts	36,959	-	4,679	-	**41,637**
PHA Direct Programme *	-	43,661	4,778	-	**48,439**
PHA Administration	-	-	-	20,956	**20,956**
Total Proposed Budgets	36,959	43,661	9,457	20,956	**111,032**
Surplus/(Deficit) - Revenue	(0)	(675)	95	695	115
Cumulative variance (%)					

The year end financial position for the PHA shows a small surplus against budget of approximately £0.1m, mainly due to underspends on Administration budgets (see page 5) offset by planned overspends on PHA Direct Programme budgets (see page 4). This small surplus is within PHA's 0.25% breakeven threshold.

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

March 2020

Programme Expenditure with Trusts



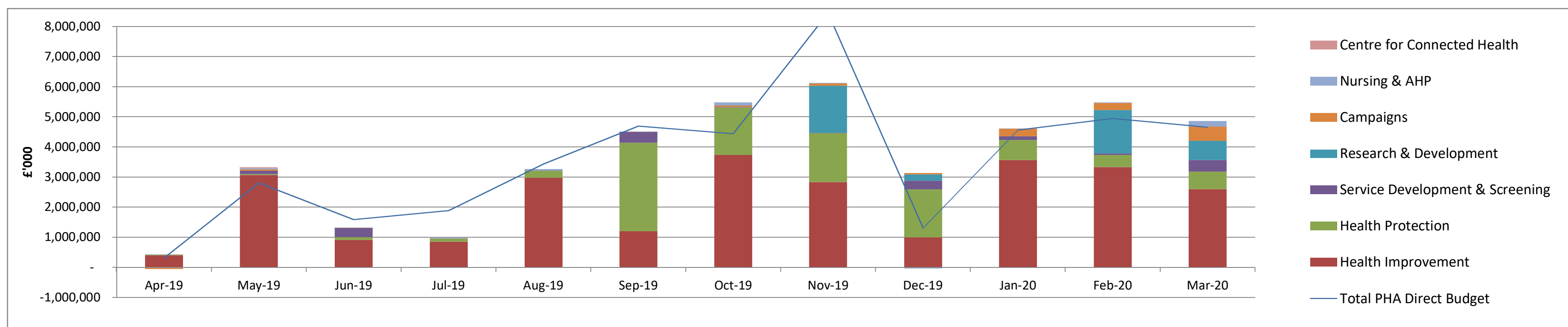
Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	NIAS Trust £'000	NIMDTA Trust £'000	Total Planned Expenditure £'000
Health Improvement	4,883	2,288	1,184	1,708	1,106	-	-	**11,169**
Health Protection	1,868	1,839	1,284	1,516	1,328	-	-	**7,835**
Service Development & Screening	4,240	2,618	538	1,698	2,459	-	-	**11,552**
Nursing & AHP	1,226	598	433	958	840	-	-	**4,055**
Centre for Connected Health	317	431	244	174	335	-	-	**1,500**
Other	240	193	109	155	151	-	-	**847**
Total current RRLs	**12,774**	**7,966**	**3,791**	**6,208**	**6,219**	**-**	**-**	**36,959**
Cumulative variance (%)								

	Belfast Trust £'000	Northern Trust £'000	South Eastern £'000	Southern Trust £'000	Western Trust £'000	NIAS Trust £'000	NIMDTA Trust £'000	Total Planned Expenditure £'000
Ringfenced Funds	**1,065**	**1,242**	**772**	**770**	**736**	**93**	**-**	**4,679**

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

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

PHA Direct Programme Expenditure



	Apr-19 £'000	May-19 £'000	Jun-19 £'000	Jul-19 £'000	Aug-19 £'000	Sep-19 £'000	Oct-19 £'000	Nov-19 £'000	Dec-19 £'000	Jan-20 £'000	Feb-20 £'000	Mar-20 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000	
Profiled Budget																	
Health Improvement	149	2,369	963	1,972	3,013	1,063	3,068	4,752	202	3,036	2,230	3,419	**26,237**	26,237	26,397	(161)	*-0.6%*
Health Protection	38	353	79	(249)	164	3,084	1,376	1,915	783	1,346	289	647	**9,826**	9,826	9,866	(40)	*-0.4%*
Service Development & Screening	2	65	517	112	132	527	(22)	129	289	(320)	226	549	**2,208**	2,208	2,085	123	*5.6%*
Research & Development	-	-	-	-	-	-	-	1,563	-	206	1,442	344	**3,555**	3,555	3,847	(292)	*0.0%*
Campaigns	23	23	23	23	23	23	(84)	47	31	268	685	97	**1,184**	1,184	1,150	34	*2.9%*
Nursing & AHP	-	-	-	1	101	-	107	44	1	29	72	228	**583**	583	428	155	*100.0%*
Centre for Connected Health	-	-	-	25	-	-	-	-	-	-	-	56	**81**	81	25	56	*100.0%*
Other	-	-	-	-	-	-	-	-	-	-	-	(687)	**(687)**	(687)	(137)	(550)	*100.0%*
Total PHA Direct Budget	**212**	**2,810**	**1,583**	**1,885**	**3,433**	**4,698**	**4,445**	**8,451**	**1,306**	**4,565**	**4,944**	**4,654**	**42,986**	**42,986**	**43,661**	**(675)**	
Cumulative variance (%)																***-1.57%***	
Actual Expenditure	**265**	**3,398**	**1,365**	**1,011**	**3,302**	**4,497**	**5,500**	**6,171**	**3,134**	**4,593**	**5,522**	**4,904**	**43,661**				
Variance	**(52)**	**(588)**	**218**	**874**	**131**	**200**	**(1,055)**	**2,281**	**(1,828)**	**(28)**	**(578)**	**(250)**	**(675)**				

Ringfenced Budgets	Apr-19 £'000	May-19 £'000	Jun-19 £'000	Jul-19 £'000	Aug-19 £'000	Sep-19 £'000	Oct-19 £'000	Nov-19 £'000	Dec-19 £'000	Jan-20 £'000	Feb-20 £'000	Mar-20 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000
Profiled Ringfenced PHA Direct Budget	-	-	572	331	397	253	604	793	181	597	416	729	**4,873**	**4,873**	**4,777**	**95**
																1.96%
Actual Expenditure	(38)	461	134	364	405	182	540	768	268	550	442	701	**4,777**			
Variance	**38**	**(461)**	**437**	**(33)**	**(8)**	**71**	**64**	**25**	**(87)**	**48**	**(26)**	**28**	**95**			

The full year position shows a £0.7m overspend which was planned to absorb an anticipated Administration underspend and manage the PHA to a breakeven position. The negative budget in the Other line is an adjustment to reflect the forecast M&A surplus having been allocated to various PHA Direct Programme budgets.

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

Non-Trust Ringfenced funds are showing a small underspend at the end of the year.

March 2020

PHA Administration
2019-20 Directorate Budgets

	Nursing & AHP £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Annual Budget							
Salaries	3,913	2,809	12,060	243	348	444	**19,818**
Goods & Services	173	1,329	413	(447)	75	291	**1,833**
Total Budget	**4,086**	**4,139**	**12,473**	**(204)**	**423**	**735**	**21,652**
Budget profiled to date							
Salaries	3,913	2,809	12,060	243	348	444	**19,818**
Goods & Services	173	1,329	413	(447)	75	291	**1,833**
Total	**4,086**	**4,139**	**12,473**	**(204)**	**423**	**735**	**21,652**
Actual expenditure to date							
Salaries	3,426	2,671	11,583	133	370	441	**18,624**
Goods & Services	267	1,273	468	(31)	64	293	**2,333**
Total	**3,693**	**3,944**	**12,051**	**101**	**434**	**734**	**20,956**
Surplus/(Deficit) to date							
Salaries	487	139	477	111	(22)	3	**1,195**
Goods & Services	(94)	56	(55)	(416)	11	(2)	**(500)**
Surplus/(Deficit)	**393**	**195**	**423**	**(305)**	**(11)**	**1**	**695**
Cumulative variance (%)	*9.62%*	*4.71%*	*3.39%*	*149.73%*	*-2.64%*	*0.14%*	***3.21%***

PHA's administration budget is showing a year to date surplus, which has been generated by a number of long standing vacancies. Although efforts continue to fill vacant posts as far as possible, this has proved to be challenging, and the surplus on the salaries budget continues to be high. In it's opening allocation letter, DoH required PHA to meet the cost of the first 1% of the 2019-20 pay award, so the impact of this is expected to reduce the year end surplus to around £0.7m.

The year end salaries position is showing a surplus which has been generated by a number of vacancies during the year. Senior management continue to monitor this closely in the context of PHA's obligation to deliver its core functions.

March 2020

Public Health Agency
2019-20 Capital Position

	Annual Budget				Year to Date			
	Programme				Programme			
	Trust £'000	PHA Direct £'000	Mgt & Admin £'000	Total £'000	Trust £'000	PHA Direct £'000	Mgt & Admin £'000	Total £'000
Available Resources								
Capital Grant Allocation & Income	8,288	4,569	-	**12,857**	8,288	4,569	-	**12,857**
Expenditure								
Capital Expenditure - Trusts	8,288			**8,288**	8,288			**8,288**
Capital Expenditure - PHA Direct		4,564		**4,564**		4,564		**4,564**
	8,288	4,564	-	**12,852**	8,288	4,564	-	**12,852**
Surplus/(Deficit) - Capital	**-**	**5**	**-**	**5**	**-**	**5**	**-**	**5**
Cumulative variance (%)								

PHA has received a Capital budget of £12.9m including income in 2019-20, most of which relates to Research & Development projects in Trusts and other organisations. An approximate breakeven position was achieved, with a small surplus of £5k shown for the full year.

PHA Prompt Payment

Prompt Payment Statistics

	March 2020 Value	March 2020 Volume	Cumulative position as at 31 March 2020 Value	Cumulative position as at 31 March 2020 Volume
Total bills paid (relating to Prompt Payment target)	£5,291,363	679	£61,517,387	7,044
Total bills paid on time (within 30 days or under other agreed terms)	£5,272,397	664	£60,350,535	6,657
Percentage of bills paid on time	**99.6%**	**97.8%**	**98.1%**	**94.5%**

Prompt Payment performance for the year shows that on value the PHA is achieving its 30 day target of 95.0%, although performance on volume is slightly below target cumulatively at the end of March Overall PHA is making progress on ensuring invoices are processed promptly, and efforts to maintain this good performance will continue for the remainder of the year.

The 10 day prompt payment performance remained strong at 93.6% by value for the year, which significantly exceeds the 10 day DoH target for 2019-20 of 60%.

HSC Public Health Agency

item 9

Title of Meeting	PHA Board Meeting
Date	21 May 2020
Title of paper	COVID19 Health Improvement Post-Peak Action Plan
Reference	PHA/02/02/20
Prepared by	Brendan Bonner
Lead Director	Hugo van Woerden
Recommendation	For **Approval** ☐ For **Noting** ☒

Summary

The context of this plan in aligned to the recommended approach as defined by World Health Organization in its publication on Outbreak Communication Planning Guide .

The overall goal of Health Improvement activity during the COVID19 post-peak period is to address the health and social wellbeing impact of the pandemic, as well as to prepare for possible future pandemic waves.

This plan will identify 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.

COVID19 Health Improvement Post-Peak Action Plan

The context of this plan in aligned to the recommended approach as defined by World Health Organization in its publication on Outbreak Communication Planning Guide[1].

The overall goal of Health Improvement activity during the COVID19 post-peak period is to address the health and social wellbeing impact of the pandemic, as well as to prepare for possible future pandemic waves.

This plan will identify 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.

1.0 Short Term Actions (Provisional - June -December 2020)

To assist in the planning phase the short term actions will focus on the latter 6 months of 2020, it is acknowledged the scale and scope of COVID19 is still being determined and this plan is designed to ensure that has flexibility built-in in such a manner that in the event of a dramatic change in the status of the pandemic management that the HI Surge Plan can be re-instated or the HI function can move to the medium terms approach.

1.1 Planning & Co-Ordination

AIM

- Identify lessons learned for immediate application, as well as for future needs.

HI ACTIONS

- Report on HI actions and key learning points
- Identify the need for additional resources and capacities during possible future pandemic waves.
- Begin rebuilding of essential services focused on recovery.
- Address the psychological impacts of the pandemic, ensuring that health workforce is also addressed.
- Review and revise Health Improvement plans.

[1] World Health Organization Outbreak Communication Planning Guide. World Health Organization 2008. ISBN 978 92 4 159744 9.

1.2 Monitoring & Assessment

AIM

- Assist estimating local impact.
- Support ongoing monitoring for local spread.
- Review lessons learned

HI ACTIONS

- Directly contribute to the Contact Tracing and surveillance activities
- Evaluate the resources needed to support EOC and Contract Tracing activities.

1.3 Support the Reduction in Continued Spread of the

AIM

- Facilitate evaluation of interventions at a local level.

HI ACTIONS

- Evaluate the effectiveness of the measures used and update guidelines, protocols, in terms of joint working with stakeholders.
- Promote vaccination programmes in accordance with national plans, priorities, and vaccine availability.

1.4 Continuity of Health Improvement

AIM

- Update on Surge Plan priorities to define essential and critical interventions.

HI ACTIONS

- Ensure that HSC Staff have the opportunity for rest and recuperation.
- Review and, if necessary, revise pandemic preparedness and Emergency Planning response plans in anticipation of possible future pandemic wave(s).
- Define and secure essential services that would be required to be rolled forward (eg Stop Smoking Services)
- Remodel communications and response actions in terms of community based interventions.

1.5 COMMUNICATIONS

AIM

- Regularly update the public and other stakeholders.
- Influence partners, and other stakeholders to make adjustments to their communications plans and systems to response to future surges.

HI ACTIONS

- Regularly update the public and other stakeholders on any changes approaches or interventions.
- Communicate to the public the ongoing need for vigilance and disease-prevention efforts to prevent any upswing in disease levels.
- Continue to update stakeholders on new information or other changes that affect the response to a future surge.

2.0 Post Pandemic Period (January 2021 and beyond)

The primary goals of this period is to address the long-term health and social wellbeing impact of the pandemic, as well as moving to restore normal improvement functions functions.

2.1 Planning and Co-ordination

AIM

- Facilitate implementation of lessons learned for immediate application, as well as for future needs.

HI ACTIONS

- Support the evaluation of the effectiveness of specific responses and interventions.
- Review the lessons learned and apply to future emergency preparedness and response programmes.
- Revise pandemic preparedness and response plans to be built into HI activities.

2.2 Monitoring and Assessment

AIM

- Report on the local situation bout regionally and Council level.
- Review lessons learned and make adjustments in supporting surveillance and

HI ACTIONS

- Support the collection and analyse available data to evaluate the epidemiological, characteristics of the pandemic.
- Review and revise situation monitoring and assessment tools for the next pandemic and/or other public health emergencies.

AIM	HI ACTIONS
contract tracing.	• Support the resumption of seasonal influenza surveillance incorporating the pandemic virus subtype. Embed best practices in terms of vacations and hygiene outcomes

2.3 Reducing the Future Spread of the Disease

AIM	HI ACTIONS
• Influence evaluates on the impact of the pandemic in NI and the UK and in particular the effectiveness and impact of interventions utilized during the pandemic.	• Support evaluation of individual, households, and societal interventions implemented. • Review and update relevant guidelines as necessary in terms of resilience and working with other stakeholders. • Work to promote the continuation of existing vaccination programmes in accordance with regional plans, priorities, and vaccine availability.

2.4 Continuity of Health Improvement Provision

AIM	HI ACTIONS
• Review clinical information and effectiveness of HI interventions; advise on knowledge gaps and research needs. • Review and revise relevant guidance. • Recommence the Public Procurement Process that had been deferred	• Collect and analyse available data to evaluate the response of the HI contracts to the pandemic. • Review the lessons learned and share experiences with the local community. • Amend plans, procedures and approaches to include lessons learned. • Prioritise support for psychosocial services to facilitate individual and community-level recovery.

2.5 Communications

AIM

- Evaluate the impact of communications response during previous phases; review lessons learned.
- Ensure that lessons learned are incorporated into revised and improved communications plans of all stakeholders, ready for use in the next pandemic/major public health event.
- Continue to work with stakeholders to increase the effectiveness of local communications activities.

HI ACTIONS

- Publicly acknowledge the contributions of all communities and sectors.
- Communicate to the public and other stakeholders the lessons learned about the effectiveness of responses during the pandemic and how the gaps that were discovered will be addressed.
- Encourage stakeholders across all sectors, public and private, to revise their pandemic and emergency plans based upon the lessons learned.
- Extend communications planning and activities to cover other epidemic diseases and use the principles of risk communications to build the capacity to dialogue with the public on all health matters of potential concern to them.
- Improve and adjust communications plan in readiness for the next major public health event and highlight the role of Health Improvement in supporting a response.

3.0 Requirement for On-going Review

It is acknowledged that this pandemic has been unprecedented in terms of its impact on people, communities, places, health and social care systems etc. 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 protective and risk factors previously known to society will shift and the future health improvement function must adjust to reflect the changing demand and challenges. The learning that is being drawn from the COVID19 experience needs to properly logged and actioned if Public Health are to be better prepared to address any future civic emergency situation.

Health Improvement will have to explore and identify how it will become a positive influencing factor in the future that will trigger change at a community and wider stakeholder level in terms of addressing public health crises. The will require redefining roles and relationships in some instances but also building in greater resilience across sectors to response to emerging demands. There will be role to be seen to becoming a clear change agent that will influence both policy and practice and a regional and local level.

Health Improvement will need to redefine its leadership role in dealing with public emergencies and crises. This will include exploring resilience can be incorporated into future commission and procurement that will give Service Providers create flexibility to address any unplanned crisis event, this includes issues such as a more proactive approach to Emergency Planning with a clear focus on the need for consideration of mandatory training and refresher awareness for all staff and service providers. This will help support the environment for better collaboration in future with a clearer focus on supporting those most vulnerable or at greater risk of inequalities.

In terms of driving forward the modelling of future Health Improvement interventions consideration will be required to broaden the scope of HI services, with greater flexibility to change at a time of need that would based on the learning from the HI COVID19 Surge plan process and ensure that in future there can be a quicker and more joint up approach to any given PH emergency.

As such the role of Health Improvement in the wider remit of Public Health will require ongoing review and evolution. This can only be facilitated with greater joint planning across all PHA divisions and revised understanding of collection leadership and refocusing of goals on those at greatest risk of inequalities.

COVID19 Health Improvement Post-Peak Action Plan

The context of this plan is aligned to the recommended approach as defined by World Health Organization in its publication on Outbreak Communication Planning Guide[2].

The overall goal of Health Improvement activity during the COVID19 post-peak period is to address the health and social wellbeing impact of the pandemic, as well as to prepare for possible future pandemic waves.

This plan will identify 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.

1.0 Short Term Actions (Provisional - May -December 2020)

To assist in the planning phase the short term actions will focus on the latter 6/7 months of 2020, it is acknowledged the scale and scope of COVID19 is still being determined and this plan is designed to ensure that has flexibility built-in in such a manner that in the event of a dramatic change in the status of the pandemic management that the HI Surge Plan can be re-instated or the HI function can move to the medium terms approach.

	1.1 Planning & Co-Ordination			
AIM	**HI APPROACH**	**ACTION**	**LEAD**	**TIMESCALE**
1.1.1 Identify lessons learned for immediate application, as well as for future needs.	• Report on HI actions and key learning points **Lead**	Business Continuity team to collate all evidence of action undertaken by health Improvement under COVID19 and to draw out the key learning points. This should be reported in full on a monthly basis. Initial reports will be weekly.	Caroline Bloomfield	1st May 2020
	• Identify the need for	A review of the key priorities identified from the	Seamus	20th April 2020

[2] World Health Organization Outbreak Communication Planning Guide. World Health Organization 2008. ISBN 978 92 4 159744 9.

AIM	HI APPROACH	ACTION	LEAD	TIMESCALE
	additional resources and capacities during possible future pandemic waves. **Influencer**	Surge Plan will identify the need for resources to address future Pandemic challenges in terms of resilience and recovery.	Mullen	
	• Begin rebuilding of essential services focused on recovery **Lead**.	Consideration should be given to a future contract commission by the PHA, can include a key element of recovery. Particular focus will commence with Emotional Wellbeing.	Fiona Teague	20th April 2020
	• Address the psychological impacts of the pandemic, ensuring that health workforce is also addressed. **Influencer**	This work is being lead under the direction of Tony Stephens of the Department of Health and the work that is being coordinated through Janet Calvert and under the guidance of Michelle Tennyson will support the delivery of this approach.	Janet Calvert	10th April 2020
	• Review and revise Health Improvement plans. **Lead**	This process has commenced under the review of the Surge Plan but also identifying the key priorities that are to move forward from the post Pandemic delay phase.	Heads and Thematic leads	20th April 2020
	1.2 Monitoring & Assessment			
AIM	**HI APPROACH**	**ACTION**	**LEAD**	**TIMESCALE**
1.2.1 Assist estimating local impact. 1.2.2 Support ongoing monitoring for local spread.	• Directly contribute to the Contact Tracing and surveillance activities **Influencer**	The next phase of the exercise in dealing with COVID19 is through design of the contact tracing and surveillance activities. This is being led by Jackie Hyland and Mary Carey but there is a role for Health Improvement in terms of how we can on one hand resource the Emergency operational Center model and then explore how we can take	Brendan Bonner	20 April 2020

1.2.3 Review lessons learned		this into a locality level response.		
	• Evaluate the resources needed to support EOC and Contract Tracing activities. **Influencer**	This resource will be identified as part of the ongoing discussion with colleagues in health protection. It is anticipated that this work will require built in resilience with a number of health improvement staff being redeployed across the support the EOC and contact tracing activity. Based on the early learning from the model it is likely there will be a number of satellites based in each of the localities. Work has commenced and Mary Carey can identify a number of locations throughout Northern Ireland that can be considered.	Brendan Bonner	17th April 2020
	1.3 Support the Reduction in Continued Spread of the Disease			
AIM	**HI APPROACH**	**ACTION**	**LEAD**	**TIMESCALE**
1.3.1 Facilitate evaluation of interventions at a local level.	• Evaluate the effectiveness of the measures used and update guidelines, protocols, in terms of joint working with stakeholders. **Direct Intervention Locally**	This work will be required at a number of different levels in terms of the model of stakeholder engagement that is taking place. Particular focus will be closer collaboration with local government in terms of a much tighter collaboration in the event of any future pandemic but also to support the reduction of the spread of the disease within each locality. The focus on this work will be taken from PHE guidelines around key issues such as hand washing, Social Distancing, Access to Support and Facilities at a locality level.	Heads	May 2020 (TBC)
	• Promote vaccination programmes in accordance with national plans, priorities, and	Consideration should be given as to how the future Health Improvement Contracts will include a commitment that providers have got to support the PHA in the promotion or roll out of vaccination	Business Continuity Group	TBC

AIM	HI APPROACH	ACTION	LEAD	TIMESCALE
	vaccine availability. **Change Agent**	programmes.		
	1.4 Continuity of Health Improvement			
AIM	**HI APPROACH**	**ACTION**	**LEAD**	**TIMESCALE**
1.4.1 Update on Surge Plan priorities to define essential and critical interventions.	• Ensure that HSC Staff have the opportunity for rest and recuperation. **Influencer**	It is critical that Rota planning and resources take account of the need to ensure that staff take the opportunity of annual leave and recuperation. Whereas PHA will be operating a 5 in 7 Rota, the remit for Health Improvement staff will be defined within the context of the work they are required to deliver.	Brendan Bonner	17th April 2020
	• Review and, if necessary, revise pandemic preparedness and Emergency Planning response plans in anticipation of possible future pandemic wave(s). **Direct Intervention**	It is critical that future health Improvement staff fully understand their role in relation to emergency planning and addressing future Public Health Emergencies. As part of the CPD for all staff from band 6 and above they will be requirement for them to undertake emergency planning training. This training should be planned over the next 2 years and be part of any appraisal system.	Heads	1st May 2020
	• Define and secure essential services that would be required to be rolled forward (eg Stop Smoking Services) **Direct Intervention**	This work will emerge from the surge planning process which is underway and identifying definition of key priorities to move forward.	Heads	20th April 2020
	• Remodel communications and	Work has commenced with Comms PR team to explore a range of improved communications in	Brendan Bonner	10th April 2020

	response actions in terms of community based interventions. **Direct Intervention**	terms of delivery of Health Improvement messaging. The primary aim is to ensure that the Public Health message is reframed and that Health Improvement take a more active role in proactive communications. A key function for this will be the blog series.		
	1.5 COMMUNICATIONS			
AIM	**HI APPROACH**	**ACTION**	**LEAD**	**TIMESCALE**
1.5.1 Regularly update the public and other stakeholders. 1.5.2 Influence partners and other stakeholders to make adjustments to their communication plans and systems to respond to future surges.	• Regularly update the public and other stakeholders on any changes approaches or interventions. **Direct Intervention**	As part of the process in moving the role of Health Improvement forward it is important that there is clear communication with all stakeholders. Part of this work will emulate from the work that is being taken forward under the surge plan but it is critical that once clear priorities have been identified that health Improvement staff begin the process of discussing this with other stakeholders so they can articulate our approach and explore how existing contracts can be reviewed to take forward future initiatives.	Heads	1st May 2020
	• Communicate to the public the ongoing need for vigilance and disease-prevention efforts to prevent any upswing in disease levels. **Influencer**	The exact nature of the role of health Improvement will play within this context will be determined as a better understanding of COVID19 as identified. In particular Health Improvement will look at opportunities through existing contracts to promote a better understanding of the need for vigilance and disease prevention and a requirement in the contract for all providers to promote the Public Health message.	Heads	May/June 2020
	• Continue to update stakeholders on new information or other changes that affect	A process of engagement with the various stakeholders that PHA works with will have to be defined. Part of this will be taken forward onto the making Life Better Network but also a	Heads	May/June 2020

	the response to a future surge. **Direct Intervention**	requirement for the continuous engagement at locality level with other stakeholders to identify the best format to a consistent message going out to all stakeholders in terms of preparedness for future surges.		

Post Pandemic Period (January 2021 and beyond)

The primary goals of this period is to address the long-term health and social wellbeing impact of the pandemic, as well as moving to restore normal improvement functions.

The determination of Action and leads to determine how we move the post pandemic period too forward will be dependent on a number of factors key to these will be how the COVID19 virus evolves in the coming 6 months. As part of the review of this ongoing action plan a review will be required in September 2020 to start to plan out more defined actions to populate section 2 of the action plan.

The key actions that emerge in this section will be built upon the lessons from Section 1 and will be required to a much closer alignment with other divisions within Public Health but also across the wider PHA and HSCB to ensure that resources with health Improvement are clearly target areas that need to resources in order to address the future impact of COVID19 Pandemic or any other Public Health Emergency that may emerge thereafter.

	2.1 Planning and Co-ordination			
AIM	**HI APPROACH**	**ACTION**	**LEAD**	**TIMESCALE**
2.1.1 Facilitate implementation of lessons learned for immediate application, as well as for future needs.	• Support the evaluation of the effectiveness of specific responses and interventions.			
	• Review the lessons learned and apply to future emergency preparedness and response programmes.			
	• Revise pandemic preparedness and response plans to be built into HI activities.			
	2.2 Monitoring and Assessment			

AIM	HI APPROACH	ACTION	LEAD	TIMESCALE
2.2.1 Report on the local situation bout regionally and Council level. 2.2.2 Review lessons learned and make adjustments in supporting surveillance and contract tracing.	• Support the collection and analyse available data to evaluate the epidemiological, characteristics of the pandemic.			
	• Review and revise situation monitoring and assessment tools for the next pandemic and/or other public health emergencies.			
	• Support the resumption of seasonal influenza surveillance incorporating the pandemic virus subtype. Embed best practices in terms of vacations and hygiene outcomes			
	2.3 Reducing the Future Spread of the Disease			
AIM	**HI APPROACH**	**ACTION**	**LEAD**	**TIMESCALE**
2.3.1 Influence evaluates on the impact of the pandemic in NI and the UK and in particular the effectiveness and impact of interventions	• Support evaluation of individual, households, and societal interventions implemented.			
	• Review and update relevant guidelines as necessary in terms of resilience and working with other stakeholders.			

AIM	HI APPROACH	ACTION	LEAD	TIMESCALE
utilized during the pandemic.	• Work to promote the continuation of existing vaccination programmes in accordance with regional plans, priorities, and vaccine availability.			
	2.4 Continuity of Health Improvement Provision			
AIM	**HI APPROACH**	**ACTION**	**LEAD**	**TIMESCALE**
2.4.1 Review clinical information and effectiveness of HI interventions; advise on knowledge gaps and research needs. 2.4.2 Review and revise relevant guidance. 2.4.3 Recommence the Public Procurement Process that had been deferred	• Collect and analyse available data to evaluate the response of the HI contracts to the pandemic.			
	• Review the lessons learned and share experiences with the local community.			
	• Amend plans, procedures and approaches to include lessons learned.			
	• Prioritise support for psychosocial services to facilitate individual and community-level recovery.			
	2.5 Communications			
AIM	**HI APPROACH**	**ACTION**	**LEAD**	**TIMESCALE**

2.5.1 Evaluate the impact of communications response during previous phases; review lessons learned. 2.5.2 Ensure that lessons learned are incorporated into revised and improved communications plans of all stakeholders, ready for use in the next pandemic/major public health event. 2.5.3 Continue to work with stakeholders to increase the effectiveness of local communications activities.	• Publicly acknowledge the contributions of all communities and sectors.			
	• Communicate to the public and other stakeholders the lessons learned about the effectiveness of responses during the pandemic and how the gaps that were discovered will be addressed.			
	• Encourage stakeholders across all sectors, public and private, to revise their pandemic and emergency plans based upon the lessons learned.			
	• Extend communications planning and activities to cover other epidemic diseases and use the principles of risk communications to build the capacity to dialogue with the public on all health matters of potential concern to them.			
	• Improve and adjust communications plan in			

	readiness for the next major public health event and highlight the role of Health Improvement in supporting a response.			