agenda

Title of Meeting	133rd Meeting of the Public Health Agency Board
Date	20 May 2021 at 1.30pm
Venue	Via Zoom

standing items

1 1.30	Welcome and apologies		Chair
2 1.30	Declaration of Interests		Chair
3 1.30	Minutes of Previous Meeting held on 15 April 2021		Chair
4 1.35	Matters Arising		Chair
5 1.40	Chair's Business		Chair
6 1.45	Chief Executive's Report		Chief Executive
7 2.00	Finance Report	**PHA/01/05/21**	Director of Finance
8 2.10	Update on COVID-19		Chief Executive

committee updates

9 2.30	Update from Chair of Governance and Audit Committee	**PHA/02/05/21**	Mr Stewart

for approval

10 2.40	PHA Rural Needs Act Annual Report 2020/21	**PHA/03/05/21**	Mr Wilson

for noting

11 2.50	Health Improvement COVID Rebuild and Recovery Plan 2021-26	**PHA/04/05/21**	Dr Bergin
12 3.20	HSCQI Annual Report 2020 : Programmes-Partners-People	**PHA/05/05/21**	Dr Keaney

closing items

13 Any Other Business
3.30

14 Details of next meeting:

Thursday 17 June 2021 at 1.30pm

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

HSC Public Health Agency

minutes

Title of Meeting	132nd Meeting of the Public Health Agency Board
Date	15 April 2021 at 1.30pm
Venue	12/22 Linenhall Street, Belfast

Present

Mr Andrew Dougal	-	Chair (*via video link*)
Mrs Olive MacLeod	-	Interim Chief Executive (*via video link*)
Dr Stephen Bergin	-	Interim Director of Public Health (*via video link*)
Mr Rodney Morton	-	Director of Nursing and Allied Health Professionals (*via video link*)
Mr Stephen Wilson	-	Interim 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*)
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 *(via video link)*
Ms Tracey McCaig	-	Interim Director of Finance, HSCB *(via video link)*
Mr Brendan Whittle	-	Director of Social Care and Children, HSCB *(via video link)*
Mr Robert Graham	-	Secretariat

Apologies

Alderman Paul Porter	-	Non-Executive Director

40/21 Item 1 – Welcome and Apologies

40/21.1 The Chair welcomed everyone to the meeting. Apologies were noted from Alderman Paul Porter.

40/21.2 The Chair welcomed Mr Aidan Dawson to the meeting following his recent appointment as PHA Chief Executive. He said that Mr Dawson will take on the role following the retirement of Mrs MacLeod in July. He also welcomed Mr Brendan Whittle to the meeting after his recent appointment as Director of Social Care and Children in HSCB following the retirement of Ms Marie Roulston.

Prior to the commencement of the meeting the Chair invited members to

join in a minute's silence in memory of the HRH Prince Philip, the Duke of Edinburgh.

41/21 **Item 2 – Declaration of Interests**

41/21.1 The Chair asked if anyone had interests to declare relevant to any items on the agenda. No declarations were made.

42/21 **Item 3 – Minutes of previous meeting held on 18 March 2021**

42/21.1 The minutes of the Board meeting held on 18 March 2021 were **APPROVED** as an accurate record of that meeting.

43/21 **Item 4 – Matters Arising**

32/21.3 Rebuild of Services

43/21.1 The Chair sought clarity about the statement regarding outpatient services. The Interim Chief Executive undertook to review this with the Secretariat **(Action – Interim Chief Executive)**.

32/21.7 Cancer Cases

43/21.2 The Chair noted the reference to the number of cases of cancer that may have been missed due to COVID-19.

44/21 **Item 5 – Chair's Business**

44/21.1 The Chair presented his Report and noted that a new Chief Executive has been recruited, Mr Aidan Dawson, and he will take up post in July.

44/21.2 The Chair informed members that he had met with Dr Janice Bailie to discuss research funding. He advised that Northern Ireland has been able to secure some additional short-term funding as a result of Covid-19 research work but in the longer term consideration needs to be given as to how it can obtain more funding as Northern Ireland only gets 50% of what it should be receiving When compared to funding for research in Scotland and Wales. The current funding is £12 million per annum. However in 2009 the budget was then £12.3 million. After taking account of inflation This figure should now be £18.3 million. In summary we are £6 million short of what was allocated in 2009 and £12 million short of the research funding given in Scotland and Wales. In order to rectify this will be necessary for the Northern Ireland executive to allocate additional funding from within its budget. Action the chair to write to the Department of Health.

44/21.3 The Chair advised that he had spoken to the Acting Chair of the South Eastern Trust about the establishment of a Resources and General Purposes Committee and had outlined some proposed changes to its remit in his Report. He noted that in principle the Board wished to

establish this Committee.

44/21.4 Mr Clayton said that he would welcome the opportunity to have a discussion about the scope of the remit of this proposed Committee given it should not cut across the role of the Board or the Governance and Audit Committee. He felt that the remit as outlined in the paper seemed very broad and that there should be consideration given to looking at how PHA allocates its resources in response, particularly given recent discussions on equality.

44/21.5 Ms Mann-Kler said that she had similar concerns about the remit of the committee. She said she understood the need to look at finance and HR and proposed that the remit be narrowed to these two areas. She expressed concern that often at Board meetings there are a higher number of items for noting than there are for approval and if the scope of the proposed committee is too broad, then it may result in even less work for the Board. She suggested that it may be helpful to see a more specific focus and clearer terms of reference.

44/21.6 Mr Stewart said that the Board should approve the establishment of this Committee in principle, but agreed that the scope should be narrowed to look at areas such as workforce planning and resource allocation, given that this is an issue that is brought up at Board meetings regularly. Professor Rooney also agreed that it would be useful to set up this Committee but she did not feel that the proposed list of areas was an appropriate terms of reference.

44/21.7 Mr Morton suggested that as there is currently an opportunity to forward plan how PHA will look going forward, this Committee could look at a resource framework and resource strategy to ensure that PHA has the required capacity and capability. Therefore, he said that if the remit was outlined in a more strategic way he would support the establishment of this Committee. He added that PHA's strategic functions should be matched by resources and that the organisation should think differently about how it uses the resources that it has.

44/21.8 The Chair said that strategic issues are the remit of the Board and operational issues the remit of the Agency Management Team, but somewhere in between there is a need to drill down into specific issues. Alderman Ashe advised that there had previously been a Committee to look at community planning but it had not met for several years. The Chair said that he was conscious that this was an area where there was a gap. He added that he was conscious that he was not seeking to place additional workload on the Non-Executive Directors, the Executive Directors and the support staff. He proposed that members correspond with him regarding the terms of reference.

44/21.9 Ms Mann-Kler suggested that this item is brought back to the next Board. meeting. The Chair proposed that members come back to him within 10 days, but Mr Clayton felt that these issues may be better

worked out in a workshop session. He said that it would be difficult to articulate the points by e-mail. He noted that at the Governance and Audit Committee meeting earlier there was a report considered about community and voluntary sector contracts and while it was a good report, he did not feel it gave an overview of what these organisations are doing. Mr Stewart and Alderman Ashe supported Mr Clayton's suggestion for a workshop. Mr Wilson volunteered to assist with setting out the structure for such a workshop. **(Action - Mr Wilson and Mr Graham to set up a workshop on the role of the Resources Committee).**

45/21 **Item 6 – Chief Executive's Report**

46/21.1 The Interim Chief Executive said that her latest Report gave an extensive overview of the work of the Agency and advised that Dr Liz Mitchell would be attending the meeting shortly to discuss contact tracing and Ms McCaig would be giving members an overview of the financial outlook so rather than go through the Report, she asked members if they had any specific queries they wished to raise.

46/21.2 Mr Clayton said that he had two issues. With regard to the vaccination programme, he noted that this was going through a difficult period in terms of issues about particular vaccines. He commented on how the Republic of Ireland is adopting a different approach to that in Northern Ireland. He also asked if there is a perception that we are through the worst of this pandemic as there seems to be an impression that once people are vaccinated they cannot carry or spread the virus so he asked if there is messaging being put out to counter this. The Interim Chief Executive advised that she, Dr Bergin and Mr Wilson sit on the Vaccination Programme Board and they are mindful about messaging and she agreed that people need to be clear that COVID-19 has not gone away. She said that Dr Bergin had written a piece in the Belfast Telegraph reminding people of their responsibilities. She added that testing and contact tracing continues, and going forward it is likely to be younger people who will contract the virus but may not end up in hospital. She said that PHA needs to use its influence and focus its efforts in places like factories where there may be people who do not accept the need to get vaccinated. Mr Wilson agreed that this is a challenging area and that the point of the programme has been reached where the target group includes those people who are vaccine resistant but he said that the PHA is working with the Department and with Trusts to get the message out there that getting the vaccine does not make you infallible. He added that PHA is currently testing new materials on a campaign aimed at younger people and there will shortly be a new UK-wide campaign called "Every Vaccine is Giving You Hope".

46/21.3 Professor Rooney asked about the recent violence on the streets and if PHA has a role in terms of any public health response to that. The Interim Chief Executive said that PHA's Health Improvement team works in communities and mobilises its resources when needed. She added

that the team has developed a forward recovery plan and it may be useful to bring this to a future Board meeting.

46/21.4 Ms Mann-Kler asked whether there will be a requirement in future for HSC staff to be vaccinated. The Interim Chief Executive advised that this is a live issue and she is aware that some private sector companies are making it mandatory. Mr Clayton, declaring an interest as an employee of a Trade Union organisation, noted that in England there have been cases where care homes have made it mandatory for staff to be vaccinated and so the Health Secretary, Matt Hancock, is beginning a consultation on the matter. However, he noted that the vaccination programme in England has not perhaps been as successful as the programme here.

46/21.5 The Chair said that he would like to see data on how many people have been screened compared to previous years across the different screening programmes.

46/21 Item 7 – Finance Report (PHA/01/04/21)

46/21.1 Ms McCaig presented the latest Finance Report and advised that this showed that PHA has a year to date surplus of £800k but that it is anticipated that PHA will achieve a break even position by the year end as there is an assumed retraction of £1.7m from the Department. She said that there is no significant change within the programme expenditure. Moving onto the ring-fenced allocations, she pointed out that there is now a separate annex for COVID-19 expenditure. She advised that PHA has received £2m to date in relation to COVID-19 and another £4.8m is expected before the end of the year.

46/21.2 Ms McCaig said that the management and administration budget position is largely unchanged, but within the capital budget there is now a small surplus due to slippage against a Digital Test Trace Protect project where software costs came in at a lower cost than anticipated. She explained that it is too late for the Department to retract these funds at this stage. She moved onto the prompt payment statistics and said that they were the same as last month. Finally, she drew members' attention to the annex which contained more details on the COVID-19 expenditure. She said that it is assumed that this budget will break even, but there could be a small overspend against health protection and a small surplus within contact tracing.

46/21.3 The Chair welcomed the separate section outlining the COVID-19 expenditure.

46/21.4 Mr Stewart noted that the amount of retraction was in the region of what he expected, and asked if it may increase further. He sought assurance that the COVID-19 funding would be covered by the Department. Ms McCaig said that at present there are no indications of any further significant surplus, but advised she would give members an update on

	the final position at the next meeting. She also said that she had no concern that COVID-19 related expenditure incurred would not be covered by an allocation from the Department.
46/21.5	Ms Mann-Kler asked about expenditure plans for 2021/22 and if PHA would be re-profiling any of its expenditure in areas such as mental health and addiction given the impact of the last year. Ms McCaig said that she would cover this in her next presentation as it outlines the resources that PHA will have its disposal. She said that while PHA can review and challenge itself in terms of where it allocates its funding, there are funds that are already contractually committed. She added that Directors will be working through that process and a plan will be brought to the Board. Action Dr Stephen Bergen
46/21.6	As there were no further queries on the Finance Report, Ms McCaig moved on to deliver a presentation on the 2021/22 budget settlement for the HSC. She noted that while there is additional funding for the HSC of up to £495m, a significant proportion of this will be absorbed by inflation and the ongoing COVID-19 response, leaving approximately £209m available for 2021/22. She advised that out of the £495m, only the Agenda for Change pay award element is recurrent with the remainder non-recurrently provided. She pointed out that of the £105m available to cover the COVID-19 response element this represents an average of 3-month's expenditure when compared to 2020/21. After accounting for other inflationary issues she advised that there was a total amount of £159.8m held for inescapables and new initiatives. She explained that the HM Treasury has permitted a change in accounting treatment which has budgeted for an estimated £175m of PPE stock in 2020/21, which was a welcome support to the HSC.
46/21.7	She took members through a list of PHA, Prevention and Population Health approved bids but pointed out that some of these are the responsibility of HSCB to implement eg Diabetes. She advised that this is the final prioritised list within the budget approved by the Minister. Ms McCaig outlined areas where the allocation was lower than the original amount bid for.
46/21.8	Ms Mann-Kler suggested that areas such as health protection and health improvement may need greater investment, to enable individuals and society rebuild resilience, as the pandemic had highlighted how people with diabetes or who are obese, are more vulnerable to COVID. She added that the Minister had recently stated that health expenditure needed to be on a longer term planning cycle rather than the current short term model. She asked how the PHA is determining its priorities for the forthcoming year and if this is being carried out as a HSC system approach that is also aligned to Programme for Government. Ms McCaig said that in terms of Transformation, £64m of prioritised schemes were put forward and a further £24m is required for growth on these schemes, initially this means that £18m of schemes have not been funded and a review of impacts and sustainability for these schemes is being

considered.

46/21.9 In terms of the COVID-19 response, Ms McCaig advised that the Department is holding funding for additional cost pressures for areas such as asymptomatic testing and whole genome sequencing. She said that if additional funding was required it would need to be secured through in year monitoring rounds.

46/21.10 Ms McCaig advised that there is a £339m draft capital budget which will contain funding for R&D.

46/21.11 In summary, Ms McCaig said that the key issues relating to this budget concerns the balance between recurrent and non-recurrent funding, the uncertainty around the ongoing COVID response, other Transformation priorities, unrealised saving plans and opening deficits. In terms of next steps, she said that her staff will support PHA Directors to help them understand the figures and that a paper will be brought to the next AMT meeting on the process for taking initiatives forward through business cases. She advised that PHA will receive its indicative allocation letter shortly so that PHA can aim to complete its financial plan by the end of April, early May which will be brought to the Board in May or June.

46/21.12 The Chair said that the presentation was comprehensive and well explained. He asked what percentage of the overall Northern Ireland allocation is given to health. Ms McCaig advised that it is over 50%.

46/21.13 Mr Clayton expressed concern that a lot of the funding is non-recurrent and shows the need for a multi-year settlement. He felt that this could be problematic for PHA in that it cannot anticipate which business cases will be funded and which will not. He noted that there appears to be no funding for areas such as long COVID. Ms McCaig said that PHA will have to think about how it can deliver against its objectives in the context of having less funding than bid for. Mr Clayton noted that while the overall spend on health is large compared to other departments, there is no indication that this will lead to having a better system. He added that health inequalities are likely to increase, there will be increasing need, more money spent, but not necessarily better outcomes. Ms McCaig noted that the Minister had recently articulated the issue of waiting lists and annual budgets.

46/21.14 Mr Stewart thanked Ms McCaig for her presentation and said that he could not remember seeing such a comprehensive presentation. He noted that the funding for preventive measures has been reduced or cut making it extremely difficult to get out of the cycle of demand. He added that demand is increasing but it cannot be met and he looked forward to seeing the outworking of this budget settlement for PHA.

46/21.15 Mr Morton said that as part of dealing with the issue of long COVID, PHA, under the remit of Ms Michelle Tennyson, will want to take a co-production overview. He added that there will be a shift to a more

preventative agenda referring to the new population planning model.

46/21.16 Ms McCaig noted Mr Morton's reference to the new population planning model and the rollout of that across the region. She said that this year there remain challenges on the ground, for example there are Transformation schemes that have to continue and others where considerations on sustainability or time limited funds would be required. She said that additional funding could come from June monitoring but there is already a pre-commitment of £20m for safe staffing. She added that the country begins to open up again after the lockdown there will be demands from other Government departments for funding, but she noted that PHA has a good track record of making use of its funding.

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46/21.17 The Chair asked if the funding for PPE would only provide a few months' worth. Ms McCaig said that the key factor is the amount of stock that can be safely stored and that if there were another surge it would be used up very quickly. The Chair sought clarity that storage capacity is an issue. Ms McCaig said that supply chain issues have settled and there is a more fluid supply than had been experienced.

46/21.18 Ms Mann-Kler said that there needs to be greater investment in areas such as health improvement and health protection and that as a society we need to be prepared to become more resilient. She noted that people who are obese or have diabetes are more vulnerable to COVID. She added that the Minister has given an assurance that there has to be long term expenditure which is above party politics. She asked how PHA is determining its priorities for the forthcoming year and if that is being done as an HSC system and is being aligned to Programme for Government. Ms McCaig referred to the £14m for PHA and explained that PHA, HSCB and Trusts were asked to put forward proposals which were then discussed with policy leads. She advised that this was a very challenging process which has seen spend in some areas reduced rather than removed in order to spread resources as far as possible. She said that the prioritisation exercise influenced the eventual final outcome and that £159m supported new or inescapable developments. She added that it will be a challenging year financially.

46/21.19 Dr Keaney asked if any funding received through monitoring rounds is recurrent but Ms McCaig advised that it is not. Dr Keaney asked what the level of spend was on PPE pre-COVID if £175m is going to be spent this year, but Ms McCaig said that she did not have that information to hand.

46/21.20 The Chair thanked members for their contributions to the discussion and thanked Ms McCaig for her presentation.

47/21 **Item 8 – Update on COVID-19**

Dr Liz Mitchell joined the meeting for this item.

47/21.1 Dr Mitchell said that the focus of her presentation today would be on the latest developments with regard to contact tracing. She noted that testing is separate and this work is led by Dr Brid Farrell.

47/21.2 Dr Mitchell advised that since the contact tracing was set up it has dealt with 110,000 cases with approximately 195,000 contacts. She said that the centre has to respond to a constantly changing situation in dealing with changes in restrictions, new variants, increased vaccinations and the impact of international travel. She advised that the work of the centre is underpinned by a team of 140 contact tracers, both part time and full time, and 135 bank staff as well as 70 staff from PHA and HSCB who are trained and can step in if required. Over the last period, she advised that PHA has developed analytics, implemented a quality assurance system and has the ability to monitor metrics on an hourly basis. For today, she advised that there have been 150 new positive cases, but added that there has been an increased number of tests done and an increase in the positivity rate. She explained that tests are now offered all close contacts of cases and with a return of children to school, there is lateral flow testing. If a child has a positive lateral flow test but then returns a negative PCR test within 48 hours then that case is stood down.

47/21.3 Dr Mitchell said that PHA recently carried out some research and surveyed people it had previously contacted about having to self-isolate. She reported that 94% indicated that they were able to self-isolate but 10 out of the 140 surveyed felt that they would not be able to complete the 10-day period for financial reasons. She added that PHA directs people to the AdviceNI helpline, but that of those surveyed, only two individuals had used the helpline, with one using it twice.

47/21.4 Dr Mitchell informed members that PHA has been carrying out reverse, or enhanced, contact tracing in a bid to determine the settings where people are getting infected. However, she said that this was temporarily stood down during the last surge as carrying out this additional work added 15 minutes onto each phone call. She advised that PHA now publishes performance data on contact tracing on its website as well as data on outbreaks and clusters. She said that data relating to schools, care homes and hospitals is dealt with separately.

47/21.5 Dr Mitchell advised that PHA is now looking at following up on international travellers coming into Northern Ireland and through the Republic of Ireland, particularly those returning from countries where they must complete a period of quarantine. She said that a period PHA was doing follow up on cases where the individual had been vaccinated, but there are alternative arrangements in place for that work.

47/21.6 Dr Mitchell said that the focus now is on the future as modelling suggests that there could be thousands of cases daily during the summer. She advised that the contracts of staff in the contact tracing centre have been extended until the end of September, but she hoped that they would be further extended until the end of March 2022. She said that her presentation represented a short summary, but showed the scale of work of the centre and the need to keep pace with any changes and the need to have a tight group of staff.

47/21.7 The Chair thanked Dr Mitchell for her presentation. He said that he thought more than 2 people would have sought help from AdviceNI. He noted that in England there is a process whereby Local Government gives out money to those in self-isolation and he asked whether a similar scheme operates here. Dr Mitchell advised that there is a means-tested scheme run through the Department for Communities and AdviceNI can provide advice to people as to whether they are eligible.

47/21.8 Mr Clayton asked about those individuals surveyed who said that they could not complete isolation due to financial reasons. He said there were some concerns about the Department for Communities scheme, but acknowledged that it is currently being reviewed. He asked whether PHA staff has any role in suggesting what a better model may look like, for example if an individual couldn't work from home, could they be entitled to a higher amount. Dr Mitchell conceded that there are issues in terms of general awareness of the scheme and she said that staff in the Health Improvement team are aware of the ongoing discussions regarding the scheme. She said that the survey did indicate that financial issues are the biggest barrier to self-isolation.

47/21.9 Ms Mann-Kler asked if there were any plans to roll out lateral flow testing to everyone in Northern Ireland. Dr Mitchell noted that Wales and Scotland have taken their own approaches, but said that there is a group within the Department of Health looking at this and it has been rolled out to all workplaces. She added that Dr Farrell is working on a project to see this rolled out to HSC professionals and people in supported living with domiciliary care workers potentially next. She said that there is a lot of active discussion on this, but ultimately it will be a policy decision.

47/21.10 The Chair asked whether it is possible for contact tracing staff to advise callers of the availability of support. Dr Mitchell said that the call handlers signpost people to the appropriate resources, and can refer them directly if required.

47/21.11 The Chair recorded his thanks to Dr Mitchell and her staff for the work they are doing to protect the population and ensuring that they receive the support to which they are entitled.

48/21 **Item 9 - Establishment of a Resources and General Purposes Committee (PHA/02/04/21)**

48/21.1 This item was covered under Item 5 above.

49/21 **Item 10 – Annual Quality Report (PHA/03/04/21)**

Ms Denise Boulter joined the meeting for this item.

49/21.1 Mr Morton advised that the Annual Quality Report is a joint HSCB/PHA Report and he asked Ms Boulter to take members through it.

49/21.2 Ms Boulter said that this is the 7th Annual Quality Report and is linked to the outcomes of Quality 2020. She explained that it contains information on a list of topics that go across a full range of quality initiatives organised through PHA, HSCB or both and in conjunction with the wider HSC. She noted that there is quantifiable data available with some of the initiatives, but not with others.

49/21.3 Ms Boulter explained that the Report follows the 5 outcomes of Quality 2020 and that normally it would be presented to the Board in September, but due to COVID-19, last year's Report was delayed so this year's Report covers the period from March 2019 to September 2020 and includes some COVID-19 related work. However, she said that it is important to note the high number of non-COVID-19 topics in the Report and acknowledged that this has been a difficult year for everyone.

49/21.4 Ms Boulter said that she judged some of the HSCQI awards and was impressed by the work that is being done. She gave an example of the Rapid Access Chest Pain Clinic where the number of people on waiting lists for over 2 weeks reduced by almost 1800 to 0. She said that the final Report is a positive one and has been signed off by the senior management teams of both HSCB and PHA and by the HSCB Board. Mr Morton added the work of HSCQI featured strongly in this year's Report and reiterated that the Report covers a full range of quality and safety work. He said that the Report is structured in such a way to make it more readable so that the public can see what difference has been made, and what the outcome was.

49/21.5 The Chair said that this Report is a tremendous tool in terms of communicating with the public and is very readable and he thanked all of those involved in its compilation.

49/21.6 Adding to what Ms Boulter had said, Dr Keaney advised that she will be participating in the judging of this year's Quality Awards tomorrow and that there are 16 projects, all of which are excellent. She added that within HSCQI, the team is currently working an Annual Report and she hoped to bring this to a future meeting.

49/21.7 Ms Mann-Kler said that the report had been easier to digest as clear

	outcomes had been articulated. She asked if the findings of recent public inquiries are integrated into lessons learnt and good practice for quality work. She asked if there had been any quality work undertaken in relation to reducing waiting lists. She also asked if the HSC system had reached a tipping point in terms of staff awareness and understanding of quality in their daily practice.
49/21.8	Mr Morton advised that next year's Report will feature outputs from work being done following the Hyponatraemia Review and the recent review in Muckamore. In terms of waiting lists, Ms Boulter gave the example of the Rapid Access clinic where a piece of QI work was carried out which resulted in 1,800 patients being put on the correct pathway so that those patients who needed an appointment could get one, and those who didn't were referred to the appropriate pathway for them. She said that there are similar pieces of work that can be taken forward. With regard to the idea of being at the tipping point, she felt that this point has almost been reached. She said that learning from incidents is now being reviewed from a QI perspective writing than through recommendations and reports. She added that work is ongoing with QI leads on taking initiatives forward.
49/21.9	The Interim Chief Executive noted that in her Report, Dr Keaney had outlined that there is good engagement with Trust QI leads, but added that the HSCQI team needs more resources. Dr Keaney said that across the HSC there is a number of trained staff and HSCQI is compiling a database of these staff and is also looking to develop a learning strategy going forward. She added that she hopes to develop a QI strategy.
49/21.10	Professor Rooney said that the Report was easy to read. She asked about PPE and the dissemination of a learning letter following the issues at the start of the pandemic, and if this had been signed by the Department. Ms Boulter explained that the letter had been issued by HSCB as it is responsible for issuing learning letters but signed off by PHA because it has responsibility for monitoring their implementation. Mr Morton added that although PHA does not procure PPE, it was involved in the development of a model to predict the level of PPE that would be required across the HSC and the independent sector, but the procurement is carried out by BSO. Picking up on the notion of a tipping point having been reached, he said that safety and quality outcomes need to be fed into the overall system and that work is under way to look at this. He added that this is important given that under the previous commissioning and planning arrangements, services were put in place to achieve the right outcomes so safety and quality are important.
49/21.11	Professor Rooney referred to a framework that was referenced in the section on strengthening the workforce and suggested that this needed to be referenced earlier in the section.
49/21.12	The Chair asked whether the graphic design in the Report had been

carried out in-house. Ms Boulter said that the Report was largely compiled by Ms Grainne Cushley who is currently on maternity leave, but in terms of the graphic decision she advised that this had been done by an external company. Mr Morton added that this was carried out in partnership with the publications team in PHA who would ordinarily have carried out this work, but were unable to due to capacity issues. Mr Wilson concurred and said that this highlights the need for more resources in his team given that commissioning this type of work externally carries a large cost.

49/21.13 The Chair asked that his thanks be conveyed to all those who worked on producing this user friendly Report

49/21.14 The Board **APPROVED** the Annual Quality Report.

50/21 Item 11 – Implementation of a Daily AMT/SMT Huddle during the First Wave of the COVID-19 Pandemic using a QI Approach (PHA/04/04/21)

50/21.1 Dr Keaney delivered a short presentation to accompany the Report that had been issued to members. She began by explaining the concept of a huddle and why it was decide to implement this approach in PHA. She said that when first established the huddle met every morning at 8.30am and cell leads would give a short overview of the work of their cells. To know if the huddle led to any improvements, she outlined a list of process, balancing and outcome measure that were considered.

50/21.2 Dr Keaney explained that initially the huddle met in person and used a visibility wall to present updates but to fulfil social distancing requirements meetings became a blend where people attended in person or virtually so each cell used a template to give their update. She showed members more detail in terms of when meetings took place, total attendance and how long each cell spent delivering their update. She noted that while some cells appeared to give longer or shorter updates than others, she said that was down to delivery style and was not reflective of one cell being seen as more important than another. Next, she showed how many actions came out of each meeting and if actions were shared between cells.

50/21.3 Dr Keaney gave an overview of the learning and the challenges from the huddle using an Appreciative Inquiry methodology. She said that the huddle concept created a sense of community and there was a willingness to embrace it, but that there was a degree of unfamiliarity at the outset and only a small QI team in place to gather data. Going forward, she suggested that PHA could identify QI or huddle "champions" and have a more regular feedback process in place.

50/21.4 The Chair asked about the role of a huddle if there is not a crisis situation. Dr Keaney said that a huddle could be used to give a real time overview of live issues. The Chair asked whether members of HSC

Silver saw the huddle as duplication, but Dr Keaney said that one of the aims of the huddle was to try to reduce the length of HSC Silver meetings and Mrs Lisa McWilliams, who chaired HSC Sliver meetings, said that she found the huddle very useful. The Interim Chief Executive noted that a huddle takes place every Monday morning to look at what has emerged over the weekend and on Thursday mornings there was, until quite recently, a huddle with HSCB Directors to share updates. She felt that the huddle was a good method of having a quick get-together.

50/21.5 The Chair thanked Dr Keaney for her presentation and said that the huddle concept has great potential for being rolled out across the organisation. He said that he welcomed any initiative that is time efficient.

50/21.6 The Board noted the Report on the Implementation of a Daily Huddle.

51/21 Item 12 - Specialist Training Programme in Public Health (PHA/05/04/21)

51/21.1 Dr Bergin said that members will be aware that there is a public health consultant training programme in Northern Ireland and that PHA employs these trainees, but the programme is governed by the Northern Ireland Medical and Dental Training Agency (NIMDTA), and there is a requirement to update the Board annually on this.

51/21.2 Dr Bergin advised that the programme has capacity for 12 trainees and there are 10 in the present cohort. He said that PHA has a responsibility to ensure that there is a steady flow of trainees and that these trainees followed a rigorous 5-year programme.

51/21.3 Dr Bergin said that the process for applying to the programme has now changed and the first non-medical trainee will be commencing this week, and that it will no longer be exclusively for doctors. He advised that NIMDTA will continue to have oversight of the programme. Dr Bergin commented that the present cohort have found the current process challenging as they have had to form part of PHA's frontline response to COVID-19. Therefore, he said that PHA is looking to increase its training programme, as recommended in the Hussey Review, and become a public health school with training available for all staff. The Chair said that this is positive move and that the training should permeate the whole organisation as in England the number of non-medical public health consultants is now 60%.

51/21.4 Mr Stewart agreed that having reviewed the Hussey Report, it seemed that the only way that PHA could get more public health consultants was to train its own and he said that he would be fully supportive of any programme that create the opportunity for staff to develop in this way. He said that it would be a positive outcome, not just for PHA, but for Northern Ireland.

51/21.5 Ms Mann-Kler, declaring an interest as a GMC member, said that she also supported this but asked if the programme is available to medical associates. Dr Bergin explained that there is an open competition process where there is initial screening followed by a final interview so provided the individual met the entry criteria they can apply. He said that non-medical staff at Band 6 or Band 7 with a relevant postgraduate qualification or equivalent should be able to apply.

51/21.6 Professor Rooney also offered her support to this opportunity and suggested it may be one way of getting more professional psychology expertise into the organisation. She noted that she saw a job advertisement for a role with the Institute for Public Health in Ireland and asked how it links with the work of PHA. Dr Bergin said that there is an all-Ireland Institute and that he had met with them recently to discuss how PHA could work with them. He added that the two Chief Medical Officers have a link. The Chair said that PHA should explore the opportunity to work with the Institute.

51/21.7 Mr Morton advised members that as part of a report by the Nursing and Midwifery Task Group, there is a requirement for PHA to take forward the development of a public health nursing framework and there is potential investment of up to £20m in this. He said that part of this will include the appointment of a senior nurse lead and five nurse practitioners who will create a public health nursing network. He added that the Chief Nursing Officer is clear that this framework will see additional investment in school nursing. He said that a critical objective for PHA will be to support the development of this framework in the context of a multi-disciplinary approach which may include psychological and behavioural science input. He suggested that he could bring to the Board an overview of the requirements of the framework. The Chair asked if it would be nursing-led. Mr Morton said that it will be, but that it will dovetail with the work of the PHA and there will be a multi-disciplinary team.

51/21.8 The Interim Chief Executive said that as part of the outworking of the Hussey Report, PHA needs to get its own house in order and offer opportunities for its own staff. She said that there has been discussion about creating a type of faculty within PHA and that COVID-19 has shown that there is a lot of staff who when required, have stood up to be counted and this is an exciting time for the organisation.

51/21.9 The Board noted the update on the specialist training programme in public health.

52/21 Item 13 – Any Other Business

52/21.1 The Chair thanked members for their participation in today's meeting and for their enthusiasm and questions which he said provided much to provoke further action. He said he hoped that Aidan Dawson was enthused by the deliberations and looked forward to working with him.

53/21 **Item 14 – Details of Next Meeting**

Thursday 20 May 2021 at 1:30pm

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

Signed by Chair:

Date:

Public Health Agency

Finance Report

2020-21

Month 12 - March 2021

PHA Financial Report - Executive Summary

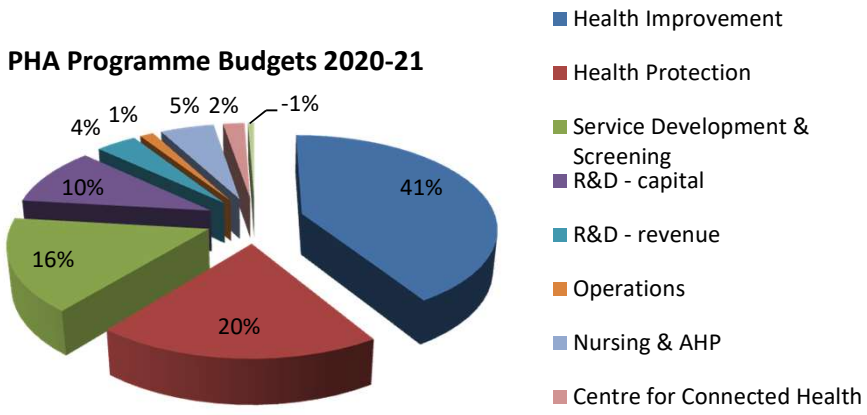
Year to Date Financial Position (page 2)

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 breakeven obligations at year-end.

Programme Budgets (pages 3&4)

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

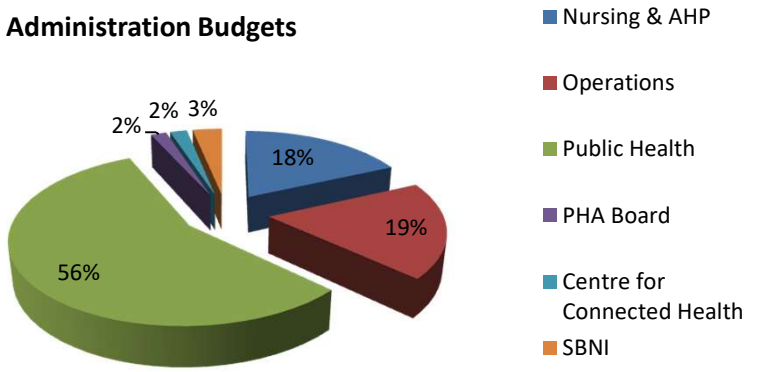


Administration Budgets (page 5)

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

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

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

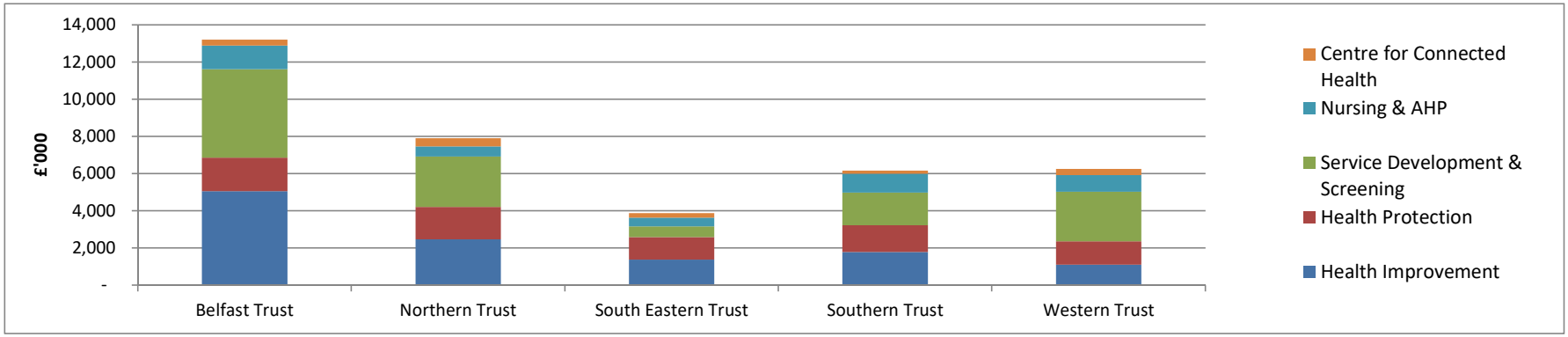


Public Health Agency
2020-21 Summary Position - March 2021

	Programme		Full Year Ringfenced	Mgt & Admin	Total
	Trust	PHA Direct	Trust & Direct		
	£'000	£'000	£'000	£'000	£'000
Available Resources					
Departmental Revenue Allocation	37,846	43,280	14,943	22,410	**118,480**
Revenue Income from Other Sources	-	35	-	808	**843**
Total Available Resources	37,846	43,315	14,943	23,218	**119,322**
Expenditure					
Trusts	37,846	-	4,478	-	**42,324**
PHA Direct Programme	-	44,114	10,388	-	**54,503**
PHA Administration	-	-		22,388	**22,388**
Total Proposed Budgets	37,846	44,114	14,867	22,388	**119,215**
Surplus/(Deficit) - Revenue	-	(799)	77	830	**108**
Cumulative variance (%)	***0.00%***	***-1.84%***	***0.51%***	***3.58%***	***0.09%***

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.

Programme Expenditure with Trusts

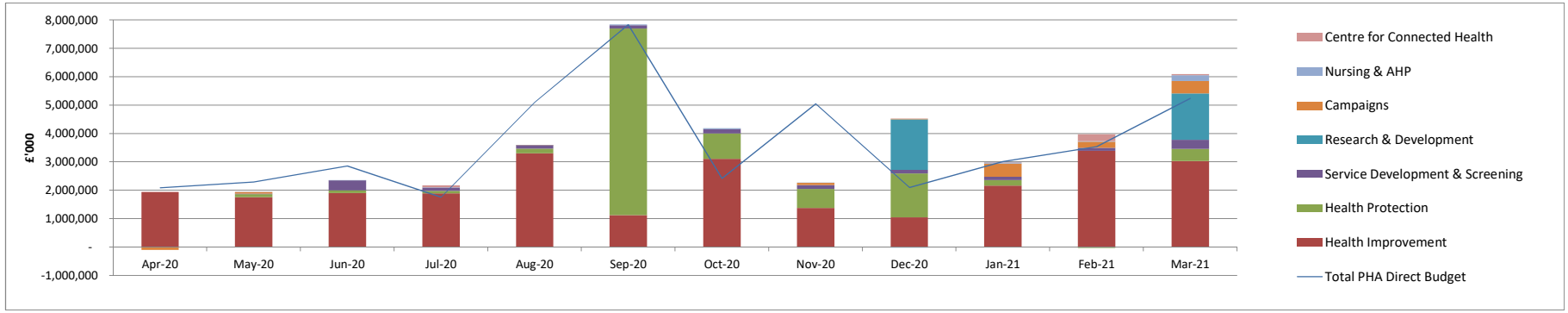


Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	5,064	2,466	1,374	1,779	1,110	**11,793**	11,793	11,793	-
Health Protection	1,793	1,737	1,214	1,440	1,246	**7,430**	7,430	7,430	-
Service Development & Screening	4,764	2,720	581	1,769	2,672	**12,506**	12,506	12,506	-
Nursing & AHP	1,262	544	466	1,003	888	**4,164**	4,164	4,164	-
Centre for Connected Health	329	431	247	172	338	**1,516**	1,516	1,516	-
Other	140	90	46	77	85	**437**	437	437	-
Total current RRLs	**13,351**	**7,989**	**3,928**	**6,240**	**6,338**	**37,846**	**37,846**	**37,846**	-
Cumulative variance (%)									***0.00%***

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-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	YTD Budget £'000	YTD Spend £'000	Variance £'000	
Profiled Budget																	
Health Improvement	2,096	2,096	2,096	1,239	4,555	972	1,209	1,856	1,157	2,465	3,247	2,883	**25,871**	25,871	26,081	(211)	*-0.8%*
Health Protection	-	100	160	192	186	6,577	917	916	958	410	70	60	**10,544**	10,544	10,737	(193)	*-1.8%*
Service Development & Screening	-	95	562	215	364	215	215	31	50	2	44	352	**2,144**	2,144	2,157	(12)	*-0.6%*
Research & Development	-	-	-	-	-	-	-	-	1,780	-	-	1,812	**3,592**	3,592	3,411	181	*0.0%*
Campaigns	-	-	-	10	20	45	60	- 15	250	80	144	613	**1,207**	1,207	1,166	42	*3.4%*
Nursing & AHP	-	-	39	39	- 21	27	19	61	98	46	5	251	**565**	565	337	228	*40.4%*
Centre for Connected Health	-	-	-	70	-	-	-	-	8	8	28	255	**369**	369	365	4	*1.1%*
Other	-	-	-	-	-	-	-	-	-	-	-	(976)	**(976)**	(976)	(140)	(836)	*100.0%*
Total PHA Direct Budget	**2,096**	**2,291**	**2,857**	**1,765**	**5,105**	**7,836**	**2,420**	**2,849**	**4,301**	**3,010**	**3,538**	**5,247**	**43,315**	**43,315**	**44,114**	**(799)**	
Cumulative variance (%)																***-1.84%***	
Actual Expenditure	**1,854**	**2,030**	**2,394**	**2,219**	**3,594**	**7,874**	**4,577**	**2,215**	**4,439**	**2,843**	**3,963**	**6,111**	**44,114**				
Variance	**242**	**261**	**463**	**(454)**	**1,510**	**(38)**	**(2,157)**	**633**	**(138)**	**167**	**(425)**	**(864)**	**(799)**				

The full year position shows a £0.8m 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.

March 2021

Public Health Agency
2020-21 Ringfenced Position

	Full Year			
	Covid £'000	Transformation £'000	DAERA & EITP £'000	Total £'000
Available Resources				
DoH Allocation	10,189	4,437	317	**14,943**
Assumed Allocation		-	-	**-**
Total	10,189	4,437	317	**14,943**
Expenditure				
Trusts	1,770	2,634	74	**4,478**
PHA Direct	8,445	1,700	243	**10,388**
Total	10,215	4,335	317	**14,867**
Surplus/(Deficit)	**(26)**	**103**	**-**	**77**

PHA received a COVID allocation of £10.2m, which is primarily for the Contact Tracing programme, an Enhanced Health Protection service, additional Flu vaccinations, COVID Infection Prevention & Control, and various staff recognition payments. Full expenditure was achieved on these allocations, with only a small overspend of £26k (0.3%) reported. A more detailed breakdown is shown on page 9.

A number of Transformation projects were also funded, with this ringfenced funding totalling £4.4m. These projects were monitored and reported on separately to DoH, and a small underspend of £0.1m (2%) was reported for the year.

The Other category includes EITP and DAERA ringfenced funds, which achieved a breakeven position.

PHA Administration

2020-21 Directorate Budgets

	Nursing & AHP £'000	Quality Improvement £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Annual Budget								
Salaries	4,010	326	2,957	12,518	337	348	466	**20,963**
Goods & Services	149	18	1,322	367	54	76	269	**2,255**
Total Budget	**4,160**	**344**	**4,279**	**12,885**	**392**	**425**	**735**	**23,218**
Budget profiled to date								
Salaries	4,010	326	2,957	12,518	337	348	466	**20,963**
Goods & Services	149	18	1,322	367	54	76	269	**2,255**
Total	**4,160**	**344**	**4,278**	**12,885**	**392**	**425**	**735**	**23,218**
Actual expenditure to date								
Salaries	3,956	340	2,805	12,441	335	372	407	**20,657**
Goods & Services	169	5	1,099	103	29	4	322	**1,731**
Total	**4,125**	**345**	**3,904**	**12,545**	**365**	**376**	**729**	**22,388**
Surplus/(Deficit) to date								
Salaries	55	(14)	152	77	2	(24)	59	**306**
Goods & Services	(20)	13	223	264	25	72	(53)	**524**
Surplus/(Deficit)	**35**	**(1)**	**375**	**341**	**27**	**48**	**6**	**830**
Cumulative variance (%)	*0.83%*	*-0.29%*	*8.76%*	*2.64%*	*6.95%*	*11.39%*	*0.78%*	***3.58%***

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. This surplus has been absorbed through a managed overspend on PHA Direct budgets to to ensure the PHA meets its breakeven obligations for the year.

DoH has required PHA to meet the cost of the first 1% of the pay award in each of the last 2 years (2019-20 and 2020-21). The impact of this is currently being masked by high levels of vacancies.

Public Health Agency
2020-21 Capital Position

	Full Year		
	Programme		
	Trust	PHA Direct	Total
	£'000	£'000	£'000
Available Resources			
Capital Grant - R&D	8,412	4,251	**12,663**
Other Capital funding	-	1,056	**1,056**
Capital Grant Allocation	**8,412**	**5,307**	**13,719**
Expenditure			
Capital Grant - R&D	8,412	4,244	**12,656**
Other Capital funding	-	815	**815**
Capital Expenditure	**8,412**	**5,059**	**13,471**
Surplus/(Deficit) - Capital	-	**248**	**248**

PHA has received a Capital budget of £13.7m in 2020-21, most of which relates to Research & Development projects in Trusts and other organisations. Expenditure of £12.7m on R&D projects is shown for the year, with an immaterial underspend of £7k on these projects.

Other Capital funding primarily consists of the Digital Test, Trace, Protect (DTTP) project (£830k) and other COVID capital funding (£119k). Slippage of £241k is reported on the DTTP project due to lower than anticipated costs, predominantly for software licences. The deliverables of the project were achieved - the lower costs have not impacted on the required outputs of the project.

PHA Prompt Payment

Prompt Payment Statistics

	March 2021 Value	March 2021 Volume	Cumulative position as at March 2021 Value	Cumulative position as at March 2021 Volume
Total bills paid (relating to Prompt Payment target)	£5,828,626	792	£59,102,572	5,764
Total bills paid on time (within 30 days or under other agreed terms)	£5,768,027	763	£58,173,062	5,433
Percentage of bills paid on time	**99.0%**	**96.3%**	**98.4%**	**94.3%**

Prompt Payment performance for March and the year to date shows that on value the PHA is achieving its 30 day target of 95.0%. Cumulatively to date PHA are not achieving the 95% target on volume and further efforts will require to be made in order to achieve the 95% target in future.

The 10 day prompt payment performance remained strong at 83.9% on volume for the year to date, which significantly exceeds the 10 day DoH target for 2020-21 of 70%.

PHA Covid-funded Expenditure

March 2021

	Full Year Budget £'000	Full Year Expenditure £'000	Variance £'000
Contact Tracing Centre	3,627	3,626	2
Enhanced Health Protection team	1,676	1,725	(49)
Additional Flu Vaccinations	2,750	2,750	-
PPE for the Community & Voluntary Sector	228	200	28
Infection Prevention & Control Nursing	519	505	14
Vaccination Project (PHA element)	184	164	20
Regional Health Resource Model - PPE	120	120	-
Staff Recognition Payment	325	325	-
Additional Medical Payments	265	265	-
Additional Annual Leave carry forward	495	535	(40)
Total	**10,189**	**10,215**	**(26)**

HSC Public Health Agency

minutes

Title of Meeting	Meeting of the Public Health Agency Governance and Audit Committee
Date	8 March 2021 at 2.00pm
Venue	Via Zoom

Present

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

In Attendance

Miss Rosemary Taylor	-	Assistant Director, Planning and Operational Services
Mr Stephen Wilson	-	Interim Director of Operations
Ms Jane Davidson	-	Head Accountant, HSCB
Ms Andrea Henderson	-	Assistant Director of Finance, HSCB
Mrs Catherine McKeown	-	Internal Audit, BSO
Mr Roger McCance	-	NIAO
Ms Christine Hagan	-	ASM
Mr Robert Graham	-	Secretariat

Apologies

Ms Tracey McCaig	-	Interim Director of Finance, HSCB

		Action
1/21	**Item 1 – Welcome and Apologies**	
1/21.1	Mr Stewart welcomed everyone to the meeting. Apologies were noted from Ms Tracey McCaig.	
2/21	**Item 2 - Declaration of Interests**	
2/21.1	Mr Stewart asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.	
3/21	**Item 3 – Minutes of previous meeting held on 3 December 2020**	
3/21.1	The minutes of the previous meeting, held on 3 December 2020 were **approved** as an accurate record of that meeting.	

4/21	**Item 4 – Matters Arising**
	54/20.1 Procurement Sub-Committee
4/21.1	Mr Stewart noted that the PHA Chair had attended the most recent of the PHA Procurement Board so he was content that matters are now in hand.
	54/20.7 Senior Recruitment
4/21.2	Mr Stewart noted that the recruitment exercise for the Chief Executive post is currently open and that interviews are taking place later this week for the Director of Public Health post.
	54/20.9 Training
4/21.3	Mr Stewart reported that he and Mr Clayton would be attending training organised later this week.
	54/20.14 Audit of Contact Tracing
4/21.3	Mr Stewart advised that following the last meeting he spoke to Internal Audit and the Interim Chief Executive about this audit, but noted that the terms of reference were then signed off without having been brought to the Committee. He said that he discussed this with Internal Audit and that in future the Committee will be consulted on terms of reference for audits that it requests.
	60/20.1 Future of Finance Function
4/21.4	Mr Stewart said that he understood that a number of options have been considered for how PHA's finance function will be managed in future, and that a long list of options has been reduced to 2, including an in-house option. Miss Taylor agreed that the two options are to maintain the current arrangements, or to bring the function in-house, but she advised that the paper prepared for the Department is a scoping paper and that the Department has advised that there will be further engagement and consultation before a final decision is made. Ms Henderson confirmed that this work remains ongoing and there is an assurance that there will be further consultation. Mr Stewart commented that it is appropriate that the PHA Board has a view on this.
5/21	**Item 5 – Chair's Business**
5/21.1	Mr Stewart advised that since the last meeting he has been involved in a number of meetings, one about the finance

	function and another around the audit of contact tracing. He said that he has received an assurance about the scope of that audit and that it will be completed within a reasonable period of time.
5/21.2	Mr Stewart noted that a new risk has been added to the PHA Corporate Risk Register about peer vaccinators and that this matter was raised at the last Board meeting. He said that he has asked Internal Audit to look into this matter and advise of any action that is required. He added that the audit will commence in April and that he will discuss the terms of reference with Internal Audit.
6/21	**Item 6 – Corporate Governance** *Corporate Risk Register as at 31 December 2020 [GAC/01/02/21]*
6/21.1	Miss Taylor presented the latest Corporate Risk Register following its most recent review as at 31 December 2020. She advised that the Public Health Directorate Risk Register will be brought to the Committee in April.
6/21.2	Miss Taylor reported that all of the risks on the Register have been updated and reviewed and that three new risks have been added, one relating to the impact of the closure of HSCB on PHA, one relating to IT systems supporting screening programmes which has been separated from another risk relating to screening, and one relating to the regional bank for COVID-19 vaccinators. She added that one risk has been removed, that relating to the contract tracing centre. She explained that as the centre is now operational that risk has been de-escalated to the appropriate directorate risk register.
6/21.3	Miss Taylor advised that for the new risk relating to peer vaccinators, PHA has now received correspondence from the Department of Health directing PHA to carry out this work. She added that a governance framework is being finalised and should be completed by next week. She explained that at this point peer vaccinators working for Trusts have now been transferred to the relevant Trust so any staff remaining on the bank are those working in GP practices. Mr Stewart said that while he welcomed the receipt of the letter from the Department he had concerns about the authority to issue it and that this would need to be investigated. He said that he would seek assurance that the necessary statutory authority is in place. Miss Taylor advised that there have been discussions with the Directorate of Legal Services in this matter.

6/21.4	Ms Mann-Kler raised a query on risk 26 regarding procurement. She noted that this has been on the Register since September 2012 and she asked whether there was an action plan that could be implemented to mitigate this risk. Miss Taylor explained that although there is a Procurement Plan, it is taking much longer than anticipated to work through due to a variety of factors outside PHA's control. She advised a delay in the publication of the Protect Life 2 Strategy has been a factor, and the Department will also be launching a Drugs and Alcohol Strategy. She said that there will always be a Procurement Plan, with a rolling programme of procurements and re-procurements. She added that this is reviewed by the Procurement Board, and that the PHA Chair is now a member. She added that she is meeting with Internal Audit to discuss this area given the audit recommendation is sitting as "partially implemented". Mr Stewart asked about the recruitment of additional staff, but Miss Taylor advised that these new staff have been redeployed to support the COVID-19 response in-year.
6/21.5	Mr Stewart said that for risk 39 relating to cyber security, there are many factors that are managed externally but PHA can work to ensure that staff complete the required mandatory training, and comply with associated policies and procedures.
6/21.6	Ms Mann-Kler sought clarity as to whether risk 46 relating to emergency planning has been mitigated in terms of PHA's response to COVID-19. Miss Taylor explained that the main issue in this risk concerns pay because staff who are banded at 8a and above under Agenda for Change are not entitled to overtime. She added that as concerns were raised about this during COVID-19 the Department put in a temporary arrangement until 31 March 2021 for staff to receive overtime payments, therefore the risk remains in place if there were to be another emergency planning situation. Ms Mann-Kler asked if this issue has been picked up by Trade Unions. Miss Taylor said that she was aware that there has been engagement with HR, but she wasn't sure if there has been discussion with Trade Unions. Mr Stewart commented that this issue relates to not only PHA, but across the whole HSC and it demonstrates that when these types of situation arise there is a reliance on the good will of staff, but this can only last for so long. Mr Clayton agreed that there is a need for a regional solution.
6/21.7	Mr Stewart asked for an update on risk 47 concerning the staff Intranet as he noted that the update on content being migrated has now been struck out. Mr Wilson explained that although the content of the previous Intranet is now

	uploaded onto the new platform and should have been operational last week, he was not content with it and has asked for some amendments and presentational adjustments to be made.
6/21.8	Mr Stewart moved onto risk 48 which is about the PHA website and asked about the reasons for the delay in the procurement. Mr Wilson expressed frustration that this work has to be approved through regional Digital HSC and PHA has not yet any success in progressing this despite the matter being escalated within the Department. Ms Mann-Kler asked if there was anything the Committee could do to add weight to PHA's request. Mr Wilson said while he is concerned with the state of the current PHA website, any development work will be competing with other COVID-19 priorities so there is nothing more than can be done at this time. He said that he anticipated a response from the Department by next week. Mr Clayton queried whether there was any work that PHA could do itself using slippage this year given we are near the end of the financial year, but Mr Wilson advised that all of the foundation work has been done and the work that needs to be undertaken requires capital investment. Ms Mann-Kler asked whether, when escalating the matter, it was pointed out that this is on PHA's Corporate Risk Register. Mr Wilson said that this had been pointed out. Ms Mann-Kler said that PHA should continue to follow this up as it is important that the organisation has a fully functioning website especially at this time.
6/21.9	Mr Stewart noted that for risk 49 related to COVID-19 expenditure, the Committee would continue to seek assurances that expenditure is being spent appropriately with the necessary authorisations in place. Mr Clayton said that this links with the risk that was previously on the Register relating to contact tracing, and he asked whether there was an assurance that the costs for contact tracing would be met. Miss Taylor informed members that PHA has received confirmation that the business case for contact tracing has been approved, although an allocation letter has not yet been received. Ms Henderson added that her team has been working with Miss Taylor and Mr Stephen Murray in respect of all of the COVID-19 workstreams. She said that although a formal allocation has not yet been received, this is to PHA's advantage because once the costs are finalised, there is an assurance that these will be met in full by the Department. She added that there has been ongoing engagement with the Department in this regard.
6/21.10	Mr Stewart said that he had no issues to raise with regard to

	risk 50 (COVID-19 procurement) or risk 52 (information governance). In relation to risk 53 on corporate priorities he noted that there have been PHA workshops so he had nothing further to add. For risk 54 (ability of third party providers to deliver commissioned services), he said that members were aware of this issues around this risk relating to COVID-19.
6/21.11	Moving onto risk 55 on staffing issues, Mr Stewart noted that this continues to be a concern. He added that the recent Hussey Review highlighted the need for additional posts within the health protection function, but there may not be funding available for these posts. Mr Clayton felt that this risk had a specific focus on the public health directorate, but there were other parts of PHA, e.g. HSCQI, where there are staffing issues. Mr Stewart pointed out that risk 56 relates to staffing in the HSCQI directorate, but he agreed with Mr Clayton's point that this needs to be viewed across the organisation as a whole so perhaps there should be one risk relating to staffing, that references issues across all Directorates. Mr Clayton agreed saying that this would help to move away from a silo mentality. Mr Stewart suggested that he and Miss Taylor could discuss this with the Interim Chief Executive. Miss Taylor advised that the next formal review of the Register is due to take place at the end of March so this discussion can be factored in to that review.
6/21.12	Mr Stewart noted that the text in risk 57 on PHA leadership needed to be updated given recent developments in the recruitment of 2 senior posts.
6/21.13	Ms Mann-Kler raised a query with regard to risk 58 on staff resilience. She noted that an indicator of staff resilience is absence levels and she asked if there was any assessment of this in terms of PHA staff, and if there are adequate support mechanisms in place given that PHA is providing advice to the people of Northern Ireland. Miss Taylor advised that there are resources for staff and that as part of the first wave a specific cell was established on staff health and wellbeing. She added that working through BSO HR, there is a contract in place with Inspire should staff require counselling or support. She said that she was not aware of any specific issues relating to PHA staff but assurance could be sought from HR in this regard.
6/21.14	Miss Taylor advised that risk 59 relating to screening has been split so that there is a separate risk in relation to the IT systems supporting screening while this risk relates to the quality assurance and commissioning aspects. Mr Stewart said that the Board has been concerned about the cessation

	of screening programmes, but when these programmes are fully up and running, he wanted to be assured that there would be confidence in the IT systems supporting them. Miss Taylor said that the system supporting the breast screening programme is a national system so the issue is that the system used in Northern Ireland needs to be replaced and upgraded so that it can link in with the national one. However, she noted that replacing the system will take time, but that work has commenced to plan and prepare for this. Mr Stewart expressed his concern about this, particularly given the delay in upgrading the PHA website. He said that the PHA Board may need to take action to get this matter resolved. Miss Taylor said that these systems may already be funded and she was not aware of any issues in this regard. Mr Stewart said that the Board would need to receive a report from Dr Stephen Bergin on this outlining the key issues, what is being done to resolve them and what the timelines are for doing so. Ms Mann-Kler said that she would support this approach as there needs to be a clear audit trail. She expressed concern that this issue affects mainly the breast and cervical screening programmes. She said that it is good news that the screening programmes are up and running, but the Board needs to have confidence in the end-to-end process. It was **AGREED** that Miss Taylor would ask Dr Bergin for an update on this for the PHA Board.	Miss Taylor
6/21.15	Mr Stewart moved on to the 3 new risks. He said that he had nothing to add in relation to risk 60 on the impact of the closure of HSCB on PHA but felt that it was important this be added to the Register. He noted that risk 61 on the IT systems for screening programmes had been covered as part of an earlier discussion, and similarly risk 62 on the regional bank for COVID-19 vaccinators has also been covered earlier in the meeting. Mr Clayton asked if members could see the correspondence received by PHA from the Department. Mr Stewart advised that this had already been shared with members and he reiterated his concerns about the authority with which the correspondence was issued. *Review of Standing Orders, Standing Financial Instructions and Scheme of Delegated Authority [GAC/02/02/21]*	
6/21.16	Mr Stewart said that he was content for the Committee to approve the review of Standing Orders, Standing Financial Instructions and Scheme of Delegated Authority, but he sought clarity as to why the change was made to the Standing Financial Instructions with the removal of the narrative around reviewing schedules of debtors/creditors	

	balances over 6 months old and £5,000. Ms Henderson explained that this was largely an operational issue and its removal is to reflect current practice.
6/21.17	Members **APPROVED** the review of Standing Orders, Standing Financial Instructions and Scheme of Delegated Authority, which will be brought to the PHA Board on 18 March.
7/21	**Item 7 – Internal Audit**
	Internal Audit Progress Report [GAC/03/02/21]
7/21.1	Mrs McKeown began her update by seeking Committee approval to cancel an audit assignment. She explained that there were two assignments to be carried out in regard to community and voluntary sector organisations, and that while the audit of the management of these contracts is ongoing, it has been identified that there is little benefit in carrying out an audit of validation of payments to these organisations. She suggested that the days allocated to that particular assignment could be utilised for the contact tracing audit which the Committee had requested. Members **APPROVED** this proposal.
7/21.2	Mrs McKeown gave an overview of the progress of all the audits during 2020/21 before moving onto the report of the Financial Review audit for which Internal Audit was giving a satisfactory level of assurance. She reported that there were no significant findings and a small number of key findings. She advised that one of these related to payments to staff where it had been noted that in 2 of 9 sampled instances positions had been filled without the necessary approvals. She also noted that 21% of sampled payments to staff were incorrect resulting in both overpayments and underpayments. However, she recognised that due to COVID-19 staff were being asked to complete and approve a timesheet that they were unfamiliar with which led to these errors. She also highlighted some instances of late processing of new starts and leavers. In terms of non-pay expenditure, she pointed out a slight dip in PHA's prompt payment performance and she also noted that the PHA has two company credit cards, but these are not with the provider stipulated by the Department and the limits need to be reviewed. She finished by saying that management have accepted all of the findings.
7/21.3	Mr Stewart said that the audit report was a fair account and indicative of an organisation under stress. Mr Clayton agreed that staff are under pressure but he sought

	assurance that the issue regarding the incorrect completion of timesheets has been rectified. Ms Henderson advised that, in conjunction with HR, the guidance on how to complete the timesheet has been re-issued to staff.	
7/21.4	Mrs McKeown advised that an audit of PHA Governance during COVID-19 had been completed and that a satisfactory level of assurance was being given. She said that the focus of the audit was on the first stage of the pandemic. She noted that the Board and Committees continued to meet and there were COVID-19 specific structures put in place. She said that a sample of actions from action logs had been selected and all were deemed to have been properly documented. She added that the audit had also looked at expenditure and that no issues were found. In terms of findings she said that there was a need to strengthen the audit trail, particularly in relation to expenditure and that although a learning report had been prepared and shared with AMT, it has not yet been brought to the PHA Board.	
7/21.5	Mr Stewart commented that although PHA is dealing with a set of exceptional circumstances the issue of audit trails is one that has been raised consistently and he sought further clarity on what the audit had found. Mrs McKeown said that during the audit she was content that the proper authorisation mechanisms were in place with regard to expenditure, but specific decisions could not be found within the action logs. She said that this needed to be strengthened.	
7/21.6	Ms Mann-Kler felt that this was a useful audit to undertake but she felt that the Report should have reflected that the Board held additional meetings 2 weeks after each Board meeting, because it was felt that a month was too long between meetings during this period. She advised that these briefings were minuted. She also expressed disappointment that the learning report had not yet been brought to the Board, and that this needed to be brought to the Board as a matter of urgency. Miss Taylor advised that the learning report was brought to AMT recently and will be brought to the Board shortly. Mr Stewart said that he will follow this up with the Secretariat.	Mr Stewart
7/21.7	Members noted the Internal Audit Progress Report.	

8/21	**Item 8 – External Audit – PHA Audit Strategy 2020-21 [GAC/04/02/21]**
8/21.1	Mr McCance invited Ms Hagan to present the Audit Strategy document as ASM will be carrying out the audit as it is sub-contracted to do so by NIAO.
8/21.2	Ms Hagan explained that the Strategy sets out how the audit will be conducted. She explained how materiality has been set and how significant risks have been determined. She advised that the audit team will remain the same as in previous years. She highlighted the areas that the Committee should consider.
8/21.3	Ms Hagan said that materiality has been set at £1.7m and therefore any misstatements about £85k will be brought to the attention of the Committee. She noted that not been many instances of misstatements over the last few years. She highlighted the areas where misstatements will be treated as material, irrespective of their value.
8/21.4	In terms of the audit approach Ms Hagan outlined that it will be a risk-based audit. She reiterated that both NIAO and ASM are independent organisations and assured members that any personal data they handle will be done so in accordance with the required data protection legislation. She added that ASM will liaise closely with Internal Audit when completing its work. She noted that there has been a change to the Financial Reporting guidance which will impact on the audit.
8/21.5	Ms Hagan highlighted two significant presumed risks, one relating to management override of controls and one relating to the risk of fraud. In terms of other risk factors she said that the auditors will look at PHA's requirement to break even, the financial impact of COVID-19 and PHA's governance structure, noting the number of changes at senior level.
8/21.6	Ms Hagan outlined the timetable for the completion of the audit. She said that the fee for the audit will be £22k and she outlined the membership of the team carrying out the audit. Finally, she referred to the appendices which she said may be of interest to members.
8/21.7	Mr Stewart said that he was content with the areas picked up in the section on "other risk factors". In terms of the governance structure, he said that he would welcome the opportunity to discuss this with the auditors and that this should be arranged at the appropriate time through the

	Secretariat.
8/21.8	Members noted the PHA Audit Strategy for 2020/21.
9/21	**Item 9 – Finance**
	Timetable for the Annual Accounts and Report Process 2020/21 [GAC/05/02/21]
9/21.1	Ms Henderson advised that the Circular has now been received relating to the timetable for the preparation of the Annual Report and Accounts. She said that the draft accounts have to be presented to NIAO by 7 May and that the auditors are already in beginning their work. She noted that the Department has not asked to have sight of the draft Governance Statement prior to 7 May but the draft would be shared with the Committee prior to submission.
9/21.2	Ms Henderson said that the draft NIAO Report will be sent to the Committee around 9 June. Miss Taylor advised members that the Committee is now due to meet on 15 April to consider the draft Report in advance of the April Board meeting and that a date for a June meeting will be circulated to members shortly now that the Circular has been received. Ms Mann-Kler sought clarity on the quorum for the Committee. Mr Stewart advised that the quorum can be 2 members in exceptional circumstances, and approved by the GAC Chair.
	Fraud Liaison Officer Update Report [GAC/06/02/21]
9/21.3	Ms Henderson reported that there were no new cases of fraud since the last report. She referred members back to a previous case where an allegation of fraud was investigated concerning a provider with which PHA has a contract. She noted that while there was no fraud with regard to PHA funding, she advised that the Health Improvement team has taken the opportunity to draw up MOUs and to review its contract monitoring arrangements.
9/21.4	Ms Henderson updated members on the National Fraud Initiative. She said that 130 higher risk matches have been identified for review and that members will be kept informed.
9/21.5	Ms Henderson informed members that with regard to fraud awareness, there has been an increase in suspected fraud due to COVID-19 and she highlighted a scam e-mail relating to the COVID-19 vaccine.
9/21.6	Members noted the Fraud Liaison Officer Update Report.

	NIAO publication - Procurement Fraud [GAC/07/02/21]	
9/21.7	Mr Stewart said that he found the NIAO publication interesting and he queried whether PHA intended to use the self-assessment checklist contained within it. Miss Taylor agreed to look at this with Ms Henderson. Mr Stewart felt it would be useful from a governance perspective. Ms Henderson suggested that it could be picked up at the next meeting of the Procurement Board. Mr Stewart asked that it be placed on the next agenda of that meeting.	Miss Taylor / Ms Henderson
10/21	**Item 10 – Information Governance Update**	
10/21.1	Mr Stewart noted that there had been a meeting of the Information Governance Steering Group (IGSG) since the last meeting and he invited Miss Taylor to give an update on that meeting.	
10/21.2	Miss Taylor confirmed that a meeting of the IGSG did take place and that it was agreed that the updated Information Governance Action Plan would be brought to the Governance and Audit Committee meeting in April.	
10/21.3	Miss Taylor informed members that PHA has received a significantly increased number of FOI requests in 2020 (117) compared to the previous year (34). She noted that this has placed quite a strain on the Information Governance team, as well as staff across the organisation who are the relevant information holders. She said that the requests have ranged from simple queries to complex issues.	
10/21.4	Miss Taylor advised that there has been an increase in the amount of personal data that is held by PHA, therefore PHA is taking its Data Protection responsibilities very seriously. She advised that PHA had to develop a Data Protection Impact Assessment (DPIA) for contact tracing as well as Data Sharing Agreements with counterparts across the United Kingdom and the Republic of Ireland. She added that the team has also had to deal with issues pertaining to EU Exit.	
10/21.5	Mr Stewart thanked Miss Taylor for her update and acknowledged the amount of time that is required to deal with all of this work. Mr Clayton agreed that there is a huge volume of work being placed on staff. However, he advised that as part of the Information Governance Action Plan for 2020/21 there will be an increased focus on information governance awareness training as there has been a decrease in the number of staff who have undertaken this	

	training during the past year. He noted that there is a difficulty in terms of keeping track of which staff have completed the training. He added that there is now a regional template for the completion of DPIAs which he said is a positive piece of work. Miss Taylor agreed that this template will help but added that the learning from this year will also help PHA as it has increased awareness in this area.
11/21	**Item 11 – Any Other Business**
11/21.1	The Chair thanked everyone for their attendance at today's meeting and their continued support to the work of the Committee.
12/21	**Item 12 – Details of Next Meeting**
	Thursday 15 April 2021 at 10:00am
	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast.
	Signed by Chair:
	Joseph Stewart
	Date: 15 April 2021

HSC Public Health Agency

item 10

Title of Meeting	PHA Board Meeting
Date	20 May 2021
Title of paper	PHA Rural Needs Act Annual Report 2020/21
Reference	PHA/03/05/21
Prepared by	Lynda Kernohan
Lead Director	Stephen Wilson
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to seek approval of the PHA's Rural Needs Act Annual Report for 2020/21.

2 Background Information

The Rural Needs Act (Northern Ireland) 2016 came into operation for public authorities including the Public Health Agency (PHA) on 1 June 2018. The purpose of the Act is to ensure that public authorities have 'due regard' to the social and economic needs of people in rural areas and to provide a mechanism for ensuring greater transparency in relation to how public authorities consider rural needs when developing, adopting, implementing or revising policies, strategies and plans and when designing and delivering public services. The Act seeks to help deliver fairer and more equitable treatment for people in rural areas which will deliver better outcomes and make rural communities more sustainable.

The Rural Needs Act has been embedded into the PHA's processes; the completion of the Rural Needs Impact Assessments has focused minds on the importance of the needs of rural dwellers, so that these are considered from an early stage in any project. In particular, ensuring consultation with rural dwellers when planning services and consideration given to alternative service delivery methods where appropriate to meet their needs.

The Act sets out that Public Authorities must complete an annual report to be published in their own Annual Report and submitted to DAERA for inclusion in the Rural Needs Annual Monitoring Report.

3 Key Issues

During 2020/21, a total of five Rural Needs Assessments were carried out, details of which are contained in the Report.

4 Next Steps

Following approval by the Board, PHA will submit its Annual Monitoring Return to DAERA, in advance of the deadline of 30 June 2021.

The PHA will continue to ensure that the Rural Needs Act is taken into consideration as part of its work and a Report on progress in 2021/22 will be brought to the Board in June 2022.

Appendix 2 - Template for Information to be Compiled

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

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

Name of Public Authority: **Public Health Agency**

Reporting Period: April 20 **20** to March 20 **21**

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

Description of the activity undertaken by the public authority which is subject to section 1(1) of the Rural Needs Act (NI) 2016[1].	*The rural policy area(s) which the activity relates to[2].*	*Describe how the public authority has had due regard to rural needs when developing, adopting, implementing or revising the policy, strategy or plan or when designing or delivering the public service[3].*
Relationship and Sexuality Education (RSE) training in the community across Northern Ireland	• Cross Cutting	The focus of the Public Health Agency in addressing the needs of young people will be to work collaboratively with partners to provide the RSE in the Community Service. This Service will benefit young people in rural areas by reducing social isolation and increase their access to information and peer support around health issues. This Service will contribute to improving the health and wellbeing outcomes in rural areas and reduce health inequalities by enabling participation, empowerment and the growth of self-efficacy. Provider organisations will be required to deliver the RSE programmes with young people which are age appropriate, accessible and evidence based with the aim of ensuring that young people in rural areas are supported to access the programme. The evidence is clear that there is a need to continue to offer the RSE in the Community programmes to young people aged 12-19 in both rural and urban

		communities. The PHA will continue to monitor the geographical spread of service delivery by asking Providers to use an online mapping tool to ensure a balance between rural and urban areas. They will also monitor accessibility of sessions for all young people including those with a disability and how Providers work with local organisations to target young people. Providers will need to link with local community organisations and others working in related areas such as drugs and alcohol, mental health etc. In planning the Service, Providers will consider the timing of the Programme as provision in winter months and during inclement weather would be challenging in rural areas with limited public transport options, which may impact on the numbers of young people attending. Other seasonal considerations during the year will also be taken into account.
Addressing Inequalities in Cancer Screening Through Promoting Informed Choice	• Cross Cutting	A variety of social and economic needs have been identified through the evaluation of the service and contract monitoring which may impact the ability of rural inhabitants to avail of this service. Although the awareness sessions are free to attend, the cost of travelling to the sessions may be higher due to further distance to travel to community or women's centers where the session is generally hosted. The current contract holders will reimburse attendees if travel is a barrier however generally the sessions are delivered in local communities. All fourteen women's centers based in Northern Ireland are in cities or large towns, with the majority based in Belfast; however a range of community centers and other venues will be used to host sessions. Childcare may present a problem for session participants, although where possible, childcare is currently provided to allow participants with child care responsibilities to attend. Not all community groups who have taken part in the programme have a crèche/child-minding facility. Those who rely on public transport may be less likely to access the service if the programme is delivered at a time that has limited transport availability. The service providers will endeavour to offer sessions at a time most suitable to attendees, including morning, afternoon or evening sessions. It is also important to note that a target group of the service is people with physical disabilities and in rural areas they may experience greater difficulties in

		accessing appropriate transport services, although transport costs will be provided. In the evaluation of the current service, adverse weather was noted to have impacted on turn-out at sessions – this may have a greater impact on people in very rural communities where roads may be less accessible and driving conditions poor. The current contract stipulates that a minimum of 10 participants must attend in order to run an awareness session. In rural areas population density is lower; therefore this number may be less achievable and has been identified as a hindrance when recruiting community groups. This may also be an issue for groups with additional support needs, e.g. those with disabilities or from the traveller community, where turn out may well be low. The PHA has agreed not to stipulate a target number of attendees for individual sessions in the next iteration of the contract. The design and delivery of the new contract for the provision of a service to address inequalities in cancer screening through promoting informed choice has been influenced by the rural needs identified above and by those previously identified in the Ipsos MORI evaluation and Health Intelligence Report 2017. Some changes have already been implemented, and others will be stipulated in the service specification for the new contract.
Faecal Immunochemical Test (FIT) As Replacement Test for the Faecal Occult Blood (FOB) Test	• Health and Social Care Services	The UK National Screening Committee (UK NSC) recommended that quantitative faecal immunochemical testing (FIT) should be adopted by the Bowel Cancer Screening Programme as the primary screening test for bowel cancer. Evidence suggests screening using FIT will be a more effective way of detecting cancerous and pre-cancerous lesions in the bowel. The bowel cancer screening test is posted to eligible individuals for them to complete at home. The completed test is posted in a prepaid envelope once completed. All tests are processed in a single laboratory, based at Causeway Hospital. It is not considered, at this time, that the proposal to change the type of test being used in the NIBCSP would have any adverse impact on people living in rural areas and the further understanding of social and economic needs is not pertinent

		at this time. It is hoped that an in depth analysis of the NIBCSP data will be undertaken to provide more granular information to examine uptake in rural areas. This change in test is being undertaken at the same time as work to address inequalities in screening through promoting informed choice is proceeding. Results of the analysis will assist in targeting this work.
Whole Genome Sequencing (WGS) of SARS-CoV-2	• Health and Social Care Services	This service is to determine viral strains and pathogens to assist with public health advice, in particular for SARS-COV-19 and has no direct impact on individuals and is therefore not likely to impact on people in rural areas. Sequencing occurs on test samples to determine viral strains and pathogens and when it occurs is based on a prioritization protocol based on the virus presenting, cluster management, possible vaccine failure and travel history. Sequencing is not determined on the individual who has provided the sample or their place of dwelling. The only potential area for impact on people in rural areas is the availability of testing which is outside of the remit of this impact assessment. However it should be noted that for SARS-COV-19 testing, a range of measures have been put in place to ensure wide availability of testing for all people in Northern Ireland. As well as regional test sites and in-hospital testing, there are also mobile testing units deployed to areas of potential outbreak and a postal testing service.
NI Contact Tracing and Advisory Service	• Health and Social Care Services	There has been no specific rural needs identified. As the service is primarily a telephone/SMS based and available across all of NI this will ensure that all confirmed cases have equal access to the Service regardless of a person's locality. It is not anticipated that this Service will impact on the needs of rural dwellers any more than people from urban areas.

NOTES

1. This information should normally be contained in section 1B of the RNIA Template completed in respect of the activity.

2. This information should normally be contained in section 2D of the RNIA Template completed in respect of the activity.

3. The information contained in sections 3D, 4A & 5B of the RNIA Template should be considered when completing this section.

HSC Public Health Agency

item 11

Title of Meeting	PHA Board Meeting
Date	20 May 2021
Title of paper	Health Improvement COVID Rebuild and Recovery Plan 2021-26
Reference	PHA/04/05/21
Prepared by	Séamus Mullen
Lead Director	Stephen Bergin
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to provide Board members with an update on the Health Improvement Recovery Planning Process.

2 Background Information

Throughout the last year, the Health Improvement Division has sustained a HI Recovery Planning Group which has overseen repurposing of Health Improvement services to adjust for COVID-led demand and capacity surges and dips.

3 Key Issues

This Recovery Plan outlines a summary of the key metrics from services delivered through the period from May 2020 to end of March 2021. During the last year services had to be repurposed given the nature of social restrictions, and the information contained in the report provided the basis for assurance on service delivery via accountability meetings to the Chief Medical Officer and the Department of Health.

The Recovery Plan also charts a map for service recovery over a short, medium and long-term planning process. This has been informed by input from regional leads across 21 areas of work led by the Health Improvement Division. The individual recovery plans will form the basis for service planning to meet adjusted demand for services as society recovers from the COVID pandemic.

4 Next Steps

The Health Improvement team will ensure that short term priorities are reflected in the Service and Budget Agreements, contracts and plans for 2021/22 financial year.

Over the next 6 months progress against the Plan will be monitored. There will be cross divisional/directorate consideration of input to the thematic plans.

A meeting will take place of regional leads to review and streamline priority work areas within the Division and there will be a reallocation of regional lead roles across newly recruited manager's structure.

Health Improvement COVID Rebuild and Recovery Plan 2021-26

Contents

1.0 Context:

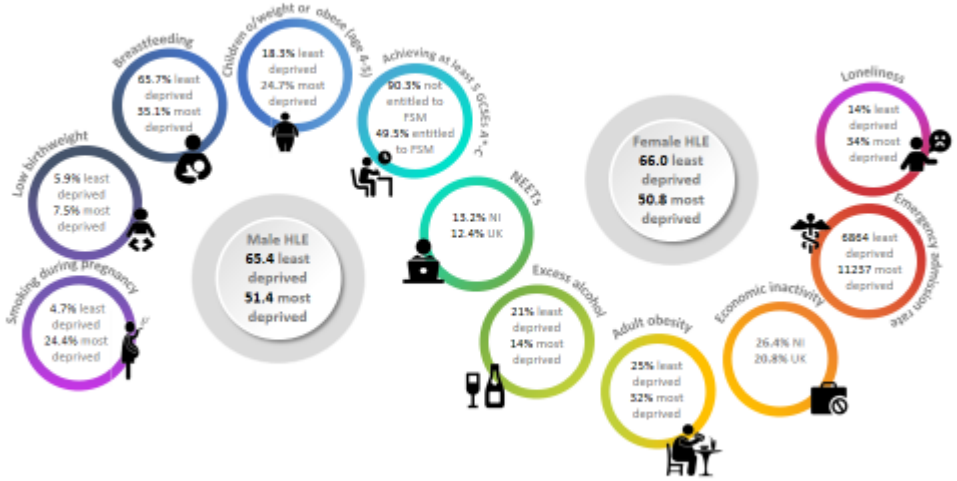
1.1 COVID-19 has posed unprecedented challenges for the Health and Social Care system, which already prior to COVID-19 was facing huge strategic challenges in the form of an ageing population, increasing demand, long and growing waiting lists, workforce pressures and the emergence of new and more expensive treatments as outlined within 'Health and Wellbeing 2026: Delivering Together'.

1.2 The impact of COVID-19 throughout communities in Northern Ireland will be profound and long lasting. Some services will not be able to resume as normal for some time due to the continued need for coherence to public health guidelines, including maintaining social distancing, reducing unnecessary travel and working from home where possible.

1.3 Whilst the restrictions imposed by The Health Protection (Coronavirus, Restrictions) (NI) Regulations 2020 ('the Regulations') were necessary, they have impacted on the wider economic and social environment, with both long and short term effects on population health. Emerging research indicates that population health is, on balance, likely to be negatively affected by the wider impacts of COVID-19. Furthermore, the greatest effects are likely to be felt by our most disadvantaged citizens.

1.4 While we all have an important role to play in stopping the spread of the virus, careful consideration needs to be given to the delivery of short, medium and long term support for people in the community, particularly the most vulnerable, many of whom as the graphic below illustrates are already subject to significant inequalities across pathways of health and wellbeing:

Factors impacting on Healthy Life Expectancy in Northern Ireland



Produced by PHA Health Intelligence Unit
Data: HLE 2016-18; maternity and child health 2018/19; education 2018/19; labour market Aug-Oct 2020; health survey 2019/20

2.0 Purpose:

2.1 This recovery plan outlines:

- Health improvement services that need to be adjusted and/or maintained in the short-term (ie next 12 months) throughout the forthcoming periods of surge, resilience, rebuild and recovery.
- An overview of the work completed throughout the period of April 2020 to March 2021 in response to the pandemic including adjustments to thematic plans and headline activities completed.
- A logic model type[1] plan on a page for each thematic area in the Health Improvement Division, outlining for each area of work:
    - Background context (including evidential need)
    - Vision
    - Inputs
    - Outputs
    - Outcomes (over three timescales: short, medium and long-term)
- Who we need to work with as a Health Improvement Division to achieve the vision, outputs and outcomes indicate for each area of health improvement. In line with the revised Corporate Plan, this will include a greater degree of agility in working across Divisions and Directorates within the Agency, much of which has been tested and consolidated throughout the past 12 months. It also include colleagues in other HSC organisations and stakeholders outside of HSC for example local councils, other government departments and the community, voluntary and private sectors.

2.2 The recovery plan adopts the principles outlines in the main steps required in surge planning[2]:

- Identify the need, including engagement with key stakeholders, service users and carers;
- Identify the resources to address the need in a timely manner;
- Move the resources at the appropriate time to locations to meet population need (as applicable);
- Manage and support the resources to their absolute maximum capacity.

2.3 The recovery plan makes the following assumptions:

- The plan must represent a living document. The vision and intended outcomes are based on current information and subject to change on the basis of emerging evidence on public and population health data. A greater degree of agile multi-disciplinary and cross directorate working will be sustained post COVID pandemic.
- The Health Iimprovement Division has for a long time recognised the fact that there are significant opportunities to strategically align thematic areas of work for greater impact across the lives that people live in our communities. Over the coming months the Division will reassess its thematic focus against the strategic plans and priorities against which we deliver on behalf of the Agency and DoH. This will inevitably lead to revision of the Recovery Plan and great alignment across areas of work both within the Agency and also with our partners.
- Further work will be required to integrate this plan across other directorates in PHA and collegiate organisations within HSC.
- Thematic leads will update the plan as required and ensure continued processes and structures are in place to harness the expertise and skills required across PHA and aforementioned partners to achieve outputs and outcomes.

[1] This is a logic model type schematic – it does not represent a full, comprehensive logic model for all thematic plans

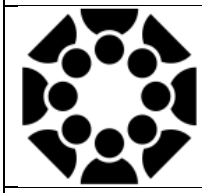
[2] COVID-19 Surge Planning Strategic Framework, DoH, 06 October 2020

3.0 COVID-19 so far:

3.1 The PHA's Health Improvement Recovery group has met on a regular basis since beginning of the pandemic and has provided monthly updates to PHA through AMT and DPH for DoH Accountability meetings.

3.2 The group set out an action plan for regional health improvement leads to identify areas of health improvement activity that needed to continue to mitigate against the worst impacts of COVID-19 in our most vulnerable communities. It also identified repurposed actions required to enable services to continue where emerging and sustained restrictions curtailed normal service delivery.

3.3 Some of the main areas of work and actions achieved are outlined in the table below:

	**Accident Prevention**	Approx. 1,300 Home Safety checks
	**Alcohol & Drugs**	No instances reported in Low Threshold Services where a client developed significant withdrawal symptoms due to self-isolating 332 Naloxone supplies made directly to service users
	**Community Development**	34 organisations received mentorship and support to deliver a localised health inequalities programme
	**Emotional wellbeing**	£976,242 invested in 334 grants awarded; 6 week Stress Awareness course with over 103,519 participants
	**Obesity, nutrition and physical activity**	Physical activity and/ or nutrition programmes eg PARS, Cook it! have been adapted in line with COVID-19 restrictions 45 families registered and taken part in 8 week Early Years Obesity Prevention Programme
	**Tobacco**	600 Stop Smoking Services delivering virtually

		16,000 visits to www. Stopsmokingni.info & 900 ‘Quit kits’ issued
	**Early years**	600 Families supported through Early Intervention Support Services 6 Odyssey parenting programmes delivered for 74 parents
	**Later years**	30,000 Keeping Well at Homes books distributed; 1,200 Move with Mary DVDs distributed & 11,000 YouTube views; media campaign reached 300,000 people.
	**Ethnic Minorities including Travellers**	Public health messages disseminated via 61 minority ethnic and migrant partners and 28 plus Traveller Forum members Browsealoud instructions translated into 22 languages
	**Homelessness**	Supported the procurement and distribution of an additional 446 Home Starter Packs and 1130 ‘Getting Started’ boxes
	**Poverty**	Through Fareshare, 129k tonnes of food delivered to 93 charities providing 307,143 meals; feeding 16,024 individuals
	**Farm Families**	298 phone calls and 58 onward referrals to support services; 6 health and wellbeing videos produced and promoted on Rural Support website
	**Cancer Services**	Online/ telephone based counselling services delivered, resulting in change from 91% to only 9% of clients reporting poor/ extremely poor stress/ anxiety/ fears levels.
	**Young people/ education**	23 families attended cool connections; 70 primary school children attended Boost, 50 kids attended 4 week summer camp

4.0: Recovery Plan Themes:

4.1 The recovery plan deals with the following thematic areas of responsibility. There are 21 overall areas of work that PHA's Health Improvement Division leads on. Some have specific regional strategies against which PHA implements actions on behalf of DoH. Other programme areas while directly impacting on the underlying determinants of health and social wellbeing, are the strategic responsibility of other Departments and Agencies and the PHA's role is more of an influencer in terms of ensuring public health is high on the agenda of the policy and implementation structures. The Division acknowledged in a previous review of services, that there is a need to streamline to number of areas of responsibility. This review is due to be picked up again and therefore the existing plan and the number of areas of responsibility covered by the Division are subject to review and approval from AMT.

4.2 For the sake of overall context, the table below outlines PHA's role in each of the areas of work. Further detail is then set out in the individual plans in the following section.

	Strategy lead?	**Influencer?**	**Funder?**	**Direct Intervention?**
Home Accident Prevention		√	√	
Ethnic Minorities		√	√	
Breastfeeding	√	√	√	
Strengthening Communities	√	√	√	
Drugs & Alcohol	√	√	√	√
Early Years		√	√	
Education		√	√	
LGBT		√	√	
Learning Disability		√		
Mental & Emotional Wellbeing & Suicide Prevention	√	√	√	√
Obesity/Physical Activity	√	√	√	
Older People		√	√	
Poverty		√		
Prisons		√	√	
Sexual Health	√	√	√	
Tobacco Control	√	√	√	√
Travellers		√	√	
Workplace Health	√	√	√	√
Homelessness		√	√	
Skin Cancer Prevention	√	√	√	

Traveller Health and Wellbeing - **Recovery Plan Model**

Background	Vision	Inputs	Outputs: Activities	Outputs: Participation	Outcomes: 12 months	Outcomes: 1-5 years	Outcomes: 5 years +
		What we invest	**What we do**	**Who we work with**	**What the short term results are**	**What the medium term results are**	**What the ultimate impact (s) is**
Estimated population of 3,905 Travellers living in 1,562 families Traveller men will live 15.1 year less and women 11.5 years less than the general population Suicide rates almost 7 times higher for Traveller men than general population (NI AITHS) MLB - emphasises the continued need to ensure a focus on vulnerable groups, inc Travellers Travellers are the most negatively viewed group in NI (Equality Commission)	To improve HWB, reduce health inequalities by focusing on the wider determinants of health (MLB)	Regional and local Partnerships Expertise, networking Staff on the ground volunteering opportunities Training & Development Capacity building Financial investment in projects Equipment & Technology mentoring	Commission direct service delivery, contributing to the improvement of Traveller health and wellbeing and addressing inequalities Raise awareness of Traveller health and wellbeing and health inequalities with internal, external partners Support awareness of Irish Travellers across PHA thematic areas, including: Home accident prevention, Drugs & Alcohol, Mental Health and Suicide Prevention, Ethnic Minorities & Migrants, Making Life Better Information sharing Influencing/ partnership working/ networking/ capacity building /sharing best practice respond to needs coming out of Covid and continued promotion / awareness of PH messaging inc vaccines Respond to consultations Identify and deliver training needs for those supporting Travellers (Support workers, HSC staff) i.e. Cultural Awareness, mental health promotion Delivery of training, health promotion with the Traveller community	Regional Traveller Health & Wellbeing Forum and task groups; *Give every child; Long healthy lives; Participation* Local Traveller Action Groups Traveller Support organisations HSC Trusts HSCB - LCGs Equality Commission Councils NIHE Education Authority Barnardos Toybox NISRA – (census) The Executive Office, Racial Equality Unit EM&M Leads	Improved understanding and adherence of Covid - 19 guidelines and recommendations for vaccinations and uptake Continued adaptation of commissioned services addressing identified needs Continued progress to move forward actions from the Regional Traveller Forum and Task groups Continued communication with The Executive Office to address actions from the Racial Equality Majority of Travellers in NI are registered with a GP and increased awareness of how to access and take up services Identification of key individuals to be provided with appropriate support to take on participatory and champion roles	A baseline of research and data i.e. Traveller Health Needs Assessment across NI completed Ethnic Monitoring is embedded within HSC Continued promotion and roll out of Traveller culture awareness training with staff in public services Continued roll out of capacity building, health promotion etc for the Traveller community Increased number of Travellers participating in community involvement, health related matters etc Improved cultural diversity awareness within workplaces Embedding of consultation and PPI practice Strengthened regional partnership working and identified priorities Travellers are well informed about services and are confident in accessing and engaging with HSC and other services increased health related behavioural awareness	Improved health and wellbeing and mental health outcomes increased health seeking behaviours Increase in number of Traveller children reaching developmental milestones Increased number of Travellers engaged in / participating in key roles i.e. health, accommodation, education etc improved Health Literacy Increased positive perception of the Traveller community. Celebrating the rich culture of this indigenous population within and across society reduction in inequality gap

Assumptions | **External factors**

Evaluation: focus and strategy → development of process and tools → collect data → analyse and interpret → report

Strengthening Communities to improve Health and Wellbeing - Recovery Plan Model

Background	Inputs	Outputs		Outcomes		
		Activities	Participation	12 months	1-5 years	5 years +
	What we invest	What we do	Who we work with	What the short term results are	What the medium term results are	What the ultimate impact (s) is
Strong resilient communities have the knowledge and skills to articulate, and address local needs. The PHA are leading the Implementation of the Expansion of the 'Community Development Approaches Framework' which aims to strengthen the capacity of communities through training and mentorship, sharing best practice, ,promote partnerships between the authorities and communities and commission services to improve health and wellbeing based on community need.	Staff Time Money Research base Materials Partners Expertise Training Mentorship Capacity building Co-ordination	Lead the development of the Community Development Framework. Build capacity: Resource and support a comprehensive multi-level capacity building training programme across sectors and volunteers as appropriate encompassing training and mentorship. Share information: Contribute, maintain and develop mechanisms to promote and share health information & best practice through facilitating signposting, networking & partnership opportunities within and between communities and Agencies. Influence: Influence, facilitate and support processes allowing communities and Agencies to work in partnership. Deliver services: Continue to commission evidence-based programmes in line with local and national priorities to improve health and wellbeing, and further develop this programme of work to incorporate area based equitable, evidenced based commissioning.	Government depts. including eg DFC (who have the Statutory remit for Community Development) & DEARA, C&V providers CD Framework Implementation Group Members (IIB) Councils Community planning Trusts ELEVATE project Team HSCB LCG CYPSP Partnerships Statutory sector eg ICP-Third Sector Forum & MDT C&V funders eg, National Lottery Academia PHA staff including CD leads , other PHA thematic leads & Health Intelligence	Communities/ C & V sector / volunteers/ stat sector are equipped with increased knowledge and skills in community development. Communities are well informed about available training, programmes and grant or resources. Communities are represented in local forums, council planning etc. A formal mechanism is established in which PHA are influencing and collaborating across other government departments. Communities have access to and participate in evidenced based services. Communities have improved understanding of and adherence to public health messaging	Individual communities are able to identify own needs/assets. Communities are connected and supported in implementing CD approaches through mentorship schemes. A practitioner's network is established regularly sharing good practice. Mechanisms are in place for communities/ C &V sector or networks to participate in, share best practice and influence local decision-making processes that affect health and wellbeing. Greater funding and strategic purpose alignment is evident between statutory funders. PHA are influencing policy decisions at a strategic level to promote the need to strengthen communities in order to tackle health inequalities Regional CD infrastructure is in place, allowing increasing numbers of community to access and participate in evidence based services. Health inequality data/community intelligence is used to effectively target and commission programmes in line with local needs.	Strong resilient communities have increased knowledge and skills to articulate, and address local needs. Heightened health equity and social capital of the population is evident through communities and statutory bodies working together to shape the health improvement agenda by responding to need and developing local initiatives through a co-design process. Health behaviour changes in areas of identified need eg nutrition, mental health, isolation, other . Reduced health inequalities in areas of programme delivery. Community development approaches are embedded across the new Integrated Care Systems and wider structures, to tackle health inequalities. Community development approaches are embedded in key departmental policies

Vision *To use our knowledge, resources and insights to lead, champion and inform strategic and operational responses to improve health and wellbeing through CD approaches*

Assumptions

External factors

Evaluation: focus and strategy → development of process and tools → collect data → analyse and interpret → report

Ethnic Minority & Migrants (EM & M) **Health and Wellbeing - Recovery Plan Model**

Background

Lack of data and ethnic monitoring resulting in a lack of accessible services.

Early EUSS registration estimates approx. 100,000 EM and M living in NI in 2021.

Lower life expectancy and high socio-economic deprivation.

Lack of health literacy and barriers accessing services.

Mental health prevalence, suicide and PTSD.

A lack of cultural awareness in communities and staff

Vision

To improve HWB, reduce health inequalities by focusing on the wider determinants of health (MLB)

Inputs

What we invest

Staff including bilingual workers

Time

Regional and local Partnerships

Expertise

Training & Development

Capacity building

Financial investment in services and projects

Resources

Outputs

Activities

What we do

Raise awareness of Ethnic Minority and Migrant health and wellbeing and health inequalities with internal and external partners

Commission direct service delivery, contributing to the improvement of EM and M service uptake, health and wellbeing and addressing inequalities

Support awareness of EM and M across PHA thematic areas, including: Early Years, Mental Health and Suicide Prevention, Poverty etc

Information sharing

Influencing and networking

Capacity building

Respond to the needs coming out of COVID and develop and disseminate information to promote/ awareness of PH messaging and vaccines to EM and M populations

Identify training needs
Community development approaches underpin practice

Participation

Who we work with

Ethnic Minority & Migrants Regional Advisory group

Local Government – Community Development and Community Planning Partnerships.

HSC Trusts

HSCB- LCG and CYPSP

Statutory partners e.g. HSENI, NISRA and Education Authority

PHA Health Protection Consultants, Communications, Health Intelligence

PHA thematic leads in Mental Health, Workplace, Travellers, Homelessness and Poverty

Outcomes

12 months

What the short term results are

*Integrating EM & M work across HI Themes and within PHA.
*Consultation/Engagement/ Co-production with EM & M communities.
*Initiation of COVID and IMT response plans.
*Improved understanding and adherence to COVID guidance and available support e.g. food parcels.
*Increased uptake of vaccinations amongst EM and M communities.
*Improved access to and uptake of services through 1+1 and Roma Community Workers
*Mental health training of EM & M C & V staff.
*Increased awareness of health risks of particular relevance to ethnic minorities (e.g. diabetes) with communities and individuals supported and empowered to address these risks
*Specific ethnic communities supported through advocacy work
*Celebration of diversity through specific events (e.g. Chinese New Year; Mela)

1-5 years

What the medium term results are

Ethnic Monitoring embedded within HSC.

Extended EM & M services across NI and increased targeting of ethnic groups.

Additional investment in EM & M work.

Building capacity of stakeholders to address mental health needs.

EM and M communities well informed about available services and how to access HSC and other services.

Increased GP registration e.g. NINES

Improved cultural diversity awareness within workplaces.

Strengthened regional partnerships.

5 years +

What the ultimate impact (s) is

Increased awareness of EM & M populations/ and decrease in racism/discrimination.

Strong resilient communities who have increased knowledge and skills

Improved Health Literacy.

Communities and statutory bodies working together to co-design and develop local initiatives.

Reduced inequalities and improved health outcomes

Improved mental health and increased health support seeking behaviours.

Assumptions

External factors

Evaluation: focus and strategy → development of process and tools → collect data → analyse and interpret → report

Mental and Emotional Wellbeing and Suicide Prevention **Recovery Plan Model**

Inputs → **Outputs** (**Activities** | **Participati**) → **Outcomes** (**12 months** | **1-5 years** | **5 years +**)

Background

There is a need to review existing commissioned services in line with new Government Strategies/Policies and ensure continued quality and improvement. E.g. Protect Life 2, Mental Health Strategy, NSD, PfG etc

Initial anecdotal evidence and some early rapid reviews are reporting people feeling increased levels of anxiety, stress and depression as a result on COVID.

Commissioned services such as SHIP are showing increase of younger people self-harming.

Vision

People experience improved mental and emotional wellbeing and have access to support when needed.

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What we invest

Staff time

Volunteers

Local organisations/ services

Money

Research

Evidence/Expertise

Training

Capacity building

What we do

Facilitate the implementation of Protect Life 2 NI Suicide Prevention Strategy regionally and within 5 HSCT areas

Promote awareness of suicide prevention through training, literature, social media, and publicity campaigns.

Commission and Promote training/ programmes that:

- *build resilience and support strategies to deal with anxiety, Stress and Depression*
- *Promote healthy behaviours and self help*
- *Increase knowledge/Skills to support others*

Raise awareness of how to access evidenced based training in MEWB &SP

Develop the leadership and support required for an effective Suicide Prevention and Mental & Emotional Wellbeing Work-force.

Work across Departments to promote positive mental & emotional wellbeing and suicide prevention

Who we work with

SP / MH Local Leads,

Regional Steering group

Protect Life Implementation Groups/ Communities of interest

PHA Colleagues:

- Nursing/AHP
- Comms.
- Health Intelligence,
- Operations

PPI
HSCT's
HSCB

Families Voices Forum ,

C&V providers,

Elected Representatives.

Academics

Thematic leads across the life course and section 75 groups

Recovery Colleges

ICPs/ MDTs

Community Planning

Other Government Departments in additional to DoH e.g. DfC, DAERA etc

What the short term results are

Establishment of new internal PHA Strategic Team for Mental and Emotional Wellbeing and Suicide Prevention with Life span approach.

Influence the new DOH MH Strategy including service reviews/redesigns

Progress alignment of work between Mental and Emotional Wellbeing, Suicide Prevention and Drugs and Alcohol

Increased knowledge awareness of and accessibility to services.

Agreed models for future suicide prevention and post-vention services.

What the medium term results are

Regionally consistent accessible information, training and support services for improved mental and emotional wellbeing and suicide prevention

Regionally consistent and compassionate suicide post vention services

Supported families and carers caring for those with suicide ideation to help them manage suicidal behaviour and emotional distress.

Suicide prevention embedded within drug and alcohol policy and services.

Networks for people bereaved by suicide facilitated and supported to influence policy and service delivery.

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What the ultimate impact (s) is

Suicide rates reduced by 10% as per Protect Life 2 aim

Appropriate suicide prevention services and support delivered appropriately in areas of need.

Appropriate suicide post-vention services and support delivered appropriately in areas of need.

Improved mental health and emotional wellbeing interventions.

Assumptions

External factors

Formative Evaluation: focus and strategy → development of process and tools → collect data → analyse and interpret → report

Later years Recovery Plan Model

[Sarah Reid, Health Improvement, 22 March 2021]

Background

More than 70% of people aged 65+ are **not** getting enough physical activity to benefit their health. (2013/14)

23% of people aged 55+ had a fall within the last 2 years. (2018/19) Approx 20% of falls require medical attention.

Older people are 'more often lonely' than younger people, especially those aged 55-64 (36%) and 75+ (37%). (2020/21)

Approx 15% of people aged 65+ have a high GHQ12 score which could indicate a mental health problem. (2019/20)

Vision:

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

Inputs

What we invest

- Staff
- Volunteers
- Time
- Money
- Research base
- Resources
- Equipment
- Partners
- Expertise
- Training
- Capacity building

Outputs

Activities

What we do

Support implementation of the Active Ageing Strategy (2016-2022) and inform development of a new strategy from 2022 onwards

Support implementation of the DoH Older People Services Framework

Promote & implement the following best practice:
- WHO Age-Friendly model
- NICE Mental wellbeing & independence for older people (QS137)
- NICE Falls in Older People (QS86)

Develop the support required for an effective workforce to identify and reduce loneliness and support mental wellbeing

Provide tailored support to enable older people to enjoy better health and active lifestyles through CV & statutory stakeholders

Support infrastructure to allow intergenerational practice to thrive

Promote and support the NI Age Friendly Network

Work with HSC family to develop a strategic framework for participation and engagement in the arts to enhance wellbeing for older people

Commission research with service users and providers

Participation

Who we work with

External:
- Active Ageing Strategy Implementation Group.
- 4-Nations Working Groups UK (Falls Prevention & Physical Activity)
- NI Frailty Network
- HSCT Managers (Falls, Carers, Health Imp, Community Mental Health)
- Compassionate Communities Network
- HSCB commissioners
- AGE NI
- Institute of Public Health
- C&V providers
- Local government
- Elected Representatives

Internal:
- Later Years and Age Friendly local leads
- Thematic leads in obesity, mental health, drugs & alcohol, community development, accident prevention
- AHP & nursing colleagues
- Communications team
- Health Intelligence team

Outcomes (program-level, system-level, population-level)

12 months

What the short term results are

Increased availability and accessibility to physical activity

Increased availability and accessibility to loneliness support services

Increased understanding of needs of frontline workforce to enable them to support lonely older people

Increased awareness of bereavement support services for older people

Mental health training needs identified for older people post-COVID.

Increased promotion and signposting amongst older people to volunteering opportunities

All local councils have signed a declaration to the WHO Age Friendly model

1-5 years

What the medium term results are

NI Strategy and local practice are better aligned to shared vision and outcomes

Older people are able to make healthier lifestyle choices

Older people are able to stay positive and cope with key challenges and transitions (retirement, bereavement, decline in health, financial pressures, becoming carers)

There is increased access to training for health professionals, volunteers, and CV sector to build capacity and develop the workforce to tackle physical inactivity, loneliness, mental health and wellbeing

Regionally consistent infrastructure in place to develop and maintain intergenerational practice

Stakeholders embrace co-production and continuous improvement

5 years +

What the ultimate impact (s) is

Older people are more physically active & less sedentary

Older people live independently for longer

Older people have better mental health and wellbeing

Older people are less lonely and more connected to family & friends

Older people are more resilient

There are improved positive attitudes towards older people

Co-production, Age Friendly and intergenerational practice are embedded within the culture and practice of how we do business.

Assumptions: Current level of Health Improvement funding remains consistent and stakeholder structures remain stable

External factors: changes in macro-economic conditions, demographics and strategic drivers

Evaluation: focus and strategy → development of process and tools → collect data → analyse and interpret → report

Prisons **Recovery Plan Model**

Inputs → **Outputs** (**Activities** | **Participation**) → **Outcomes** (**12 months** | **1-5 years** | **5 years +**)

Background

There are 3 Prisons in the Northern Ireland Prison Estate

Maghaberry, Magilligan and Hydebank Wood College.

Avg daily Prison Population in 2019/20 =1,516

Annual receptions into prison in 2019/20 =5,322.

The prison population is relatively small. However, those detained often exhibit a poor and complex health status on admission to prison.

Due to COVID 19 all non-essential personnel are not permitted on the prison estate effective March 2020.

VISION

To work collaboratively with other agencies & people in prison to improve the health and wellbeing of the prison community, embedding a whole prison approach to reduce health inequalities

What we invest

Staff

Time

Money – HSCB c.8.5m pa for delivery of healthcare in Prisons

Money- PHA HI (c.117kpa)

Research base

Resource

Expertise

Training

Capacity building

What we do

Promote a 'Whole Prisons' approach as reinforced by Health in prisons-A WHO guide to the essentials in prison health 2007 . Key areas to include mental health promotion and wellbeing; smoking cessation; healthy eating and nutrition; sexual health and relationships; active living; and drug and other substance misuse.

Support implementation of the current DOH/DOJ Improving Health Within Criminal Justice Strategy and Action Plan 2019 with regard to health promotion and ill health prevention.

PHA Health Improvement is represented on the multi-disciplinary **HSCB/PHA Improving Health in Criminal Justice Planning and Commissioning Group** which was refreshed in 2017. This group has 10 key deliverables - **Deliverable 2**.relates to health and social wellbeing improvement. A three year Health Improvement Action Plan for Prison Health 2018-2021 has been produced by SEHSCT Health Development Department in conjunction with Prison Healthcare.

NIPS led -Smoke Free Prisons NI initiative has been placed on 'pause' in 2020 due to COVID 19.

Who we work with

Improving Health in Criminal Justice Planning and Commissioning Team Membership DOH/ HSCB/PHA Commissioners.

DOH & HSCB Commissioning Leads - AD & Head of Service &Senior Commissioners Dentistry/Finance/ GP Medical Adviser/Social Care Mental Health & Learning Disability/ Optometry/Palliative Care.

PHA Leads- AD & Consultant & B7 – AHP/Health Improvement/Nursing/ Public Health

NIPS responsible for the operation and delivery of services within the Northern Ireland Prison system.

SEHSCT - responsible for the delivery of health care in the region's prisons

PHA Health Intelligence

PHA Operations

What the short term results are

PHA Health Improvement AD/Heads to consider current PHA HI commissioning arrangements in addition to senior level HI leadership and input into this work area. To note - focus of HSCB/PHA commissioning has expanded to Criminal Justice.

The Improving Health within Criminal Justice Planning and Commissioning Team is leading on a complex health needs assessment (HNA) in addition to a n updated staffing profile. The HNA will be phased - to include mental health (including emotional wellbeing) and addiction needs of the NI prison population.

PHA/SEHSCT will work to develop a 3 year HI Action Plan 2022 – 2025.

PHA HI will procure a Shared Reading Service in Criminal Justice Setting– new service to commence 1 April 2022.

Smoke Free Prisons initiative will be kept under review.

Continue to support the design and delivery of alternative HI interventions in prisons due to COVID 19

What the medium term results are

Resources and services better aligned to need

Improved multidisciplinary working

Service User more engaged in managing their own health and emotional wellbeing

Better ill health prevention

SEHSCT plans to explore the future role and remit of 'Health and Wellbeing Engagement Team/s' using the learning from COVID-19.

SEHSCT plans to explore the future role and remit of the Peer Mentor model.

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What the ultimate impact (s) is

HSCB/PHA supports the principle of equivalency - ensuring that people in prison get the same level of healthcare as those in the community

Improved health and wellbeing of people in custody

Improved health and wellbeing of people working in prisons

HI interventions designed and delivered in partnership; involving people in custody in both design and feedback.

Assumptions

External factors

Tobacco Control **Recovery Plan Model**

Background

Smoking prevalence (adults) in NI is 17%.

This prevalence raises to 27% for those living in the most deprived areas.

Prevalence in pregnant mothers is 13%.

6% of adults here use Electronic cigarettes (E-cigs)

6% of young people (age 11-16) user E-cigs and 4 %of those in this age range are smokers of tobacco cigarettes.

There are over 2300 deaths per year in NI due to Tobacco related illness.

Vision

A Tobacco Free Society in NI , achieved by partnership working across statutory and non-statutory organisations which keeps the service user at the centre.

Inputs

What we invest

- Staff
- Time
- Money
- Research base
- Materials
- Equipment
- Technology
- Partners
- Expertise
- Training
- Capacity building

Outputs

Activities

What we do

Lead on the implementation of the Tobacco Control Strategy 2012-2022 for Northern Ireland.

Commission stop smoking services across a variety of disciplines including GP, Pharmacy, Midwifery, and utilise a variety of settings such as Hospitals, Community settings and workplaces. PHA partner with statutory and non -statutory organisations to deliver the recommendations of the Tobacco Control Strategy.

Commission enforcement of Tobacco Control legislation via all 11 local councils in NI.

Commission specialist training to all stop smoking service providers.

Ensure governance of all services via adherence to PHA Quality Standards for stop smoking services regionally.

Benchmark services against best practice nationally. Utilising WHO MPOWER model and NICE guidance and quality standards. Ongoing monitoring of evidence base.

Commission primary school programmes re: dangers of smoking.

Raise awareness through media.

Provide Action Plan for Strategic Implementation Steering group.

Participation

Who we work with

Tobacco Strategy Implementation Steering Group (TSISG),

Department of Health

PHA Tobacco local leads

PHA Thematic Leads for Mental Health and Emotional Wellbeing, Early Years and Cancer Prevention ,

PHA Comms Team,

PHA Health Intelligence,

PHA midwife & nursing consultants,

HSCB and CPNI,

Tobacco Leads & HSCT Managers,

All councils across NI

Community and Voluntary partners, BHF, BLF, CFNI, HLCA, ASH NI

QUB and UU

Private sector businesses

Outcomes

12 months

What the short term results are

Reenergised stop smoking services that have recovered from the impact of the Covid-19 pandemic and utilised the learning from this period. E.g. online/ virtual service delivery options for example.

Increased awareness and uptake of stop smoking services regionally across all sectors.

Decline in smoking initiation and prevalence rate.

Review of accessibility of services in line with Section 75 statutory duties.

Expansion of the enforcement element of tobacco control to take account of new NI legislation in relation to smoking in cars with minors and age of sales of electronic cigarettes.

1-5 years

What the medium term results are

Delivery on the recommendations from new tobacco control strategy.

Regionally consistent infrastructure in place to ensure access to high quality services for all with particular attention being given to the needs of those from priority group such as children and young people, pregnant women and partners who smoke, those living in areas of higher deprivation and also service users with a diagnosis relating to mental health and emotional well- being who smoke.

Improvement in web based data capture to inform and evidence impact in relation to service reach and impact on NI prevalence rates.

5 years +

What the ultimate impact (s) is

Decreased smoking initiation and prevalence rates in NI.

Decreased inequalities between smoking prevalence rates in NI.

Assumptions

External factors

Evaluation: focus and strategy → development of process and tools → collect data → analyse and interpret → report

Home Accident Prevention **(HAP) Recovery Plan Model**

Background	Vision	Inputs	Outputs		Outcomes		
			Activities	Participation	12 months	1-5 years	5 years +
		What we invest	What we do	Who we work with	What the short term results are	What the medium term results are	What the ultimate impact (s) is
In NI in a typical week 2 people die as a result an accident in the home. Vulnerable groups are under 5s, over 65s and those with greater social, economic and health disadvantage. Home accidents result in significant pressures and costs in health and social care. Home accidents are preventable. COVID restrictions have resulted in more time being spent at home, with a potential implication of additional people working from home in future.	**The population of NI has the best chance of living safely in the home environment where there is negligible risk of unintentional injury.**	Staff Time Money Research base Materials Equipment Technology Partners Expertise Leadership Influence Capacity building	Facilitate and lead on the implementation of the HAP Strategy 2015-2025. Develop and promote social media and other publicity campaigns to increase awareness of risks and promote safe choices. Support and monitor the home safety check scheme (in partnership with local councils, Trusts and Sure Starts) to raise awareness through community engagement and to provide home safety equipment to those at risk. Promote awareness of product safety. Promote professional standards including accredited training and support for CPD. Identify baseline information for the collection of data by all partners and develop indicators. Work across partners to consider how to enhance the capacity of information systems from all relevant agencies to capture and provide key data. Raise awareness with relevant agencies on safe housing.	Home Accident Prevention Strategy Implementation Group (HAPSIG) PHA Nursing and AHP consultants PHA Comms Team HSCTs – health visitors, falls prevention teams, older people's teams NIAS DoH HSCB Local councils RoSPA NIFRS Sure Starts HSE NIHE Landlords	Facilitate the mid-term review of the HAP Strategy. Baseline of accidental injuries in the home developed further to the implementation of a pilot in EDs to collate the numbers of home accidents, the injuries incurred and the treatments required. Public and professional awareness is increased on a specific risk in the home (to be agreed) further to the development and promotion of a social media campaign. At least 6,000 vulnerable individuals / families will have the risk of accidents reduced due to receiving a home safety checks, including the provision of equipment to those at risk. Increased public knowledge through the ongoing promotion of awareness campaigns (blind cord safety, burns and scalds, button cell batteries, magnetic tongue piercings, choking in the under 5s and falls prevention in the over 65s).	Implementation of the findings of the mid-term review. Data collected through EDs is used to inform the actions of partners in targeting interventions. Increased awareness and links with services provided to vulnerable people, including BAME, addictions, mental health, learning disability and those living in poverty. Continued support for the home safety check scheme and community and professional awareness raising which will result in approximately 6,000 vulnerable individuals / families pa having a reduced risk of accidental injury in the home.	All partners can report on the numbers and impacts of home accidents. There are negligible numbers of home accidents and resulting injuries. There are decreased inequalities in those who are experiencing unintentional injuries in the home. Public and professional perception has changed to believe that accidents are preventable by identifying causes, removing risks and/or reducing exposure to same.

Assumptions

External factors

Evaluation: focus and strategy → development of process and tools → collect data → analyse and interpret → report

Education **Recovery Plan Model**

Inputs	Outputs		Outcomes		
	Activities	Participation	12 months	1-5 years	5 years +
Background	**What we invest**	**What we do**	**Who we work with**	**What the short term results are**	**What the medium term results are**	**What the ultimate impact (s) is**
Effective collaboration between health and education is crucial in terms of personal and social development, educational attainment and future life outcomes. Individuals who perform well at school and achieve qualifications are more likely to adopt healthy lifestyle behaviours, to find employment and less likely to engage in risk taking behaviours. Education is also a way of breaking the cycle of poverty and a route to social mobility. Impact of COVID and schools, college and university closures.	Staff Time Research base Facilitation Influence Partners Expertise Training Capacity building	Support the DE / DoH Emotional Health and Wellbeing in Education Framework Implementation. Support the delivery of Roots of Empathy in primary schools. Work in partnership with DE to implement the Derrytrasna Award to recognise excellence in pastoral care in schools. Support nutrition and physical activity programmes in schools through the obesity prevention thematic plan. Support mental health and suicide prevention programmes and training through the MH/SP thematic plan. Support sexual health programmes and training through the sexual health thematic plan. Work in partnership with schools, EA, DE, NHSCT and C&V partners to tackle educational underachievement in the Monkstown and Rathcoole areas (THRiVE). Work in partnership with EA and Northern Ireland Forest Schools Association to support outdoor learning and Take 5. Member of the UK Healthy Universities Steering Group and link with local universities on related areas of work.	PHA Heath Improvement Thematic Teams, particularly; mental health / suicide prevention, drug and alcohol, sexual health, early years PHA Nursing and AHP consultants PHA Health Protection Consultants PHA Health Intelligence HSCB / CYPSP HSCTs Department of Education Education Authority UK Healthy University Network FE / HE Department for the Economy C&V sector	Establish a new PHA cross Directorate group to consider how we collaborate with the education sector and to share information on PHA work with schools, FE and HE. Influence future actions under the Framework. Establish a clear understanding of the links between education and each of the HI thematic areas, including and having a shared understanding and overview of the curriculum (primary and post primary) in relation to health and wellbeing.	Development of a health and education system wide understanding of the health and wellbeing support in place, such as a continuum of services, from pre-school to post primary – to cover: Universal prevention Early interventions Specialist interventions. Family support services across health and education are mapped and shared with stakeholders. Shared understanding of the need of schools staff on emotional health and wellbeing and how the sectors can work together to support this.	Reduction in educational underachievement, particularly for those who experience social disadvantage. Schools, youth service providers, colleges and universities recognise and can fulfil their role in supporting children and young people to be resilient and mentally healthy. PHA acts as an enabler to influence health and education interventions to improve outcomes through the provision of research and evidence.

Vision

Children and young people are supported to reach their full potential and have the knowledge and support required to make safe, healthy and sustainable life choices.

Assumptions

External factors

Evaluation: focus and strategy → development of process and tools → collect data → analyse and interpret → report

Homelessness **Recovery Plan Model**

Background

People who experience homelessness face some of the worst health inequalities - the average age of death is 44 years for men and 42 years for women.

People who are homeless often have multiple needs in relation to their physical and mental health and this can be impacted further for those with substance reliance or addiction issues and for those from other vulnerable groups.

The Northern Ireland Housing Executive have reported 16,802 presentations in 2019/2020

Vision

To work collaboratively across a range of sectors to influence and improve the health outcomes for people who are homeless or at risk of homelessness.

Inputs

What we invest

- Staff
- Research base
- Materials
- Equipment
- Partners
- Expertise
- Capacity building

Outputs

Activities

What we do

Work in collaboration with others to improve the health outcomes of people who are homeless by supporting, influencing and informing both multi-disciplinary (HSC) and multi-agency homelessness planning. Including the Interdepartmental Homelessness Action Plan led by DfC and DoH priority actions.

Contribute to the development of a HSCB/PHA strategic homelessness approach to improve HSC homelessness planning.

Contribute to the identification of agreed priorities and HSC responses, pertaining to the health, wellbeing and social care needs of people who are experiencing or are at risk of homelessness.

Work with key stakeholders across a range of sectors to assess/improve/ implement services or interventions that improve health outcomes for people who are homeless within Northern Ireland. Ensuring that action can be appropriately targeted to address the needs of people who are homeless or at risk of homelessness.

NB: all of the above to be considered within the context of COVID-19 i.e. emerging priorities &resources.

Participation

Who we work with

- DfC
- NIHE
- DoH
- PHA (Nursing; Health Protection; Health Improvement Leads esp. D&A; MH; BAME; Prisoners)
- HSCB
- HSCTs
- Homelessness Sector
- Academics/QUB
- HSCB/PHA Multi-Disciplinary Group
- Multi-Agency Homelessness Group (COVID-19)
- Homelessness Strategic Steering Group
- Central Homelessness Forum

Outcomes

12 months

What the short term results are

Support, influence and complement DoH and other priorities within the Department for Communities (DfC) Interdepartmental Homelessness Action Plan, and the Northern Ireland Housing Executive's (NIHE) Homelessness Strategy (2017-2022).

Development and implementation of HSCB/PHA Homelessness Strategic Framework.

Identification and review of PHA & HSCB health, wellbeing and social care priorities for people who are homeless. Including Health Improvement funded Home Starter Pack Scheme and Resources for Rough Sleepers.

1-5 years

What the medium term results are

TBC pending further development of HSCB/PHA Homelessness Strategic Framework and identified health priorities within the Interdepartmental Homelessness Action Plan.

5 years +

What the ultimate impact (s) is

For all homeless populations, Including those rough sleeping and those impacted by chronic homelessness i.e. people living in differing types of temporary accommodation or requiring other homelessness support; and those at risk of homelessness:

Improved health outcomes and working towards improving heath inequalities for people who are homeless.

Reducing risk factors and increasing protective factors and consequently positively influencing health and wellbeing outcomes.

Improved homelessness commissioning process, pertaining to the health wellbeing and social care needs of people who are at risk of, or who are experiencing homelessness.

Improved HSC profes… awareness and respo… meet the needs of people who are homeless or at risk homelessness.

Assumptions: CE/SMT endorsement of a proposed HSCB/PHA Homelessness Strategic Framework to improve collaborative HSC multi-disciplinary homelessness planning.

External factors: The statutory responsibility for homelessness sits with the Northern Ireland Housing Executive (NIHE) and the Department for Communities leads on the Interdepartmental Homelessness Action Plan. // Impacts of COVID-19 on future rates of homelessness.

Poverty **Recovery Plan Model**

Background

The most recent, pre-COVID-19 statistics (April 2018/2019) state that around 350,000 (19%) people in Northern Ireland lived in relative income poverty including approximately 107,000 (24%) children.

22% of the population are living in fuel poverty (NIHE House Condition Survey 2018)

People reporting health problems are significantly more likely to be entitled to unclaimed benefits (BMJ 1993).

The inability to consume an adequate quality or sufficient quantity of food for health, in socially acceptable ways, or the uncertainty that one will be able to do so. (Radimer et al., 1990

Vision

To work collaboratively across a range of sectors to influence and improve the health outcomes for people most vulnerable to the impacts of poverty, with a current focus on fuel, income and food poverty.

Inputs

What we invest

- Staff
- Research base
- Materials
- Equipment
- Partners
- Expertise
- Capacity building

Outputs

Activities

What we do

Work collaboratively to support, influence and inform multi-disciplinary (HSC) and multi-agency health inequalities and poverty planning. Including the pending Anti-Poverty Strategy and identified poverty priorities led by DfC.

Review the PHA Health Improvement remit pertaining to poverty within the wider context of health inequalities and DfC's pending Anti-Poverty Strategy. To include currently funded/ commissioned PHA poverty interventions.

Agree PHA priorities and/or responses pertaining to the health and wellbeing of those most vulnerable to the impacts of poverty.

Work with key stakeholders across a range of sectors to assess/improve/influence/ implement services or interventions that improve health outcomes for those most vulnerable to the impacts of poverty, with a current focus on fuel, food and income.

Identify emerging priorities or any strategic changes /developments which may impact PHA poverty or health inequality priorities or action.

NB: all of the above to be considered within the context of COVID-19 i.e. emerging priorities &resources.

Participation

Who we work with

DfC

DoH

PHA (Health Protection; Emergency Planning, Health Improvement Leads esp. D&A; MH; BAME; Prisoners, Travellers, Later Years, Early Years, Obesity)

HSCB

HSCTs

Fuel/Food/ Community Advice Sector

Local Government

Community & Voluntary sector

Academics/UU

All Ireland Food Poverty Network

Outcomes

12 months

What the short term results are

Support, influence and complement Department for Communities (DfC) poverty priorities and pending Poverty Strategy.

Review and identification of agreed PHA Health Improvement priorities for people who are most vulnerable to the impacts of poverty. Including currently funded/ commissioned PHA poverty interventions.

Connections and links established across key Health Improvement thematic issues – taking cognisance of cause and consequences of poverty for particularly vulnerable groups i.e. those at risk or experiencing homelessness; BAME; Travellers, those with underlying health issues including addiction or mental health; children; older people.

1-5 years

What the medium term results are

TBC pending Health Improvement Review including thematic issues and publication of DfC Poverty Strategy

5 years +

What the ultimate impact (s) is

Improved health outcomes, reduction of risk factors and increase of protective factors for those most vulnerable to the impacts of poverty.

Increasing and influencing evidence based investment across Government Departments and ALB's with those experiencing or at risk of poverty.

PHA Health Improvement Team, other divisions and key external stakeholders have a clear understanding of the links between poverty and health inequalities and the PHA Health Improvement remit for both.

Improved professional awareness and responses to meet the needs of those most vulnerable to the impacts of poverty.

Assumptions: Health Improvement review of priority work/action. // Publication of Anti-Poverty and Child Poverty Strategy.

External factors: The Department for Communities are currently progressing a co-design, co-production approach to develop an Anti-Poverty and Child Poverty Strategy.

LGBT+ Recovery Plan Model

Background

Making Life Better highlights that some population groups including LGB&T face specific challenges to health and wellbeing including vulnerability to certain conditions and to broader issues such as social exclusion.

Protect Life 2 recognises LGB&T groups to be vulnerable to an increased risk of suicide. Emphasis is on ensuring interventions are inclusive, non-stigmatising and tailored to meet the needs and experiences of

Vision

Improved health and wellbeing with access to appropriate support when needed.

Inputs

What we invest

Staff Time

Money

Local organisations

Services

Research base

Materials

Expertise

Training

Capacity building

Outputs

Activities

What we do

Commission interventions to :

- Support individuals who identify as LGBT+
- Support individuals/ families and communities to build resilience to improve the mental health and wellbeing of LGBT+ individuals and families.

Support the development of local networks for LGBT+ individuals and their families.

Ensure those working in the community/ voluntary and statutory sector organisations have the knowledge to meet the specific needs of individuals who identify as LGBT+

Work in partnership with key stakeholders to ensure individuals who identify as LGBT+ are signposted to services as appropriate.

Participation

Who we work with

Thematic Leads Sexual Health/Drug & Alcohol SP / MH Local/ vulnerable groups

Protect Life 2 Regional Steering Group

Protect Life Implementation Groups/ Communities of interest

H&SC Board

Trusts

Community & Voluntary organisations

PHA Health Intelligence

Workplace Health

Outcomes

12 months

What the short term results are

Increased involvement to inform future service models.

Increased resilience and improved health and wellbeing of those who identify as LGBT+.

Interventions tailored to the specific needs of Transgender Individuals and their families.

Work in partnership to offer support to vulnerable groups including LGBT+.

Facilitate awareness raising sessions on the needs of vulnerable groups including LGBT+ to local communities, community, voluntary & statutory organisations.

Promotion of *Creating Inclusive Workplaces*. e-Learning programme

1-5 years

What the medium term results are

Prevention and intervention for vulnerable groups embedded in services.

Provision of inclusive, non-stigmatising services.

Improved knowledge and skills for wellbeing.

Increased awareness of the needs of the LGBT+ community/ voluntary and statutory sector service providers.

Increased partnership working and signposting to ensure LGBT+ individuals are supported.

5 years +

What the ultimate impact (s) is

Improved mental health and wellbeing.

Improved health and wellbeing

Social connectedness

Assumptions

External factors

Evaluation: focus and strategy → development of process and tools → collect data → analyse and → report

Alcohol & Drugs Recovery Plan Model

Background

Substance use, and the related harm, is not just an issue of personal responsibility and people's behaviours. It is very much interlinked with wider health outcomes, including health inequalities, and more widely with the economic, social and environmental circumstances in which people are born, grow, live, work and age

The cost of alcohol & drug misuse to the NI economy is estimated at over £1 billion annually.

284 people in Northern Ireland lost their lives related to an alcohol-specific cause in 2018 and 191 from a drug-related death in 2019

Alcohol specific mortality in the most deprived areas is **over four times** that in least deprived.

People living in the most deprived areas of NI are five **times more likely to die** from a drug-related death than those in the least deprived areas.

Vision

People in Northern Ireland are supported in the prevention and reduction of harm related to the use and misuse of alcohol and other drugs, and are empowered to maintain recovery.

Inputs

What we invest

Staff

Time

Money

Research & Health Intelligence

Materials

Equipment

Technology

Partnership

Expertise

Training

Capacity building

Outputs

Activities

What we do

Lead in the implementation of the current **New Strategic Direction for Alcohol and Drugs Phase 2 (2011-2016)** and inform the development of a new Strategy for 2021 onwards

Commission, procure and manage high quality prevention, early intervention and harm reduction substance misuse services consistently across NI in support / delivery of strategic outcomes.

Facilitate local Drug & Alcohol Co-Ordination Teams in developing local plans to address substance misuse.

Develop the skills and capacity of those who work directly with people who misuse alcohol and/or drugs through a workforce development training programme.

Provide regular and accurate health messaging via publications, press releases / responses and use of social media platforms.

Fund, support and facilitate service user involvement at both a local and regional level.

Facilitate the Drug and Alcohol Monitoring and Information System (DAMIS)

Participation

Who we work with

Departments of Health & Justice

Health & Social Care Board Commissioners

Health & Social Care Trusts

Drug and Alcohol Co-Ordination Teams

Voluntary & Community Sector
Community Pharmacy

HSC Primary & Secondary Care

PHA Health Protection & Nursing

PHA thematic leads in in Mental Health, Suicide Prevention & Cancer prevention

PHA Communications Team, Health Intelligence & locality leads

NI Alcohol & Drugs Alliance

Regional Service User Network

Elected Representatives

Local Government Community Planning / PCSPs

Outcomes

12 months

What the short term results are

Continued delivery of prevention, early intervention and harm reduction substance misuse services across NI throughout the COVID pandemic and related restrictions.

Service improvements identified as a result of the current service review of drug and alcohol services are actioned, and agreed with Providers.

Pilot and evaluate the Take Home Naloxone programme (THN) within community pharmacy settings with the aim of increasing Naloxone supply to service-users.

Pilot and evaluate the use of Nasal Naloxone for use and roll-out across NI as an expansion to the Take Home Naloxone programme.

Increased number of community pharmacies providing Needle and Syringe exchange (NSES).

Implementation and management of a harm reduction database which will support the provision of NSES, THN and DAMIS and meet current information gaps on near misses on drug and alcohol overdoses and Hepatitis C / BBV.

1-5 years

What the medium term results are

Service improvements implemented with current alcohol and drug services.

Alcohol and drug services are re-procured and aligned with mental health / suicide prevention services to ensure the best outcomes for clients are achieved.

Take Home Naloxone (either in injectable or nasal form) is available and accessible to all people who need it.

Increased availability of Needle and syringe exchange services (NSES) across all settings to ensure accessibility to all those who require the service.

Accurate & live data and information available on THN, NSES, DAMIS, near miss overdoses and Hep C / HIV outbreaks allowing increased targeting of services / health messaging.

Maintain the skills and capacity of those who work directly with people who misuse alcohol and/or drugs in order to increase capacity and development of the alcohol & drugs workforce.

Improved pathways in place for those with co-related mental health and alcohol / drug related issues to secure appropriate early intervention and support.

5 years +

What the ultimate impact (s) is

Reduction in alcohol related deaths and harm.

Reduction in drug related deaths and harm.

Decrease inequalities between alcohol & drug related deaths.

Decrease in the number of people drinking over the Chief Medical Officers' weekly alcohol guidelines.

Increase in the number of people who are aware of the Chief Medical Officers' weekly alcohol guidelines.

Decrease in the prevalence of drug misuse.

Increased community awareness and trust in alcohol and drug prevention, early intervention and harm reduction services.

Reduction in the stigma associated with substance use and related harm.

Early Years & Early Intervention **Recovery Plan Model**

Inputs	Outputs		Outcomes		
	Activities	Participation	12 months	1-5 years	5 years +

Background

Evidence demonstrates that effective intervention in early child development brings significant benefits throughout childhood and into adult life in terms of health, educational attainment and economic status.

1001 Critical Days- the importance of impact of early intervention from conception to age 2 years.

Impact of Adverse Childhood Experiences on later life outcomes.

Annual cost of late intervention in Northern Ireland is estimated to be £536 million, the equivalent to £1,166 per child(EIF, 2018)

Impact of COVID-19 on psychological health and wellbeing of children, young people and families.

Vision

Parents/Carers are supported to give their children and young people the best start in life through effective early intervention support at the time that it is needed to enable children and young people to achieve their full health and wellbeing potential.

What we invest	What we do	Who we work with	What the short term results are	What the medium term results are	What the ultimate impact (s) is
Staff Volunteers Time Money Research base Materials Equipment Technology Partners Expertise Training Capacity building	Develop strong strategic leadership and collaboration Work to ensure alignment to various strategies & planning processes. Promote early years agenda within public health priorities through Making Life Better Network and other public health platforms. Lead on implementation and development of Infant Mental Health plan. Support infant mental health workforce development. Implement a range of evidenced based parenting support services and programmes. Support the quality, fidelity and implementation of evidenced based parenting support programmes through workforce development. Support Adverse Childhood Experience Agenda. Support the development of a trauma informed workforce across the PHA.	Childcare Partnerships. Children & Young People's Strategic Partnership. Children, Young People & Families. Councils. CV Providers. Department of Health. Department of Education & Education Authority. Family Support Hubs. HSCB Commissioners. HSCT Health Improvement Leads. Outcomes Groups. PHA Health Intelligence. PHA Midwife, Nursing & AHP Consultants. PHA Thematic Leads in EWB, Obesity & Physical Activity, Breast Feeding, Drugs & Alcohol, Education, Sexual Health. Safe Guarding Board for Northern Ireland.	Priority areas for investment agreed. Existing early years investments reviewed and aligned to priority areas identified. Early years investments aligned with other PHA thematic areas. Early years investments aligned with PHA midwifery, nursing & AHP. Areas for disinvestment identified and process for concluding investments completed. Project Initiation Document developed for approval by AMT to proceed to procurement. Pre procurement work commenced.	Resources are invested effectively to support early years/early intervention agenda. Procurement of new services completed. Access to a range of evidenced informed parenting programmes and family support services for children, young people and families. Framework developed to support quality, fidelity and implementation of parenting support programmes. Infrastructure in place to facilitate workforce development and capacity building of frontline practitioners. Infrastructure in place to develop a trauma in formed workforce across the PHA. PHA Influence on planning and budget allocation on early years across Government	Regionally consistent evidenced based early intervention family support service model in place. Parents & families get high quality, tailored support when they need it. Improved range of outcomes for children, young people and families reducing the need for costly crisis intervention. Improved wellbeing for children and young people. Highly skilled early years/early intervention workforce. PHA commissioning across all areas informed through understanding of early trauma childhood adversity.

Assumptions | **External factors**

Evaluation: focus and strategy → development of process and tools → collect data → analyse and interpret → report

Sexual Health **Recovery Plan Model**

Background

Teen pregnancy

- In 2019: **631** births to mothers under 20 years (↓4%) including **62** births to mothers under 17 years (↑19%).
- 2016-2018: Inequality gap in the teenage birth rate (U20) **400%**; Most deprived 17.2 per 1,000 vs Least deprived 3.4 per 1,000.

Sexually Transmitted Infections - In 2019, new diagnoses:

- Chlamydia 1,863 (↑ 4%)
- Gonorrhoea 951 (↑ 8%)
- Genital herpes 487 (↓ 3%)
- Genital warts 1,367 (↓ 5%);
- Syphilis 66 (↑ 32%).

HIV - In 2019:

- 52 new diagnoses (↓ 35% from 2018).
- Transmission 40% gay/bisexual, **52% heterosexual,** 8% other/unknown.
- 62% aged 25-49 years, 29% over 50 years.
- 9 people diagnosed with AIDS at HIV diagnosis. 9 deaths reported.
- 1,123 NI residents received HIV-related care.

Vision

Improve, protect & promote the sexual health and well-being of the population of Northern Ireland

Inputs

What we invest

- Staff
- Volunteers
- Partners
- Time
- Money
- Resources
- Technology
- Evidence /Research base
- Expertise
- Training
- Capacity building

Outputs

Activities

What we do

- Facilitate the development of a new Sexual Health Action Plan for 2021-2026 and lead on implementation across the 5 HSCT areas.
  - Review annually the Sexual Health Action Plan progress/outputs.
- Lead on the development of a regional co-designed and agreed sexual health communication framework.
- Ensure evidence based sexual health improvement programmes are available in a range of settings for all, and in particular for vulnerable and at risk groups:
  - Implement regional roll out of the C-Card condom distribution scheme.
  - Continue current contract and re-tender of contract of community RSE programmes for young people
- Provide support to parents on sexual health issues and keeping children safe:
  - Implement the regional roll out of 'Talk PANTS'
- Ensure that commissioned services adhere to relevant clinical and service delivery standards.
- Review evidence based practice and promote sexual health research.
- Support individuals, family and friends of those living with HIV.
- Establish links with other strategies to promote and improve sexual health outcomes.
  - Northern Ireland Hepatitis C Elimination Plan, phase 1 2021-2025.

Participation

Who we work with

Department of Health

HSCB Commissioners Sexual Health

Sexual Health Improvement Network (SHIN)

PHA colleagues:

- Health Improvement sexual health leads
- Health Protection and Nursing consultants
- Health Intelligence
- Communications

HSCT colleagues:

- Health Improvement managers
- Sexual health leads
- Communications
- GUM consultants and clinical staff

Service providers

Service users

Department of Education

Education Authority

CCEA

Outcomes

12 months

What the short term results are

A Sexual Health Action Plan 2021- 2026 approved by CMO.

An agreed inclusive implementation plan to deliver action plan strategic objectives.

Opportunities for young people to access Relationship and Sexuality Education programmes in community settings.

Increased access to sexual health advice and condoms for young people.

Increased sharing and use of evidence and best practice to inform sexual health interventions.

Provision of free and confidential advice on HIV via telephone helpline and befriending service (individual and group contacts).

Development of a funding proposal for health professional training on BBV (including Hepatitis C and HIV).

1-5 years

What the medium term results are

Annual review of progress/outputs reports on implementation plan to inform planning.

Increase in consistent sexual health messaging across five HSCTs through an agreed communication framework.

Improved knowledge and attitudes among young people about healthy relationships and sexual behaviours. (684 programmes over 3 years)

Increased and correct condom use among young people.

Increased awareness among parents and prevention of child sexual abuse.

Improved sexual health services through Implementation of RQIA clinical service standards.

Improved health and well-being outcomes for people living with or affected by HIV. (1,250 calls; 4,305 contacts)

Development of curricula and implementation and training to increase knowledge and tackle stigma among all healthcare staff, those working in prisons, custody suites and police services.

5 years +

What the ultimate impact (s) is

Reduction in births to teenage mothers.

Narrow the inequality gap in teenage birth rates.

Decreased rates in new diagnoses of Sexually Transmitted Infections, BBVs and HIV.

Reduction in stigma associated with BBV including HIV.

Sexual health services meet quality standards.

Assumptions

External factors

Evaluation: focus and strategy → development of process and tools → collect data → analyse and interpret → report

Obesity Prevention **Recovery Plan Model**

Background

22% of children in NI entering P1 are already overweight or obese, with this rising to 27% in Year 8 (DOH Health Inequalities Annual Report, 2020.

65% of adults were either overweight (38%) or obese (27%) - up from 62% in 2018/19 (HSNI 2019/20).

45% of the adult population do not meet the recommended levels of PA in NI (2016/17)

87.3% of children aged 11-16 do not meet the recommended levels of Physical Activity. (YPBAS 2016)

People living in the most deprived areas of NI are more likely to be obese (32%) / and less likely to take PA (56%) compared to those living in the least deprived areas (25% and 37% respectively).

COVID pressures have required changes towards more online support.

Vision

NI operates a Whole Systems approach to Obesity, empowering the population of Northern Ireland to make healthy choices, reduce the risk of overweight and obesity related diseases and improve health and wellbeing, by creating an environment that supports and promotes a physically active lifestyle and a healthy diet".

Inputs

What we invest

Staff

Volunteers

Time

Money

Research base

Materials

Equipment

Technology

Partners

Expertise

Training

Capacity Building

Communication expertise

Outputs

Activities

What we do

Lead implementation of the current Obesity Prevention Strategy 2012-22 and inform the development of a new Strategy for 2023 onwards

Develop and Implement a Whole System Approach to Obesity, influencing across govt depts. For collaborative gain

Implement evidence based & best practice

Ensure key stakeholders e.g. HSC, Councils, schools, communities etc. have the necessary knowledge and skills to promote, support and sustain increased levels of physical activity, healthy eating and active travel.

Provide targeted support to address health inequalities.

Commission research with service users and providers.

Promote obesity prevention via a variety of formats – media, PIC, publications etc.

Embed a range of programmes across NI in relation to:

- Physical Activity
- Health Eating
- Active Travel

Work with PHA thematic teams and public health directorates to address obesity.

Participation

Who we work with

Obesity Prevention Steering Group (OPSG) & Regional Obesity Prevention Implementation Group (ROPIG)

PHA nursing consultants (C&YP services, District Nursing, School Nursing), AHPs, Health Protection, Education, health intelligence, communications, research & development

PHA thematic leads in later years, early years, MH&EWB, breastfeeding

PHA obesity, physical activity, active travel local leads

NI Diabetes Network - Prevention Workstream.

HSCT Heads of Service – Health Visiting, Health Improvement teams

HSCB commissioners,

Sure Start,C&V providers,

Elected Representatives

Public, private sector business & Local councils

Community planning partners

Safefood & Food Standards Agency

UK Physical Activity Leads

Outcomes

12 months

What the short term results are

Increased awareness of resources and opportunities to prevent obesity, particularly focussed on addressing health inequalities

Increased obesity prevention knowledge and skills across a range of sectors and across the lifecourse through provision of training and conferences.

A structure to implement required change to address obesity.

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1-5 years

What the medium term results are

Ongoing increased awareness of resources and opportunities to prevent obesity, particularly focussed on addressing health inequalities

Ongoing increased obesity prevention knowledge and skills across a range of sectors and across the lifecourse through provision of training and conferences.

Infrastructure is in place to drive regionally consistent, evidenced based / innovative obesity prevention work (R&D / Communications & Education / Services / Policy & Legislation etc) in line with a whole system approach to obesity to improve health and reduce health inequalities.

Maintain the knowledge and skills of key stakeholders and offer additional training opportunities in order to build capacity and address obesity.

People, across the life course are supported to be active and eat healthily, through regionally consistent programmes, existing or new, that meet local need

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5 years +

What the ultimate impact (s) is

Reduction in the number of people (adults & children that are classified as overweight and / obese).

Increased % of population (adults and children) meeting CMO Physical Activity Guidelines.

Reduction in inequality gap in relation to rates of Obesity, physical activity levels and associated chronic conditions.

Assumptions

External factors

Evaluation: focus and strategy → development of process and tools → collect data → analyse and interpret → report

Workplace Health and Wellbeing **Recovery Plan Model**

Inputs → **Outputs** (Activities, Participation) → **Outcomes** (12 months, 1-5 years, 5 years +)

Background

In 2020 there were 76,090 registered businesses in NI. NISRA_IDBR2020

27% of jobs are in the public sector and 73% private sector. The main industries are construction, manufacturing and services NIBRES2019

(89%) of all businesses in Northern Ireland have less than 10 employees). 2% of businesses had 50 or more employees. NISRA_IDBR2020

'Making Life Better (9.17) Support systems to encourage and maximise the commitment of employers to health and wellbeing and share effective practice will need to be in place.

Vision

Workplace health and wellbeing is a recognised as a priority and effective programmes are implemented to address the identified needs of employees.

What we invest	What we do	Who we work with	What the short term results are	What the medium term results are	What the ultimate impact (s) is
Work Well Live Well contracted service Partnerships Money PHA staff time Research Technology Expertise	Promote and support evidence based whole system approaches to workplace health and wellbeing using the WHO Workplace Framework. Support a Regional Workplace health and wellbeing service to 250 businesses on an annual basis as detailed in the Work Well Live Well service specification. Target Work Well Live Well support towards businesses with Migrant, low income and sedentary workers. Support targeted action within specific workplaces with identified COVID concerns; as directed by AD and Heads promote COVID-19 generic messaging. Work with the HSENI to promote the importance of employee health and wellbeing and identify priority areas of work. Promoting and supporting a regionally consistent approach to addressing HSC staff health and wellbeing. Establish and maintain a COVID PHA/HSCB/BSO staff health and wellbeing support group.	Public and Private sector employees and employers across NI. Work Well Live Well Providers i.e. NICHS and Developing Healthy Communities PHA Regional and Local Workplace Health Leads PHA BAME Leads Equality Commission PHA Health Protection, IMTs& PHA Comms HSENI Workplace Health Leadership Group(WHLGNI) HSC Healthier Workplaces Network HSCT Heads of Psychology PHA/HSCB/BSO Staff Health and Wellbeing Group	Regionally a total of 250 businesses committed at Level 1, 125 at Level 2 and 75 at Level 3 to the Work Well Live Well programme Regionally 250 businesses signed up to the Equality Commission Mental Health Charter. 150 health promotion events delivered by providers to workplaces. 15 Workplace Health Champion courses facilitated by Work Well Live Well providers. 75 Mental Health First Aiders trained within Work Well Live Well businesses. 10 Learning Network events provided to workplace champions. 5 Mental Health Webinars provided by the WHLGNI Regional Wellbeing Hub developed and maintained for HSC staff support Sharepoint site established for PHA/HSCB/BSO staff health and wellbeing	Work Well Live Well, the PHA commissioned workplace health programme is meeting annual KPIs in delivering a targeted evidence based approach to workplace health and wellbeing to benefit the most marginalised and vulnerable employees in NI. The service specifications as detailed are met and adjustments made to address COVID effects and restrictions. The effects of COVID-19 across the workplace setting are recognised and support is in place for those that need it most. Partnership working with HSENI, NISG and IOSH to identify and prioritise employee needs and deliver webinars and an annual conference. The 17 HSCT organisations are provided with network opportunities to share best practice and inform implementation of the Workforce Strategy. An effective PHA Staff health and wellbeing group in-situ.	The Workplace is recognised as a key setting to support employee health and wellbeing. An effective Regional PHA workplace programme is in place and delivering targeted support across more than 250 businesses a year. HSC Staff have easy access to Regionally consistent workplace health and wellbeing programmes and resources.

Assumptions | **External factors**

Evaluation: focus and strategy → development of process and tools → collect data → analyse and interpret → report

Skin Cancer Prevention **Recovery Plan Model**

Background	Improved public awareness of the impact of over exposure to UV radiation and the importance of early detection	Inputs	Outputs: Activities	Outputs: Participation	Outcomes: 12 months	Outcomes: 1-5 years	Outcomes: 5 years +
		What we invest	**What we do**	**Who we work with**	**What the short term results are**	**What the medium term results are**	**What the ultimate impact (s) is**
Skin cancer accounts for over 31% of all cancers. 4,210 people develop the disease each year and around 9% (387) of these are malignant melanomas During the COVID period 31% reduction NMSC and 25% reduction melanomas over the period March 2020-mid Jan 2021 This may result in higher than normal incidence and later stage diagnosis in the next 1-2 years. By 2040 the incidence rates of melanoma are projected to increase by 65% and 48% in males and females respectively.		Staff Volunteers Time Money Research base Materials Equipment Technology Partners Expertise Training Capacity building Media	Support the implementation of the current Skin Cancer Prevention Strategy and inform the development of a new Strategy for 2022 onwards Support implementation of the Skin Cancer Prevention Action Plan: 1. Increase public awareness of the risks of over exposure to UV radiation 2. Reduce the use of sunbeds 3. Increase individual and organisation wide UV awareness and practice of sun safety behaviours 4. Encourage earlier detection and treatment of skin cancer. 5. Promote further research into knowledge, attitudes and behaviour and the epidemiology of skin cancer. 6. An economic analysis of the costs to the Department of Health of treating skin cancer against the cost-effectiveness of skin cancer prevention programmes. Support the development of the NI Cancer Strategy.	Skin Cancer Prevention Steering Group, Skin Cancer Prevention Sub Groups Cancer Focus NI PHA Service Development & Screening PHA Comms Team PHA Health Intelligence PPI representatives Volunteers, HSCTS Local Councils Universities European Cancer League (ECL) **European Academy of Dermatology and Venereology- EADV** DOH Cross Government Departments Employers Unions Sport NI Sport Governing Bodies Ordnance Survey Tourism NI HSE / NCCP Northern Ireland Cancer Registry	An agreed implementation plan to deliver the action plan's strategic objectives. Increased public awareness of the risks associated with UV exposure from both the sun and sunbeds. Increased public awareness of the importance of being skin aware and self-skin checks and early detection. E-Learning module on skin cancer prevention rolled out to target audience within the beauty industry.	An agreed implementation plan to deliver on the actions of the New Skin Cancer Strategy post September 2022. Increased awareness raising, knowledge & attitudes in relation to: • UV awareness & sun protection. • Sunbed use. • Self-skin checking & early detection. Data on skin cancer incidence and evidence based strategies will inform planning development. Increased awareness among professionals in identifying skin cancer. .	To reduce the anticipated long-term rise in melanoma and NMSC incidence and deaths. Positive change in sun safety behaviour. Increase in early detection and treatment. .

Assumptions | **External factors**

Evaluation: focus and strategy → development of process and tools → collect data → analyse and interpret → report

Breastfeeding Recovery Plan Model

Background

Data from the Child Health System indicates the rate of any breastfeeding at discharge is 48.4% (2018)

Prevalence data shows a drop in the rates 29.8% at 6 weeks, 24.2% at 3 months, 17.1% at 6 months and 10.5% at 12 months (2017)

Mothers living in the most deprived areas of NI are half as likely to breastfeed compared to the least deprived areas.

COVID pressures have required changes towards more online support.

Vision

Breastfeeding is the social and biological norm and mothers will be supported to give their babies a good start in life.

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Inputs

What we invest

- Staff
- Volunteers
- Time
- Money
- Research base
- Materials
- Equipment
- Technology
- Partners
- Expertise
- Training
- Capacity building

Outputs

Activities

What we do

Lead implementation of the current Breastfeeding Strategy 2013-2023 and inform the development of a new Strategy for 2024 onwards

Support implementation of UNICEF UK BFI Neonatal standards and maintain standards across maternity and community settings.

Ensure HSC workers, Sure Start and volunteers have the necessary knowledge and skills to promote, support and sustain breastfeeding.

Develop the leadership and support required for an effective Breastfeeding Workforce

Establish and maintain an effective network of breastfeeding CV sector support.

Implement best practice breastfeeding information and support ante-natal/ postnatally.

Provide targeted support to women in areas of socio-economic deprivation through BFI, Sure Starts.

Commission research with service users and providers.

Promote and manage the Breastfeeding Welcome ere scheme.

Participation

Who we work with

Breastfeeding Strategy Implementation Steering Group (BSISG),

PHA midwife & nursing consultants,

PHA thematic leads in obesity, early years,

PHA breastfeeding local leads,

PHA Comms Team,

UNICEF UK,

Neonatal Network,

PHA Health Intelligence,

Infant Feeding Leads & HSCT Managers,

HSCB commissioners,

peer volunteers,

Sure Start,C&V providers,

Elected Representatives

Public, private sector business & councils

Outcomes

12 months

What the short term results are

Increased breastfeeding knowledge and skills across HSCTs and C & V sector through provision of BFI training and conferences.

Increased service based knowledge of women's ante- and post-natal support needs, utilised in continual service development

100% birth rates in BFI maintained, 100%, HV services maintained.

Enhanced parental access to neonatal units.

Increased availability / access to midwifery-led tongue tie services for breastfed babies.

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1-5 years

What the medium term results are

100% birth rates in BFI maintained, 100%, HV services maintained. 100% Neonatal Units and 50% of Sure Starts fully BFI accredited.

Maintain the knowledge and skills of a range of supporters, increased access to training for health professionals, peer supporters, Sure Start and C &V sector in order to build capacity and develop the breastfeeding workforce.

Regionally consistent infrastructure is in place to develop and maintain effective information and support e.g infant feeding leads and specialist support in maternity, HV and neonatal settings.

Women have access to, and are effectively supported to breastfeed through peer support programmes within each HSCT and have access to LLL and NCT Voluntary Counselling across NI.

Women have access to, and are effectively educated and supported though appropriate antenatal /postnatal services delivered through blended approaches with targeted effective interventions available within Sure Start projects.

Increase in acceptability of breastfeeding overall and in public.

5 years +

What the ultimate impact (s) is

Increased Breastfeeding initiation and prevalence.

Decreased inequalities between breastfeeding rates

Assumptions

External factors

Evaluation: focus and strategy → development of process and tools → collect data → analyse and interpret → report

HSC Public Health Agency

item 12

Title of Meeting	PHA Board Meeting
Date	20 May 2021
Title of paper	HSCQI Annual Report: Programmes-Partners-People
Reference	PHA/05/05/21
Prepared by	Tracey White
Lead Director	Aideen Keaney
Recommendation	For **Approval** ☐ For **Noting** ☒

Purpose

The purpose of this paper is to share with Board members the HSCQI Annual Report. It has been produced on a PageTiger interactive format. This is HSCQI's first ever Annual Report.

Please click on the link to access the report:
https://view.pagetiger.com/fyjwoy/1