HSC Public Health Agency

agenda

Title of Meeting	143rd Meeting of the Public Health Agency Board
Date	19 May 2022 at 1.30pm
Venue	Olympic 1, Clayton Hotel, Ormeau Avenue, Belfast

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 24 March 2022		Chair
4 1.35	Matters Arising • COVID-19 Inquiry Terms of Reference		Chair
5 1.40	Chair's Business		Chair
6 1.50	Chief Executive's Business		Chief Executive
7 2.05	Finance Report	**PHA/01/05/22**	Director of Finance
8 2.20	Update on COVID-19		Dr Farrell

committee updates

9 2.35	Update from Chair of Governance and Audit Committee	**PHA/02/05/22**	Mr Stewart
10 2.50	Update from Chair of Remuneration Committee		Chair

items for approval

11 2.55	PHA Business Plan 2022/23	**PHA/03/05/22**	Mr Wilson

items for noting

12 3.10	Performance Management Report	**PHA/04/05/22**	Mr Wilson
13 3.20	Update on Population Screening Programmes	**PHA/05/05/22**	Dr Farrell
14 3.35	Annual Report on the Specialist Training Programme in Public Health	**PHA/06/05/22**	Dr Farrell

closing items

15 Any Other Business
3.50

16 Details of next meeting:

Thursday 16 June 2022 at 1.30pm

Board Room, Gransha Park House, L'derry

HSC Public Health Agency

minutes

Title of Meeting	142nd Meeting of the Public Health Agency Board
Date	24 March 2022 at 1.30pm
Venue	Innovation Factory, Springfield Road, Belfast

Present

Mr Joseph Stewart	-	Non-Executive Director (Chair)
Mr Andrew Dougal	-	Chair (*via video link*)
Mr Aidan Dawson	-	Chief Executive
Mr Rodney Morton	-	Director of Nursing and Allied Health Professionals
Mr Stephen Wilson	-	Interim Director of Operations
Alderman Phillip Brett	-	Non-Executive Director (*via video link*)
Mr John Patrick Clayton	-	Non-Executive Director
Ms Anne Henderson	-	Non-Executive Director (*via video link*)
Mr Robert Irvine	-	Non-Executive Director
Ms Deepa Mann-Kler	-	Non-Executive Director (*via video link*)

In Attendance

Dr Aideen Keaney	-	Director of Quality Improvement
Ms Tracey McCaig	-	Interim Director of Finance, HSCB
Mr Robert Graham	-	Secretariat

Apologies

Dr Stephen Bergin	-	Interim Director of Public Health
Professor Nichola Rooney	-	Non-Executive Director
Mr Brendan Whittle	-	Director of Social Care and Children, HSCB

25/22 **Item 1 – Welcome and Apologies**

25/22.1 Mr Stewart welcomed everyone to the meeting. Apologies were noted from Dr Stephen Bergin, Professor Nichola Rooney and Mr Brendan Whittle.

26/22 **Item 2 – Declaration of Interests**

26/22.1 Mr Stewart asked if anyone had interests to declare relevant to any items on the agenda. Mr Clayton advised that in advance of any discussion on the terms of reference for the COVID-19 Inquiry, he should declare an interest as he is involved in some work around this in his role in Unison.

27/22 | Item 3 – Minutes of previous meeting held on 17 February 2022

27/22.1 | The minutes of the Board meeting held on 17 February 2022 were **APPROVED** as an accurate record of that meeting.

28/22 | Item 4 – Matters Arising

28/22.1 | Mr Stewart went through the action log and asked Mr Wilson to update members on the first two actions relating to the minimum wage.

28/22.2 | Mr Wilson advised that from a contractual point of view, there are no specific clauses requiring organisations PHA contracts to pay staff the living wage, but there is a general clause about applying with all aspects of the law. He added that there is some further work being done in looking at the crossover between the living wage and the national minimum wage. He advised the national living wage applies from age 23. In terms of whether all PHA staff are paid at the appropriate level, he reported that he is content that this is the case.

28/22.3 | Mr Clayton said that the issue for him is not the national minimum wage, but the real living wage. He advised that there is an Executive policy around this and while he was content that PHA's contracted organisations pay the minimum wage, he said that this is not the real living wage. He explained that the real living wage is set every November by the Living Wage Foundation and currently sits at £9.90 per hour, but the national living wage will only increase to £9.50 from 1 April 2022 so there is a gap. He added that the increase in the cost of living will likely see the real living wage increase again, and this is the level that PHA should benchmark to. He noted that from June 2022 the Executive is committed to paying the real living wage.

28/22.4 | Ms McCaig advised that PHA is not funded to the levels of the real living wage and there is no commitment to go beyond the national living wage, adding that this is much wider than just the PHA. She said that PHA will take cognisance of the direction of the Executive.

28/22.5 | Mr Clayton queried whether Ms McCaig should raise this matter with the Department. He said that this is a Department of Finance policy and it should be resourced across all Government bodies and he queried whether this is being factored into the Executive budget. He felt that PHA should be setting an example in this area.

28/22.6 | Ms McCaig said that she agreed with Mr Clayton but explained that PHA cannot go ahead of an Executive commitment and act in isolation. She said that she was happy to go and talk to the Department about this **(Action 1 – Ms McCaig)**.

28/22.7 | Mr Stewart noted that there is a difficulty if a rate is already established in an existing contract. The Chair said that he did not expect contracts to be changed, but Ms McCaig suggested that they could be if the policy

position supported that, but she did not know at what stage the Executive decisions are.

28/22.8 Mr Stewart noted that action 3 relating to the "buddy" project was complete as this initiative has now commenced, and that action 4 has also been completed as information regarding the PPI webinars had been shared with members. He said that action 5 regarding the future planning group looking at health intelligence would be picked up later in the meeting by the Chief Executive.

28/22.9 Moving onto the outstanding actions from the January meeting, Mr Stewart said that a timetable of workshops is being prepared and that fuel poverty will form part of one of those. He noted that the Chief Executive will bring an update on vacant posts to a future meeting and that the Chief Executive would update members later in the meeting regarding his discussion with Ms Heather Stevens.

29/22 Item 5 – Chair's Business

29/22.1 The Chair began by commenting that the financial outlook was not good for those on benefits.

29/22.2 The Chair commented on the launch of the Food Standards Agency UK Strategy but said there needs to be more work done in this area.

29/22.3 The Chair advised that he had received correspondence from Mr Paul Montgomery in the Department of Health which relates to a finding in the report on the resignation of the RQIA Board and that it indicated that if Boards wish to approach the Minister, they are free to do so, but should keep their Sponsor Branch apprised.

29/22.4 Ms Henderson noted that she was unable to attend the recent business planning workshop and asked about the status of the plan and the next steps. Mr Wilson reported that the outworkings of that workshop have been taken away and that PHA will be taking a slightly different approach with its business plan for next year in that there will 8 high level priority KPIs and an accompanying action plan with further KPIs. He said that the draft plan has gone back to relevant staff to be reviewed and will be brought back to the Board when it is ready. He added that there has been some discussion with the Department about the timing of the submission of the plan, and that there is some flexibility in that regard. He reiterated that members will be kept updated. Ms Henderson sought clarity that the Board would be seeing the plan again in the next 2/3 weeks and Mr Wilson confirmed that the plan will be circulated to members in advance of the next meeting. Mr Stewart confirmed that the principles that were established at the pre-meeting in advance of the workshop have been followed through.

29/22.5 Ms Mann-Kler asked how PHA intends to respond to the correspondence from the Department. She said that it was an important

opportunity to explore, and that the timing of it is interesting. The Chair advised that the Minister is keen to meet with Boards and he assured members that he will be raising this matter at the next meetings of the Health Chairs' Forum and the Public Sector Chairs' Forum. He said that the Minister should be able to be reached through both the Private Office and the Special Advisor (SpAd).

29/22.6 Mr Clayton noted the reference in the Chair's Report to Ernst and Young (EY) carrying out work on the development of the new operating model for PHA and asked for more detail on that. He queried whether this had been a decision made by the Department or by the PHA. He expressed concern that they had been brought in without the Board's knowledge and he noted the point about ensuring that they carry out the work that PHA wants them to do. With regard to the business plan, he hoped that the squeeze on living standards will feature within one of the 8 KPIs. The Chief Executive said that he would pick up matters relating to the review of PHA later in the meeting under Item 11.

30/22 Item 6 – Chief Executive's Business

30/22.1 The Chief Executive reported that the Minister has made an announcement regarding the future of Test Trace Protect (TTP) in Northern Ireland. He said that in advance of the announcement being made public he addressed those staff working in contact tracing as it was felt to be important that they heard it from him. He advised that an e-mail was issued to staff and it would be shared with members.

30/22.2 Mr Wilson gave an overview of the e-mail that was issued and outlined the changes to testing which are that PCR testing is no longer recommended for most people, apart from those for whom it is recommended for clinical reasons. However, he advised that home testing PCR kits are available. He explained that publicly accessible testing sites will close and local Trusts will provide testing to support clinical care.

30/22.3 With regard to regular asymptomatic testing, Mr Wilson said that this will continue to be advised for those working and visiting healthcare settings, but for workplaces and education settings (after Easter), it will cease. However, he added that it will continue in special schools until at least the end of June 2022.

30/22.4 Mr Wilson advised that contact tracing will be phased out between mid-April and June 2022.

30/22.5 Mr Stewart asked about the next steps for PHA. Mr Wilson advised that the contracts of employment for contact tracing staff will be honoured until the end of June. However, he added that any staff who have been working for over 2 years and now have permanent employment rights will also have their contracts honoured and work is ongoing with HR in this regard. As a result of the reduction in testing, he said that contact

tracing will be scaled back, but contact tracers will be used to work in other areas, for example they could assist in work relating to the Ukraine response and refugees. He advised that they will most likely be involved in work relating to clinically vulnerable people and ensuring that they can access testing, antivirals and clinical services. However, he said that a lot of the detail has yet to be determined on this as further clarity is awaited from the Department. Mr Stewart asked how many staff this will impact, and the Chief Executive replied that it would be around 200, but he noted that with staff looking for new jobs there is presently an attrition rate of 10/15 staff per week. He added that the last group to leave will likely be those who are about to retire, or who have come out of retirement to help.

30/22.6 Ms Henderson asked who will be carrying out surveillance and how it can be done in the absence of PCR or LFD testing. The Chief Executive advised that PHA will still have a significant role in terms of surveillance, and explained that waste water is being used as a type of early alert system, and that PHA will undertake outbreak management. Dr Owen clarified that surveillance is part and parcel of the role of the PHA. She advised that the ONS survey will continue and it is a better indicator of prevalence. She said that testing only picks up a small percentage of those who have COVID-19 whereas the ONS survey is population based.

30/22.7 In relation to LFD testing and the removal of the provision of free tests, Mr Clayton asked how people can still access these at a reasonable cost given other pressures as there is a risk of individuals profiteering. He asked how much this decision has been driven by financial issues. He noted that some staff will still be able to access tests while others will not and asked if there has been an assessment on this from a budgetary perspective. Mr Stewart added that he would like the view of the Director of Public Health of this announcement and if PHA is content that it represents a sensible move. The Chief Executive responded that some of this is HSC policy which is directed by the Minister so PHA has no control. He added that it would be too early to give an assessment as the detail of this was only received yesterday evening and this morning. He said that the question as to whether this is being driven by the budget is one for the Minister to determine. He advised that PHA had extended, at risk, the contracts of contact tracing staff up to the end of June 2022 as it will be able to cover these in its budget. Ms McCaig echoed this, noting that PHA usually carries a surplus in its management and administration budget and therefore it was felt to be a risk that PHA could manage. In terms of the wider context, she advised that some planning assumptions have been made, but it does not mean they are the same assumptions when it comes to managing the disease and disease outbreak. She said that these two areas have been kept separate. She added that she is still trying to get information on the financial outlook for the HSC.

30/22.8 The Chief Executive said that the pandemic will come to an end at some

point, and some of the decisions being made are based on the scientific evidence that the dominant variant in Northern Ireland is BA2 which accounts for over 95% of cases and does not have a severe impact on health. He advised that Northern Ireland has the lowest rate of cases across the UK, and even though people are being admitted to hospital, very few are on supported oxygen or ending up in ICU. He said that TTP was put in place to prevent severe illness and death so with numbers of cases reducing, the need to isolate and test is also reducing as this was always going to be the case, although it has happened quite quickly. He advised that the health impact of Omicron has only been known since mid-January and while he welcomed its reduced impact, he noted that there still remains a section of the population that needs to be protected. He added that the functions of surveillance, testing and contact tracing will remain with PHA to ensure these people are protected. Mr Wilson advised that LFDs are still available free of charge for those who develop symptoms.

30/22.9 The Chief Executive advised that there is a number of programmes which will be transitioned into PHA. He began by explaining that the vaccination programme which has been led by the Department over the last 2 years will transfer to PHA as vaccination sits within the remit of PHA. He said that the spring booster programme will be led by the Department, but then the autumn programme will be led by PHA. He added that a workshop on this is taking place this afternoon.

30/22.10 The Chief Executive said that the Vaccine Management System (VMS) will also transfer to PHA as well a number of other digital platforms and he has been in discussion with Mr Dan West to get a stocktake on this work.

30/22.11 The Chief Executive reported that there is work ongoing between the different UK nations and the new UK Health Security Agency (UKHSA) to determine relationships, i.e. what matters will be dealt with at a national level, and what matters will be devolved. He noted that Northern Ireland will have a bigger reliance on UKHSA than other nations, and therefore discussions will be taking place over the next 6 months. However, he expressed concern that UKHSA is seeing a considerable cut in its budget and that may have implications for PHA.

30/22.12 The Chief Executive advised that he and the Chair attended an Extraordinary Sponsorship Meeting with the Chief Medical Officer (CMO) and Deputy Chief Medical Officer (DCMO) on Tuesday which he said was positive and helpful. He said that there was a discussion about the restart of sponsorship activities going forward, although he commented that the PHA had had a lot of Sponsorship Meetings with the Department over the last 2 years. He added that there will be an Accountability Meeting with the new Permanent Secretary.

30/22.13 The Chief Executive reported that in addition to issues relating to the COVID-19 response, there was discussion about resilience in PHA and

staffing given the number of PHA staff who are likely to retire soon. He said that PHA does not presently have as many public health consultants as it would like. He said that there was also discussion about PHA's approach to its Business Plan for next year. He added that there was reference to how Northern Ireland can respond as a nation to the Ukraine crisis, but noting that refugees come under the auspices of the Executive Office, and within HSC, it sits under social care even though there may be significant public health issues.

30/22.14 The Chief Executive said that there was discussion at the meeting on the new planning model, as well as on the development of Partnership Agreements, which was an issue that had come out of the recent report into the resignation of the RQIA Board. He advised that these Agreements will be developed over the next 12/18 months. The Chair agreed that it was a positive meeting.

30/22.15 Mr Stewart said that based on his previous experience, he was confident that the new Permanent Secretary will wish to see the new Partnership Agreements put into place and that it will be important for the Board to meet with him as soon as possible.

30/22.16 The Chief Executive highlighted some risks. Beginning with the PHA's relationship with UKHSA, he said that there is a risk of services being withdrawn that would previously have been provided. In terms of the vaccination programme and the digital elements which accompany it, he highlighted that there is a risk of no additional financial resources, but given the necessity of the programme, PHA will run it at risk. He advised that he had no conduct issues to bring to the Board's attention.

30/22.17 The Chief Executive reported that the new Permanent Secretary will take up post on 4 April, and 1 April will see the closure of HSCB and its transition into the Department of Health.

30/22.18 The Chief Executive said that he felt that the recent workshop on the Business Plan had gone well and that KPIs will be developed and a further iteration shared with members by e-mail. He added that the "buddy" initiative has now commenced and HSCQI will be developing an evaluation.

30/22.19 The Chief Executive reported that he had attended the launch of the "Breastfeeding Welcome Here" scheme with Translink and he had also attended the launch by the Minister of the revised Nutrition Standards. He added that he and Mr Stewart had visited Kilcooley on Monday for the launch of the Sustrans Big Wheel and Walk initiative.

30/22.20 Ms Mann-Kler asked how the meeting with the Permanent Secretary had gone. The Chief Executive reiterated that the meeting was very positive and the CMO was very complimentary about the work of PHA in its response to COVID-19 and that he is looking forward to working with PHA through the review. The Chair echoed that and indicated that the

new Permanent Secretary will be attending a Board meeting soon as he felt it is important to have constructive dialogue, both with the Permanent Secretary, and with the Sponsor Branch.

30/22.21 Ms Henderson asked about specialist advice for the population in terms of nutrition. She noted that there is information about taking Vitamin D, folic, Vitamin B6, but she asked about general advice about nutritional supplements. She felt that people do not generally have a balanced diet and asked about getting messages out. Mr Wilson said that he would be happy to have a discussion about this outside the meeting, but in essence he explained that this is a crowded space in Northern Ireland as in addition to PHA, there is both the Food Standards Agency and Safefood. However, he advised that there are some resources available on NI Direct and there is a PHA website, "Choose 2 Live Better" which although it does not cover the area of supplementation, it does signpost to other resources.

31/22 Item 7 – Finance Report (PHA/01/03/22)

31/22.1 Ms McCaig said that the Finance Report showed the position as at the end of January 2022, but she would give members an update on the February position.

31/22.2 Ms McCaig advised that the year to date position had remained largely unchanged with a surplus created by a combination of some timing issues relating to programme spend, an overspend on COVID-19, an underspend in management and administration and a surplus in one area of ring fenced funding relating to Delivering Care that the Department has not agreed to retract.

31/22.3 Ms McCaig said that that the projected year end surplus is around £500k, but she advised that she has been informed of a potential significant slippage and she has asked for a briefing on this by tomorrow. She said that while she is still looking for opportunities across the PHA and wider HSC budget, she wished to highlight to the Board that PHA will have a £500k surplus, but this figure will likely increase. She added that there are other risks to be managed including internal programme expenditure, management and administration and ring fenced funding related to COVID-19. She said that additional information regarding annual leave has been obtained, but there is still some clarity required on annual leave within contact tracing as this is managed outside the main system. She reported that she is not as concerned about Trust funding as progress has been made. She said that there is work ongoing to get a final cost for contact tracing.

31/22.4 Ms McCaig reported that the capital budget of £14m, of which £12.6m is related to R&D, is expected to break even.

31/22.5 Ms Henderson thanked Ms McCaig for setting out the position clearly and she expressed confidence that budget holders are doing all that

they can. In terms of next year's budget, she asked where PHA is going in terms of filling vacant posts, and how will PHA get its normal working plan back on schedule following COVID-19. She noted that bowel screening will not be back on track until August. She offered her congratulations to the team for their work during what has been a tough set of circumstances and she commended the reporting which she said has been very clear.

31/22.6 Ms McCaig said that budget holders are working to manage the situation, but noted that there is a reliance on the ability of PHA's partner organisations to be able to respond quickly. She advised that while she did not know what the final outturn would be, she would do her best. She said she would like to see the £200k retracted by the Department and she would do what she could, and she would have a better update by the time of the next meeting. Mr Stewart said that if PHA were able to achieve a break even position it would be miraculous. Ms McCaig agreed that it will be challenging. Mr Stewart asked what the implications would be for PHA if it did not achieve break even. Ms McCaig noted that it would be an underspend and, as such, there may be a public perception issue. However, in the scheme of the overall health budget, she said that it would not be huge, but it will be picked up on by External Audit. She did not expect that it would result in a significant challenge from an accountability point of view given that this has not been a normal year.

31/22.7 Ms Henderson asked about the scale of the potential slippage that was identified yesterday. Ms McCaig said that she would prefer to wait until she had received a briefing and spoken to the budget holder before commenting further. She undertook to update Ms Henderson outside of the meeting **(Action 2 – Ms McCaig)**.

31/22.8 Mr Clayton asked why the Department is reluctant to take back the £200k relating to Delivering Care and if the surplus is due to recruitment issues. Ms McCaig explained that COVID-19 had caused a delay, but at the same time once an organisation has declared its budget it is expected to utilise it. In normal circumstances, she advised that there is an expectation that ring fenced funding can be returned but there is some diplomacy required in this case. She assured members that she is working on number of fronts to resolve this.

31/22.9 The Chief Executive agreed that this has been an exceptional year with a lot of staff from health intelligence, HSCQI and nursing being redeployed into contact tracing and other parts of the emergency response, which has meant that progress in areas such as this has not been able to take place. He said he would have expected the money to have been spent, but at the same time he was not expecting people to do 2 jobs and he accepted that tasks that needed to be done were not done, but this was a decision he had to make. Ms McCaig concurred saying that PHA is not in a situation that it would normally be, but budget managers have worked hard and she will handle whatever happens at

the end of the year no matter what the final outturn is.

31/22.10 Mr Morton said that several of the posts that had to be recruited were of a high level, therefore these jobs had to be matched by HR and HR staff were also responding to the pandemic. He advised that there is a recovery plan in place and he hoped that the recruitment for these posts would be on track by the summer.

31/22.11 The Board noted the Finance Report.

32/22 Item 8 – Update on COVID-19

32/22.1 Dr Owen presented the latest data relating to COVID-19. She showed how the incidence rate in Northern Ireland has been declining whereas it has been increasing in other parts of the UK. She hoped that cases here would not start to increase again as in the other regions. She then showed the incidence by vaccination status.

32/22.2 Dr Owen presented the breakdown of cases by lineage which demonstrated that the majority of cases here are of the BA2 variant. She showed a breakdown of the case numbers by age which highlighted a fall in the number of cases in the 10-19 year old category and that the highest number is now among the 30-39 age group.

32/22.3 Dr Owen advised that there has been a lot of work carried out in relation to hospital based outbreaks with PHA staff having regular meetings with the Southern Trust. She said that the increase in hospital acquired infections is having an impact on the delivery of other services. In terms of hospital bed occupancy, she said that the data indicate that there is a low number of COVID-19 inpatients. The Chief Executive advised that at a recent meeting, it was agreed to move away from the notification process for deaths and use the data on the HCN Index and PAS.

32/22.4 Dr Owen reported that there are 152 care homes where there is an outbreak, of which 147 are nursing homes, and that the majority of these are where both staff and patients are affected. She said that a lot of this data is being picked up by routine testing. Mr Morton added that there is not a pattern of acuity and that the booster programme is adding a layer of protection. He hoped that the number of cases will remain low.

32/22.5 Dr Owen showed the number of vaccinations administered per day and commented that the uptake in the 5/11 year old programme has been particularly poor with only around 2,500 so there is work ongoing to promote that. She advised that the spring booster programme is about to be rolled out through GPs, community pharmacies and Trusts. She added that immuno-supressed individuals will receive a spring booster.

32/22.6 Dr Owen advised that the draft terms of reference for the COVID-19 Public Inquiry have been published and although this is a UK-wide Inquiry, devolved nations can undertake their own. She said that it is a

wide ranging Inquiry and will cover many aspects including testing, contact tracing and how organisations responded. She added that it will be interesting to see the volume of evidence that is put together. She advised that the draft terms of reference are out for public consultation so people are being asked whether they feel it covers all of the areas they would expect. She said the Inquiry will look at how families were impacted by COVID-19.

32/22.7 Mr Stewart commented that while case numbers in Northern Ireland appear to be flat lining, a high number of people seem to be infected. The Chief Executive said that this was raised with the Department, and the figures presented relate to testing and the ONS survey. However, he noted that people's behaviour has changed as has the ability to pick up on whether people get themselves tested. Furthermore, he said that people's social behaviour has also changed and they are going out in wider gatherings and there is less use of face coverings and less adherence to social distancing. He added that this is to be expected as there will be a degree of COVID-19 fatigue. On the flip side, he noted that hospital numbers are reducing as are the number of people in ICU and the number of deaths. However, he pointed out that this is related to the current variant and a new variant could emerge that PHA needs to be ready to deal with.

32/22.8 Mr Clayton asked if PHA will have the ability to ramp up its contact tracing operation if it needs to. He asked whether the asymptomatic testing in care homes will continue given the high level of outbreaks there and if care workers will continue to be able to avail of testing. He commented that the low level of uptake in the vaccination programme for 5/11 year olds may be due to a lack of information coming out from schools or GPs. He added that there may be some work required in convincing parents about doing this. He commented that it is bizarre how the number of cases here remains high, but also flat lines.

32/22.9 Mr Wilson said that he agreed with Mr Clayton's point about the vaccination programme for 5/11 year olds and that PHA finds itself in a curious position because normally this type of programme would be carried out by school nurses and the approach here is different than in other parts of the UK. He felt that this is a difficult issue as there is a resistance from parents to vaccinate their children and maybe a new variant emerging could turn the tide. Mr Clayton said that he would have expected information to come out from schools or GPs. Mr Wilson noted that accessibility has also been an issue for the vaccination programme. He said that while the big regional centres have had an impact, he pointed out that in Wales for example, centres have been located in town centres.

32/22.10 The Chief Executive confirmed that care home testing will continue and staff testing will also continue until at least the end of June. He said that the school cell in PHA, which has been busy over the last 2 years, is seeing less activity. He noted that while there has been a lot of cases

among schoolchildren, less of these are coming through to PHA as this beginning to become normalised within a school context. He added that there will continue to be variations of COVID-19.

32/22.11 Mr Morton noted that there needs to be a focus on Long COVID as although the intelligence on this is only starting to emerge, there is evidence to suggest that it will have a detrimental impact. While symptomatically the current variant may be mild, he said that people will not want to have a lifetime of fatigue and this should be borne in mind when considering whether to vaccinate children. He added that normally Northern Ireland has a good record when it comes to childhood vaccination. Mr Clayton said that although he had heard the announcement about the vaccination programme, he was not aware of the pathway.

32/22.12 Mr Stewart suggested that as the terms of reference for the COVID Inquiry are out for consultation, the Board may wish to take a view as to whether it makes a submission to the Inquiry and this should be put on the agenda for the next meeting **(Action 3 – Secretariat).** The Chief Executive advised that PHA is having a meeting with the Directorate of Legal Services about how it prepares itself for the Inquiry. He noted that there has been no decision as to whether Northern Ireland will have its own local Inquiry, but he said that he would be happy to come back to the Board and report on the outcome of that meeting which will be about how PHA prepares its records in the event of having to make a submission **(Action 4 – Chief Executive)**. The Chair advised that a meeting has been offered by the Deputy Director of the Inquiry to Health Chairs in England.

33/22 Item 9 – Update from Chair of Remuneration Committee

33/22.1 This item was deferred to the next meeting.

At this point the Chair left the meeting

34/22 Item 10 – Family Nurse Partnership Report 2020 (PHA/02/03/22)

Ms Emily Roberts joined the meeting for this item

34/22.1 Mr Morton said that Family Nurse Partnership (FNP) is a flagship programme in PHA. As part of nursing reforms, he advised that the Nursing and Midwifery Task Group Report was launched in 2020 and it set out a number of commitments, including the need to support the development of public health nursing roles across Northern Ireland, as well as to enhance the role of nurses and FNP. He said that FNP sits within this strategic context and over the last year there has been additional investment with another 5 practitioners employed.

34/22.2 Ms Roberts delivered a presentation and began by outlining the background to FNP and stating the objectives of the programme. She

highlighted some of the benefits and then moved on to give an overview of the current profile. She advised that the expansion of the programme has resulted in 850 individuals accessing it and each nurse having a caseload of 25 young mothers.

34/22.3 Ms Roberts reported the key outcomes of the programme and showed that there was a low attrition rate. She added that the data indicated that there were benefits for the children across each of the 5 main areas of child development. She advised that 97% of the children have their immunisations up to date after 24 months and a low number of infants have been hospitalised due to injury.

34/22.4 Ms Roberts advised that there were 3 key actions carried over from 2019 and 1 of these has been completed with the other 2 in progress. She said that the information system continues to be a challenge as the current system needs to be improved. She reported that there is now a data analyst in PHA and BSO is also providing support. She said that the existing system is not smart enough for the data analysis that is required.

34/22.5 Ms Roberts said that there has been good feedback from participants on the programme and in particular she highlighted the positive reviews from a breastfeeding session with 3 of the young mothers on Zoom.

34/22.6 Ms Roberts said that the Board is being asked to note the Report and to consider the need for a Northern Ireland study to look at the long term benefits of the programme.

34/22.7 Mr Stewart asked what the scale of the challenge was in terms of expanding the programme. Ms Roberts advised that there are presently around 900 teenage pregnancies per year, and that rate is plateauing, but the programme is presently reaching around 850 young people. In the early stages, she said that it was only 37/40% of those young people so there has been an improvement but until there is further investment there will be people that the programme will not reach. She added that the most vulnerable people are likely to have the best outcomes.

34/22.8 Mr Stewart sought clarity on the arrangement with the University of Colorado. Ms Roberts explained that it has the licence and the fidelity measures and PHA pays for consultancy fees. Mr Stewart asked therefore if PHA is tied into the use of the licence permanently. Mr Morton explained that it is an internationally licenced programme and Northern Ireland is a member. He added that it is useful to stay engaged to be able to do comparisons with other countries and Northern Ireland is seen as an exemplar. He noted that what is not known at this stage is the impact ten years after the programme for the participants and what their outcomes would have been had there not been this intervention, and therefore it is best to remain within the international community until there is some long term data available.

34/22.9 Mr Irvine commented that there are a lot of American euphemisms in the Report. He noted that while the benefits of the work have been highlighted, he would like to see measureable outcomes. He said that it was reported that there are 900 teenage pregnancies, but if only 850 of these individuals are being reached, how can the outcomes rather than the benefits be measured. He added that there is not an assurance that each pregnant woman receives a good intervention across a range of attributable benefits, and therefore there needs to be some baseline data. He asked that if the aim is to incrementally grow by 5/10% each year, why are there still people not being reached. He felt that the long term benefits are not necessarily visible. He asked whether after 2 years there is added benefit to the health system. He suggested that there should be a test group who are monitored 3/4 years after the programme. He asked whether the money spent is being directed in the right way and if outcomes are being delivered in the right way.

34/22.10 Ms Roberts agreed that there needs to be a baseline. She said that once the data systems have been improved and the data in place then it will be possible to measure impact going forward. She agreed that there is a need for a longitudinal study in order to get the evidence. She said that from speaking to the young mothers, it is clear that they are benefitting from the programme and that is evidenced in the Report. Mr Morton added that there will be a supplementary report that will be produced in the next 8/12 weeks which will look at critical development milestones and health data, i.e. are children reaching key milestones. He said that there will be a focus on mental health and emotional wellbeing. He assured members that the programme will focus on key data and also the socio-economic benefits. He reported that some mothers are moving into education and employment so this demonstrates that having had that FNP intervention, it can set up a young mother for life.

34/22.11 Ms Mann-Kler asked for an update on the investment in a long term study. She commented that having seen previous reports on FNP and its impact, it is a profound piece of work where there are lifelong changes for individuals which are not evidenced in the savings to the HSC for early intervention. She said that by teaching people how to have a healthy family and healthy relationships brings benefits, and there is a need to demonstrate that impact at a societal level so she would be supportive of a socio-economic study. She asked whether PHA publicises this Report and whilst understanding that there has been a delay to this Report, she asked when the 2021 Report would be produced.

34/22.12 Mr Morton advised that a business case would need to be put together and submitted to the Agency Management Team (AMT) for the socio-economic study and then one of the local universities could carry out that piece of work. He noted that a study could cost between £50k and £100k but this would be money well spent if the long term benefits to society can be demonstrated. In relation to the earlier work, that would

	need to be scaled up and the progress of young mothers tracked over a 5/10 year period. He said that colleagues in R&D could assist with this.
34/22.13	Mr Wilson advised that the Report is promoted and published, but there is a balance to be struck with programmes of this type in terms of promoting the benefits, but not being seen to target new people. He noted that there has not been much pick up on the Report in the past.
34/22.14	Ms Roberts said that the 2021 Report is being worked on and she hoped that it would not be as delayed, given that the Report is normally completed by June.
34/22.15	Mr Clayton said that it is clear that this programme does a lot of good, and he felt that it should be funded centrally given the points made about data and how it links to Programme for Government. He asked whether it would be possible to map this programme against Trust data from a social services point of view. He acknowledged that there may be some instances where the individuals are still in care, but the benefits of the programme could be mapped against child protection data. He suggested that there may be partner organisations in the community and voluntary sector who could demonstrate this. He added that a socio-economic study would be beneficial. Ms Roberts said that getting data from social services should be possible.
34/22.16	Dr Keaney noted the data about the reducing number of injuries and said that this was a good outcome. She suggested that a reduction in the incidence of sudden infant death would be an outcome. Mr Morton agreed and said that this programme is about giving mothers and babies time to build a relationship and it creates hope and when you hear the stories first hand from mothers it gives a sense of the learning that there is from a healthcare design point of view. He noted that no other service has a situation where 1 care worker has a caseload of 25.
34/22.17	Ms McCaig said that she found the report interesting and she asked whether the data can be used to support the prevention of pregnancy. She added that when an individual becomes pregnant, is there a way of using the data differently to target a more effective communication to reduce pregnancies. Mr Morton said that this is a good point and it would be worth taking this away to see if there is anything further than can be done. He added that there is some evidence of participating in this programme reduces the rate of a second pregnancy as the mothers are more awareness of areas such as sexual health and family planning. Ms McCaig said that there is a lot of information about the profile of individuals who may find themselves on this programme so it would be good to be able to support these individuals before they become pregnant. Ms Roberts said that efforts are being made to reduce teenage pregnancies and agreed some of the information from this programme could be used in a different way.
34/22.18	Mr Stewart thanked Ms Roberts for her presentation sand said that members understood and appreciated the importance of this

programme. He hoped that it will be possible to find the funding for the longitudinal study.

34/22.19 The Board noted the Family Nurse Partnership Report 2020.

35/22 Item 11 - Update on the Development of a new Operating Model for PHA

35/22.1 The Chief Executive delivered a presentation giving an update on the development of a new operating model for PHA. He began by reminding members that the Hussey Review had been carried out and this had resulted in 4 recommendations, but as this review had been carried out during the pandemic, its focus had been on health protection and since then the context has changed. He outlined that health protection is not the only function of the PHA as it is also involved in planning, reducing health inequalities, commissioning and service development and the emergence of the new Integrated Care Model will also mean changes, but there will be more on that over the coming months. He said that PHA needs to be able to continue to support the COVID-19 response.

35/22.2 The Chief Executive advised that in order to resource the work on developing this new model, an approach was made to the Leadership Centre but this was unsuccessful and initially there was some support from within the Department but due to other pressures this was not sustainable so in December 2021, Ms Heather Stevens was identified as the lead. He added that Ms Stevens had sought support from the Permanent Secretary about bringing in external consultants and following his endorsement, work began in December and January to develop a specification, but the timetable for this work would have gone to the end of June or beginning of July. He advised that the Permanent Secretary had suggested using EY as they had delivered other health service consultancy, and following an approach to the Executive Office, it was confirmed that this would fall under the remit of that contract. He added that it would cost £400k and while the Permanent Secretary has made a recommendation, it is still subject to Ministerial approval. However, he said that he was hopeful as the CMO is also supportive. He explained that if this was not successful, then a public procurement exercise would have to be carried out..

35/22.3 The Chief Executive advised that there will be two phases to the work, design and implementation. He said that the design phase will be about identifying what PHA wants and what EY can help with. He noted that there isn't a detailed specification which goes through what PHA wants to see delivered.

35/22.4 Mr Stewart asked that, if there is a difficulty in securing approval for the outline business case, can PHA get approval for a scoping exercise if the value of it is below a certain approval level. Ms McCaig explained that the difficulty is more to do with budgetary constraints, and this is tied

up at Ministerial level. Mr Irvine sought clarity as to whether the outline business case is for the consultancy for the scoping exercise and Ms McCaig confirmed that this was the case. Mr Irvine asked then if a further business case is needed for implementation costs. He noted that if this scoping exercise generates ideas that cost money and there is no funding for it, then there is no point in doing the work. Ms McCaig suggested that this will be an iterative process and she agreed that there will be challenges ahead. The Chief Executive acknowledged that there will be different elements that will come out, but some of these PHA can implement by itself while others will need investment. He advised that over the last period, he has met with members of the Health Committee and he has reminded them that they have stated that PHA needs to be bigger so to remember that if PHA puts forward a request for additional funding because this investment will be important to protect the health of the people of Northern Ireland. He said that there are areas PHA can take forward but he has asked the Health Committee members to be mindful of their commitments.

35/22.5 The Chief Executive said that once there is clarity on the financial situation progress can be made on delivering many elements of this work all at once. He recalled that the recent listening exercise highlighted an issue with regard to staff knowledge of the strategic vision of the organisation so there needs to be a strategy going forward and staff asked for their help in designing an implementation plan.

35/22.6 Ms Henderson expressed concern that this process could run for years, but the Chief Executive assured members that he was clear that the design phase is to be completed in 10/12 weeks and that by the end of the summer there would be an understanding of the type of organisation that needs to be created. He added that the implementation phase will then be completed over the following 12/18 months. He advised that the team involved in this work have recently completed a similar exercise in the Justice Department in the Republic of Ireland.

35/22.7 The Chief Executive advised that the Oversight Board will have 4 members, the Chair, himself, the CMO and the DCMO. He said that at a recent meeting with the CMO and DCMO, there was further discussion on what the membership of the Oversight Board with a suggested that there should be a "critical friend", for example Ms Tracey Cooper, the Chief Executive of Public Health Wales, and an individual outside of health with a background in organisational development (OD). He added that the CMO is keen that the Oversight Board should be small and compact and that the PHA Chair should sit on it, but the CMO would like to meet the Board to talk about it and it is hoped that he will attend the workshop on 26 April. He advised that Ms Stevens will be managing the whole process.

35/22.8 The Chief Executive said that Health Intelligence will form part of the scoping exercise, and that there is another piece of work that Dr Declan Bradley and Dr Diane Anderson are involved in looking at aligning the

work of public health and health intelligence and moving away from silo working.

35/22.9 The Chief Executive advised that the outline of Phase 2 has yet to be agreed, but it will be determined by Phase 1.

At this point Ms Mann-Kler left the meeting.

35/22.10 Mr Clayton said that £400k represents a high level of expenditure and asked if EY has capacity to undertake this work. He asked what added value EY can bring given that the Hussey Review pointed out the areas where PHA needed strengthened. He queried if the issue was about capacity within the Department or about what EY could bring. The Chief Executive replied that the main issue is capacity within the Department as there have been a lot of conversations between he and the Department about wanting to progress this work but there not being any capacity to go out and speak to people, look at other models, bring back a paper and then engage in co-production and co-design. He said that he could not comment on EY's capability, but the assurance is that they have been brought in through a competitive tendering process with the Executive Office and it will be EY's health group that will do this work. He added that a number of their consultants have worked with PHA staff previously, for example in the design of the nosocomial dashboard. He acknowledged that there are always risks, but PHA can bring its knowledge to the table and then there is the "critical friend" and the individual with an OD background, and they can monitor EY's work and comment on whether their advice is appropriate.

35/22.11 Mr Clayton said that the Chief Executive's overview provided some reassurance, and if it is a capacity issue then that is fair enough, but he noted that PHA will not know about EY's level of public health expertise until they start their work. He noted from the overview of the Sponsorship Review Meeting that the CMO is keen to speak to the Board and have the Chair involved, which shows a spirit of co-operation. The Chief Executive said that he was confident that there will be that co-operation. Mr Stewart said that EY has a level of independence, and added that the reason why consultants can get a bad reputation is because they are not managed so it will be up to Ms Stevens to do that. Ms McCaig agreed that there needs to be a "hand in glove" approach and co-production. She said that this is a significant organisational change and it is better that PHA is involved. She added that this work is seen to be important enough to have this level of funding spent on it and having that level of independence from EY is also a good thing. She commented that it is important for the whole of Northern Ireland that this is got right.

35/22.12 The Chief Executive commented that when the cost was raised in his conversation with the Permanent Secretary, his response was that this work was so important, it could not afford not to be done.

35/22.13 Ms Henderson said that she was trying to understand why PHA is being reviewed and why the review has now expanded. She asked if there was something wrong and if PHA's role needed to be changed. Mr Stewart said that PHA needs to change in the post-pandemic era. The Chief Executive added that PHA is 10 years old and given that HSCB is closing and the new Integrated Care model taking shape, it is a timely intervention and it is about making sure that PHA is fit for the future and can deliver what it needs to deliver and carry out its role of protecting health and reducing inequalities.

At this point Mr Clayton left the meeting

35/22.14 Mr Morton commented that while he understood the breadth and depth of the review and the oversight arrangements, he noted that it is the CMO and DCMO who are leading this, and felt that there should be ownership across a number of disciplines. He reminded members that PHA's role is about protecting health and social wellbeing so it is important that this is not seen as a medical model and there should be clarity on how public health is being defined. Mr Stewart said that the Chair would agree with those sentiments. The Chief Executive said that there will be a small Oversight Board and it will sit under the CMO because he is the head of PHA's Sponsor Branch. He assured members that the CMO is clear that social wellbeing is a key element as this is defined in legislation. He pointed out that PHA is the only public health organisation in the UK that has social wellbeing in its title. He added that there will be a co-design approach and regular engagement with both AMT and the Board. He advised that the membership of the Programme Board Steering Group has not yet been signed off.

35/22.15 The Board noted the update on the development of a new operating model for PHA.

36/22 Item 12 – Staff Recognition

36/22.1 The Chief Executive advised that he had a request for one or two Non-Executive Directors to work with Executive Directors on some options regarding staff recognition during the course of the pandemic. He suggested that a short meeting be convened and that there would be some Non-Executive Director input. The proposal was **AGREED** by members and expressions of interest would be sought through the Chair **(Action 5 – Secretariat)**.

37/22 Item 13 – Any Other Business

37/22.1 With there being no other business, the Chair thanked members for their time and drew the meeting to a close.

38/22 Item 14 – Details of Next Meeting

Wednesday 19 May 2022 at 1:30pm

Location to be agreed

Signed by Chair:

Date:

Finance Report
March 2022

Tracey McCaig
Director of Finance

April 2022

Section A: Introduction/Background

1. The PHA Financial Plan for 2021/22 was approved by the PHA Board in the June 2021 Board meeting, which described the opening financial position of the organisation and reported an anticipated breakeven position within 2021/22.
2. The Financial Plan identified a number of areas of projected slippage and how this was to be used to address in-year pressures and priorities.
3. This executive summary report reflects the year-end position as at the end of March 2022 (month 12). Supplementary detail is provided in Annex A.

Section B: Update – Revenue position

4. The PHA has reported a year to date surplus, at February 2022, of £0.1m (£1.2m at February 2022). The forecast year end position as at February 2022 was £1.4m surplus which was managed via a number of measures.
5. In respect of the year to date surplus of £0.1m:
   - The PHA Programme budget was underspent by approx. £1m for the year, primarily caused by slippage within Health Improvement (£0.5m, primarily the Regional Smoking Cessation budget) and Service Development & Screening (£0.25m across various budgets).
   - There was significant underspend in the Management & Admin budget (c£0.7m). This was expected and has been highlighted in previous reports. It primarily relates to the areas of Nursing & AHP and Operations, with a high number of vacant posts in this area, along with reduced non-pay expenditure due to different working arrangements associated with the pandemic. Efforts are on-going to fill vacant posts as soon as possible. The level of the surplus decreased at year-end from that previously forecast, primarily as a result of an increased adjustment for Annual Leave unused at 31 March 2022, with many staff unable to fully utilise their annual leave allocation due to the pressures of responding to the pandemic.
   - An overspend is noted in respect of Covid funding (c£1.6m) which is a managed position reflecting the plan to use Covid downturn in core operations to partially fund the activity of the Contact Tracing Centre. A

small overspend is reported on NDNA Transformation funding (£24k). This relates to slightly higher than anticipated expenditure on the Suicide Prevention project.

6. The updated position is summarised in the table below.

PHA Summary financial position - March 2022

	Full Year budget £'000	Full Year Expenditure £'000	Full Year variance £'000
Health Improvement	12,506	12,506	0
Health Protection	8,144	8,144	0
Service Development & Screening	14,055	14,055	0
Nursing & AHP	7,811	7,811	0
Centre for Connected Health	1,566	1,566	0
Other	798	798	0
Programme expenditure - Trusts	**44,881**	**44,881**	**0**
Health Improvement	27,375	26,885	490
Health Protection	10,368	10,324	43
Service Development & Screening	2,474	2,227	247
Research & Development	3,411	3,411	0
Campaigns	1,421	1,748	(327)
Nursing & AHP	731	712	19
Centre for Connected Health	323	265	59
Quality Improvement	149	120	28
Other	418	(4)	423
Programme expenditure - PHA	**46,669**	**45,687**	**982**
Subtotal Programme expenditure	**91,550**	**90,568**	**982**
Nursing & AHP	5,239	4,831	408
Quality Improvement	607	539	67
Operations	4,239	3,975	265
Public Health	16,769	16,590	179
PHA Board	618	860	(242)
Centre for Connected Health	426	409	18
SBNI	771	737	34
Subtotal Management & Admin	**28,668**	**27,939**	**729**
Trusts	1,705	1,705	0
PHA Direct	11,908	13,505	(1,597)
Subtotal Covid-19	**13,613**	**15,210**	**(1,597)**
Trusts	142	142	0
PHA Direct	64	89	(24)
Subtotal Transformation	**206**	**230**	**(24)**
Trusts	287	287	0
PHA Direct	241	238	3
Other ringfenced	**528**	**525**	**3**
TOTAL	**134,565**	**134,474**	**92**

N.B. Table may be subject to minor rounding differences

7. It should be noted that the PHA's breakeven limit is approximately c£0.3m and therefore PHA has achieved it's statutory breakeven duty (subject to Audit).

Section C: Management of Risks

8. The risks which have been articulated in previous reports have been managed to arrive at the surplus position outlined above, which is within the breakeven tolerance for the organisation.
9. **Internal Programme expenditure outturn.** Programme expenditure was monitored closely throughout the year with any slippages or pressures highlighted and managed.
10. **Management and Administration expenditure outturn.** This was closely monitored by the Finance team, in conjunction with PHA management, to ensure that the forecast financial position was updated on a monthly basis. The underspend was managed in the context of the wider PHA financial outturn
11. **Ring-fenced funding - Covid.** Expenditure funded via Covid funding was managed within a breakeven position, with the exception of the Contact Tracing Centre where, in liaison with DoH colleagues, Covid downturn within PHA was identified to offset Covid funding required as part of the planned actions in respect of the financial position.
12. **Annual leave.** The financial impact of the movement in annual leave usage levels was closely monitored in the approach to 31 March 2022 and the final position as at 31 March 2022 was managed in the context of the PHA's wider financial position.
13. **Funds not yet allocated to Trusts.** This risk had reduced in the approach to year end and was managed to achieve the reported position.
14. **Covid response impact on PHA.** It has been a challenging period for PHA, not least from the focus on the operational nature of the Contact Tracing Service and the support to manage service pressures due to Covid response. Staff members have been diverted internally to support the response, which has impacted the PHA's ability to fully conduct its business as usual operational requirements. The

management of the financial position has continued despite these challenges to arrive at the reported breakeven position.

Section D: Update - Capital position

15. The PHA had a capital allocation (CRL) of £14.4m for 2021-22. The majority of this (£13.2m) relates to Research & Development (R&D).

16. Other PHA Capital includes an allocation of £141k for the Congenital Heart Disease Professorship Network to be set up across Ireland and £800k for a Covid-19 Wastewater project. There is also currently a small allocation of £92k for ICT capital expenditure within PHA, and £141k for ICT linked to the Contact Tracing Centre.

17. The overall summary position is reflected in the following table.

Capital Summary	Total CRL £'000	Full year Expenditure £'000	Surplus / (Deficit) £'000
HSC R&D:			
R&D - Other Bodies	5,523	5,520	3
R&D - Trusts	8,249	8,249	0
R&D Capital Receipts	(520)	(520)	0
Subtotal HSC R&D	13,252	13,249	3
CHITIN Project:			
CHITIN - Other Bodies	1,655	1,655	0
CHITIN - Trusts	103	103	0
CHITIN - Capital Receipts	(1,758)	(1,758)	0
Subtotal CHITIN	0	0	0
Other:			
Congenital Heart Disease (CHD) Network	141	142	(1)
Covid-19 Wastewater	800	800	0
Covid-19 ICT	141	133	8
ICT	92	92	0
Subtotal Other	1,174	1,166	7
Total HSCB Capital position	**14,426**	**14,416**	**10**

18. R&D expenditure is managed through the R&D Division within PHA, and funds essential infrastructure for research such as information databanks, tissue banks, clinical research facilities, clinical trials units and research networks. The element relating to 'Trusts' is allocated throughout the financial year, and the allocation for 'Other Bodies' is used predominantly within universities – both allocations fund agreed projects that enable and support clinical and academic researchers. There was a small underspend of £3k in this area at year end.

19. CHITIN (Cross-border Healthcare Intervention Trials in Ireland Network) is a unique cross-border partnership between the Public Health Agency in Northern Ireland and the Health Research Board in the Republic of Ireland, to develop infrastructure and deliver Healthcare Intervention Trials (HITs). The CHITIN project is funded from the EU's INTERREG VA programme, and the funding for each financial year from the Special EU Programmes Body (SEUPB) matches expenditure claims, ensuring a breakeven position. As is usual, most of the activity on this project happened during March.
20. The Congenital Heart Disease network funding (£141k) is being managed by the Research & Development team, and has achieved full spend in year. The Covid-19 Wastewater allocation (£800k) funded a QUB project analysing wastewater to help with tracking of outbreaks of Covid-19. There was a small overspend of less than £1k in this area at year end.
21. There was an underspend (c£8k) in the area of Covid-19 ICT. All items have been purchased as planned, however there was a small price differential to that planned in the final charge for these items, creating the small underspend noted.
22. In overall terms, there was a small underspend of £10k against the CRL funding of £14.4m.

Recommendation

23. PHA Board are asked to note the PHA financial update as at March 2022.

HSC Public Health Agency

Public Health Agency

Annex A - Finance Report

2021-22

Month 12 - March 2022

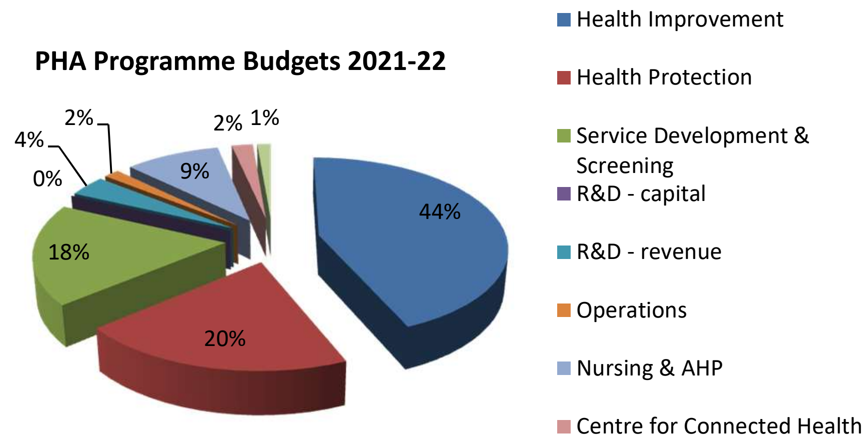
PHA Financial Report - Executive Summary

Year End Financial Position (page 2)

At the end of the year PHA is reporting an underspend of £0.1m against its annual allocation. All figures in this report are subject to any final year-end audit adjustments. This underspend is primarily the result of underspends on Programme and Administration budgets across the Agency, offset by planned overspends on Covid-19 funding managed closely with DoH Finance.

Programme Budgets (pages 3&4)

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

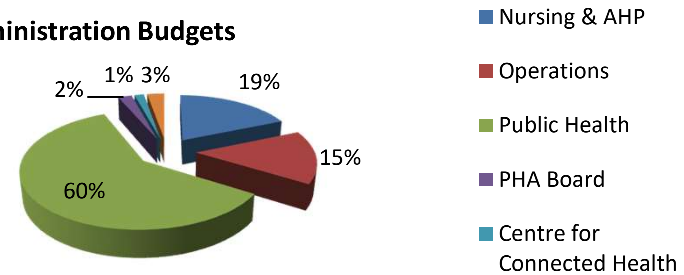


Administration Budgets (page 5)

Over 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
2021 -22 Summary Position - March 2022

	Programme Trust £'000	Programme PHA Direct £'000	Annual Budget Ringfenced Trust & Direct £'000	Mgt & Admin £'000	Total £'000
Available Resources					
Departmental Revenue Allocation	44,881	46,582	14,347	27,372	**133,180**
Assumed Retraction	-	-	-	-	**-**
Revenue Income from Other Sources	-	87	-	1,296	**1,383**
Total Available Resources	44,881	46,669	14,347	28,668	**134,566**
Expenditure					
Trusts	44,881	-	2,134	-	**47,015**
PHA Direct Programme *	-	45,687	13,833	-	**59,520**
PHA Administration	-	-	-	27,939	**27,939**
Total Proposed Budgets	44,881	45,687	15,967	27,939	**134,474**
Surplus/(Deficit) - Revenue	-	982	(1,620)	729	**92**
Cumulative variance (%)					

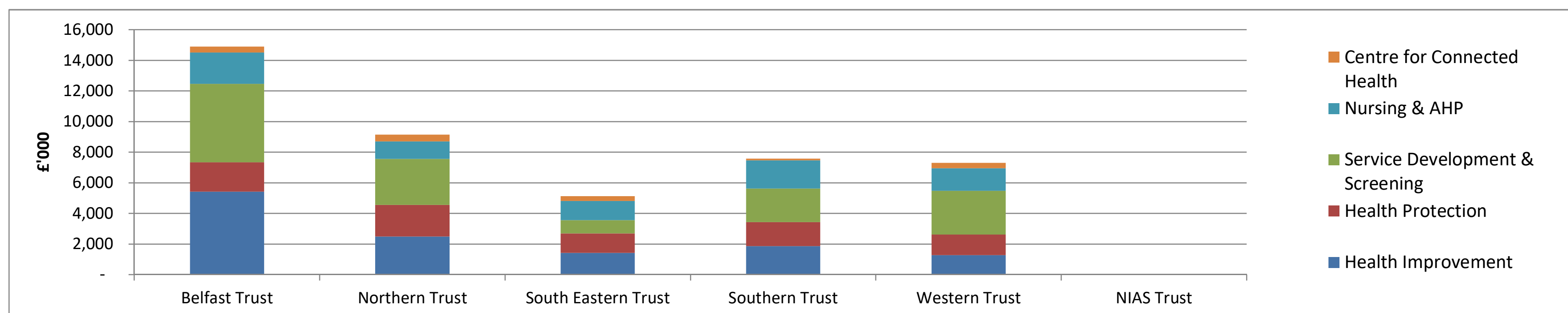
The year to date financial position for the PHA shows an underspend of £0.1m, which meets the financial breakeven target for PHA.

** Please note that a number of minor roundings may appear througout this report.*

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

March 2022

Programme Expenditure with Trusts

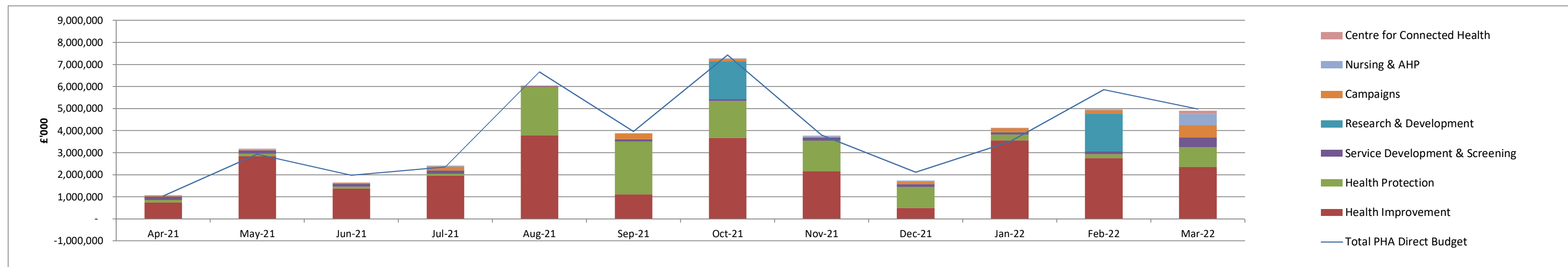


Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	NIAS Trust £'001	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	5,422	2,495	1,436	1,877	1,276	-	**12,506**	12,506	12,506	-
Health Protection	1,915	2,072	1,255	1,561	1,342	-	**8,144**	8,144	8,144	-
Service Development & Screening	5,127	2,998	874	2,199	2,856	-	**14,055**	14,055	14,055	-
Nursing & AHP	2,055	1,149	1,262	1,835	1,486	24	**7,812**	7,812	7,812	-
Centre for Connected Health	375	434	298	118	341	-	**1,566**	1,566	1,566	-
Other	253	160	100	135	148	-	**797**	798	798	-
Total current RRLs	**15,147**	**9,309**	**5,225**	**7,725**	**7,448**	**24**	**44,880**	**44,881**	**44,881**	-
Cumulative variance (%)										***0.00%***

The above table shows the current Trust allocations split by budget area. Budgets have been realigned in the current month and therefore a breakeven position is shown for the year to date as funds previously held against PHA Direct budget have now been issued to Trusts.

March 2022

PHA Direct Programme Expenditure



	Apr-21 £'000	May-21 £'000	Jun-21 £'000	Jul-21 £'000	Aug-21 £'000	Sep-21 £'000	Oct-21 £'000	Nov-21 £'000	Dec-21 £'000	Jan-22 £'000	Feb-22 £'000	Mar-22 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000	
Profiled Budget																	
Health Improvement	884	2,625	1,357	1,788	4,478	740	3,937	1,656	1,067	2,325	3,498	3,020	**27,375**	27,375	26,885	490	*1.8%*
Health Protection	77	100	87	85	2,142	2,976	1,585	1,638	775	713	324	(133)	**10,368**	10,368	10,324	43	*0.4%*
Service Development & Scree	51	158	470	192	29	235	102	50	159	199	120	708	**2,474**	2,474	2,227	247	*10.0%*
Research & Development	-	-	-	-	-	-	1,700	-	-	-	1,711	-	**3,411**	3,411	3,411	-	*0.0%*
Campaigns	10	10	20	227	10	5	19	414	77	282	132	215	**1,421**	1,421	1,748	(327)	*-23.0%*
Nursing & AHP	4	22	4	1	10	0	56	10	49	(28)	50	551	**731**	731	712	19	*2.6%*
Centre for Connected Health	20	20	43	11	5	4	5	5	(9)	10	1	209	**323**	323	265	59	*18.1%*
Quality Improvement	-	-	-	58	-	7	34	31	1	-	26	(8)	**149**	149	120	28	*19.1%*
Other	-	-	-	-	-	-	-	-	-	-	-	418	**418**	418	(4)	423	*100.0%*
Total PHA Direct Budget	**1,046**	**2,935**	**1,981**	**2,363**	**6,674**	**3,967**	**7,438**	**3,805**	**2,118**	**3,501**	**5,862**	**4,980**	**46,670**	**46,669**	**45,687**	**982**	
Cumulative variance (%)																***2.10%***	
Actual Expenditure	**1,128**	**3,228**	**1,693**	**2,462**	**6,060**	**3,924**	**7,324**	**3,874**	**1,848**	**4,178**	**5,012**	**4,957**	**45,688**				
Variance	**(82)**	**(293)**	**288**	**(98)**	**613**	**44**	**113**	**(69)**	**270**	**(677)**	**850**	**24**	**982**				

The year-end position shows an underspend of approximately £1.0m. The underspend arose in the areas of Health Improvement, Service Development & Screening and Other offset by an overspend within Campaigns.

March 2022

Public Health Agency
2021-22 Ringfenced Position

	Annual Budget			
	Covid £'000	NDNA £'000	Other ringfenced £'000	Total £'000
Available Resources				
DoH Allocation	13,613	206	528	**14,347**
Assumed Allocation/(Retraction)	-			0
Total	13,613	206	528	**14,347**
Expenditure				
Trusts	1,705	142	287	**2,134**
PHA Direct	13,505	89	238	**13,832**
Total	15,210	230	525	**15,966**
Surplus/(Deficit)	**(1,597)**	**(24)**	**3**	**(1,620)**

PHA has received a COVID allocation of £13.6m to date, £7.0m of which is for Contract Tracing. More detail on the COVID funding allocations PHA has received is provided in page 9 of this report.

Transformation funding has been received for a Suicide Prevention project totalling £0.2m. There was a small overspend of £24k in this area.

Other ringfenced areas include Safe Staffing and Fresh Start funding for SBNI.

March 2022

PHA Administration

2021-22 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	5,080	596	3,090	16,443	552	385	505	**26,650**
Goods & Services	159	10	1,149	326	66	42	266	**2,019**
Total Budget	**5,239**	**606**	**4,239**	**16,769**	**618**	**426**	**771**	**28,668**
Budget profiled to date								
Salaries	5,080	596	3,090	16,443	552	385	505	**26,650**
Goods & Services	159	10	1,149	326	66	42	266	**2,019**
Total	**5,239**	**606**	**4,239**	**16,769**	**618**	**426**	**771**	**28,668**
Actual expenditure to date								
Salaries	4,556	527	2,734	16,282	811	385	522	**25,817**
Goods & Services	275	13	1,240	308	48	24	214	**2,122**
Total	**4,831**	**539**	**3,975**	**16,590**	**860**	**409**	**736**	**27,939**
Surplus/(Deficit) to date								
Salaries	524	69	356	161	(259)	(0)	(17)	**832**
Goods & Services	(116)	(2)	(91)	18	18	18	52	**(103)**
Surplus/(Deficit)	**408**	**67**	**265**	**179**	**(242)**	**18**	**34**	**729**
Cumulative variance (%)	*7.78%*	*11.06%*	*6.25%*	*1.07%*	*-39.16%*	*4.17%*	*4.46%*	***2.54%***

PHA’s administration budget is showing a year-to-date surplus of £0.7m, which is being generated by a number of long standing vacancies along with the impact of many staff continuing to work primarily from home. This is driving reduced expenditure in areas such as travel and courses. Senior management monitored this position closely in order to achieve the PHA's obligation of a breakeven position for the financial year.

March 2022

Public Health Agency
2021-22 Capital Position

	Capital Resource Limit (CRL) £'000	Full Year Expenditure £'000	Surplus / (Deficit) £'000
HSC Research & Development			
R&D - Other Bodies	5,523	5,520	**3**
R&D - Trusts	8,249	8,249	**-**
R&D - Capital Receipts	(520)	(520)	**-**
	13,252	**13,249**	**3**
CHITIN Project			
CHITIN - Other Bodies	1,655	1,655	**-**
CHITIN - Trusts	103	103	**-**
CHITIN - Capital Receipts	(1,758)	(1,758)	**-**
	-	**-**	**-**
Total R&D Position	**13,252**	**13,249**	**3**
Other PHA Capital			
Congenital Heart Disease (CHD) Network	141	142	**(1)**
Covid-19 Wastewater	800	800	**-**
Covid-19 ICT	141	133	**8**
ICT	92	92	**-**
Total Other Capital Position	**1,174**	**1,166**	**7**
Total PHA Capital Position	**14,426**	**14,416**	**10**

The PHA holds the regional Capital Resource Limit (CRL) for HSC Research & Development (R&D), which currently totals £12.9m. This is managed through the R&D Division within PHA, and funds essential infrastructure for research such as information databanks, tissue banks, clinical research facilities, clinical trials units and research networks. The element relating to ‘Trusts’ is allocated throughout the financial year, and the allocation for ‘Other Bodies’ is used predominantly within universities – both allocations fund agreed projects that enable and support clinical and academic researchers.

CHITIN (Cross-border Healthcare Intervention Trials in Ireland Network) is a unique cross-border partnership between the Public Health Agency in Northern Ireland and the Health Research Board in the Republic of Ireland, to develop infrastructure and deliver Healthcare Intervention Trials (HITs). The CHITIN project is funded from the EU's INTERREG VA programme of €8.84m, and the funding for each financial year from the Special EU Programmes Body (SEUPB) matches expenditure claims, ensuring a breakeven position.

Other PHA Capital includes an allocation of £0.141m for the Congenital Heart Disease Professorship Network to be set up across Ireland and £0.8m for a Covid-19 Wastewater project. There is also currently a small allocation of £92k for ICT capital expenditure within PHA, and £141k for ICT linked to the Contact Tracing Centre.

PHA Prompt Payment

Prompt Payment Statistics

	March 2022 Value	March 2022 Volume	Cumulative position as at March 2022 Value	Cumulative position as at March 2022 Volume
Total bills paid (relating to Prompt Payment target)	£7,783,625	781	£72,466,534	7,090
Total bills paid on time (within 30 days or under other agreed terms)	£7,737,542	778	£68,085,679	6,992
Percentage of bills paid on time	**99.4%**	**99.6%**	**94.0%**	**98.6%**

Prompt Payment performance for March shows that PHA has exceeded the 95.0% target on both volume and value. The year to date position shows that on volume, PHA has achieved its 30 day target of 95.0% but on value it has fallen to 94.0%. The failure to meet prompt payment on value was due to a delay in paying Flu Vaccine invoices of £3.9m in October.

The 10 day prompt payment performance remains very strong at 87.7% on volume for the year to date, which significantly exceeds the 10 day DoH target for 2021-22 of 70%.

PHA COVID-funded Expenditure

	Annual Budget £'000	Spend to 31 March 2022 £'000	Varaince £'000	*Notes*
Contact Tracing Centre	7,028	8,781	(1,753)	*1*
Screening	560	560	0	
Vaccine Roll Out Programme	614	664	(50)	
Infection Prevention Control Nursing	550	560	(10)	
NI Advanced Care Planning	350	332	18	
Band 8s Overtime	50	51	(1)	
Schools Support Team	116	124	(8)	
Additional Flu Response	3,573	3,573	0	
HP Team - Covid Vaccination in Schools	500	500	0	
Other incl. Data Analysis	272	65	207	
Total	**13,613**	**15,210**	**(1,597)**	

Notes

1 An allocation of £7.028m has been received for Contact Tracing from DoH and the remaining costs are being funded via PHA Covid downturn in PHA core business. PHA have worked closely with DoH Finance to manage the overall position to breakeven.

HSC Public Health Agency

minutes

Title of Meeting	Meeting of the Public Health Agency Governance and Audit Committee
Date	27 January 2022 at 2pm
Venue	Via Zoom

Present

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

In Attendance

Mr Stephen Wilson	-	Interim Director of Operations
Mr Stephen Murray	-	Interim Assistant Director of Planning and Business Services
Ms Karen Braithwaite	-	Senior Operations Manager (Delivery)
Ms Tracey McCaig	-	Interim Director of Finance, HSCB
Mr David Charles	-	Internal Audit, BSO
Mr Roger McCance	-	NIAO
Ms Christine Hagan	-	ASM
Mr Robert Graham	-	Secretariat

Apologies

Mr Robert Irvine	-	Non-Executive Director

1/22	**Item 1 – Welcome and Apologies**
1/22.1	Mr Stewart welcomed everyone to the meeting. Apologies were noted from Mr Robert Irvine.
2/22	**Item 2 - Declaration of Interests**
2/22.1	Mr Stewart asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.
3/22	**Item 3 – Minutes of previous meeting held on 3 December 2021**
3/22.1	The minutes of the previous meeting, held on 3 December 2021 were **approved** as an accurate record of that meeting, subject to minor amendments proposed by Ms McCaig in paragraph 58/21.14.

4/22 Item 4 – Matters Arising

56/21.2 Contact Tracing Service

4/22.1 Mr Stewart noted that there had been an update from the Chief Executive at the last Board meeting about the status of the Contact Tracing Service and the view of the Department with regard to its future, so this remained a live issue.

56/21.3 Recruitment of Vaccinators

4/22.2 Mr Stewart said that he was not satisfied that PHA received the legal opinion he was seeking as to whether the Department had the authority to direct PHA to carry out this work, and that this remained an open question. Mr Clayton noted that some actions had been discussed and it would be useful to get an update from the Agency Management Team (AMT), and that this should be taken up with the Chair and Chief Executive. Ms Mann-Kler said that there remains this gap and this would need covered in any update. Mr Stewart agreed and said that his point was there was an assumption that the Department could instruct PHA as it saw fit and its view was that as PHA is responsible for safeguarding public health it was a legitimate request, but he queried whether it is within PHA's statutory remit to hire vaccinators. He added that when the question was sent to Counsel he had made it clear what question he wanted asked, and that question still remained unanswered.

4/22.3 Mr Clayton noted that the Chief Executive had subsequently reported to the Board that he had been linking with RQIA regarding registration and he would like to receive an update on how that is progressing. He added that he had had a conversation with the Chair and suggested to him that there should be a discussion about these issues at a workshop in order to reach a resolution. He said that the Chair was going to give consideration to that proposal.

4/22.4 Mr Stewart said that he was raising this again as the Board needs to be sure that there were legitimate grounds for making the request, and he did not want there to be a gap in PHA's governance. He undertook to speak to the Chair and Chief Executive about this **(Action 1 – Mr Stewart)**.

4/22.5 Mr Wilson noted that he recalled the discussions at the last Board meeting about the issue of what question should have been put, and he agreed with the suggestion of discussing this in a workshop. Mr Stewart said that he had asked to see the question before it was sent because the response received to any question will depend on the question that is asked.

56/21.6 Closure of HSCB

4/22.6 Mr Stewart noted that the HSCB is due to close at the end of March, and

said that the Board and Governance and Audit Committee should be more aware of how that work is progressing given it touches on a range of areas that may impact on PHA, e.g. the finance function.

4/22.7 Ms McCaig advised that she has prepared a letter for the Chair and Chief Executive setting out that, from a finance perspective, there will be no change for PHA until PHA makes a decision regarding a Director of Finance and that the service provided by her staff will continue to be ring fenced. She said that she was holding off until the right time to send this correspondence. Mr Stewart expressed his relief as the date is looming very quickly and he said that he would speak to the Chair about ensuring that the PHA Board is kept fully informed **(Action 2 – Mr Stewart)**.

4/22.8 Ms Mann-Kler asked if there is a document which outlines the governance implications of the closure of HSCB on PHA. Ms McCaig explained that although HSCB is closing, its staff will be hosted by BSO and there will be no change in how PHA receives its services and therefore there is no specific document. She added that there will be an MOU between PHA and BSO, and that although HSCB is closing and being replaced by the Strategic Planning and Performance Group (SPPG), it will be using the same finance system and the same HR system. She reiterated that she will set all of this out in her correspondence.

4/22.9 Mr Clayton agreed that it would be useful to get a sense of the work and he noted that this is on the Corporate Risk Register where there is reference to the creation of the new integrated care system. He said that he would welcome an update on what impact the closure of HSCB will have on PHA staff. He recalled that last year there was a discussion with Department officials and he felt it would be useful to have a further briefing within the next few months. He noted that Local Commissioning Groups (LCGs) will remain in place until the new Area Programme Boards are set up so he reiterated that it would be useful to understand the implications of all of this for PHA.

4/22.10 Ms McCaig advised that there is a lot of work ongoing with regard to the new planning boards and that PHA staff are involved in this. She suggested that the Chair and Chief Executive should write to Ms Martina Moore to invite her to give a briefing to the Board. She indicated that the end of April may be a good time for this. Mr Stewart agreed that the PHA Board should receive a briefing so it knows where it stands across a range of integrated services. Ms McCaig commented that while many things are changing, many others will remain the same. She suggested that the bigger changes will not take place on 1 April, but further down the line. Mr Stewart said that the PHA Board needs to know what the changes are so that is on the record and to be assured so that even an indication that there is no change represents an assurance.

4/22.11 Mr Wilson said that he agreed with what Ms McCaig said and advised

that he and Mr Murray had met recently with Ms Moore and he had no issue with bringing an update to the PHA Board **(Action 3 – Mr Wilson)**.

7/22 **Item 7 – Corporate Governance**

Public Health Directorate Risk Register as at 31 December 2021 [GAC/03/01/22]

Dr Stephen Bergin joined the meeting for this item.

7/22.1 Mr Stewart thanked Dr Bergin for joining the meeting to discuss the public health directorate risk register.

7/22.2 Dr Bergin recalled his previous Committee attendance and said that many of the issues that were flagged up then remain live as the team has been tasked with other duties. He said that the public health directorate is under staffing pressures and other directorates have stepped in to help. He added that there is need for a rebuild, but that is a strategic issue for the PHA as a whole, and therefore some of the staffing issues may have to be carried forward until the wider capacity issues in PHA are worked out. He suggested that in the future there may not be a directorate of public health.

7/22.3 Mr Stewart asked if not filling posts heightens the risk. He noted the reference in the risk register about apprenticeships and development opportunities and asked if there was any possibility of that work going forward. Dr Bergin said that there are a lot of ideas. He pointed out that in terms of public health qualifications, only 10% of the PHA workforce have those but this should be higher. He said that there should be an incentive for staff to develop on a public health career pathway, but that work will take a couple of years. Mr Stewart said that Dr Bergin would have the Committee's support in advancing such work as PHA continues to have difficulties in recruiting staff. Ms Mann-Kler asked about the blockages that exist, and whether these are that the PHA is not an attractive place to work, or if there is a global shortage of public health staff and if other similar agencies are facing the same challenge. She noted that this problem has existed since before the pandemic. Dr Bergin replied that there should be a pathway for staff development, but he explained that in order for staff to develop they would have to do this outside PHA and there is no incentive to do that. He noted that the process could be more agile but this would go outside Agenda for Change terms and conditions. Mr Stewart said that this is about organisational development as a whole. Mr Clayton added that getting the workforce trained to have that level of public health knowledge and expertise should be a discussion for the whole Board, but he noted that it is a complex area.

7/22.4 Mr Stewart said that issues about the IT systems for screening programmes had been raised previously. He noted that on the Corporate Risk Register, there is a reference to the IT support for

screening programmes indicating that these are legacy systems. He asked whether that will impact on PHA's ability to mitigate the risk. He noted that there was a risk that by April 2021 the IT system for breast screening would be obsolete, but given that was almost a year ago, he asked whether a mitigation had been put in place. Dr Bergin explained that the computer system will not stop working, but it is the updating of the system that is the issue which has resulted in some processes becoming more manual, therefore there is a need to get a more modern system in place. He added that for those systems that are out of date, the solution is not for PHA to procure its own system, but to link in nationally with the NHS and if a system is developed, Northern Ireland can avail of it. He noted that at present PHA is working with private companies because it does not have the capacity to do this work. He said that the development of the Vaccine Management System for COVID-19, which will come to PHA, reinforces the need for PHA to get more staff.

7/22.5 Mr Stewart asked if there was a possibility of the business case for breast screening getting approved in-year given PHA is in a position where it will be returning funding. Dr Bergin advised that there has been in-year funding, but many programmes of work have suffered as a result of COVID-19 and are running behind. He said that PHA is in the queue to get funding next year. Ms McCaig concurred that the budget for next year has not yet been finalised and is awaiting Ministerial approval. She added that any IT requests would go to the digital team at the Department.

7/22.6 Ms Mann-Kler asked that when talking about data intelligence functions, what aspirations does PHA have in terms of the system that it needs, and how can it be future proofed. She noted that it is going to take 12/18 months for programmes to get back on track, and asked how PHA is dealing with the risk in terms of targeting screening for high risk and vulnerable groups. Dr Bergin advised that there will be an update on screening brought to the PHA Board. He said that for Abdominal Aortic Aneurysm (AAA) screening, those at higher risk would have continued to have been screened, but it will take time for the programme to catch up for those at lower risk.

7/22.7 Mr Stewart noted the impact of COVID-19 when reading the directorate risk register. He asked whether the risk referring to CBRN incidents was rated appropriately and if this was really likely. Dr Bergin explained that as PHA's lens is firmly focused on COVID-19, there is a risk of other infectious diseases being overlooked. Mr Stewart said that he understood the rationale.

7/22.8 Mr Stewart thanked Dr Bergin for attending the meeting and expressed his thanks to Dr Bergin and his staff for their work in getting this directorate risk register updated.

7/22.9 Members noted the public health directorate risk register.

4/22	**Item 4 – Matters Arising**
	58/21.4 Workforce Issues
4/22.12	Mr Stewart noted that there had been a discussion at the last PHA Board about the need for a workforce plan.
	58/21.8 Staff Resilience
4/22.13	Mr Stewart noted that this had also been discussed at the last PHA Board meeting.
5/22	**Item 5 – Chair's Business**
5/22.1	Mr Stewart advised that he had no Chair's Business.
6/22	**Item 6 – Internal Audit**
	Internal Audit Progress Report [GAC/01/01/22]
6/22.1	Mr Charles advised that a draft report on the audit of Board effectiveness has been shared with the Chair and Chief Executive. He said that there has been an exit meeting and he is hopeful that the report can be finalised by mid-February. In terms of other audits, he reported that the fieldwork is ongoing for the financial review audit with a view to a draft report being issued in the next 7/10 days. He added that a joint HSCB/PHA audit of Serious Adverse Incidents (SAIs) is being carried out and a draft report should be issued in early February.
6/22.2	Mr Charles advised that there has been a request to defer the audit on vaccination programmes given the challenges facing the public health directorate, but this would need to be approved by the Committee. Mr Stewart said that Mr Wilson had written to him regarding this and he had shared that correspondence with Mr Clayton and Ms Mann-Kler. Members **approved** the deferral of the audit.
6/22.3	Mr Stewart said that he had spoken to Ms McKeown about the SAI audit as the issue of SAIs has concerned Non-Executive members for some time. He added that NEDs have been asking for clarity in terms of where PHA's responsibility lies in this area and he is concerned that there is a gap. He said that reporting on SAIs is listed for "noting" on PHA's Assurance Framework and he has spoken to the Chief Executive to express his view that this is not appropriate.
6/22.4	Mr Charles asked if the issue is that the Board does not have visibility of the outworking of SAIs. Mr Stewart said that as the Board is unsure as to its responsibilities, it cannot properly oversee the process. He noted that an update had been given to members but he felt that it did not cover the queries raised. Mr Clayton commented that he is not clear in terms of how PHA oversees this area. He said that part of the

responsibility lies within Mr Rodney Morton's directorate, in a not dissimilar way to other areas of joint working with HSCB. He added that the Board is not totally clear on the process and from a governance perspective, PHA's role may be affected by the closure of HSCB.

6/22.5 Mr Charles explained that if an SAI were to occur in a Trust, the Trust has 72 hours to report it to HSCB who then assign a Designated Responsible Officer (DRO). He said that there are number of groups in HSCB which look at SAIs and which PHA staff are involved in. He added that there are regular reports on SAIs which come through HSCB, but perhaps there is no visibility for PHA NEDs. He said that while there may be clarity on the process at an operational level, there is not at NED level.

6/22.6 Mr Charles said that the audit work is progressing well, but noted that there has been more time spent on audits than envisaged, particularly the Board effectiveness audit.

6/22.7 Members noted the Internal Audit Progress Report.

7/22 Item 7 – Corporate Governance

Corporate Risk Register as at 31 December 2021 [GAC/02/01/22]

7/22.10 Mr Wilson explained that this version of the Corporate Risk Register represents a review as at 31 December 2021. He advised that two risks have had their rating reduced, one relating to PHA leadership and one relating to Lifeline; and two others have been removed, both relating to finance. He said that a new risk has been added which relates to finance and in particular PHA's requirement to achieve a break even position.

7/22.11 Ms Mann-Kler said that it was useful to get the Corporate Risk Register to the Committee in a timely way. She asked what action is being proposed to deal with the risk on cyber security (risk 39). Mr Wilson advised that BSO lead on this area on a regional basis. He said that the recent incidents at Queen's University and in the HSE in the Republic of Ireland have opened up some complexities. He added that this is an area that is expanding and PHA will work with BSO and HSC to understand the gaps.

7/22.12 Ms Braithwaite advised that on the back of the incident at Queen's, a lot of work was carried out to bring HSC systems and processes up to date, and there was a proposal to carry out a piece of work across Northern Ireland on cyber security but when an update on this work was asked about at a meeting this morning, the response was that at present the Department does not have the capacity to take this forward and that no progress is expected this year.

7/22.13 Mr Stewart asked about risk 52, which relates to information

governance, and noted that the review date had changed to March 2022 for all staff in contact tracing to complete information governance training prior to deployment as it was his understanding that all staff are trained before they commence duties. Mr Wilson assured members that contact tracing staff are not deployed until they have done their training.

7/22.14 Moving onto risk 54, regarding the the ability of third party providers to deliver commissioned services, Mr Stewart noted that 96% of providers are delivering services fully or with reasonable adjustment, and therefore he did not feel that this represented a risk. Mr Wilson reported that he had raised this with staff in Health Improvement and it was felt that this risk should be kept as "medium" because there remain some issues with contract management and there are also issues in terms of the extent to which staff can pick these up as they have been redeployed to support contact tracing. He said that he envisaged this risk having a lower risk when it is next reviewed.

7/22.15 Returning to risk 52, Mr Clayton noted that there was reference to arrangements with the new UK Health Security Agency (UKHSA) being finalised and he asked what this related to. From a cyber security point of view, he asked if there were risks to data sharing and if the agreements are being put in place because UKHSA is a new body, or because there are risks. Ms Braithwaite said that there is a lot of change at the moment and PHA is being careful it is not sharing information simply because it is being asked to. She said that PHA had shared data related to genome sequencing, but it is now being careful with regard to other requests. Mr Clayton said that he asked this because there was a discussion about an MOU between UKHSA and other nations and therefore he had this concern that PHA wasn't sharing information because it was being asked for.

7/22.16 Mr Stewart noted that in risk 62 relating to regional vaccinators, two of the gaps concerned not having a formal letter and not having confirmed funding, but his understanding was that these were in place. Mr Wilson agreed and said that this needs to be updated.

7/22.17 Mr Clayton said that a previous meeting, there was discussion about the removal of a risk relating to contact tracing and he queried whether this should be placed back on the register given the current number of daily cases and given the impact it is having on other aspects of PHA's business. He noted that previously an element of the risk was about funding, but perhaps on this occasion it is about resilience and PHA's ability to cope. He felt it may be worth considering as it may take months for the number of daily cases to decline. He added that there was also discussion about AMT considering combining the risks about workforce into one risk rather than having separate for public health and HSCQI which could be placed on the appropriate directorate risk registers. He also asked why the rating for risk 63 relating to Lifeline has been reduced.

7/22.18 Mr Wilson said that in terms of contact tracing, this is kept under review on a daily basis and there are currently discussions about what will happen to contact tracing after the end of June. He suggested that there is potential for a digital solution. He expressed his surprise about the situation in England whereby many elements of the pandemic are starting to be scaled down e.g. testing and contact tracing. He said that this is being kept under review by AMT. Mr Clayton suggested that there may be a broader risk in terms of PHA's future COVID-19 response. He noted that at the last Board meeting, Dr Bergin had talked about a central contact tracing hub for COVID-19 and other infectious diseases. Mr Wilson pointed out that PHA has always had a contact tracing element to its work.

7/22.19 Mr Wilson advised that there are discussions taking place about staffing pressures and that on the next iteration of the Register, the two risks relating to workforce will be combined. In terms of the risk on Lifeline, he was not certain what had changed, but he suggested that it related to the contract that is in place with the service provider. He undertook to come back to the Committee with more detail **(Action 4 – Mr Wilson)**.

7/22.20 Members **APPROVED** the Corporate Risk Register.

8/22 Item 8 – External Audit – PHA Audit Strategy 2021-22 [GAC/04/01/22]

8/22.1 Mr McCance said that the Committee will be familiar with the content of the Audit Strategy which outlines how the audit will be completed and the proposed timeline. He advised that while the Comptroller and Auditor General signs off the audit, the work is sub-contracted to ASM.

8/22.2 Ms Hagan took members through the Strategy beginning with the key messages outlining the purpose of the document and advising that the level of materiality has been set at £1.86m. She highlighted the significant audit risks and then the actions required for the Committee. Returning to the level of materiality, she advised that any misstatements above £93k will be reported to the Committee.

8/22.3 Ms Hagan moved onto the next section which outlines the audit approach. She highlighted the changes in the financial reporting guidance in that IFRS 16 will come into effect so PHA may be required to make some transactional disclosures.

8/22.4 Ms Hagan gave more detail on the two significant risks, namely management override of controls and risk of fraud in revenue recognition. She advised that there are two other risk factors which will be monitored during the audit, the first of which is the requirement to break even. She noted that given the impact of COVID-19 on spend profiles, there may be manipulation of data in order to achieve a break even position. She added that there will also be a focus on accruals and holiday pay. She said that the second risk relates to funding and Direct

	Award Contracts and ensuring that these were not applied retrospectively due to COVID-19 pressures.
	At this point Ms Braithwaite left the meeting.
8/22.5	Ms Hagan outlined the proposed timetable for the audit and the makeup of the audit team. She advised that there were three appendices to the Strategy, including some public reports which may be of interest to members. She said that the final appendix indicated that there are no prior concerns being brought forward to this audit.
8/22.6	Mr Stewart asked whether the Committee was content that the assessment of risks is adequate and members said they were content.
8/22.7	Ms McCaig advised that she has had a meeting with Ms Hagan and there are no other matters to be raised. She referred to the Grant Fraud Risks publication and that while PHA does not award grants in that way, there was some good practice in the document that Ms Lyn Benson will review and bring through into PHA's practice.
8/22.8	Ms Mann-Kler asked how the public reports could be obtained. Mr McCance advised that all of the reports are published on the NIAO website and that he had previously brought two of the reports, those relating to addition services and workforce planning, to the Committee. He said that he was happy to bring future reports to the Committee's attention and give a presentation if requested.
8/22.9	Members noted the PHA Audit Strategy 2021/22.
9/22	**Item 9 – Finance**
	Updated Anti-Fraud and Anti-Bribery Policy and Response Plan [GAC/05/01/22]
9/22.1	Ms McCaig said that regular reviews of policies are carried out and that Ms Benson has worked with regional colleagues to bring this policy up to date and ensure that it complies with current good practice.
9/22.2	Ms McCaig advised that the policy begins by defining fraud and bribery and some key areas to be mindful of. She said that PHA has a zero tolerance approach to fraud so takes seriously any matters that are brought to its attention. She added that the policy also outlines the disciplinary process that may need to be followed.
9/22.3	Ms McCaig said that staff are encouraged to report suspected fraud or bribery and raise their concerns, and these concerns will be investigated. She advised that PHA has not had a lot of cases but will continue to promote awareness. She said that if the policy is approved a communication will issue to staff drawing it to their attention and reiterating that if staff have concerns, they should raise them, and they

will be supported. She advised that an equality screening has been conducted and is included with the policy.

9/22.4 Mr Stewart asked why staff are asked not to contact the PSNI, and how this policy links with the Whistleblowing Policy. Ms McCaig advised that previously there have been matters which have been reported to the PSNI and HSCB/PHA has not been made aware so it is about ensuring that the policy is correctly followed. She assured members that the Counter Fraud and Probity Unit will link with the PSNI if appropriate. She said that whistleblowing is a process which may ultimately lead to a fraud investigation so it is about ensuring that matters are dealt with in the right way and that there is no cross over.

9/22.5 Mr Clayton said that he hadn't picked up on the issue of staff contacting the PSNI directly and suggested that the reasons for not doing so should be explained. In relation to the link with the whistleblowing policy, he accepted that they are two separate policies, but a member of staff may go to someone to raise a whistleblowing issue that relates to fraud so it may be useful to point out the distinction between the two. Ms McCaig said that she is always mindful about saying that the policies are completely connected, but it is important not to put staff off from raising concerns. She said that the policies may be linked in some matters, but not in others and it's important not to draw conclusions. She added that the outworking of each policy will determine which one is more appropriate.

9/22.6 Mr Stewart felt that the instruction for staff not to contact the PSNI needs to be moderated. He also suggested that there should be a box in the flow chart diagram referring to whistleblowing. Ms McCaig said that she would wish to give that further consideration as whistleblowing does not necessarily mean fraud and she was concerned about the message that this conveys. She reiterated that she did not wish to put people off raising issues.

9/22.7 Ms Mann-Kler said that it was her view that the policies should be separate as she concurred with Ms McCaig's view that it could prevent people from coming forward. She asked if there was any good practice in the system, and how other organisations promote this. Ms McCaig said that the policies would be separate. On balance, she suggested that by connecting them formally it gives people a direction, but people need to consider each policy on its own merit.

9/22.8 Mr Clayton said that he understood the points being made, but one the reasons he raised it is because in the whistleblowing policy, there is an assurance about staff being protected, and he did not know if that language applied in these policies. He suggested that this could be highlighted in any training. Ms McCaig advised that part of the policy is about supporting individuals. She added that policies are developed in order to prevent these incidents happening and are designed to be supportive. She said that staff can also pass information to Counter

Fraud and Probity anonymously.

9/22.9 Mr Stewart said that he was happy to approve the policies subject to an amendment around the narrative about contacting PSNI.

9/22.10 Subject to amendment, members **APPROVED** the Anti-Fraud and Anti-Bribery Policy and Response Plan.

Fraud Liaison Officer Report [GAC/06/01/22]

9/22.11 Ms McCaig advised that there were two matters that she wished to bring to the Committee's attention. However, she noted that in both cases there has been no suspected actual fraud found following preliminary investigations.

9/22.12 Ms McCaig said that the first case related to an organisation which provides services in relation to substance misuse. She advised that some irregularities in reporting on a particular project had been reported to the Department of Health by another Department and given that the organisation has a range of contracts with HSC bodies, a process was established to review each contract and the latest performance management information. She added that an assessment had to made about stopping payments. She reported that each service provider has received a phone call and face to face meetings with a sample of providers will take place over the next week.

9/22.13 Ms McCaig advised that there are no indications that PHA is not receiving the services it has commissioned. She clarified that there has not been a PSNI investigation and at this point there is no indication that this matter needs to be taken to the next stage and that this is the case for all HSC bodies with one exception, where an irregularity in reporting was picked up.

9/22.14 Ms McCaig reported that there is a regional review being chaired by the Director of Finance in the Department of Health and that all contract managers and fraud liaison officers have been asked to determine if this matter needs taken to the next stage. She reiterated that to date, she has not seen anything that would merit this. She advised that she is required to send an assurance to the Department, which she will undertake following completion of the face to face meetings.

9/22.15 Ms Mann-Kler asked whether the action taken was proportionate in this case. Ms McCaig said that a meeting in December with Directors of Finance there was a request to suspend payments, but it was pointed out that this would put HSC bodies in breach of contract so there was an agreement that each organisation would carry out its own due diligence. She added that she has almost completed her assurance, and to date there are no concerns, but if that situation changes she would update the PHA Board. Mr Murray agreed that PHA was happy with the services it was receiving and felt that there had been over reporting of

	the matter. Ms McCaig said that there are lessons to be learnt, and added that PHA has received a lot of information, has had telephone conversations with providers and will be following up with visits.
9/22.16	Mr Clayton thanked Ms McCaig for the update and asked whether the sample of services reflects the diverse nature of the work that this organisation does for PHA. He also asked about the timeline for this work. Ms McCaig replied that the work should be completed in the next week, and that she chose the sample ensuring that there was a range of services in different areas so there were different contract managers and it was not the same staff going out and doing the visits. Mr Clayton said that this was a sensible approach. With regard to the suggested PSNI investigation, he asked where PHA got the information that there wasn't an investigation. Ms McCaig thought that this information had come from a press release but she undertook to check this **(Action 5 – Ms McCaig)**. Mr Clayton said that the conjecture did not help, but Ms McCaig said that it would not have changed PHA's approach. She added that PHA will continue to work with the evidence it has and if there is no evidence of fraud, the matter will not go any further. Mr Murray said that he hoped that the investigations would be completed by the end of next week and reported back to Ms McCaig as soon as possible in order to draw a line under this matter.
9/22.17	Ms McCaig advised that the second matter was a situation where the PHA was contacted by the Chief Executive of a third party to advise that a review of financial accounting and governance was being initiated at the request of another funder. She added that on 12 January a draft report was received which indicated that there may be irregularities and so a meeting was held with joint funders on 18 January to plan further actions. She said that the Fraud Liaison Officer provided a report to BSO Counter Fraud. She noted that this is a difficult one as there are many different organisations involved, but she agreed to keep the Committee informed.
9/22.18	Ms McCaig said that the rest of the Report gives an update on the fraud action plan for the year. She advised that the data matching exercise has been completed and there were no suspected fraud issues.
9/22.19	Mr Stewart asked about the financial value of the 117 high risk matches relating to duplicate records. Ms McCaig suggested that the issue may not be in relation to the payment but she agreed to get some further information on this **(Action 6 – Ms McCaig)**. She explained that the Shared Services centre has monthly processes in place so any issues of overpayment would be picked up in the monthly reports.
10/22	**Item 10 – Any Other Business**
10/22.1	With there being no other business, Mr Stewart thanked members for their time and drew the meeting to a close.

11/22 Item 11 – Details of Next Meeting

Monday 11 April 2022 at 10am

Fifth Floor Meeting Room (or via Zoom).

12/22 Linenhall Street, Belfast, BT2 8BS

Signed by Chair:

Joseph Stewart

Date: 11 April 2022

Public Health Agency

item 11

Title of Meeting	PHA Board Meeting
Date	19 May 2022
Title of paper	PHA Business Plan 2022/23
Reference	PHA/03/05/22
Prepared by	Stephen Murray
Lead Director	Stephen Wilson
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to seek approval of PHA's Business Plan for 2022/23.

2 Background Information

Since March 2022, work has been on-going to develop the PHA Annual Business Plan (ABP) for 2022/23.

Following engagement with PHA Board members it was agreed that the ABP should be focused on a smaller number of high priority actions that will represent the key corporate issues that PHA needs to specifically make progress on over the coming 12 month period.

3 Key Issues

The ABP sets out the 9 key corporate actions that PHA Board will primarily focus on progressing in 2022/23, broken down across the following 5 Thematic areas;

- Managing Covid 19 response
- Protecting our Population's Health
- Improving Health and Social Wellbeing and reducing health inequalities
- Shaping future health
- Our Organisation Works Effectively

In support of the ABP a separate Action Plan is currently being finalised that will set out the specific areas of work that PHA will take forward during 2022/23 to progress a number of important Ministerial / DoH policy priorities as well as continue to progress the many strategic priorities that underpin the on-going delivery of the PHA Corporate Plan.

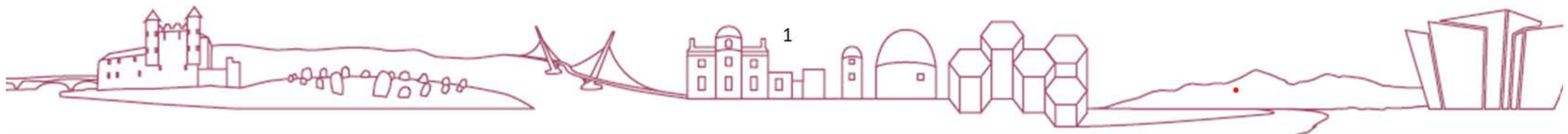
The actions set out in the ABP and the more detailed PHA Action Plan will cascade down into the development of respective Directorate Business plans to ensure delivery at a Directorate operational level.

4 Next Steps

Following approval, the Board will receive quarterly Performance Management Report updates against the Business Plan.

PHA Annual Business Plan

2022/23



Introduction

The Public Health Agency (PHA) Annual Business Plan sets out the key strategic actions that will be taken forward by PHA during 2022/23.

The Annual Business Plan does not set out all of the specific areas of work that are being progressed by the Agency on an on-going basis in meeting both the wide range of Ministerial priorities and outcomes set out in the PHA Corporate Plan. Rather it identifies those key areas of work that the Agency recognises require particular attention at this time to enable strategic progress to be achieved both during 22/23 and in future years.

The plan is broken down under the following Thematic areas:

- Managing Covid 19 response
- Protecting our Population's Health
- Improving Health and Social Wellbeing and reducing health inequalities
- Shaping future health
- Our Organisation Works Effectively

During 2022/23, the Agency can be expected to continue to focus a significant element of its resources on addressing the on-going COVID-19 pandemic and ensure that key interventions to contain and manage the virus, such as further roll out of the vaccination programme, targeted Covid 19 testing and contact tracing, surveillance and public behaviour messaging are deployed in a proportionate and effective way.

Whilst the Agency will continue to prioritise all actions necessary to effectively manage the COVID-19 pandemic, it is important that in 2022/23, the PHA also focuses as much as possible on returning to 'business as usual' and addressing its wider corporate priorities such as addressing health inequalities which have been further exacerbated during the Pandemic.

Significantly, 2022/23 will see several strategic changes within the planning and delivery of Health and Social Care across Northern Ireland. From April 2022 the Health and Social Care Board will be replaced by a new Strategic Performance Planning Group (SPPG) under the direction of the DoH. New arrangements for the planning and commissioning of services will be stood up during the course of the year as a new Area Based Integrated Planning system is rolled out. The Agency will be required to engage fully to ensure we successfully optimise the potential for Population Health outcomes to be realised in partnership with the wider HSC and other key bodies.

At the same time there is also a need to plan how the Agency as the strategic lead for Public Health in Northern Ireland needs to change, taking on board the learning from the pandemic response to date and developments across health and social care and wider society, so that we ensure we have the appropriate skills, knowledge and expertise to best address the significant public health challenges facing Northern Ireland both now and in the future.

The Action Plan attached as appendix 1 to the ABP contains more detailed information on the wide range of actions that will be progressed by the PHA in 2022/23 in meeting the on-going Ministerial and Corporate Plan priorities.

Accountability

The Annual Business plan will be monitored quarterly and update reports provided to PHA Board. AMT will be collectively responsible for ensuring the actions and associated KPIs are achieved. Where actions are not on target to deliver these will be considered by AMT and mitigating actions agreed to ensure maximum progress is made by March 2023.

2022/23 Key Priorities

Key Priorities	Strategic Theme	Action programme	Measurable Key performance Indicators
1	Managing Covid 19 response. Protecting the community (or any part of the community) against communicable disease and other transmissible dangers to health and social well-being including dangers arising on environmental or public health grounds or arising out of emergencies.	Protecting the population of NI by leading work to effectively manage the COVID 19 pandemic and ensure we save lives, protect our health and social care services and rebuild services to ensure the health and wellbeing needs of society are effectively addressed.	
		- Vaccination	Deliver the Spring booster programme by end of May 2022 and Autumn booster programme, as advised by DoH
		- Testing and Contact Tracing	Complete the transition of testing (pillar 1 and 2) and contact tracing by the end of June 2022.
		- Infection Prevention and Control	Review and plan for a refresh of the IPC guidance for Health care setting by February 2023

2	Protecting our population's health Improving health and social wellbeing and reducing health inequalities	Implement the agreed action plan for 2022/23 that sets out the key programmes of work that will be progressed by PHA officers in meeting Ministerial, DOH and PHA Corporate priorities.	- Quarterly update reports on PHA Business Plan to be provided to PHA Board - 90% of actions in the 22/23 Action Plan to be RAG rated as Green and exception reports to be provided to PHA board to address those rated Red/Amber.
3	Improving Health and Social Wellbeing and reducing health inequalities Shaping future health	Re-build and further develop services where access and performance have been adversely impacted during the pandemic,	- Return bowel cancer screening programme to a 2 year screening interval by September 2022 - Reinstate formal quality assurance visits in the breast screening programme by June 2022 - Establish a project structure for the implementation of primary HPV testing in cervical screening by June 2022. - Identification by June 2022 of potential additional support measures to enable full return of screening programmes. - Increase uptake rates across all vaccination programme areas in 2022/23
4	Shaping Future Health	Shape and influence the design and implementation of the proposed new Integrated Care system and ensure the role of the Public Health Agency is embedded appropriately into the new planning and commissioning model	- PHA to be represented on all project Team implementation structures - 5 key public health areas to be identified for incorporation into ICS plans by end of September 2022 [KPIs to be reviewed in September when more clarity on ICS model]

		being established.	
5	Shaping Future Health	HSCQI will continue to support the rebuild of Health & Social Care by increasing QI knowledge and capability across the HSC System.	- HSCQI has agreed a workplan to support the 'timeliness' theme with the Alliance by end of June 2022
6	Our Organisation Works Effectively	Work with DoH to reshape and refresh the PHA and agree a new operating model that will deliver a re-focused professional, high quality public health service for the population of NI	- Phase 1 of Review completed by end of June 2022 - Quarterly newsletter to update staff on progress to be published (first issue September 2022) - Implementation of phase 2 of the review to commence by end of September 2022
7	Our Organisation Works Effectively	PHA will place additional focus on staff welfare and wellbeing and agree and implement a range of appropriate actions to help staff recover from the impact that the Covid 19 pandemic has had in both a professional and personal capacity.	- Organisational Workforce Development Plan drafted by end of October 2022 - New appropriate policies and procedures to facilitate new working arrangements developed in partnership with staff side and BSO HR by Sept 2022 - 80% of Individual appraisals and personal development plans agreed by 29th July 2022 which clearly demonstrate the staff member's role in helping to contribute to the Agency's ABP key priorities. 100% by 30 September 2022 (subject to sickness absence, maternity and those seconded out of the PHA) - All temporary appointments to be reviewed by end of September 2022 and plan agreed for permanency of position.

			- Staff absence will be effectively managed and will perform in line with 2021/22 at 2.56% or better - Staff will have completed all mandatory training as required by the organisation. 90% compliance by end of March 2023
8	Our Organisation Works Effectively	Ensure good financial governance and stewardship of PHA budgets and expenditure decisions and develop a new performance management framework for the organisation to establish clear processes of accountability and performance reporting across all levels of the organisation.	- 90% of Internal Audit recommendations from 2021/22 addressed and progress reported to GAC by October 2022 - 100% of Internal Audit recommendations from 2021/22 addressed and progress reported to GAC by March 2023 - All Directorate Business Plans approved by 30 May 2022 - Delivery of a balanced Financial Plan by end of May 2022, taking into account budgetary uncertainties and agreed investment plan – approval by Board in June 2022 - Budget holders to manage their agreed budgets to support the statutory breakeven target of +0.25% or circa 0.3m within 2022/23
9	Our Organisation Works Effectively	Further improve the level of public and professional awareness, recognition and confidence in the PHA as the leading Public Health organisation in order to encourage wider	- Baseline public awareness levels of PHA (including role and functions) established through quantitative/qualitative research programme by end of August 2022 and 3% increase achieved by March 2023. - PHA media training development programme implemented, by end of Sept 2022 - Marketing strategy developed to maximise PHA Brand awareness including promotion of funded programmes and projects, by end of Dec 2022.

		engagement with and support for public health priorities.	- New digital communications strategy launched, targeting increased engagement with target audiences, by Feb 2022

HSC Public Health Agency

item 12

Title of Meeting	PHA Board Meeting
Date	19 May 2022
Title of paper	Performance Management Report
Reference	PHA/04/05/22
Prepared by	Stephen Murray / Rossa Keegan
Lead Director	Stephen Wilson
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to provide the PHA Board with a report on progress against the objectives set out in the PHA Annual Business Plan 2021/22.

2 Background Information

PHA's Annual Business Plan was approved by the PHA Board in June 2021. Against this plan 53 actions were developed for 2021/22.

3 Key Issues

The attached paper provides the progress report, including RAG status, on the actions set out in the PHA Annual Business Plan 2021/22 as at March 31st 2022.

Of the 53 actions:

- No action has been categorised as red (significantly behind target/will not be completed)
- 9 actions have been categorised as amber (will be completed, but with slight delay)
- 44 actions have been categorised as green (on target to be achieved/already completed).

3 actions that were previously amber RAG status are now green (1.10, 4.5 and 5.7.)

1 action that was previously green RAG status is now amber (3.15)

4 Next Steps

The Board will receive quarterly Performance Management Report updates against the 2022/23 Business Plan.

PERFORMANCE MANAGEMENT REPORT

Monitoring of Targets Identified in

The Annual Business Plan 2021 – 2022

As at 31st March 2022

This report provides an update on achievement of the actions identified in the PHA Annual Business Plan 2021-22.

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

There are a total of 53 actions in the Annual Business Plan. Each action has been given a RAG status as follows:

(Green)	On target to be achieved or already completed	(Amber)	Will be completed, but with slight delay
(Red)	Significantly behind target/will not be completed		

Of these 53 actions 44 have been rated green, 9 as amber and 0 as red.

Outcome	Red	Amber	Green	Total
1) Covid 19 Response	-	2	13	**15**
2) Health Protection	-	1	5	**6**
3) Health Improvement	-	3	12	**15**
4) Shaping future health	-	1	9	**10**
5) Our organisation works effectively	-	2	5	**7**
Total	**-**	**9**	**44**	**53**

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

All actions for which RAG status is Amber

1. Covid 19 Response

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
6	Lead the Regional Infection Prevention Control Response. This will include the Development of New Managed Care IPC Network. New IPC Resource Framework, and development of professional guidance in the modelling and use of PPE Operationalise the updated Infection Protection and Control (IPC) infrastructure including anti-microbial resistance stewardship	We are in the final stages of developing the Regional IPC Framework which has been shared with the Regional IPC Cell and colleagues in Health Protection (PHA) for consultation before submission to the DoH for consideration. We are in the process of Recruiting Nursing Assistant Director and Nurse Consultant for IPC and this will strengthen the PHA Directorate of Nursing IPC response. Following the submission of the Regional IPC Framework a Regional Managed Care IPC Network will be developed and will replace the current Regional IPC Cell. The Managed Care Network will be multidisciplinary and will provide an opportunity to promote consistency, standardisation and shared learning. Northern Ireland currently follows the UK Health Security Agency (formally PHE) national guidance which outlines the PPE requirements in various settings. BSO are engaged in forecasting PPE based on historical usage and volume data, through the last 3 surges. In relation to modelling, it has been agreed that it is no longer required to scientifically correlate other factors and therefore modelling PPE has been stood down. The IPC infrastructure will be operationalised when the DoH have approved the Regional IPC Framework and following development of the IPC Managed Care Network.	Amber	Amber	Amber	R.Morton, Director of Nursing, Midwifery and AHPs The Regional IPC Framework to be finalised and submitted to DoH for agreement and approval as soon as possible. Further discussions with Trusts and Health Protection colleagues are required.

1. Covid 19 Response						
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Oct	Jan	Mar	**Mitigating actions where performance is Amber / Red**
14	Continue to progress quality improvement work linked to Covid learning / recovery	**Regional Learning System** On 24th April 2020 Trust CEOs asked the HSCQI Network to provide support to Trusts and to the wider system in order to develop a regional learning system focused on lessons learned from COVID-19 to date. Harvesting of examples during a 90 day cycle resulted in regional agreement to focus the collective improvement effort on 3 key themes: virtual visiting, virtual consultations and staff psychological wellbeing. This work was supported in partnership with the ECHO team. Following discussion with strategic leaders, HSCQI carried out a literature review to identify a robust framework for scale and spread (*diagram 10 appendix 1.14).* This has now been endorsed by the HSCQI QI Leads and the HSCQI Leadership Alliance. The HSCQI Leadership Alliance meeting on 11th November 2021 was chaired by a newly appointed Chair. The theme of "Timely Access" was agreed by the Alliance as a regional priority for the HSCQI Network going forward. The HSCQI Covid-19 Learning System work has been impacted by reduced capacity in the HSCQI Hub, ie, one WTE resigned in December and redeployment of 1 WTE to contact tracing in December 2021.				Dr A. Keaney, Director HSCQI • The Hub Team are currently engaging in a series of discussions with regional leaders to identify priority areas of focus. • Linking with HR to recruit to vacant funded posts and linking with AMT to identify funding for additional temporary posts.

2. Health Protection

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
1	Drive increased uptake of childhood and adult preventable disease vaccines, through targeting low uptake groups.	**Pregnancy vaccines** The HP consultant lead for pregnancy vaccines has prioritised delivery of COVID vaccine in pregnancy. Vaccine coverage has been established via NIMATS and through the analytics platform system. Progressing linkage of VMS and NIMATS data . Uptake as of end of January • at delivery – 61% of women delivering in January had a least one dose of vaccine (+5% from previous month), with 56% having had two vaccines (+6%) across NI. • Increases observed across Trusts on previous month with variation between Trusts narrowing (62% SET vs 55% ST) • Under 30 remains lowest age group, however coverage increasing - at least 1 dose now 50% (+5%). • Booster and third doses not included this month – very small numbers from NIMATS, data field only added 20th December – we will review possible inclusion in next report. Interventions – promotion materials, letter to pregnant women via Trusts, working with Trusts to establish vaccine clinics through maternity services, audio recorded midwife training slides add to website. **Other children's vaccines** Since prior to pandemic, preschool vaccines were falling in a small but persistent way, similar to England, especially in 12mt	Amber	Amber	Amber	S.Bergin, Director of Public Health (interim) Developments are taking place to improve childhood vaccine uptake monitoring through the analytics platform, which will also enable a quantitative study to identify causes of low uptake in preschool children. Engagement with GPs, health visitors and school nurses responsible for childhood vaccine delivery will take place following completion of COVID booster programme delivered through GP

2. Health Protection

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
		and 24mt age groups, and is now appearing to plateau at a lower level. It is too early to see the impact of the pandemic on uptake but early indications suggest that there has not been further decline. Further analysis to assess falling uptake is being carried out to identify causes of low uptake in preschool children. Trusts child health teams are aware and have been following up.				

3. Health Improvement						
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Oct	Jan	Mar	**Mitigating actions where performance is Amber / Red**
12	In line with the Nursing and Midwifery Task Group set up the infrastructure to develop a New Nursing and Public Health Nursing & Midwifery Framework	Within the £20m Delivering Care Investment for 21/22, in line with the NMTG, the PHA is leading on the development and establishment of a new Public Health and Population Health Nursing Network. These new roles will work with Public Health Consultants and other Public Health and Social Care Roles to ensure that prevention, early intervention and recovery are at the heart of all nursing and midwifery practices. It is also anticipated these roles will support the nursing and midwifery contribution to the development and implementation of the new NI Population Health Planning model, and will be expected to support the development of population health planning across ICS's. Trusts are making progress on recruiting their public health nurse consultants and we expected all post to be appointment by March 22. A number of regional Nurse Consultant posts are currently being progressed.				R.Morton, Director of Nursing, Midwifery and AHPs The Associate Director for Public Health Nursing Post has been Job Matched and is awating DOH Approval. The work on developing a Nursing and Midwifery Public Health Nursing Framework has been delayed due the Pandemic, However the DON has now established a plan to progress theme 1 of the NMTG which is expected to now deliver by December 2022.
14	Develop A Public Health Model For Homeless Services and develop a business case for the expansion of homeless health care hubs.	The Homeless Inclusion service has now been extended to each Trust area. The Belfast Inclusion Hub will offer support to other Homeless Hub Nurses. The Homeless Inclusion teams have played an important role in Covid support to the Homeless Sector. Whilst additional investment has now gone to each Trust to support the development of their Homeless health care services further needs assessment work is required in 22/23 ahead of a new business case for further expansion of these services. In				R.Morton, Director of Nursing, Midwifery and AHPs Additional business planning support will be sought to enable business case and strategic plan to

3. Health Improvement

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
	Develop a strategic plan for the reduction of Hepatitis C and HIV through case finding, harm reduction and treatment planning	addition the PHA will need to bid for additional staff resource to support this work Work is ongoing in relation to the HIV and Hep C outbreak, so there has been a focus on work with the highest risk groups, with an increase in testing in prisons, People who inject Drugs and people who are homeless.	Amber	Amber	Amber	be progressed with a revised anticipated timescale of March 23. The work on the business case has been delayed due to an unplanned period of leave for PHA Lead
15	Deliver improved health care outcome across criminal justice through reviewing, progress and implement the Health in Criminal Justice Action Plan.	HSCB/PHA Improving Health Within Criminal Justice Planning & Commissioning Team continue to work on progressing up to 21 actions emanating from The DoH/DoJ Improving Health Within Criminal Justice Strategy and Action Plan (2019). This strategy and action plan sets out a collaborative approach to address the health inequalities and unmet health needs faced by those within the criminal justice system. HSCB/PHA planning and commission team contributed to a refresh of the DoJ/DoH action plan to ensure resources are better aligned to meet need, enhance access to services, improve continuity of care, develop workforce and the way collaboration operates and also to increase diversion of vulnerable people & improve health protection and health promotion. HSCB/PHA planning and commissioning team commenced work on addressing fourteen of sixteen recommendations made by RQIA in their October 2021 Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons. A series of task and finish groups have been established and are progressing workplans in keeping with the recommendations to be	Green	Green	Amber	R.Morton Director of Nursing, Midwifery and AHPs Majority of Actions are green with the exception of the RQIA review timetable of receommendations although the following mitigating actions have been progressed. Task & Finish groups established and prioritised based on initial targets. Discussion with Project Team and RQIA re: timeframes-Delivery Plan being developed for RQIA containing a proposal for new timeframes.

3. Health Improvement

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
		implemented within 6 months/12 months and 18 month period. PHA AHPs have contributed to the Health & Therapeutic Workstream of the DoJ/DoH led Review of Regional Facilities for Children and Young people (1.2 Health to provide advice on improving the health and social care model in Police, Courts and YJA.) – Following AHP professional input, a proposal for a Core MDT team within the secure unit now includes OT, SLT and Art Therapy and Nursing alongside other professions.				Will be submitted by end May 2022 and Task & Finish Groups working to an extended timframe as follows: Priority 1 Recommendations September 2022 Pririty 2 Recommendations: October 2022 Priority 3 Recommendations: March 2023

4. Shaping future health

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
2	Establish a 'lived experience' network across NI and use information as a source of evidence to inform all our core activities	PHA has provided leadership, support and guidance to the HSC to help enable and facilitate those with lived experience to become more actively involved in the work of the HSC. This has been essential pre-cursor work and a key foundation for the establishment of the Network and has included: • Investing in the Partnership Working officers posts. • Development of formal Guidance on reimbursement of expenses for service user / carer involvement, which was subsequently issued by DoH to the HSC. • Initial funding having been made available to PCC to build on PHA led work around advancing the concept and practice of remuneration of Service Users /Carers who partner with the HSC. • Providing guidance and advice to HSC organisations to bring forth and support tangible opportunities for involvement and utilising lived experience input in commissioning, service development and review. • PHA Peer Mentor Lead for Service Users /Carers in HSC taking up post in last quarter of 2021/22 A work plan for the Peer Mentor Lead has been developed for 2022/23	Green	Amber	Amber	R.Morton, Director of Nursing, Midwifery and AHPs A communication, scoping and mapping exercise is commencing. The infrastructure to support the Network is being developed and the Network will be operational in 22/23

5. Our organisation works effectively						
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Oct	Jan	Mar	**Mitigating actions where performance is Amber / Red**
1	Finalise the new PHA Corporate Plan for 2021/22-24/25 in line with DoH requirements and timescales. (when notified)	DoH has written to PHA on 23rd September 2021, confirming that 'the intention will be to align ALB Corporate Plans to the next Assembly mandate (2022-2027). Although it will not be possible to have agreed plans in place for April 2022, further guidance will issue to commence this process as early as possible in the next Assembly mandate'.				S.Wilson, Director of Operations (interim) PHA Business plan 21/22. will be reviewed and updated for 22/23 in line with DoH guidance to ensure key strategic priorities for PHA continue to be addressed.
2	Work with DoH colleagues to oversee the reform and transition of the PHA to a new operating model, taking into account lessons learned from responding to Covid 19 and manage the process of organisational change in line with further clarification from the DoH, ensuring appropriate and timely internal and external communication.	Progress on this action has been delayed during 21/22 due to the on-going pressures and focus of senior staff both in PHA and DoH on managing the response to Covid 19. DoH appointed a new lead officer to take this work forward in January 2021 and Ernest & Young has now been appointed to support the work and an action plan agreed to complete phase 1 of the process by end of June 2022.				All Directors Series of staff engagement sessions have been scheduled over the period April – June 2022 to inform phase 2 of the PHA refresh and reset process.

All actions for which RAG status is **Green**

1. Covid 19 Response

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
1	Continue to provide professional Health Protection leadership to effectively manage the impact of the Covid-19 pandemic on our population.	The Health Protection service has secured support and assistance from other PHA Directorates during the Covid-19 pandemic. Health Protection has also secured staff for the contact tracing service via an HSCNI workforce appeal and HSCNI recruitment service. Clinicians have also been secured via local recruitment agencies to support the contact tracing service, acute response service, care home teams and the PHA education cell. Recruitment is currently underway to enhance the Health Protection service. The Director of Public Health office/function (to address COVID) has been enhanced through the appointment of a deputy Director of Public Health The Health Protection service and contact tracing service have been supported by other PHA Directorates during the Covid-19 pandemic, most recently for the Omicron wave.	Green	Green	Green	S.Bergin, Director of Public Health (interim)

1. Covid 19 Response

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
2	Maintain a professional Contract Tracing service that will have the capability and capacity to respond effectively to changes in infection levels and ensure people in receipt of a positive test result are contacted as quickly as possible.	Performance of the CTS has mostly been in line with agreed indicators for the year. However, the arrival of the omicron variant and the unprecedented increase in case numbers inevitably affected performance during late quarter 3 and into early quarter 4. In response, an enhanced escalation plan was agreed with DoH which was based on a much reduced call script to reduce call handling time and an increased reliance on digital self-trace. PHA staff were again temporarily redeployed to the Service to increase capacity during this period. In late February 22, the CTS moved out of high escalation, continuing to work on a reduced tracing script that prioritised positive PCR tests and under 18 LFTs with calls made to other LFT cases where resource allowed. In light of reduced case volumes and improved performance the CTS continued to de-escalate during March with a reduced reliance on additional and bank hours from both its band 6 and band 4 tracing staff. Additional information on performance of the service is attached as appendix 1.2				S.Bergin, Director of Public Health (interim)

1. Covid 19 Response

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
3	Ensure there is continued appropriate timely access to testing services both in Pillar 1 (HSC) and Pillar 2 (National testing service). Identification of variants of concern through timely reflex assays and whole genome sequencing of positive cases. Ongoing support for roll out of lateral flow devices across the community and in specific settings e.g. care homes, healthcare workers, education.	Timely access to testing continues across Pillars 1 and 2 in accordance with The Department of Health COVID-19 Test, Trace and Protect Transition Plan on 24 March 2022. Pillar 2 test sites closed 22 April having completed 2,459,520 tests. LFT results reported 3,148,900 on 29/04/22. Procedures are in place for monitoring variants of concern through genotyping and Whole genome sequencing of samples from HSC laboratories and the national testing programs. Current capacity for 1000 whole genome sequencing tests per week for surveillance purposes however reducing community prevalence will dictate if this is feasible. Lateral flow use continues to be fully utilised as a first testing option with a reduction in PCR testing need and capacity. Various reports on testing are completed and shared as appropriate / available on request to include monthly care home reports, asymptomatic HCW staff testing LFD.	Green	Green	Green	S.Bergin, Director of Public Health (interim)
4	Strengthen PHA capacity to provide the intelligence needed to meet organisational goals by supporting staff to	Progress has been made on this objective with further activity planned in the short term. • A small data science team has been formed, using mainly temporary and external staff, which has been working with PHA analysts to support data engineering and analysis to meet PHA information needs.	Green	Green	Green	S.Bergin, Director of Public Health (interim)

1. Covid 19 Response

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
	develop their knowledge and skills; providing tools needed to deliver intelligence effectively and efficiently; and by designing organisational and governance arrangements enabling sharing knowledge and skills across topic areas.	• Modern data science infrastructure has been adopted for data engineering for several key work programmes. • PHA analysts have benefited from numerous online courses, seminars and conferences, relating, for example, to the application of statistical programming, automation, data visualisation, dashboarding and bioinformatics. • A Future Model planning group to strengthen PHA capacity to provide intelligence was convened in December 2021 to commence a project to explore the resources, demand and capacity related to intelligence.				
5	Ensure that the health protection service has robust surveillance systems in place to respond to the current Covid-19 pandemic. Review the current IT systems such as the Covid-19 surveillance dashboard and the data analytics systems.	Work is ongoing to continually improve the surveillance systems and outputs with regards to COVID-19: The PHA HP Surveillance team continues to work with colleagues in the rest of the UK and ROI to support work on the COVID-19 pandemic. The HP surveillance team have been working with external colleagues (e.g. SIB, Ernst and Young, Kainos and QUB) to produce and improve reporting around Whole Genome Sequencing of COVID-19 samples, nosocomial infections of COVID-19, COVID-19 outputs. Work is continuing around developing, accessing and utilising the COVID-19 vaccination data held in the Vaccine Management System and using this data to respond to requests for information to inform multiple areas of work within the PHA and responding to requests from DoH and other external colleagues.				S.Bergin, Director of Public Health (interim)

1. Covid 19 Response						
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Oct	Jan	Mar	**Mitigating actions where performance is Amber / Red**
		The contact tracing service now produces a range of reports to assist in monitoring and managing the Covid-19 pandemic: Weekly performance metrics (https://www.publichealth.hscni.net/covid-19-coronavirus/testing-and-tracing-covid-19/contact-tracing-service-management-information) Weekly cluster reports (https://www.publichealth.hscni.net/publications/covid-19-clusteroutbreak-summary) Weekly data on schools (https://www.publichealth.hscni.net/publications/coronavirus-bulletin) Educaion Dasboard – to assist School cell risk assessemnts. CT Huddle Dashboard (produced 3 times daily and circulated to Senior PHA team – summary headline numbers on cases and contacts and key performance measures), and a Daily report circulated to Senior PHA team with detailed measures of call numbers, performance e.g. 24/48/72 age breakdown, % using Digital self-trace etc.) Reports are used for a range of purposes, such as: Daily CTC report – to inform CT Program Board of current cases levels, trends and perforamnce to seek to identify common exposure settings (e.g. workplaces), to provide a twice weekly multi-disciplinary Covid overview (assessing HP Surveillance data, schools data and estimated transmission patterns data from a number of sources (Virology database, cluster data from CTC etc.)), a 2-Weekly Travel Report (summary of cases for DOH Travel Programme Board) and a weekly report of situations (outbreaks and clusters) by LGD	Green	Green	Green	

1. Covid 19 Response						
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Oct	Jan	Mar	**Mitigating actions where performance is Amber / Red**
7	Provide input to the development of professional guidance on how to effectively manage Covid 19 in various settings and reduce the risk of spreading the virus, based on up to date evidence and best practice.	The PHA has continued to provide detailed Health protection advice to a range of professional audiences – eg. the School's team worked extensively with DE, EA and Trade Unions to implement the outworking of the change in policy regarding close contacts definition in Education settings. In addition the acute Duty Room team provides advice across a wide range of settings, both HSC and non HSC settings (eg. wider public sector, private/commercial sector, and to other individual organisations and groups). This input and advice is provided on a seven day basis with a 24/7 on call service to encompass the full weekly period. The Public Health team continues to provide expert advice to DoH strategic programme Boards including, Testing, Tracing and Vaccination and is also contributing to specialist cells eg. Modelling. A Health protection guidance cell provides evidence based advice to a range of partner organisations and the Health protection team continues to facilitate management of outbreak situations. The availability of clear, accurate and up to date public and professional communications has been of paramount importance at each stage of the Pandemic and the Agency's Communications team continues to ensure that appropriate communications are delivered on a timely and effective basis meeting the specific needs of a diverse range of audiences. This has included publications and online information for various audiences as COVID, COVID information and policy altered eg				S.Bergin, Director of Public Health (interim) / S.Wilson, Director of Operations (interim)

	1. Covid 19 Response					
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Oct	Jan	Mar	**Mitigating actions where performance is Amber / Red**
		health care workers, care homes, EA and schools.				
8	Rebuild the screening programmes post COVID to ensure that services are operating to the standard required and that capacity for all programmes is maximised to ensure as many people as possible from the target populations are able to access services	All screening programmes impacted by Covid continue to build capacity and reduce delays for screening invites. The current position across each screening programme is below and more detail is available at Appendix 1.8 **Bowel cancer screening:** The delay in routine invitations is currently 16 weeks (reduced from 29 weeks). The catch up exercise will be completed by Autumn 2022. **Breast screening:** The round length is currently an average of 36 months + 5 weeks. This is down from 41 months in September 2020 (although it remains above the standard of 36 months). This is being achieved through the provision of additional screening clinics. Progress will not be linear as it is dependent upon the continued availability of staff. **Cervical screening:** The programme continues to operate with a 5 month delay in routine invitations, but activity has returned to pre-covid levels. **Diabetic eye screening:** The programme continues to use a risk stratified approach to invite individuals for screening. Additional in year funding was secured via the June monitoring review to support recovery, and further expansion of capacity is being taken forward with the Trust to move towards reintroducing routine screening. This programme has faced significant logistical challenges due to the impact of covid. As well as a reduced				S.Bergin, Director of Public Health (interim)

1. Covid 19 Response						
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Oct	Jan	Mar	**Mitigating actions where performance is Amber / Red**
		patient throughput required for infection control purposes, programme has had to develop a new model of service delivery. **AAA screening:** Surveillance scanning for men with small/medium AAA is operating as normal. Approximately 97% of men in the 20/21 cohort for primary screening have now been called for their initial appointment and screening for the 2021/22 cohort commenced in January 2022				
9	Continue to support the roll out of the Covid 19 Vaccination programme and any subsequent booster programmes and ensure that action is taken to improve uptake rates for vulnerable populations or in specific localities where uptake is low	All PHA Directorates continue to support roll out of the programme, now led by the Public Health Agency including Public Health Direcotate Health Protection and Health Improvement Divisions, Operations Directorate, communications and the Nursing Directorate. PHA Lead on the following aspects of implenetation: • Implementation of children;s COVID vaccine: 12-15 year olds have been introduced intitial through school programme and now through Trust clinics. 5-11 year olds have continue through trust clinics, Overall uptake for dose one 53.75% • Implementation of COVID vaccine in pregnancy: increasing uptake, better provision of uptake data and increased promotion, March coverage at delivery – 65.19% of women delivering in March had a least one dose of vaccine (+2.80% from previous month), with 60.40% having had two vaccines (+2.33% since February) across NI.				R.Morton, Director of Nursing, Midwifery and AHPs

1. Covid 19 Response

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
		• Chair low uptake group: ation plan being developed to look at vaccine equity including access, promotion and communication materials. • Development of vaccine coverage surveillance sytem, • Development of dashboard for the public and HSC organisatrions including Trusts, GPs, pharmacies and councils • Production of all publications, PGDs and website coordaintion PHA has taken forward a number of actions to improve uptake of vaccine for vulnerable populations including : • Workplace interventions to target Ethnic Minority & Migrant communities in food processing sector; • Moy Park (May/June 2021) • NI Meat Exporters Association and NI Pork & Bacon Association (July – Sept 2021) • Low vaccine uptake data shared with Trusts-via access to dashboard, Awareness session carried out with Trusts • Communications developed (translated materials & videos) to encourage vaccine uptake in Ethnic Minority & Migrant communities. • Engaged with DAERA & PHA funded Farm Families health Check Programme (Sept/Oct) to target low vaccine uptake in targeted rural areas. • Engaging with Community Pharmacy (Oct onwards) to encourage primary dose vaccination options in targeted low vaccine uptake areas across NI				

1. Covid 19 Response						
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Oct	Jan	Mar	**Mitigating actions where performance is Amber / Red**
		• Established a 6 week vaccine uptake clinic programme for those returning to Colleges and Universities to increase vaccine uptake in the 16-29 age group in particular. Covid Vaccine ToolkitNI has been developed https://www.covidvaccinetoolkitni.info/	Green	Green	Green	
10	Expand the routine adult and child influenza vaccines to help manage the impact of the ongoing Covid -19 pandemic. The 2021/22 influenza programme will be targeted at: people aged 50 years and over in the age based programme; School age children to year 12; and other at risk groups and HSCNI workers.	The flu vaccine programme officially commenced on 4th October and is progressing for the public in GP Practices, Community Pharmacy and schools, and for health and social care workers, through the Trust Health and Social Care worker campaign, including mobile visits to Care homes, and community pharmacy. The school based childrens programme and health and social care programme is now complete. The overall programme will formally finish end of March 2022 The PHA is responsible for delivering flu vaccine uptake monitoring. In previous years monitoring was carried out using HSCB GP claim returns and auto-extraction of limited data from GP clinical systems. This year, however, a new regional Vaccine Management System (VMS) has been introduced to record COVID and flu vaccines. To date, there are issues with GP use of VMS for seasonal influenza with incomplete use of the system and difficulties recording data in a timely way (due to lack of admin support within practices): this is currently being addressed. There is a risk therefore that uptake may be reported as artificially lower than the true uptake, until the VMS is fully utilised by GPs.	Green	Amber	Green	S.Bergin, Director of Public Health (interim)

1. Covid 19 Response

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
		Public programme Uptake: As of 31st December 2021, 46% (77% year before) in over 65 year olds, 32% in 5-64 year olds, 42% under 50 year olds at risk (61% previoous year in under 65 at risk) 27% in pregnant women, 65% in school aged children 20% in 2-4 year olds - Uptake has increased in all public programme reporting groups, though still quite far off previous seasons and the GP claims data - . The clinical eligibility variable in VMS is poorly populated, included a count using <50 years recorded as CEV and/or underlying health condition for information. **HSCW** As of 31st December 2021, 36% in all Trust employed health and social care wokers This year HSCW data is limited due to limts to introduction of the VMS for Trusts. Uptake covers all hscws and can not be disaggegrated for frontline only this has been rectified for next year				
11	Ensure Incident Management Teams are established to effectively manage outbreaks, especially in responding to clusters and new variants, to minimise	The Health Protection service continues to provide expert advice and support to all stakeholders in relation to new Covid-19 variants and clusters. Health Protection consultants also provide advice and support to Trusts and external stakeholders by joining IMT's and outbreak control management teams to ensure the health and wellbeing of the N. Ireland population.				S.Bergin, Director of Public Health (interim)

1. Covid 19 Response						
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Oct	Jan	Mar	**Mitigating actions where performance is Amber / Red**
	the potential for wide spread infection.	This includes establishing and chairing Incident Management Teams to effectively manage outbreaks and clusters, including in response to new variants of concern. Health Protection consultants and Infection Prevention Control nurses also provide advice and support to Trusts in relation to healthcare acquired COVID-19 infections and outbreaks.				
12	Take forward the implementation of the Health Improvement Recovery Plan and work with wider stakeholders, to continue to support those individuals and communities who have been adversely affected by Covid.	Health Improvement Recovery Plan presented to AMT and PHA Board in May 2021, focussed on short term actions (2021-22), medium term (2022-25) and long term (2025 +). Actions outlined in the recovery plan have been re-profiled into population health outcomes using a theory of change approach. HIMF (HI Managers Forum) currently working through a range of system workshops, to help inform HI Priorities, based on the model.				S.Bergin, Director of Public Health (interim)
13	Use research funding programmes (CHITIN, NIHR, Opportunity Led, Research Fellowships) to effectively manage the COVID 19 pandemic and ensure we save lives, protect our health and social	Nine studies funded through the HSC R&D Covid-19 call are ongoing as well as those funded through the national prioritisation exercise. Over 30,000 participants from NI including staff, patients, carers, students, children and the wider public have now been recruited to these studies. Findings have identified new therapies to prevent and treat Covid-19 including vaccines as well strategies to address the longer term physical and psychological impacts of Covid-19 meaning the evidence base to deal with the ongoing and future pandemics is ever expanding.				S.Bergin, Director of Public Health (interim)

1. Covid 19 Response

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
	care services and rebuild services to ensure the health and wellbeing needs of society are effectively addressed	Seven studies were funded/co-funded through the COVID-19 Rapid Response Funding Call: • A mixed methods study of the community pharmacy workforce's preparedness for, and response to, the COVID-19 pandemic • Effectiveness of staff well-being interventions in response to COVID-19 in Northern Ireland • A survey of hospital dialysis patients during the COVID-19 pandemic in Northern Ireland • Modulation of the innate immune response to SARS-CoV-2 with bradykinin inhibition • Advance care planning for nursing homes in a COVID-19 outbreak • Health & Social Care Workers' quality of working life and coping while working during COVID-19 Pandemic • Seroprevalence and symptomatology of SARS-Cov-2 infection in healthy children across the UK (The COVID Warriors Study). A further nine were funded as needs/opportunity-led projects: • The REALIST Study - Repair of Acute Respiratory Distress Syndrome by Stromal Cell Administration • COVID-19 Possible options for analysis and intervention via social media • The SIREN Study • Repurposing FDA-approved drugs for treatment of 2019-nCoV-induced disease • Estimate of Northern Ireland community seroprevalence of				

1. Covid 19 Response

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
		antibodies against SARS-CoV-2 from anonymised residual blood samples • Student Psychological Intervention Study (COVID-specific extension) • Optigene Saliva Test • COVRES2: Identifying temporal immune responses associated with COVID-19 severity • A new Covid Cluster within the Northern Ireland Clinical Research Network (NICRN) has been established to create a dedicated Covid 19 group to support new and ongoing clinical research proposals • Senescence biomarkers for predicting risk in Covid-19 patients • The PANORAMIC trial, a new platform trial for anti-viral COVID treatments, is being led by the University of Oxford at sites across the UK. It will test new antiviral treatments for COVID-19 to help patients to stay at home without the need for hospital admission HSC R&D and NICRN Primary Care have supported Northern Ireland's participation. One arm paused to recruitment on 27/04/2022 due to changes to testing processes. 1,020 participants from Northern Ireland were recruited to this arm. Work is underway to set up sites for a further arm to test another new treatment. These studies will add new knowledge in terms of the wellbeing of young people, patients and staff, staff and community infection levels and antibody status efficacy of treatments and tests for infection.				

1. Covid 19 Response						
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Oct	Jan	Mar	**Mitigating actions where performance is Amber / Red**
		The impacts of each study will be reported separately, and reports will be made available on the HSC R&D Division website, but will include recommendations for staff, student and patient support, treatment and testing options, and contribute data to modelling and public health messaging plans.				
15	Develop a regional and consistent approach to promoting staff health and wellbeing across HSC through the HSC Healthier Workplace Health Network. Ensure support systems are in place to mitigate and understand impact of COVID on staff.	Regional HSC Workforce Wellbeing group has completed and launched a Regional Staff Health and Wellbeing mini-website to collate and streamline resources across all HSC organisations for ease of access and signposting for staff. Website now added to Intranet.				S.Bergin, Director of Public Health (interim)

2. Health Protection

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
2	Based on learning from responding to the pandemic, increase the PHA's Health Protection capacity to effectively manage on-going issues arising from the Covid 19 and enable it to develop the skills, knowledge and capacity to ensure that it can respond effectively to other health Protection issues and plan for managing future pandemics that may arise.	The Health Protection service has secured funding from DoH to enhance the service. Recruitment is underway to establish and enhanced a robust Health Protection service for the future. The posts range from consultant to administrative level. Recruitment should be completed with all new staff in post by the end of 2022. 1 x temporary Locum HP consultant post recruited February 2022. Advertising for below posts to commence May 2022 • 2 X Perm HP consultants. • 1 x Locum HP consultant (6-12months). • 2 x Speciality Dr's (staff grade – temp for 2 years) • 1 x Perm SD&S consultant. • 1 x Locum SD&S consultant (6-12months).				S.Bergin, Director of Public Health (interim)
3	Update the Emergency Plan and Pandemic Plan with partners, in light of learning from the COVID 19	The Senior Emergency Planner for the PHA has co-ordinated and led on the development of the update of the Joint Response Emergency Plan with the HSCB and BSO in line with the time line for the migration of the HSCB to SPPG (1st April 2022). In addition the PHA emergency response plan is also being developed. .				S.Bergin, Director of Public Health (interim)

2. Health Protection

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
	pandemic, to ensure preparedness and response readiness	Organisational training and resource implications for both plans are being reviewed as part of the update, the outcome of which has been incorporated into the agreed training and exercise programme for 2022-2023 (Endorsed by JEP Board 28.04.22) Reference the PHA emergency response plan – Update PHA health protection plans are part of the agreed programme of work for 2022-2023 (JEP Board 28.04.22) Health Protection Covid debrief is scheduled for the 18th May 2022. Learning from the debrief will be incorporated in the updated pandemic plan and Incident Response Plan for HP as reflected in the 2022-2023 programme of work.				
4	Ensure the timely availability of intelligence about antimicrobial use, antimicrobial resistance and healthcare-associated infections in secondary care by publishing regular reports and through an integrated dashboard.	HCAI/AMR surveillance team produce monthly 'Target' reports for each HSC Trust on secondary care antimicrobial prescribing data, in addition to the three key gram-negative bacteraemia (E.coli, Pseudomonas aeruginosa and Klebsiella spp), as well as MRSA and C. difficile. The team are working with Trust colleagues to develop an interactive Target monitoring dashboard to supplement the monthly reports by providing more timely and accessible data to support improvements in this area. There are also interactive dashboards with Trust and NI level data for: • HCAIs (C. difficile, S. aureus and gram-negative bacteraemias) • Antimicrobial prescribing data in secondary care • Hospital acquired COVID-19 dashboard. • Multi drug resistant organisms e.g. CPE, ESBL				S.Bergin, Director of Public Health (interim)

2. Health Protection

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
		One session per week from a consultant microbiologist with a particular interest in AMR has been secured on a temporary basis to help improve surveillance and reporting of antimicrobial usage and resistant infections, and provide training and advice to the acute HP and surveillance staff. The HCAI./AMR surveillance team are working with data analytics team to identify where data analytics can support the key workstreams.				
5	Undertake a multi-channel programme of proactive public communication to influence public behaviour around a range of health protection issues, including vaccination and infectious diseases, and providing emergency response communications as required on clusters and outbreaks.	Working strategically with DoH, PHA Comms has undertaken a sustained and agile programme of multi-channel communications to inform, advise and influence behaviour change within key target audiences across Covid and wider Health protection issues. Key activities have included: Corporate and Public Affairs: • proactive news releases and managing significant volumes of media requests (complex/fast moving), social media messages development/publishing including the development of infographics and video content, and stakeholder engagement • delivering a 24/7 service to promote PHA messaging and facilitate media enquiries on health protection issues Outputs: On average – 10 daily outputs across all channels.				S.Wilson, Director of Operations (interim)

2. Health Protection						
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Oct	Jan	Mar	**Mitigating actions where performance is Amber / Red**
		Campaigns: • Ongoing mass media campaign programme including: • *Covid Vaccination tactical campaign* - raise awareness of the age call up • *Every vaccination brings us closer campaign* - promote and encourage uptake of the COVID vaccine particularly among younger cohorts. • *Revised youth campaign* including BIG Jab Weekend promotion, Grab a Jab, Moderna Community Pharmacy promotion. • Winter vaccines campaign to encourage uptake of flu and booster vaccines among over 50s and those at risk as per JCVI advice • As new cohorts eligible for the booster vaccine (16-49 year olds) campaign to encourage uptake Results: Vaccination uptake levels as per the dashboard. Campaign tracking survey results – 75.7% aware of seeing/hearing media promoting COVID vaccination programme. The mass vaccine, youth, big jab, jabbathon/grabbathon campaigns delivered 57.075 million impressions overall meaning on average adults would have seen or heard the campaign 38.1 times Digital Self Trace campaign – to raise awareness of the Digital Self-Trace service and to encourage usage of it by those who test positive for coronavirus. The campaign also highlighted the importance of contact tracing and insights from research and contact tracing informed social messaging. Outputs: campaign ran from 1 August – 27 September 2021 supported by PR, organic social media and via online				

2. Health Protection						
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Oct	Jan	Mar	**Mitigating actions where performance is Amber / Red**
		materials (publications); posters and PVC banners were displayed at test sites; and 125,000 easy explainers for the service were distributed via test sites from 2 August 2021. Results: • Use of the service increased during the campaign period – hitting a peak at 29%. • Campaign media exposed over one million times and it is estimated that 91% of NI adults saw/heard the campaign at least once. Publications: Bespoke range of professionally designed publications developed across key topic areas eg. Vaccination programme, Testing, Contact tracing and emergency response areasincluding RSV and Blood bourne viruses. Outputs: in excess of 125 titles produced. Materials available in 17 (max) languages Alternative formats produced on demand – including easy read / braille, ISI/BSL and large print accessible word documents . To support the evolving COVID vaccination programme the following materials were created: • 120,000 packs containing a range of materials for post primary school children. PDFs created in 17 translations, BSL and ISL videos and large print versions as well as online Q&As. These PDFs have been revised as details have changed. • Guides to the booster programme in PDF and 750,000 leaflets for after the Covid booster/primary doses.	Green	Green	Green	

2. Health Protection

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
		Translated into 17 languages and large print accessible format and later revised twice when PDFs were updated as eligible cohorts were lowered. New record cards were produced and between OCT and Dec 2,070,000 have been printed to keep up with the demand for vaccines . • PDF materials shared with HSCT vaccination hubs, GPs and Pharmacies for immediate download covering the temporary suspension of 15 minute wait for adults after COVID vaccination while 705,000 copies were being printed for distribution to the venues . Translations in 17 languages, an audio recording and a large print accessible format were also available online. • Range of publications produced for parents of 5-11 year olds for the continuing rollout of the programme. • Resources to support the spring booster campaign and updates to online health professional materials . Materials for the public on Test trace protect, car share and advice for parents and carers of school children were updated as policy on isolation and advice for contacts changed . Online documents for various audiences on testing including LFD, PCR and lamp were also produced, including easy read versions for those with learning disabilities.				

2. Health Protection

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
6	Use research funding programmes (CHITIN, NIHR, Opportunity Led, Research Fellowships) to protect the community (or any part of the community) against communicable disease and other transmissible dangers to health and social well-being including dangers arising on environmental or public health grounds or arising out of emergencies.	Nine studies funded through the HSC R&D Covid-19 call are ongoing as well as those funded through the national prioritisation exercise. Over 30,000 participants from NI including staff, patients, carers, students, children and the wider public have now been recruited to these studies. Findings have identified new therapies to prevent and treat Covid-19 including vaccines as well strategies to address the longer term physical and psychological impacts of Covid-19 meaning the evidence base to deal with the ongoing and future pandemics is ever expanding. Seven studies were funded/co-funded through the COVID-19 Rapid Response Funding Call: • A mixed methods study of the community pharmacy workforce's preparedness for, and response to, the COVID-19 pandemic • Effectiveness of staff well-being interventions in response to COVID-19 in Northern Ireland • A survey of hospital dialysis patients during the COVID-19 pandemic in Northern Ireland • Modulation of the innate immune response to SARS-CoV-2 with bradykinin inhibition • Advance care planning for nursing homes in a COVID-19 outbreak • Health & Social Care Workers' quality of working life and coping while working during COVID-19 Pandemic • Seroprevalence and symptomatology of SARS-Cov-2 infection in healthy children across the UK (The COVID Warriors Study).				S.Bergin, Director of Public Health (interim)

2. Health Protection

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
		A further nine were funded as needs/opportunity-led projects: • The REALIST Study - Repair of Acute Respiratory Distress Syndrome by Stromal Cell Administration • COVID-19 Possible options for analysis and intervention via social media • The SIREN Study • Repurposing FDA-approved drugs for treatment of 2019-nCoV-induced disease • Estimate of Northern Ireland community seroprevalence of antibodies against SARS-CoV-2 from anonymised residual blood samples • Student Psychological Intervention Study (COVID-specific extension) • Optigene Saliva Test • COVRES2: Identifying temporal immune responses associated with COVID-19 severity • A new Covid Cluster within the Northern Ireland Clinical Research Network (NICRN) has been established to create a dedicated Covid 19 group to support new and ongoing clinical research proposals • Senescence biomarkers for predicting risk in Covid-19 patients • The PANORAMIC trial, a new platform trial for anti-viral COVID treatments, is being led by the University of Oxford at sites across the UK. It will test new antiviral treatments for COVID-19 to help patients to stay at home without the need for hospital admission HSC R&D and NICRN Primary Care have supported Northern Ireland's participation. One arm paused to	Green	Green	Green	

2. Health Protection

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
		recruitment on 27/04/2022 due to changes to testing processes. 1,020 participants from Northern Ireland were recruited to this arm. Work is underway to set up sites for a further arm to test another new treatment. These studies will add new knowledge in terms of the wellbeing of young people, patients and staff, staff and community infection levels and antibody status efficacy of treatments and tests for infection. The impacts of each study will be reported separately, and reports will be made available on the HSC R&D Division website, but will include recommendations for staff, student and patient support, treatment and testing options, and contribute data to modelling and public health messaging plans.				

3. Health Improvement

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
1	Establish a Health Inequalities Network to improve access to data, co-ordination of resources and implementation of evidence based practice in Health & wellbeing improvement	Implementation of evidence based practice and use of population data to address health inequalities is key to the unique role of the PHA and applies across the organisation's work corporately. A PHA Corporate Plan is currently in development and will incorporate an OBA approach to outcomes. This will inform a multi-disciplinary approach to tackling Health Inequalities. The ongoing review of the PHA by Ernst Young will also inform this aspect of the PHA's function corporately. A separate network for Health Improvement is therefore not being progressed as this will be addressed and incorporated at corporate level across the organisation	Green	Green	Green	S.Bergin, Director of Public Health (interim)
2	Progress the planning and commissioning of health improvement services including: • Procurement of the new Regional Sexual Education service that meets specifications of diversity, communication methods and measurement of	**RSE** Revised Regional Sexual Education service tender was successfully evaluated Wednesday 26th January 2022 and will be offered to successful Providers. New contracts will be awarded February 2022 with contracts commencing 01 April 2022. Positive multi-disciplinary approach to the process including cross-directorate involvement across the CAG. The three tender contracts will now be managed by one experienced individual to insure quality and consistency of delivery. The CAG completed a review of the process with PALS which was very positive especially the learning across Directorates involved	Green	Green	Green	S.Bergin, Director of Public Health (interim)

3. Health Improvement						
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Oct	Jan	Mar	**Mitigating actions where performance is Amber / Red**

	impact and implement in target areas
	
	• Protect Life 2 services that have completed the engagement and consultation processes including; training framework and bereaved by suicide support service.
		Protect Life 2
		• An Involvement Plan for Consultation processes related to community based suicide prevention completed.
		• PHA are currently at Stage 2 of this process:
		• Draft discussion paper for a Bereaved By Suicide service complete.
		
		• Draft discussion paper for community based suicide prevention services in development.
		  • Evidence base Reviewing the effectiveness of interventions for Suicide Prevention complete and approved by AMT.
		  • Timeframes in relation to procurement to be agreed with Operations and PaLs.
		  • Planning stage in relation to the procurement of services linked to the Training Framework in development. Timeframes in relation to procurement to be agreed with Operations and PaLs.				

3	Deliver through multi-disciplinary working, a programme of 5 public information campaigns as part of the 'Living Well' programme in specific areas (eg. smoking, alcohol, physical activity, Covid	Distance aware, alcohol, mental health, cancer, winter vaccines (flu and COVID booster) and healthy weight campaigns were developed and delivered in 521 community pharmacies. All 6 campaigns included public-facing materials (e.g. printed materials, promotional items, briefing newsletter for pharmacy teams, engagement activities and FAQs. Additional online materials produced and a supporting social media schedule issued with each campaign (posts also go out on PHA channels), along with a media release.				S.Wilson, Director of Operations (interim)

3. Health Improvement

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
	transmission and mental well-being) based on behavioural science.	165,000 leaflets are distributed to the public and 1,500 are posters displayed in pharmacies, per campaign. Results: Evaluation for each campaign is conducted through a tailored survey to all pharmacies. Survey results are collated into a report.				
4	Deliver a sustained and varied programme of communication though PR, mass media advertising campaigns, features, social media, video and graphics on the range of health improvement portfolios to raise awareness, influence behaviour and signpost to support.	PHA Corporate and Public Affairs has undertaken an intense programme of messaging and content development on health improvement portfolios, balancing this with the ongoing priorities and pressures of managing the pandemic. As the Health Improvement team has been restarting activities that were paused during the height of the pandemic, and non-COVID activity continues across other teams, CPA has been working with respective leads to develop messaging. Core health improvement messaging has also been disseminated throughout this financial year, including on issues such as smoking cessation, mental health, physical activity, weight management and drugs and alcohol. From 1 January to 31 March 2022, Facebook page reach was 2,415,637 people and Instagram account reach was 112,467. The number of followers on Facebook was 243,716on 1 April 2022. The number of followers on Instagram was 12,296 on 1 April 2022.				S.Wilson, Director of Operations (interim)

3. Health Improvement

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
		The number of followers on Twitter was 32,676 on 1 April 2022. PHA's posts on Twitter had 1.619 million impressions in the from January to March 2022. There were nearly 4,000 mentions of the PHA on Twitter during this period. Corporate and Publics Affairs has also been working closely with Health Improvement to develop strategic communications to reflect programmes and core work areas which will be enhanced and rolled out post-COVID. Public Information Campaigns (PICs) A number of multi-channel mass media advertising campaigns were delivered over the year as follows: • Obesity – portion control.The campaign was exposed over 36.5million times and it is estimated 98% of adults would have seen the campaign at least once • Stroke – Act FAST. The campaign was exposed over 36 million times and it is estimated 84% adults in Northern Ireland saw / heard the campaign at least once. • Smoking in private vehicles regulations. (campaign exposure TBC) • Nicotine inhaling products regulations. The campaign was exposed over 8.7 million times and it is estimated that 66.7% of adults would have seen/heard the campaign at least once. • COVID vaccine multiple campaigns (Every vaccination				

3. Health Improvement

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
		bring us closer together 5/5/21 -31/7/22, Big Jab Weekend COVID vaccine promotion August 2021, Grab-a-jab and Jabbathon student vaccine campaign Sept/Oct 2021, Flu/Winter vaccines Nov 21- March 22, Young people's promotion and Big Jab Weekend Dec 22, COVID Booster Jan – Feb 22, COVID vaccine for 12-15 year olds, COVID vaccine for 5 and over. Mass media campaign outputs included TV, video on demand, radio, outdoor poster, digital and social media advertising in multiple formats. All campaigns were further promoted and campaign reach extended via communications briefings and toolkits developed and distributed to stakeholders and partner organisations. The communications team has continued to support key health improvement topics by producing and disseminating materials on mental health, breastfeeding, smoking cessation, weight management in pregnancy, and the two extensive books The Pregnancy Book and Birth to Five. This in addition to publications to support other directorates delivering key services during the pandemic Organ Donation Following the approval of the Organ and Tissue (Deemed Consent) Act in the NI Assembly on 8 February 2022 and the Act receiving Royal Assent on 30 March 2022, planning work has				

3. Health Improvement						
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Oct	Jan	Mar	**Mitigating actions where performance is Amber / Red**
		been taken to the next stage for a sustained programme of education and awareness across NI. The programme of work includes public information campaigns and outreach and engagement work. A new website was developed and launched in February to support the promotional work required around the law change. A new public information campaign has been developed for launch in May 2022. The campaign will run across a range of media channels, and work has involved the development of a Communications Toolkit and supporting resources for partners and stakeholders to help share messaging. Supporting materials will meet the needs of various target audiences and will be rolled out in digital and hard copy across the general public from May. Posters, flyers and information cards have been developed and will be available ina range of formats and languages. The Community Pharmacy network and GP practices will form a large part of the community distribution. An outreach and engagement programme is underway which will target a range of organisations, events, and audiences across NI, with plans in place for the PHA prescence at the Balmoral Show to be focused on organ donation and law change.				
5	Work towards implementing a Whole Systems Approach (WSA) to obesity and align Fitter Future for All	A schema has been approved for a WSA approach to obesity prevention, along with a new ROPIG structure, with input from DoH Policy Branch. ROPIG (at a workshop on 18th October 2021) and individual meetings with key stakeholders				S.Bergin, Director of Public Health (interim)

3. Health Improvement

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
	and Physical Activity in a new strategic approach to the prevention of obesity through Regional Obesity Prevention Implementation Group (ROPIG).	PHA presented at the All Island Obesity Action Forum's Workshop on WSA on 16th November 2021. PHA is represented on the project board for the development of a new obesity strategy (5 meetings have been held) and an evidence base for WSA is being developed as part of the strategy development. A ROPIG working group has been established to oversee and direct the process and implementation of a Whole System Approach to Obesity in Northern Ireland. WSA training (for PHA staff and the ROPIG WSA working group), via Leeds Beckett University has started and will continue, and be extended to other partners, as we move through 2022/23. PHA has presented to SOLACE to engage Councils and drive this work through community planning. Identification of 2-3 early adopter sites is underway.				
6	Lead, champion and inform strategic and operational responses to improve health and wellbeing through community-led approaches	The Strengthening Communities for Health Steering Group met in November 2021 . A Capacity Building Subgroup and Funding subgroup have been established. Initial group will feed into ICS Model and later brings together a range of agencies and Government Departments and connects into wider Cross-Departmental planning and investment structures. Both subgroups have now met twice and work is underway to take forward action plans. A key piece of work for the Capacity				S.Bergin, Director of Public Health (interim)

3. Health Improvement						
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Oct	Jan	Mar	**Mitigating actions where performance is Amber / Red**
		Building subgroup has been beginning to look at training opportunities available to community development practitioners and the review of an online portal. A key piece of work for the Funding subgroup has been planning a GIS mapping exercise tin Partnership with QUB, to look at sustainable and equitable funding for the sector. The Community Development Practitioners' Forum has now been established with topic areas agreed for the next 12 months. The first session was attended by a number of Community Development Practitioners from both the Community & Voluntary and statutory sectors and focused on an update on the Community Development Framework. Practitioners welcomed the opportunity to use the forum as a way of informing and influencing the work of the Strengthening Communities for Health Steering Group going forward.				
7	Lead implementation of the current Breastfeeding Strategy 2013-2023 and inform the development of a new Strategy for 2024 onwards	Input into development of new Strategy through Regional Breastfeeding Corodinator and IPH.				S.Bergin, Director of Public Health (interim)
8	Improve, protect & promote the sexual health and well-being	A Sexual Health Action Plan 2022-2026 is currently sitting with CMO for approval.				S.Bergin, Director of Public Health (interim)

3. Health Improvement

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
	of the population of Northern Ireland	A draft implementation plan template is with DoH intention is to populate by 31st March 2022. Review of Sexual Health Information Network (SHIN) membership completed. Continued engagement to increase membership (currently40) especially outside of the health sector e.g. criminal Justice and Education. In partnership with Health protection the contents of BBV training programme for professionals and C&V sector has been drafted. Training programme to be commissioned by 31st March 2022. Work has commenced to develop a Regional C-Card condom distribution programme with a scoping exercise on available training programmes to be completed by 31st March 2022. Through monitoring and progress reports all sexual health contracts are on target. A training programme suitable for NI is now available to be piloted And training will be rolled out Q3,Q4 22/23. DoH have decided to enhance the existing draft Action Plan by engaging with UK & ROI and other Departments e.g. Criminal Justice and Exectutive Office. New draft action plan to be available for sign off by March 2023.				

3. Health Improvement

	Action from Business Plan:	Progress	Achievability (RAG)			Mitigating actions where performance is Amber / Red
			Oct	Jan	Mar	
9	Progress the development of evidence based family support and parenting programmes	Early Intervention Support Service is well established in all 5 HSCT areas, with 3,133 families supported between August 2015 and March 2021. Recurrent baseline funding of £900k is now in place to allow these services to be re-tendered on a long term basis. PHA Procurement Board approved a plan for the re-tender of these services with the aim of having new contracts in place by April 2023. An OBA report card showing the impact the service has had over the period 2016 - 2021 is attached as appendix <3.9> Stats for 2021/2022 will not be collated until April 2022. A number of workforce training evidenced based programmes have been commissioned including Parents Plus and Incredible Years to build the workforce capacity contributing to the development of sustainable infrastructures for future programme delivery.				S.Bergin, Director of Public Health (interim)
10	Lead on the implementation of the Tobacco Control Strategy 2012-2022 for Northern Ireland and inform the development of a new Strategy from 2022 onwards	Work continues to implement the ten year Tobacco Control Strategy for NI (2012 -2022). The Health Minister has issued an extension of the current strategy until March 2024, to support development of a new strategy. Additional recommendations have been added to the strategy as a result of the mid-term review and these continue to be implemented. An event to mark the achievements of the Ten Year Strategy in NI is proposed alongside a final report, and work to develop the new strategy will commence in September 2022, led by the DoH and supported by the Institute of Public Health. Services have been significantly impacted by decreased capacity				S.Bergin, Director of Public Health (interim)

3. Health Improvement

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
		in community pharmacies as they are supporting Covid 19 vaccine and Flu vaccine roll out, however negotiations are ongoing between PHA, HSCB and CPNI to reinstate and refresh these services and a 2 year plan has been produced to fully reset and refresh Pharmacy based services. Service outcomes are currently producing quit rates of ~ 51%, which is greater than NICE guidelines for commissioners which recommends achieving a 35 % quit rate from services. Work is ongoing to reset and refresh membership of the Strategic Group for Tobacco Control for NI and ongoing 4-nations discussions have been taking place to support development of Tobacco Control Strategies, action plans and to share best practice across NI, Scotland, England and Wales. Legislation in relation to 'Age of Sales of E-cigarettes' and also 'Prevention of smoking in cars with minors present' went live in NI in February with a PHA led mass media campaign increasing public awareness of the dangers of second hand smoke to children and young people and the penalties for breaching the legislation. Media coverage included television, social media videos and infographics and radio interviews with PHA and supported signposting current smokers to stop smoking services.The PHA commissioned Tobacco Control services in all 11 local councils will be working collaboratively with the Police Service of Northern Ireland to support implementation of this legislation.				

3. Health Improvement

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
		March 2022 was No Smoking Month and featured a range of media and communications efforts across all Tobacco Control partners to direct smokers to services and support them to quit. Data is not yet available to demonstrate the impact of this work from Jan – March to increase footfall to services, but should be available for the next update report.	Green	Green	Green	
11	Use research funding programmes (CHITIN, NIHR, Opportunity Led, Research Fellowships) which have involved patients and public in their design to develop an evidence base to inform health and well-being at individual, community and regional levels by developing and securing the provision of programmes and initiatives which have been designed with patient and public involvement to secure the improvement of	A PPI Sub group has been established as part of the NI Clinical Research Recovery, Resilience and Growth Taskforce, co-chaired by a member of PIER and a clinical researcher has developed an action plan to strengthen PPI in the NI Research Infrastructure as part of its recovery plan. This work aims to increase the diversity of participants to clinical trials in NI including those seldom reached and ensure patients and public are involved as partners in research studies. This will include the identification of research priorities for NI through a priority setting partnership using James Lind methodology. HSC R&D Division is also represented on several UK working groups as part of the UK wide RRG programme to strengthen and standardise PPI in research across the UK including the development of a statement supporting a shared commitment to Public Involvement which was published on 13th March, the implementation of the UK Public Involvement Standards and the production of UK guidance for the payment of public contributors, now being piloted through consultation in use. An event involving a range of stakeholders from across NI including service leads and commissioners presented findings	Green	Green	Green	S.Bergin, Director of Public Health (interim)

3. Health Improvement

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
	the health and social well-being of and reduce health inequalities between people in Northern Ireland.	from one of the CHITIN Trials which has recently completed on Inhaler Compliance in partnership with RCS Dublin and HRB. An online course, Building Research Partnerships, will be run in May with 50 attendees to introduce the concept of PPI in Research to researchers in academia, HSC, the Voluntary Sector and service users, carers and members of the public. The course is led by a member of PIER NI.				
13	Lead and implement the UK AHP Public Health Strategy in NI	Multi Professional AHP Team now in place and progressing with implementation of the UK Allied Health Professions Public Health Strategic Framework and local regional workplan. This work aims to help AHPs, as well as their professional bodies and partner organisations, to further develop their role in public health, share best practice with colleagues and partners and ultimately embed preventative healthcare across all of their work.				R.Morton, Director of Nursing, Midwifery and AHPs.

4. Shaping future health

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
1	Work with DoH and HSCB to establish a population health approach within the new integrated care systems, as part of the new HSC planning model.	PHA continues to work with DoH and HSCB colleagues to ensure a population health Planning approach is embedded into new organisational structures being designed to support an Integrated Care System. The draft Framework document for establishing a new planning model is currently being reviewed and updated to take into account comments received from the consultation process. PHA is represented on the Project Board and various project planning teams that have been established to take forward the implementation of a new planning model for HSC.				All Directors
3	Support the development of multi-disciplinary strategic Planning teams that will agree future priorities for the agency on specific thematic areas, starting with an initial planning team to look at Mental and Emotional Wellbeing, Suicide Prevention and Drugs and Alcohol	AMT agreed the establishment of a Mental Health, Emotional Wellbeing and Suicide Prevention Multi-disciplinary strategic planning team in July 2021. The first meeting of the Team took place on 30th November 2021 where the ToR was agreed. The team continues to meet and as well as having a draft action plan for 22/23, is working to develop a 3-5yr outcomes framework. Work was also initiated in July 2021, with HSCB colleagues, to establish a Multi-disciplinary planning team to take forward the new Drug and Alcohol Substance Misuse Strategy. This work was delayed but the first meeting has now taken place. Work is now being progressed to look at further developing multi-disciplinary strategic planning teams within PHA and how such teams would support the new Planning Model currently being developed by DoH.				S.Wilson, Director of Operations (interim)

4. Shaping future health

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
4	Develop a population health planning guide for the HSC NI	A population health planning guide for HSCNI has been completed with the final draft for approval submitted to PHA senior management in February 2022. Plans on how to launch the guidance are currently being developed and will take into consideration necessary timings relating to the implementation of the new planning model.	Green	Green	Green	S.Wilson, Director of Operations (interim)
5	Expand and develop population health intelligence resources which enable the organisation to fulfil its role in improving and protecting health and wellbeing, planning and policy development.	There are two elements to this action: 1. The ongoing provision of timely and relevant evidence-based insights – the production of our existing reports has been impacted by the re-deployment of Health Intelligence Unit staff to Health Protection in previous quarters. This has resulted in delays in the release of our annual official statistics reports, ie the Statistical Profile of Children's Health In Northern Ireand and the Director of Public Health Core Tables. Redeployment ended during this quarter and work on these reports and other areas has re-commenced. Behavioural analyses completed or underway Jan-Mar 2022 include public knowledge, attitudes and behaviours with regard to: • COVID-19 • obesity • smoking • organ donation • suicide prevention • breastfeeding • alcohol and drugs	Green	Amber	Green	S.Wilson, Director of Operations (interim)

4. Shaping future health

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
		2. Development of our range of strategic analyses and resources to ensure they match organisational goals to reduce population health inequalities and improve population health - whilst our work on this continues, it has been slowed by the the re-deployment of staff in the Health Intelligence Unit to support Contact Tracing and Health Protection in previous quarters, as stated above. Population health analyses completed or underway Jan-Mar 2022 include: • NI population health profile • Complex lives • Long term conditions • Births • Mental health • Antenatal education • BME	Green	Amber	Green	
6	Support DoH colleagues to ensure that public health policy is embedded in the development and delivery of Programme for Government eg transport, housing, air quality, greenways, economic development.	Further to the public consultation on the draft outcomes framework for PfG that closed at the end of March 2021, PHA officers continue to support DoH colleagues in public health policy discussions, when approached for input.	Green	Green	Green	S.Bergin, Director of Public Health (interim)

4. Shaping future health						
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Oct	Jan	Mar	**Mitigating actions where performance is Amber / Red**
7	Continue to work with each of the Local Councils and their Community Planning Partnerships to take forward implementation of agreed action plans.	PHA has continued to work collaboratively with local councils and Community Planning Partnerships to take forward agreed actions. Since April 2021, the key focus has continued to be on working collectively to develop and deliver programmes aimed at supporting those most affected by Covid 19. This has included supporting vulnerable families and individuals with direct assistance; addressing issues of social isolation for older people and promoting programmes aimed at improving mental health and well-being.				S.Wilson, Director of Operations (interim)
8	Deliver a rolling creative communications programme to educate, empower and assist communities to improve their health and wellbeing by taking a range of steps, focused on core areas identified as presenting challenges.	PHA Corporate and Public Affairs has undertaken a sustained programme of messaging and content development on both COVID-19 and non-COVID issues, striking a balance between the ongoing priorities and pressures of managing the pandemic, aligned with the priorities of the agency. Between 1 January to 31 March 2022, reach was 2,415,637 individual people organically (ie without paid promotion) through Facebook, reflecting how the programme of social messaging is resonated beyond the jurisdiction, with the highest reach on 6 January (634,180). This has run in parallel with proactive messaging through the mainstream media – over news releases and statements were issued in this period on issues as diverse as hepatitis, breastfeeding, eyesight loss, MMR vaccination and new smoking regulations, on top of a range of COVID-related topics and changing advice on issues such as testing, symptoms, schools, contact tracing and general advice. With this has come a significant requirement to manage media.				S.Wilson, Director of Operations (interim)

4. Shaping future health

	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
		Corporate and Public Affairs has been working with directorates across the agency on planning and delivering communications programmes on a range of topics in a post-COVID context.	Green	Green	Green	
9	Scope baseline QI capability across all PHA Directorates	Scope baseline QI capability across all PHA - HSCQI have completed a scoping exercise with HSC Trusts to identify QI trained staff (aligned with the Q2020 Attributes Framework) from across the region. PHA scoping template initially developed and tested by one division. In the final quarter of 2021/22, HSCQI extended the scoping exercise across all PHA Directorates to obtain baseline data for the organisation for future planning of the PHA Quality and Improvement strategy. Scoping exercise completed and this data will be collated and analysed in first quarter of 2022/23.	Amber	Green	Green	Dr A Keaney, Director HSCQI

4. Shaping future health						
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Oct	Jan	Mar	**Mitigating actions where performance is Amber / Red**
	Scope Quality Improvement training for Boards.	<u>Scope Quality Improvement training for Boards</u> In accordance with the Q2020 Attributes framework Level 4 QI training should be offered to staff who are charged with leading QI across organisations and the HSC system. These individuals are also responsible for ensuring QI is embedded in the day to day work of their organisation. The HSCQI Hub team are currently exploring options with a range of potential suppliers.	Green	Green	Green	
10	Ensuring that all Northern Ireland legislation, regulations and media are conducive to the health and social well-being of our young people and of future generations	PHA is actively contributing to DOH scoping of evidence of increase in gambling particularly among school aged young people. The All Party Group Report on 'Reducing Harm related to Gambling' includes recommendations on legislation, regulations and media and PHA will contribute to DOH input, as relevant, on the Department of Community led Inter-Departmental Group. PHA made a submission and presentation to the Committee of Communities raising specific concerns on the draft gambling legislation being introduced by the Department of Communities. That submission represented detailed evidence and research about the increased prevelance of gambling amoung young people and increased numbers of those experiencing gambling harms. Additional consideration of impact of increased opening days for Betting Shops in NI and option for application of a Gambling Levy to pay for prevention and treatment services on gambling harm were raised. DOH are requesting PHA support on actively considering how local evidence and research on local	Green	Green	Green	S.Bergin, Director of Public Health (interim)

4. Shaping future health						
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Oct	Jan	Mar	**Mitigating actions where performance is Amber / Red**
		need in this area could be secured. The Young People's Covid Messaging Group (YPCMG) was established by PHA to specifically engage with, support and platform appropriate COVID-19 public health messaging for young people. Following the completion of the school nursing vaccination programme, YPCMG have been involved reviewing COVID vaccination uptake in 12-17yr olds. YPCMG members are leading on engagement and data collection to identify vaccine hesitation and barriers to uptake faced by young people. When requested, the YPCMG also support engagement and consultation with young people for other areas of work than COVID-19, eg. organ donation.				

5. Our organisation works effectively						
	Action from Business Plan:	**Progress**	**Achievability (RAG)** Oct	Jan	Mar	**Mitigating actions where performance is Amber / Red**
3	Maintain operational workforce capacity to deliver core duties and deliverables identified for the PHA in 2021/22	The PHA has expanded operational capacity, where required, to ensure it has the necessary professional skills to continue to respond effectively to the Covid 19 pandemic. Following the ministerial announcement to scale back mass testing and contact tracing, work has been ongoing to deescalate the service and return people to their substantive posts or end their temporary contracts. PHA currently employs 594 staff with a whole time equivalent of 504.03 This includes a temporary headcount of 247 (173 WTE) to support the pandemic response. Sickness absence was 2.56% (cumulative) at the end of the period comparing to 2.39% for the previous year.	Green	Green	Green	All Directors
4	Scope out accommodation requirements to allow staff to return to work safely in line with Covid 19 guidelines and work with BSO colleagues to develop appropriate policies and procedures to facilitate new working arrangements	The PHA worked with BSO colleagues to ensure that safety inspections were completed in all offices and that appropriate measures were in place for staff safety during the pandemic. Policies and procedures for new working arrangements are being developed regionally and the PHA will implement these when they are published. A "Report on a Review of the Accommodation Needs for the Public Health Agency" has been completed and a number of recommendations were made. Implementation of these recommendations has been delayed due to the prioritisation of the covid response, but Terms of Reference have been drafted for an Accommodation Project Board to take these forward. The process of implementing some of the recommendations from the Review will integrate very closely with implementation of the	Green	Green	Green	S.Wilson, Director of Operations (interim)

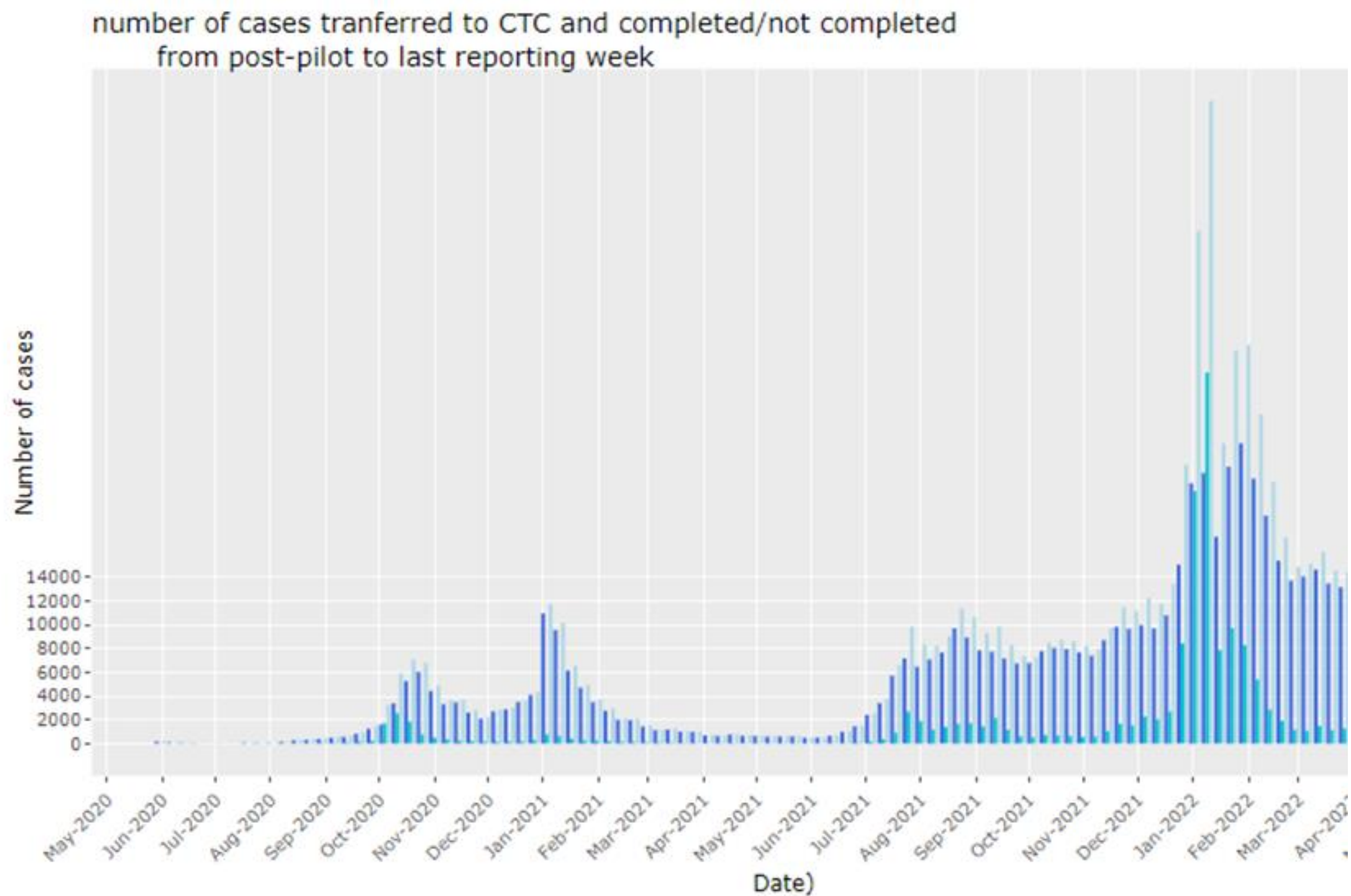
5. Our organisation works effectively

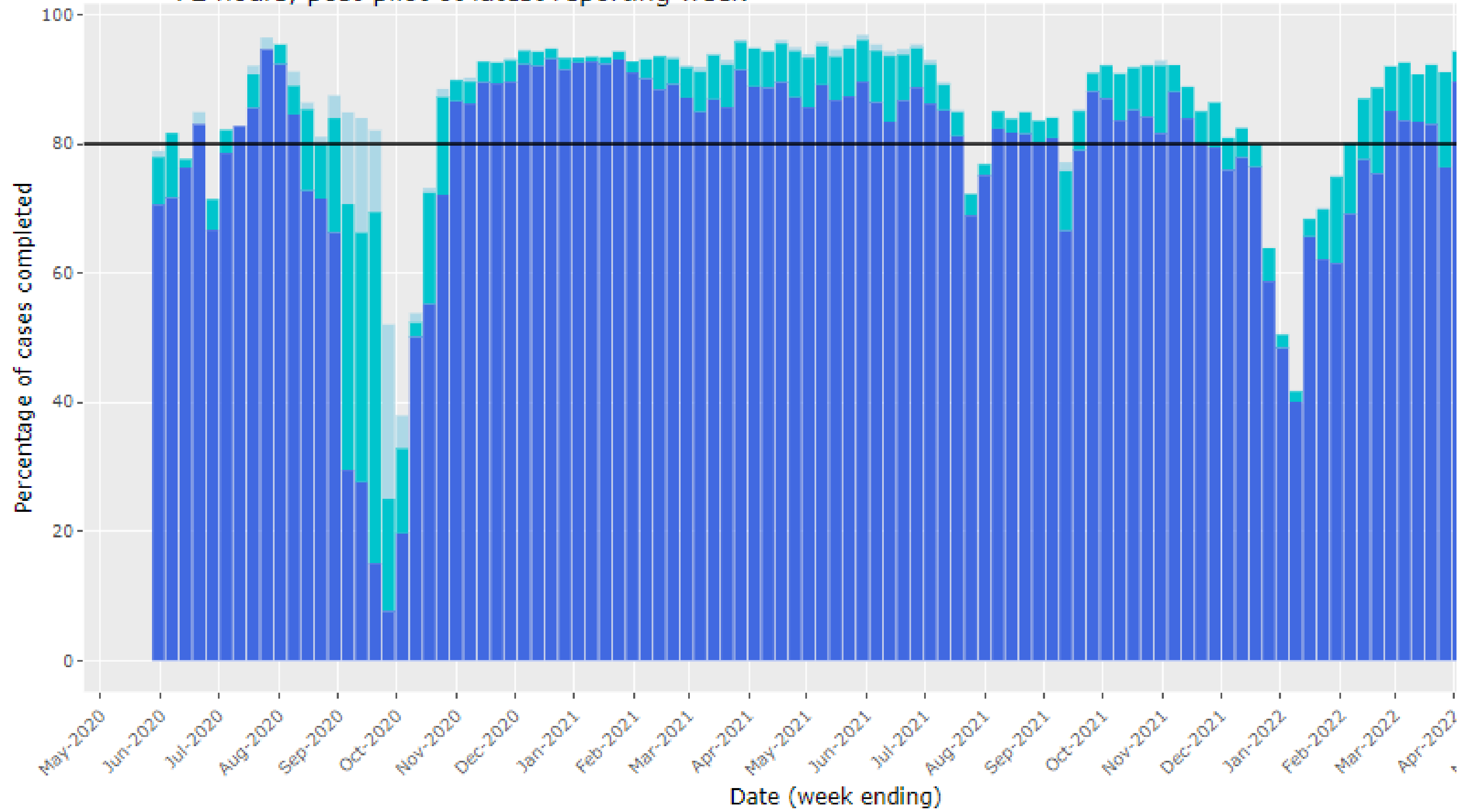
	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
		regional policies and procedures that are being developed.	Green	Green	Green	
5	Develop a comprehensive outcomes -based performance management and reporting system at all levels of the PHA.	Although the COVID response has delayed progress, work is underway to develop an outcomes based performance management and reporting system across PHA. OBA style reporting is in place already or is currently developing across a number of work areas and work continues to build organisational capacity. Work had started in 2019/20 to refocus business planning and performance management reporting around an outcomes based approach and a review of corporate performance documents is also now taking place to build on and progress this work. OBA style working is at the core of the the annual business plan 2022/23 and a draft performance framework with a focus on outcomes and impact is in development. Corporately, we have developed and agreed our strategic alignment across key strategic documents and illustrated this using the golden thread. A draft strategic outcomes framework is also underway for use within the outcomes based performance framework. AMT approved the development of a strategic planning team for mental health in July 2021 which has since met and is working to agree an 3-5yr outcomes framework. This group will act as a prototype for future teams and work has begun to identify key thematic areas that would find the SPT model effective.	Green	Green	Green	S.Wilson, Director of Operations (interim)

5. Our organisation works effectively

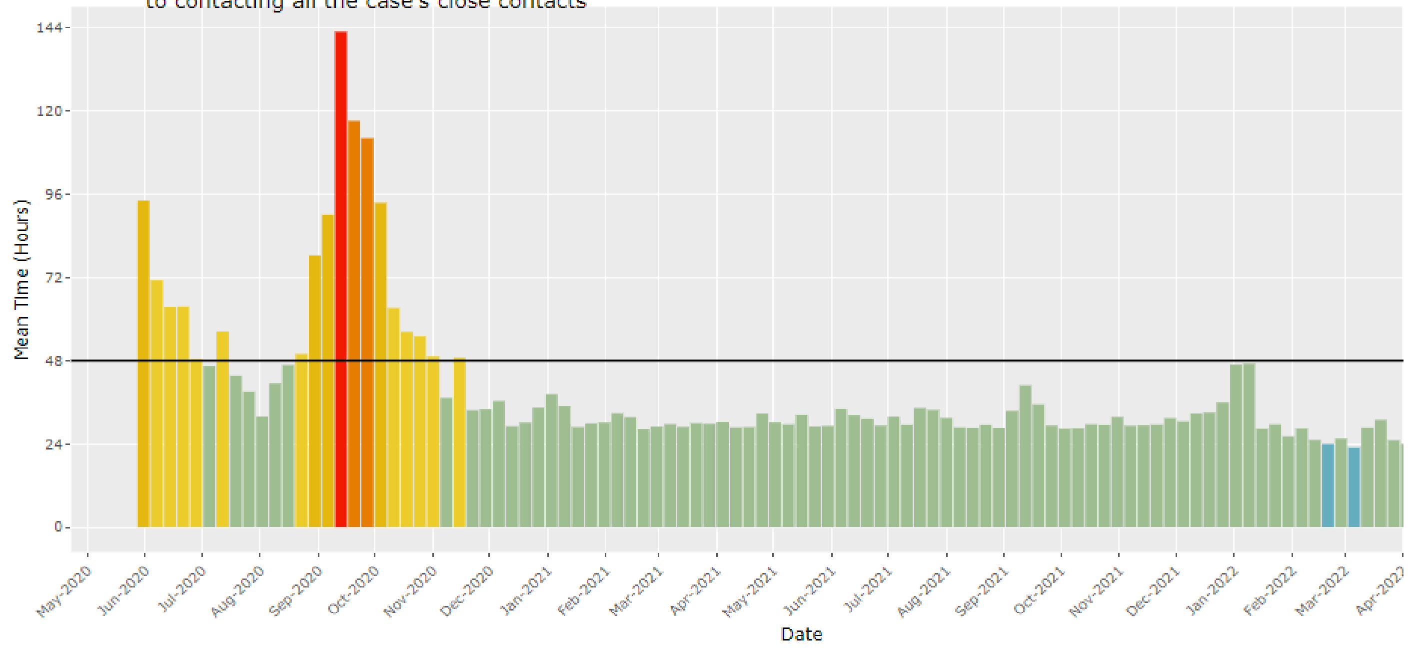
	Action from Business Plan:	Progress	Achievability (RAG) Oct	Jan	Mar	Mitigating actions where performance is Amber / Red
6	Build organisational knowledge and capacity of Outcome Based Accountability (OBA)	OBA style reporting is in place already or is currently developing across a number of work areas such as Family Nurse Partnership and others are developing outcomes frameworks e.g. PL2 implementation. As well as implementing OBA style reporting to build capacity and knowledge, the focus this year so far has been on promoting the 'golden thread' illustration of PHA's strategic alignment and the outcomes across a number of strategies that PHA contribute to. As well as providing support to new areas implementing OBA. A focus on impact and OBA style working is at the core of the annual business plan 2022/23 and targeted work has begun with smaller teams in PHA to implement OBA approaches. Work is underway to arrange a series of in-houseOBA awareness sessions for all staff in 2022.	Green	Green	Green	S.Wilson, Director of Operations (interim)
7	Meet DoH financial, budget and reporting requirements.	Financial plan approved by Board June 2021 Financial reports to DOH delivered on time on a monthly basis. Financial Reports provided on a monthly basis to AMT and Board Financial position at month 12 shows a 94k surplus, which is within the statutory duty to breakeven within 0.025%.	Amber	Amber	Green	Tracey McCaig

Appendix 1.2 - Summary of KPIs for Contact Tracing Service.





weekly cases completed successfully (%) within 24, 48 and 72 hours, post-pilot ot latest reporting week
Percentage of cases completed
100
80
60
40
20
0
May-2020
Jun-2020
Jul-2020
Aug-2020
Sep-2020
Oct-2020
Nov-2020
Dec-2020
Jan-2021
Feb-2021
Mar-2021
Apr-2021
May-2021
Jun-2021
Jul-2021
Aug-2021
Sep-2021
Oct-2021
Nov-2021
Dec-2021
Jan-2022
Feb-2022
Mar-2022
Apr-2022
Date (week ending)


mean average time taken from date of sample of positive case
to contacting all the case's close contacts
Mean Time (Hours)
144
120
96
72
48
24
0
May-2020
Jun-2020
Jul-2020
Aug-2020
Sep-2020
Oct-2020
Nov-2020
Dec-2020
Jan-2021
Feb-2021
Mar-2021
Apr-2021
May-2021
Jun-2021
Jul-2021
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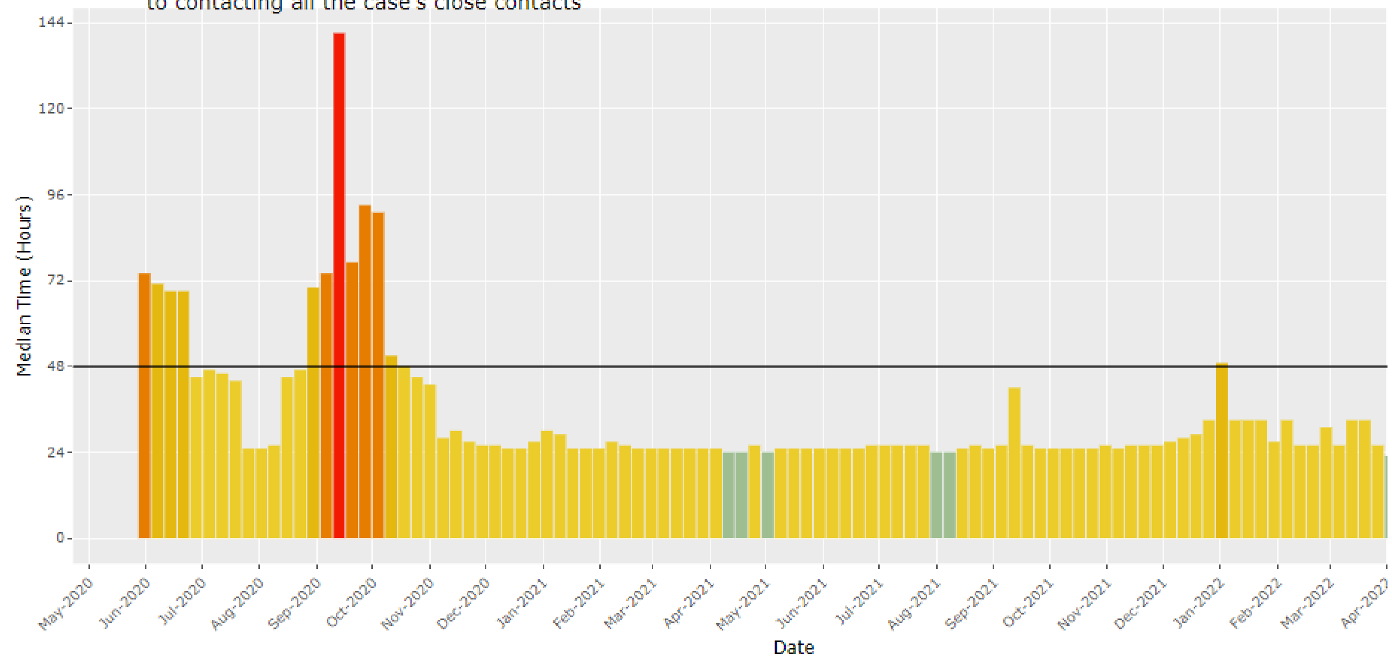
Dec-2021
Jan-2022
Feb-2022
Mar-2022
Apr-2022
Date


to contacting all the case's close contacts
Median Time (Hours)
144
120
96
72
48
24
0
May-2020
Jun-2020
Jul-2020
Aug-2020
Sep-2020
Oct-2020
Nov-2020
Dec-2020
Jan-2021
Feb-2021
Mar-2021
Apr-2021
May-2021
Jun-2021
Jul-2021
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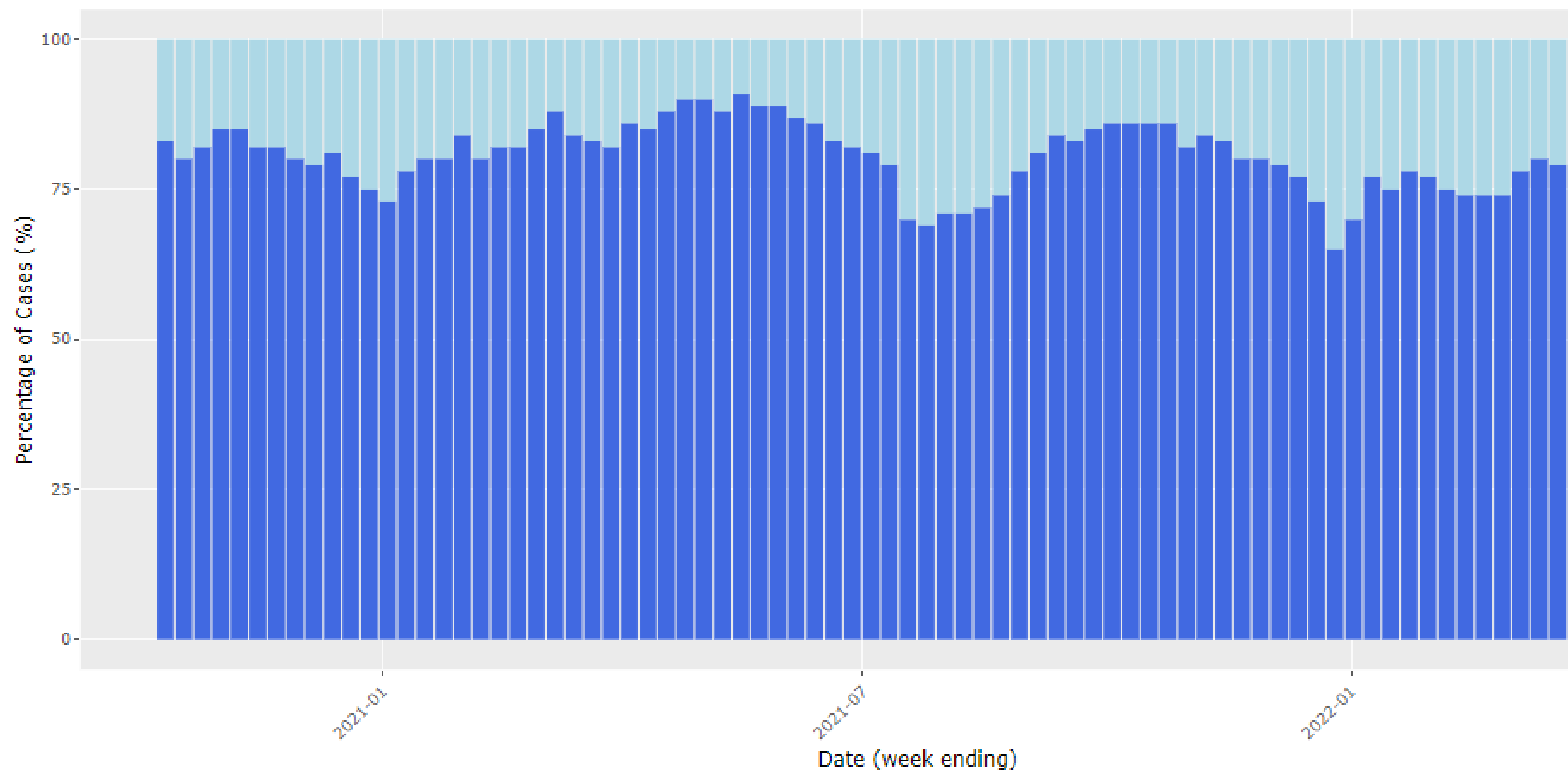
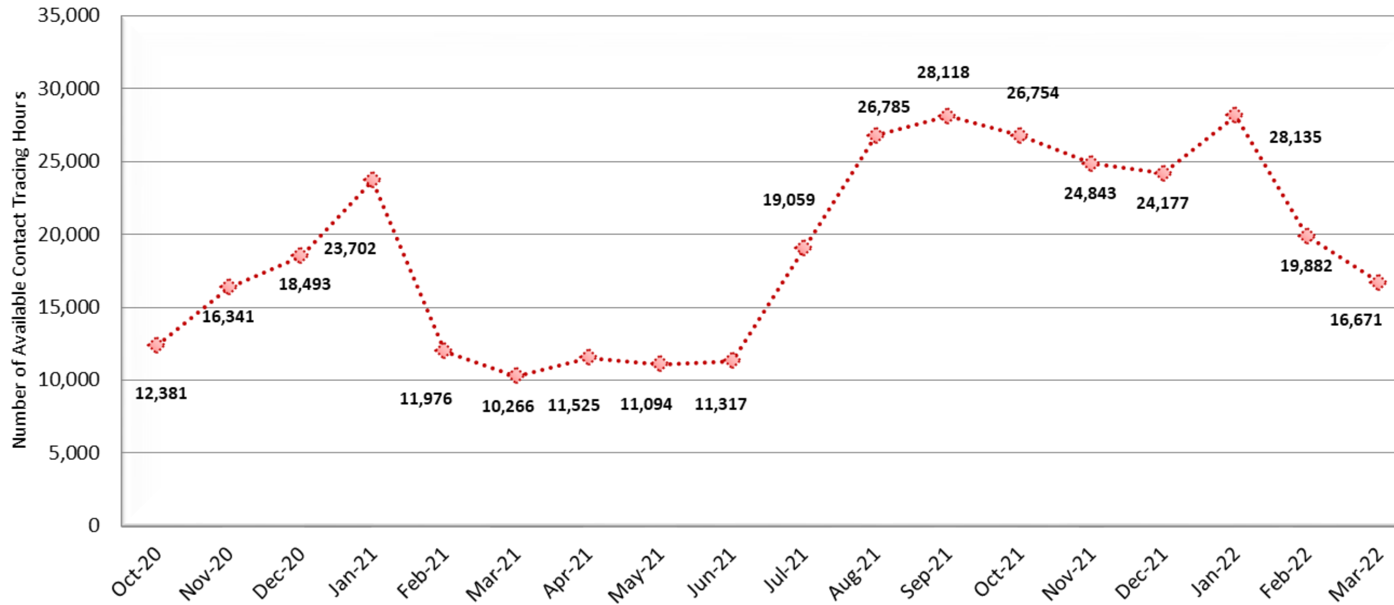
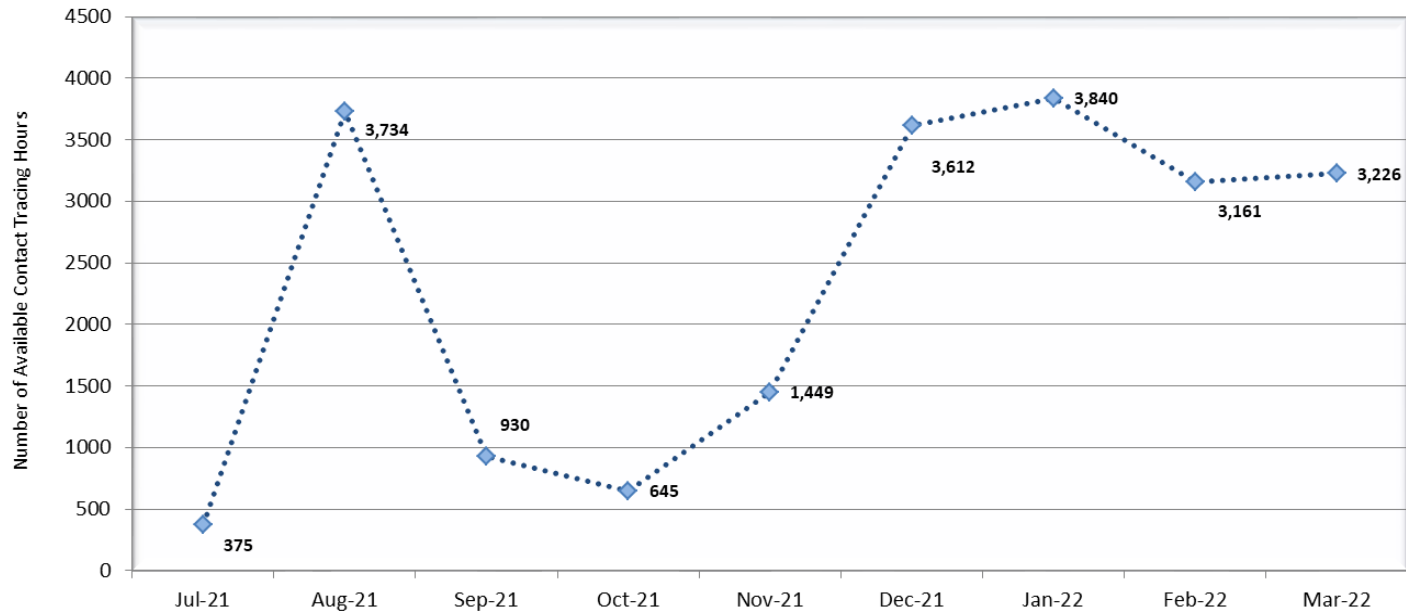
Feb-2022
Mar-2022
Apr-2022
Date


Proportion of Cases contacted via DST vs MCT
Percentage of Cases (%)
100
75
50
25
0
2021-01
2021-07
2022-01
Date (week ending)


Number of Available Contact Tracing Hours (Band 6) Per Month
(Available Hours excludes time spent by Contact Tracers in induction training and on annual/public holiday leave)
Number of Available Contact Tracing Hours
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
12,381
16,341
18,493
23,702
11,976
10,266
11,525
11,094
11,317
19,059
26,785
28,118
26,754
24,843
24,177
28,135
19,882
16,671
Oct-20
Nov-20
Dec-20
Jan-21
Feb-21
Mar-21
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22


Number of Available Health Technician Contact Tracing Hours (Band 4) Per Month
(Available Hours excludes time spent by Contact Tracers in induction training and on annual/public holiday leave)
Number of Available Contact Tracing Hours
4500
4000
3500
3000
2500
2000
1500
1000
500
0
375
3,734
930
645
1,449
3,612
3,840
3,161
3,226
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22

Appendix 1.8 Screening Programmes - Current Position

All screening programmes impacted by Covid continue to build capacity and reduce delays for screening invites. The current position across each programme is below:

Bowel cancer screening: The delay in routine invitations is currently 16 weeks (reduced from 29 weeks). The catch up exercise will be completed by Autumn 2022.

	No of individuals with a completed screening test result		**21/22 activity as a % of 19/20 activity**
	2019/20	**2021/22**	
Quarter 4 (Jan - Mar)	20,153	33,773	168%

**note the type of screening test used in the programme changed from January 2021.The above numbers can reflect invites/test kits that were sent out several months prior.*

Breast screening: The round length is currently 36 months + 5 weeks. This is down from 41 months in September 2020 (although it remains above the standard of 36 months). This is being achieved through the provision of additional screening clinics. Progress will not be linear as it is dependent upon the continued availability of staff.

	September 2019 to February 2020	**September 2021 to February 2022**	**21/22 activity as a % of 19/20 activity**
No of women invited	43594	50937	117%
No of women screened	28022 (64% uptake)	36801 (72% uptake)	131%

Cervical screening: The programme continues to operate with a 5 month delay in routine invitations with a formal catch up programme not likely to be feasible. Ongoing pressures are noted in relation to turnaround times for lab results and some colposcopy services. The number of screening samples received by the labs provides an indication of activity for women being screened. This figure is dependent on the number of women due for screening at a given time, the availability of appointments at GP practices, and the uptake by women, so it is subject to fluctuation.

	Number of cervical samples taken (as recorded received at a NI laboratory)		**21/22 samples taken as a % of 19/20 samples**
	2019/20	**2021/22**	
Quarter 4 (Jan-March)	27,621	31,348	113%

Diabetic eye screening: The programme continues to use a risk stratified approach to invite individuals for screening. Additional in year funding was secured via the June monitoring review to support recovery, and further expansion of capacity is being taken forward with the Trust to move towards reintroducing routine screening. This programme has faced significant logistical challenges due to the impact of covid. As well as a reduced patient throughput required for infection control purposes, programme has had to develop a new model of service delivery.

	No. of people screened		**2021 activity as a % of 2019 activity**
	2019/20	**2021/22**	
Quarter 3 (Sept –Dec)	17,770	11,255	63.3%

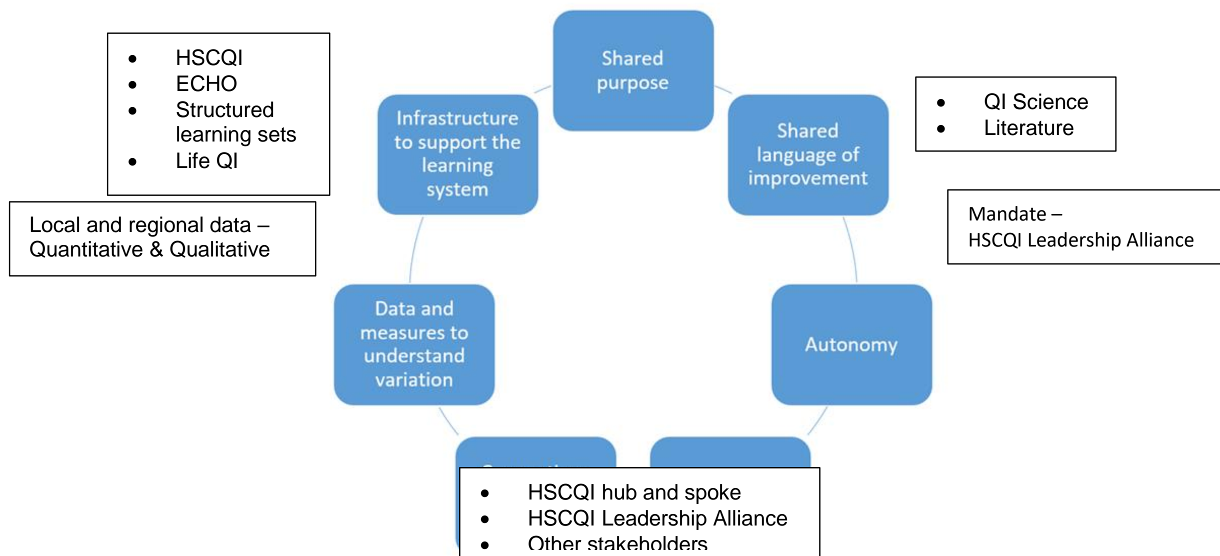
AAA screening: Surveillance scanning for men with small/medium AAA is operating as normal. Approximately 97% of men in the 20/21 cohort for primary screening have now been called for their initial appointment.

	No. of appointments completed		**2021 activity as a % of 2019 activity**
	2019/20	**2021/22**	
Quarter 4 (Jan – Mar)	2417	2266	94%

Appendix 1.14 - HSQQI

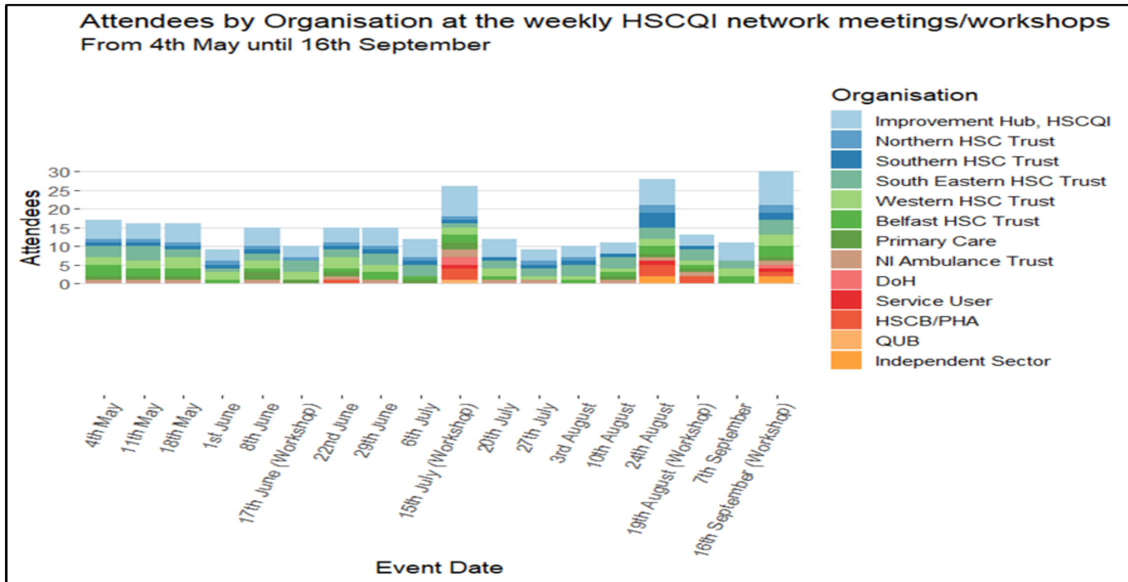
On 24th April 2020 Trust CEOs asked the HSCQI Network to provide support to Trusts and to the wider system in order to develop a regional learning system focused on lessons learned from Covid-19 to date.
During weekly meetings with QI Leads (May and June 2020) HSCQI members from across the system explored the core components of a learning system, depicted in Diagram 1(Amar Shah, Chief Quality Officer at East London Foundation Trust). This diagram has been used to assess the readiness of HSCQI as a regional learning system.

Diagram 1: Core components of a learning system.
Diagram Credit: Amar Shah, ELFT 2019



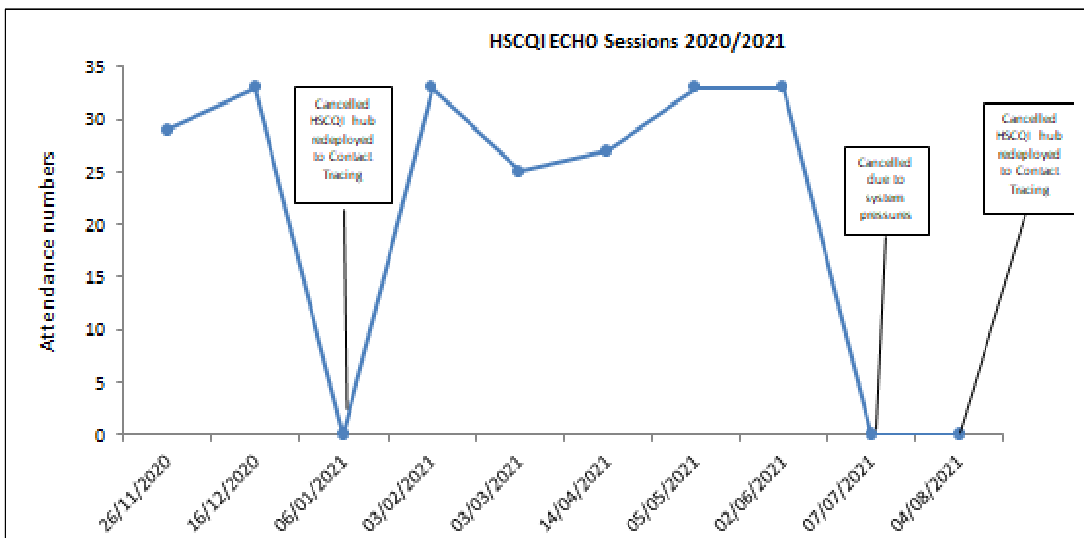
Using the structure of a 90 day learning cycle the HSCQI Network continued with these weekly meetings. A number of regional workshops were designed to identify a wide range of learning. Attendance at each of the meetings and workshops and the diversity of attendees is shown below in Diagram 2. Harvesting of examples during the 90 day cycle resulted in regional agreement to focus the collective improvement effort on 3 key areas: virtual visiting, virtual consultations and staff psychological wellbeing.

Diagram 2: Attendance at HSCQI Network meetings/workshops



Work streams for each of these 3 themes were established with representation from across the HSCQI network. To support this work the HSCQI Hub partnered with the Regional ECHO team to co-deliver monthly HSCQI learning sessions. Diagram 3 shows attendance numbers at each of the 7 sessions held between November 2020 and June 2021. The ECHO/HSCQI learning sessions were paused early June due to PHA Covid-19 pressures.

Diagram 3: ECHO session



Virtual Visiting:
The scale and spread of virtual visiting across Trusts during 2020/21 during the COVID 19 pandemic has been a real success story, accelerated by the focus of HSCQI and of the HSCQI Leadership Alliance.
Quality Improvement Teams from across the region engaged with HSCQI and collected data on activity as displayed below looking at the number of participating wards and uptake of virtual visiting slots. These QI teams used run and SPC charts

to tell the story and show their tests of change. Examples of QI data collected from one of these teams shown in the appendix – diagrams 4 and 5.

Diagram 4

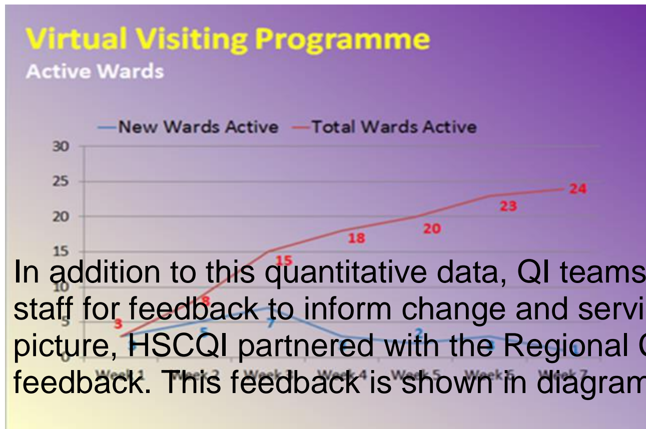
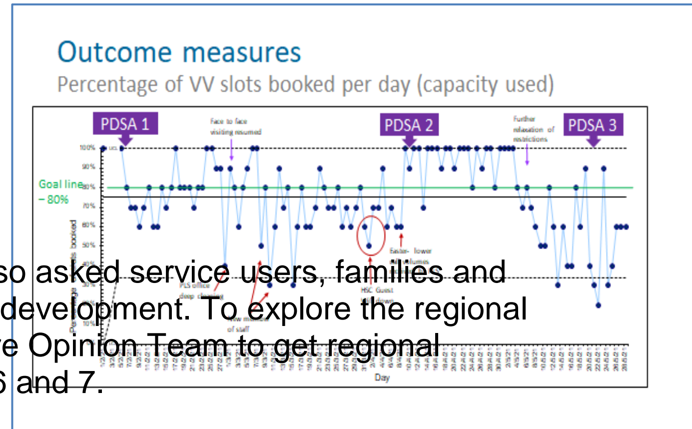


Diagram 5



In addition to this quantitative data, QI teams also asked service users, families and staff for feedback to inform change and service development. To explore the regional picture, HSCQI partnered with the Regional Care Opinion Team to get regional feedback. This feedback is shown in diagrams 6 and 7.

Diagram 6

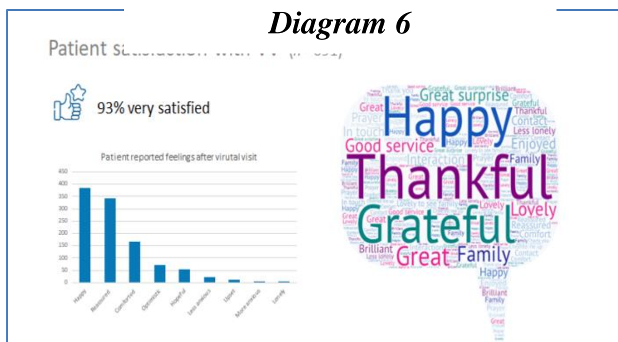
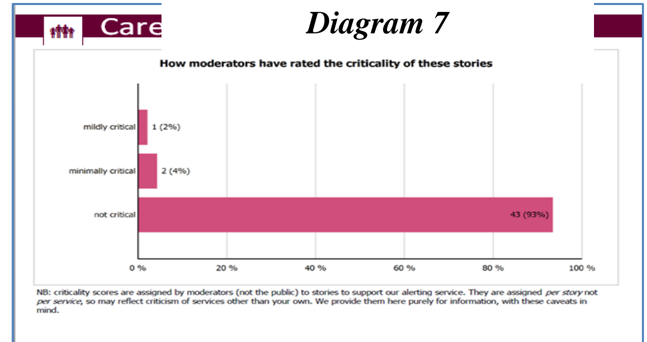


Diagram 7



Following agreement with the HSCQI Leadership Alliance in June 2021, responsibility for sustaining virtual visiting now sits locally with Trusts, with regular "check-ins" from the HSCQI Hub to ensure sustainability.

Staff psychological wellbeing:
A number of examples of initiatives to support staff psychological wellbeing during the first wave of Covid-19 were harvested.
Given the scope of this work, this workstram connected with other regional groups, for example colleagues in the Public Health Agency Staff Wellbeing group and with the DoH Regional Staff Health and Wellbeing group.
Work has been progressed through all of these groups to develop a regional infographic and animation to promote the 'Bridge to Recovery' message for staff – diagram 8.

Diagram 8

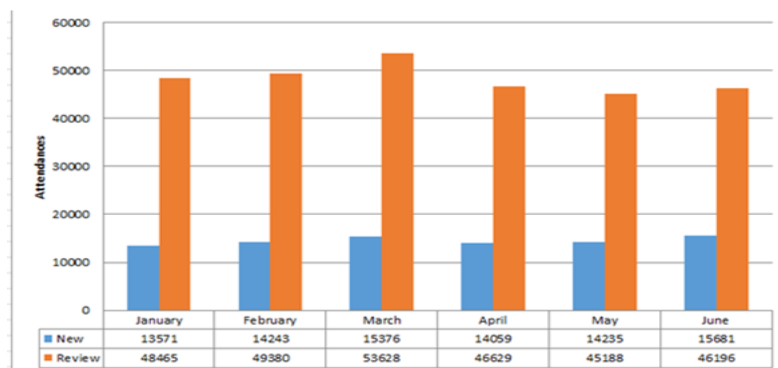
Virtual Consultations

All Trusts have made progress in this area with many developing local guidance. Through the HSCQI Learning System sub group many are beginning to focus on data and measures to demonstrate the effectiveness or "quality" of Virtual Consultations.

Measures being progressed through the virtual consultations work stream include:

1. Patient or service user feedback
2. Staff Feedback
3. The number of virtual consultations offered and the number of consultations that actually took place. Diagram 9 shows regional virtual activity between January and June 2021.

Diagram 9



	January	February	March	April	May	June
New	13571	14243	15376	14059	14235	15681
Review	48465	49380	53628	46629	45188	46196

Framework for scale up:

In order to support regional scale and spread within these learning themes, HSCQI carried out a literature review to identify a robust framework for scale and spread. A proposed framework has been discussed with QI Leads and the HSCQI Leadership Alliance. If endorsed, this regional scale up framework will become an integral part of HSCQI Learning System going forward.

Early Intervention Support Service
Regional Summary Report Card No 31

EISS

The Early Intervention Support Service

for families with children between 0 and 18 years old

WHAT IS THE EARLY INTERVENTION SUPPORT SERVICE?

The Early Intervention Transformation Programme (EITP) is delivered as part of the Delivering Social Change agenda in partnership with Atlantic Philanthropies. It represents a new joined up working and funding across five Government Departments to drive through initiatives which will have a significant impact on outcomes for families with children 0-18 years old. As part of EITP a new Early Intervention Support Service (EISS) is being established in five areas across Northern Ireland. The aim of the EISS is to support families when difficulties arise before they need involvement with statutory services. The EISS will deliver and coordinate person centred, evidence based, early intervention for families with children 0-18 years old within Tier 2 of the Hardiker Model.

Data presented- 01 April 2016 – 31 March 2021

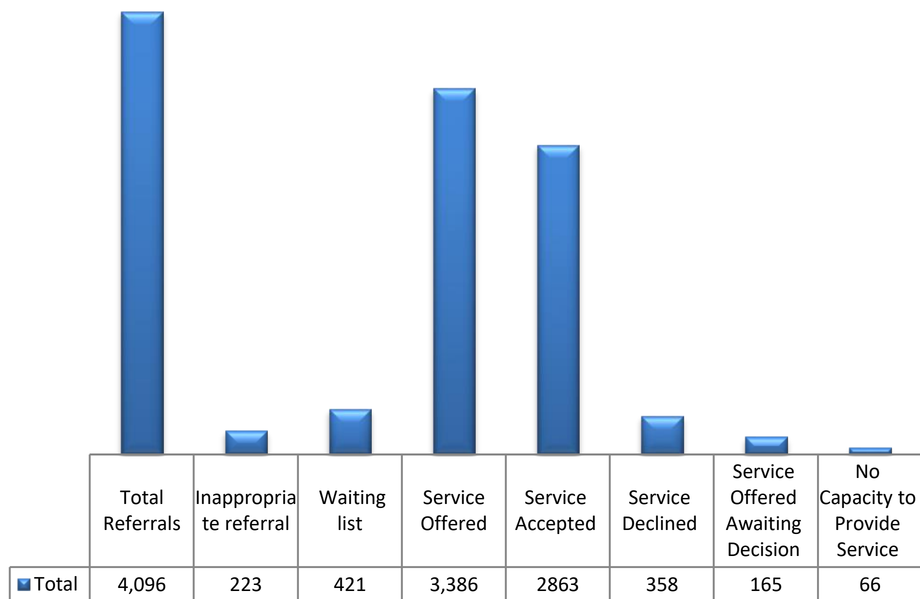
Northern Ireland Executive

www.northernireland.gov.uk

DELIVERING SOCIAL CHANGE

The ATLANTIC Philanthropies

How much did Regional EISS do? April 2016 – March 2021



	Total Referrals	Inappropriate referral	Waiting list	Service Offered	Service Accepted	Service Declined	Service Offered Awaiting Decision	No Capacity to Provide Service
Total	4,096	223	421	3,386	2863	358	165	66

Referrals

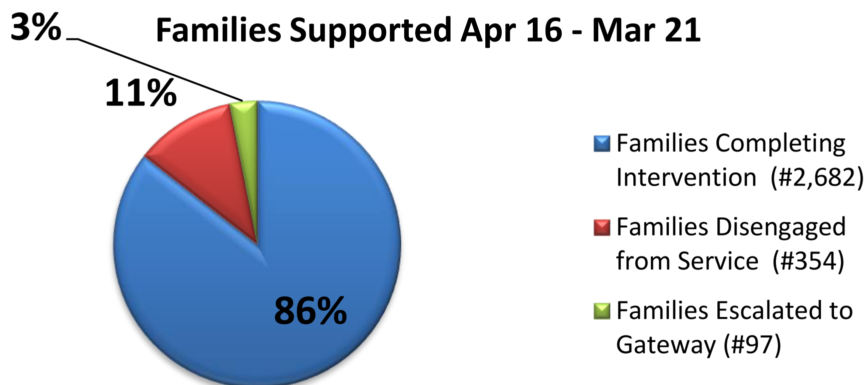
Referrals to the EISS are for children and young people 0-18 years. Referrals are from a variety of sources including Family Support Hubs (44%); Self-referral (16%) Health Visitors (13%); Schools (8%); other sources (19%).

Approximately 16% of referrals received did not receive the EISS as the referral was inappropriate, there was no capacity to provide the service or the family declined the offer of the EISS. Families on the waiting list will receive a first visit within 8 weeks.

Interventions

Families are assigned a key worker each practitioner holds a case load of between 10 – 15 families, home/school based support is provided for a period of approximately 12 weeks. Therapeutic sessions account for 91% of the interventions used by practitioners. Therapeutic interventions used include motivational interviewing, Solihull Approach and Solution Focused Brief Intervention Therapy.

How well did Regional EISS do? April 2016 – March 2021



April 16 – March 2021 there were 3,670 closed cases
*Note 537 (15%) of Families did not go onto receive EISS as when contacted they did not wish to receive the EISS

Contract Targets

- Annual targets for families supported are 125 families per EISS
- 3,133 families were supported between 1/04/16 & 31/03/21

Service User Feedback

Parent: “The service was amazing for our whole family. [Worker] was amazing and my son really enjoyed opening up to him and accepting help. Thank you very much, we are a happy family now.”

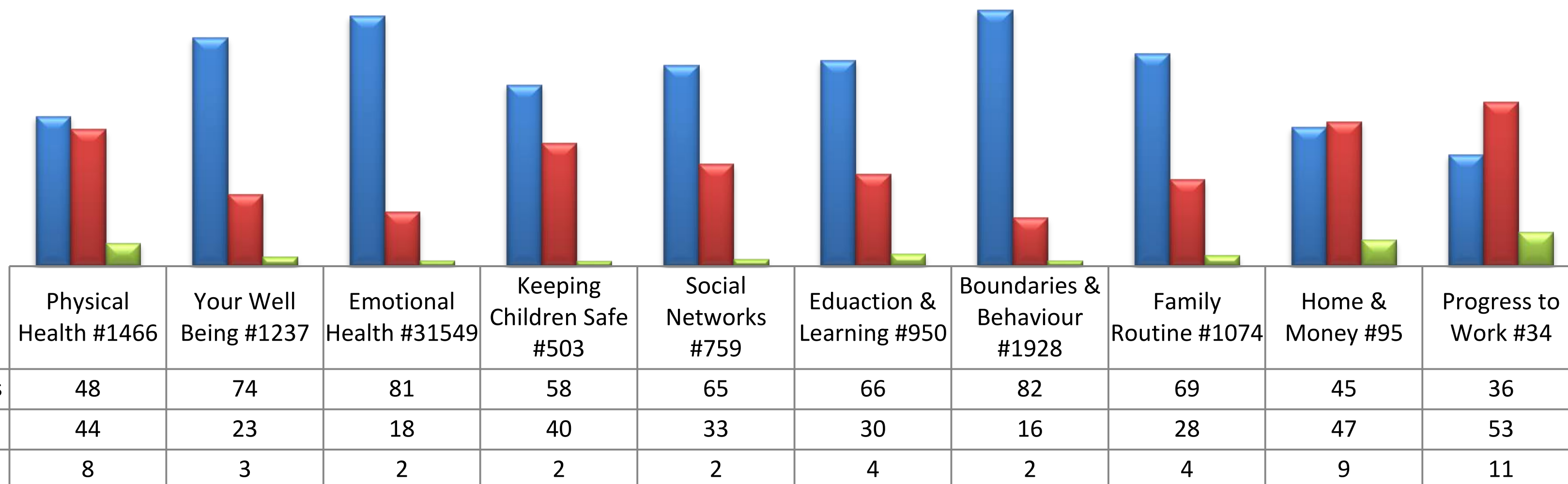
Young person: “[practitioner] helped me start to open up about my problems and gave me different exercises to help me cope with anxiety”

Family Support Hub: “Niacro EISS is such a valuable service to the Family Support Hub. We know that families are in good hands with the team and that they will receive tailored support to meet their individual needs. It is an essential service we often refer to and see positive outcomes for families who engage.”

Regional EISS - Is anyone better off? April 2016 – March 2021

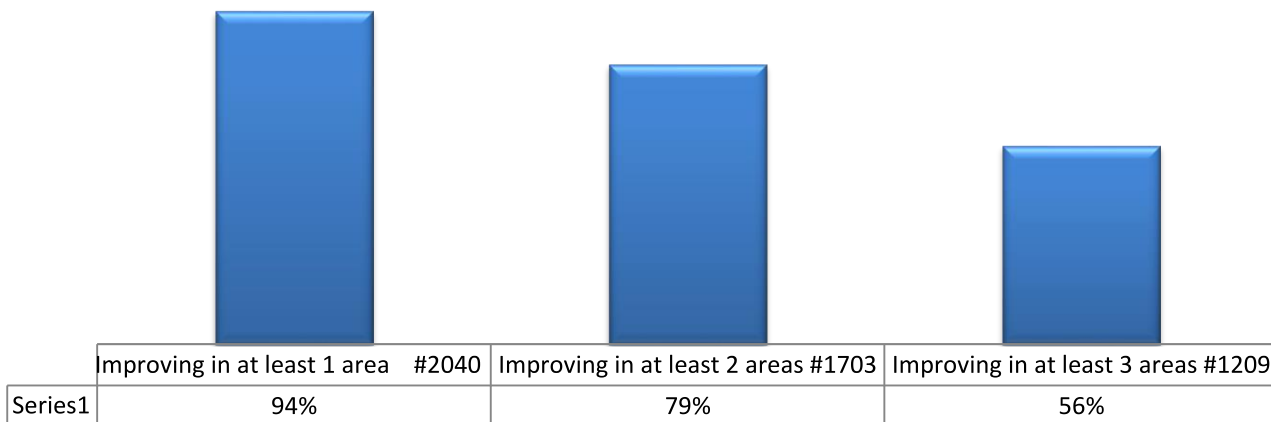
PM 8 Apr 16– Mar 21 based on #2163 Families

Family Star Plus (Cumulative from Apr 16- Mar 21 #2163 Families)



	Physical Health #1466	Your Well Being #1237	Emotional Health #31549	Keeping Children Safe #503	Social Networks #759	Eduaction & Learning #950	Boundaries & Behaviour #1928	Family Routine #1074	Home & Money #95	Progress to Work #34
% Made Progress	48	74	81	58	65	66	82	69	45	36
% No Change	44	23	18	40	33	30	16	28	47	53
% Dropped Back	8	3	2	2	2	4	2	4	9	11

How many Service Users Improved - Family Star Plus (Cumulative from Apr 16 - Mar 21# 2163 Families)



	Improving in at least 1 area #2040	Improving in at least 2 areas #1703	Improving in at least 3 areas #1209
Series1	94%	79%	56%

The Family Star Plus focuses on ten core areas that have been found to be critical in enabling children and young people to thrive.
Project workers agree with families which areas they want to focus on.
Interventions would generally be focused on a maximum of three areas.

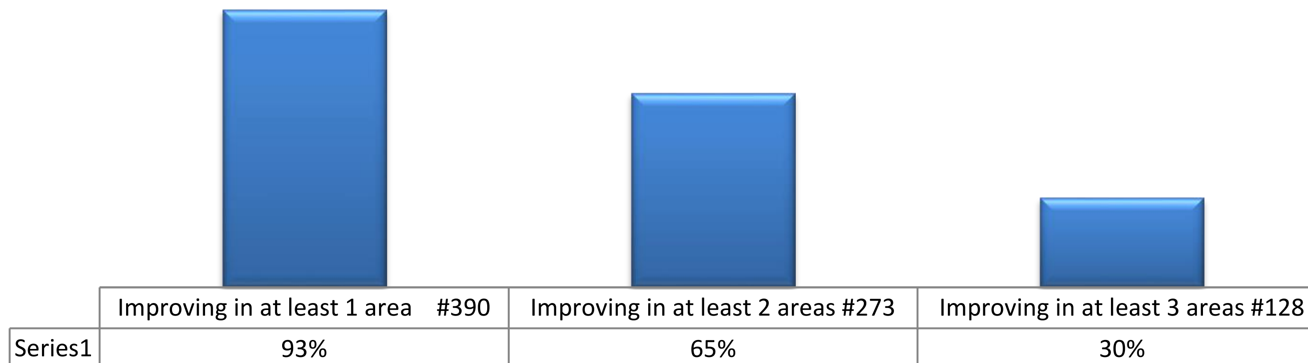
Regional EISS - Is anyone better off? April 2016 – March 2021

PM 8 Apr 16 – Mar 21 Based on #419 Families

My Star (Cumulative from Apr 16- Mar 21 #419 Families)

	Physical Health #50	Where you live #25	Being Safe #47	Relationships #92	Feelings and Behaviour #394	Friends #113	Confidence and self esteem #248	Education & Learning #15
% Made Progress	52	44	68	76	90	80	81	63
% No Change	46	56	26	20	10	14	19	34
% Dropped Back	2	0	6	4	0	6	0	3

How many Service Users Improved
(Cumulative from Apr 16 - Mar 21 #419 Families)



My Star focuses on ten core areas that have been found to be critical in enabling children and young people to thrive. Project workers agree with children and young people which areas they want to focus on. Interventions would generally be focused on a maximum of three areas.

Case Study: Northern Early Intervention Support Service March 2019

Request for service

Mum self-referred to NEISS for support regarding her 9yrs old son whom suffered from anxiety and continually tried to avoid going to school. She requested counselling and advice to help him and them as parents cope. O lives at home with his mother, father and two brothers aged 12yrs and 6yrs. Mum reported that O has been suffering from anxiety for the past 2 years and it has been progressively worse. Main issue around going to school, he becomes very nervous, suffers from tummy aches and cries every day before school. He refuses to go out to the playground and currently is refusing to go after school activities and community activities.

Assessment with O using My Star

O was open to talking and receiving individual help. His main concerns from the My STAR are identified below:

- **Feelings and Behaviour:** O described himself as being fearful. He is scared about going to school in case; he would get shouted at, be bullied or be sent to the principal's office. He was also afraid of the dark and being on his own.
- **Friends:** O was worried about hurting others' feelings, making them cry and getting into trouble. He also worried about being left on his own or people being mean to him and not want to be his friend
- **Confidence & Self-esteem:** O stated he did not like the way he looked and hated wearing glasses. He said he felt different and that people would make fun of him.
- **Education and Learning:** O shared that he did not like school. He worried that if he did his work wrong he would get shouted at and would be embarrassed. He also talked about people annoying him and being afraid of getting into trouble.

When reviewing his assessment and beginning to develop a plan of action with O, it was identified that O had only been shouted at once in school for talking and that he had been sent to the principal's office once, but it was due to someone else's behaviour towards him. These events both happened in P3 and he is now in P5.

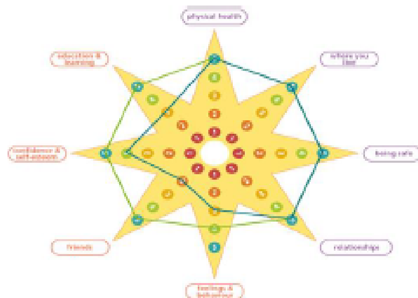
Intervention

Began using a CBT approach to:

- Explore what causes anxiety, the effects on your body and the fight, flight, freeze response
- Developed strategies for dealing with these feelings
- Looked concretely if there was evidence supporting his fears, worst case scenario and how to respond
- Discuss thinking traps and challenging automatic negative thoughts
- Set out weekly goals to begin to face fearful thoughts
- Provide education around bullying, strategies on how to deal with it and actions to stop it

Outcomes

- **Feelings and Behaviour:** O no longer has the fears he had when the intervention began. He quoted at our last session, "A thought is just a thought it's not real. Even a scary thought is just a scary thought."
- **Friends:** O recognises he has good friends and now has the knowledge and strategies to know how to respond to being teased or handle a potential bullying situation.
- **Confidence& Self-esteem:** O is back attending all his extracurricular activities
- **Education & Learning:** O is now attending school without any issues. He now does not worry about being shouted at, whether his work is perfect or going to the principal's office



Service User Feedback

T rated the Service as very good. Mum rated the service as excellent and wrote, "This service has been fantastic for my son. I never thought that it would be such a success. The practitioner has worked so so well with him and he enjoyed every session. I can't thank her enough for all her help. He is a different child and it's all because of her. He has all the tools he needs to face any situation."

My STAR

	Pre- Score	Post Score
Feelings and behaviour:	3	4
Friends:	2	5
Confidence& Self Esteem:	4	5
Education & Learning:	3	5

HSC Public Health Agency

item 13

Title of Meeting	PHA Board Meeting
Date	19 May 2022
Title of paper	Update on Population Screening Programmes
Reference	PHA/05/05/22
Prepared by	Dr Tracy Owen
Lead Director	Dr Brid Farrell
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to provide the PHA Board with an update on screening programmes. Dr Stephen Bergin had previously agreed to bring an update on screening programmes to a future PHA Board meeting.

2 Key Issues

This paper sets out the impact that the Covid-19 pandemic has had on the population screening programmes and provides an update on where they now are in the recovery process. It also describes some of the ongoing work being led by the screening team in the PHA and horizon scanning of potential important changes and developments in this area.

Population Screening Programmes: An Update to PHA Board

May 2022

1. Background

1.1. The PHA is the lead organisation for commissioning and quality assuring the population screening programmes in Northern Ireland. Screening policy is approved by the Minister, based on the recommendations of the UK National Screening Committee and informed by a Northern Ireland Screening Committee chaired by the Chief Medical Officer.

1.2. There are currently five young person and adult screening programmes and three antenatal and newborn programmes.

Cancer screening programmes	Non-cancer young person and adult screening programmes	Antenatal and newborn screening programmes
Bowel	Abdominal aortic aneurysm	Infectious diseases in pregnancy
Breast	Diabetic eye	Newborn blood spot
Cervical		Newborn hearing

In addition, there is a very high risk breast cancer screening surveillance programme aimed at women who meet agreed risk criteria.

1.3 Within the PHA, the work on screening programmes is led by a small team, comprising consultants, programme managers, information support and administrative staff.

1.4 This paper sets out the impact that the Covid-19 pandemic had on the screening programmes and where they now are in the recovery process. It also describes some of the ongoing work being led by the screening team in the PHA and horizon scanning of potential changes and developments in this area.

2 Impact of Covid-19

2.1 A number of the population screening programmes were paused from mid-March 2020 in response to the COVID-19 pandemic. The purpose of pausing programmes was to:

- reduce the risk of COVID-19 infection in the population groups eligible for these screening programmes;
- reduce the risk of COVID-19 infection in screening staff; and
- ensure adequate healthcare and laboratory resources could be redirected to the pandemic response.

The abdominal aortic aneurysm (AAA), bowel cancer, breast cancer, cervical and diabetic eye (DESP) screening programmes were paused during this period.

2.2 The antenatal and newborn programmes along with the higher risk breast cancer screening surveillance programme, were considered time critical and were not paused. Screening for diabetic eye disease also continued for pregnant women.

3 Restoration and recovery

3.1 All programmes recommenced activity in summer/autumn 2020. As each programme is delivered in a different way, and requires a different type of screening test, they have had individual challenges which have dictated the pace of the recovery. Issues which have had to be taken into account include:

- Screening programmes normally operate on the ability to process large numbers of people to filter out those who are at risk of disease. Ongoing social distancing and infection control requirements have impacted on the throughput of patients at clinics.
- Staff who perform screening tests are often highly skilled, so there is a limited trained workforce to undertake these tasks and facilitate expanded capacity on a short term basis.
- Access to some screening sites was withdrawn in some cases.
- Screening activity has to be balanced with availability of further investigative and treatment services.
- As screening is a cyclical process, large variations in activity can have a knock on effect for many years to come, destabilising the delivery of the future programme.
- Quality and standards had to be maintained at all costs. An adverse event in a screening programme can impact on thousands of individuals.

3.2 Recovery work is ongoing and the current position of each screening programme is set out in the Appendix.

4 Quality assurance activities

4.1 Quality assurance (QA) is a core requirement of any population screening programme, to ensure that maximum benefits are achieved, potential harm is minimised and the programme operates within a culture of continuous improvement. It is much more than just performance management and is underpinned by benchmarking against national standards.

4.2 By their nature, screening programmes carry significant risk. While quality assurance activities act to minimise risk, false negative and false positive results are inevitable and predictable. Screening is considered a risk reduction activity and will not pick up every case of potential disease.

4.3 The PHA leads on a range of QA activities within each screening programme including:

- regular meetings with professional disciplines delivering the programme
- oversight of quality management systems and failsafe processes
- training advice and support
- leading formal peer review QA visits
- facilitating shared learning opportunities
- collation and review of statistical data
- supporting audit
- monitoring learning events and advising on the management of adverse incidents

4.4 In the context of Covid-19, core quality assurance functions were maintained to provide continuous oversight of the delivery of the programmes during the recovery phase. Some quality assurance activities were paused or have been delivered in a slightly different way – for example, as in person site visits have not been possible, desktop peer review exercises have been undertaken instead.

4.5 Most of these activities are now fully operational again, with plans to restart in person formal peer review QA visits in breast screening from June 2022.

5 New developments

5.1 The PHA is also currently involved in a number of large change projects involving screening programmes.

5.2 Planning is underway for the introduction of primary HPV testing in the cervical screening programme. This development was given policy endorsement in the Regional Cancer Strategy and the PHA has commenced

discussions with the SPPG and the Pathology Network to establish the project structure and coordination of this significant change to the programme.

5.3 Modelling work is being undertaken in association with Queens University Belfast to inform the options for the future expansion of the age range for bowel cancer screening in Northern Ireland.

5.4 A large project has been established alongside the Trusts to replace the mammography equipment and mobile screening units for breast screening in Northern Ireland.

5.5 New IT software to support the functions of the breast screening system is being progressed, with a business case having been submitted to the DoH.

6 Promoting Informed Choice

6.1 The benefits of screening can only be fully achieved at population level if people take up the invitation to participate. However, as would be expected, there are inequalities in terms of who responds to screening invites.

6.2 Studies have shown that those less likely to participate in screening include those living in areas of deprivation, those with disabilities, LGBTQI individuals, and those from an ethnic minority background.

6.3 Ongoing work is needed in this area to ensure that all eligible individuals have access to information and are supported in making an informed choice about attendance at screening.

6.4 The UK NSC is very clear that both the benefits, potential harms and limitations of screening need to be communicated to inform this decision making process, with a recognition that some people will choose not to participate.

6.5 In order to address the inequalities in cancer screening participation the PHA has commissioned the Women's Resource and Development Agency (WRDA) to deliver educational sessions on informed choice in cancer screening , targeted at those less likely to participate. This peer delivered programme has continued throughout the pandemic, moving temporarily to virtual delivery. Examples of their work includes delivering sessions on bowel screening through the Mens Shed network, sessions on breast and cervical screening to a Syrian women's group and development of new resources to make the sessions accessible to people with a sensory impairment.

7 Horizon scanning

7.1 The UK National Screening Committee has recently extended its remit to actively consider:

- targeted screening for high risk groups
- stratified screening that is more tailored to the individual
- average risk population screening (former approach)

It will have closer links with research bodies and guideline-making organisations such as the National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guideline Network (SIGN).

7.2 It is unclear what the implications of this extended approach will have, but going forward it is anticipated that the UK NSC will make recommendations for a much broader range of screening programmes. The role that PHA will have in implementation of policies that are outside our traditional population screening remit is still to be determined.

7.3 The UK NSC is currently consulting on screening for lung cancer, which if recommended, would be the first targeted screening programme to be taken forward, as screening would only be offered to a proportion of individuals after a targeted risk assessment process.

7.4 Within existing programmes, there is also ongoing review by the UK NSC, assessing options for service and quality improvements. For example, there is a current focus on the potential use of Artificial Intelligence (AI) in some screening programmes. Any such recommendations have implications for PHA in terms of leading the implementation.

Appendix: Screening programmes recovery position

	Current position re: backlogs	Plans to address backlogs
Bowel cancer screening	A catch-up exercise is ongoing to reduce the seven-month delay caused by the initial pause in the programme during the first surge of the COVID-19 pandemic and down time in December 2020 to facilitate implementation of FIT. Managed catch-up commenced from 24 May 2021, with an additional 'call' or 'recall' list being issued every other week.	The pace of the catch-up will accelerate from June 2022 to coincide with the cyclical reduction in invitations two years after the 'pandemic pause' in bowel screening invites, with the intention that this catch-up will be completed in Autumn 2022.
Breast screening	There is currently an extended round length (interval between each offered invitation for screening mammography). The round length should normally be 36 months, but the average at end March 2022 was 36 months plus 4 weeks (down from 40 months in October 2020).	There is ongoing requirement for social distancing and infection control measures which mean that breast screening appointments now take between 7 ½ and 8 minutes (reduced from 10 minutes over the past few months); instead of 6 minutes pre-COVID-19. The backlog is being addressed by working to decrease the appointment time and the provision of additional screening clinics, both in-hours and out-of-hours, within mobile and static sites. In 2021/22 Action Cancer provided 2,000 additional mammography appointments. However, it is unable to provide further support during 2022/23.
Cervical screening	The programme continues to operate with a 5 month delay in the issue of routine letters to inform women that their next test is due.	There are no current plans to address this backlog as there are ongoing service pressures at all stages of the screening pathway (GP practices, laboratories and colposcopy services) with very limited ability to further increase capacity in these areas. In line with the principles of population screening, it is considered inappropriate to address the backlog in letters, if women are then unable to access screening appointments, receive test results and undergo follow up investigations in a timely way. Catch up will be achieved through the natural run through of a screening round. A similar approach is being taken to backlogs in Scotland.
Diabetic Eye Screening	A risk-stratified approach to invites was introduced during covid and continues as the programme recovers. This focuses on screening	Screening staff are fully deployed including 7 day working and it is unlikely that any significant additional activity can be generated from the existing resource within

	the highest risk patients. As a contingency measure during 2020/21 and 2021/22 lower risk patients were moved to a 2 year interval for screening. Further work is being done to confirm figures however the backlog is substantial and could be approximately one fifth to one third of the screening cohort.	the programme given the IPC guidance in place. Non-recurrent funding was secured in 2020/21 from the June monitoring round to support this recovery. The need for recurrent funding has been highlighted as a PHA investment priority for the 2022-2025 period: to implement a recovery plan developed with the Trust, address the backlog and consolidate the modernisation of this programme into the future. This will require additional screening sites and staff to be made available. The use of the Independent Sector is also being explored, with the Trust engaged in discussions with the provider.
Abdominal Aortic Aneurysm screening	97% of men within the 2020/21 cohort have now been offered an initial screening appointment. Invitations commenced for men within the 2021/22 cohort in January 2022.	From April 2022, the screening programme has regained access to all of their screening venues. The intention is that all individuals from the 2020/21 cohort will have been offered an initial screening appointment by the end of June 2022. Staffing issues, screening venue limitations, new training requirements, difficulty recruiting into the Lead Sonographer post and accommodation issues are all impacting the programme's ability to accelerate the catch-up activity. A recovery plan is being developed to deliver additional activity during 2022/23, focusing on weekend clinics. This is dependent on securing non-recurrent funding. The programme also continues to link with other AAA programmes within the UK, to help identify additional suggestions or options to explore to improve attendance rates within clinics, and to minimise any lost appointments within clinics.

HSC Public Health Agency

item 14

Title of Meeting	PHA Board Meeting
Date	19 May 2022
Title of paper	Annual Report on the Specialist Training Programme in Public Health
Reference	PHA/06/05/22
Prepared by	Dr Denise O'Hagan/Dr Tracy Owen
Lead Director	Dr Brid Farrell
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to present the Annual Report on Specialist Training Programmes in Public Health to the PHA Board for information.

2 Key Issues

The PHA is the lead employer and main training provider for specialty registrars in both Public Health and Dental Public Health. Specialty training is overseen by the Northern Ireland Medical and Dental Training Agency (NIMDTA) and under a Learning and Development Agreement, it is expected that the PHA Board will receive an annual update relating to training.

This annual report outlines the role of the PHA in training, notes the expansion of the programme to non-medical trainees in 2021, plans for NIMDTA to be the single lead employer for new medical appointments from August 2022, concerns about the training experience highlighted through the GMC training survey in 2021 and actions being taken to address these concerns.

Annual Report on the Specialist Training Programme in Public Health

1. Purpose

This paper aims to an update the Public Health Agency (PHA) Board members regarding the Specialist Training Programme in Public Health and the recently introduced programme in Dental Public Health.

2. Background

The specialist training programmes in Public Health are overseen by the Northern Ireland Medical and Dental Training Agency (NIMDTA). PHA is the lead employer and main training provider for specialty registrars in both Public Health and Dental Public Health.

Both training programmes aim to equip trainees with the appropriate knowledge and skills to complete the curriculum set out by the UK Faculty of Public Health (FPH) and subsequently register as a specialist /consultant with the General Medical Council or UK Public Health Register; or in the case of Dental Public Health with the General Dental Council. They are then eligible to apply for Consultant or Specialist posts in Public Health in organisations such as the PHA, academic institutions etc.

A region such as Northern Ireland (NI) needs to have an adequate number of consultants/ specialists in place to deliver on the Public Health agenda, particularly in relation to being able to respond to health protection threats, input to service planning and address health inequalities. This has been particularly evidenced by the key role of Public Health Consultants and Specialists in the response to the Covid-19 pandemic. Recent reports by Dr Ruth Hussey and also by the FPH have highlighted the need to enhance consultant capacity in NI. A review of the public health workforce led by the Department of Health is also due to commence shortly.

3. Role of the PHA in the delivery of training

A Learning and Development Agreement (LDA) is issued to the PHA each year by NIMDTA for signature by the Chief Executive. The LDA highlights the roles and responsbilities of both parties. In addition, an annual review meeting takes place with NIMDTA, most recently in early April 2022.

The LDA highlights that the PHA Board must be kept appraised of training matters. The PHA has a responsibility to engage at Director level or equivalent with NIMDTA on training issues. The assistant Director for Screening and Professional Standards has delegated responsibliity in this area and has line management responsibility for the group of specialty registrars.

The PHA has a responsibility to ensure that there are sufficient numbers of supervisors available to deliver training and that supervisors have time in their job plans to meet their commitments in relation to their training role. Since July 2016, all Educational Supervisors and Attachment Supervisors must be approved by NIMDTA and the GMC. It is important that the PHA ensures that all consultants / specialists undertake the appropriate training in order to meet NIMDTA and GMC requirements and maintain their skills as supervisors. This forms part of annual consultant

appraisal and needs to be given enhanced focus going forward to ensure an adequate pool of supervisors is maintained.

4. Structure of the training programmes

General Public Health Training Programme

The five year training programme follows the curriculum set out by the UK Faculty of Public Health (FPH). During the first year trainees undertake a funded Masters in Public Health to provide the underpinning knowledge base to sit the professional examinations. During the remaining four years trainees undertake service work in approved training locations to further develop their public health knowledge and skills. The PHA is the main training location but placements are also offered in the Department of Health, the Centre for Public Health at Queen's University and other approved locations. There is an annual review of each trainee's progress which is overseen by NIMDTA.

Dental Public Health Training Programme

This is a four year training programme which follows the curriculum set out by the Faculty of Dental Surgery. As above the trainee undertakes a Masters in Public Health during their first year in training. Over the remaining three years trainees undertake service work in approved training locations. In the case of the Dental Public Health trainee placements will include PHA, Department of Health and an external placement in Stirling, Scotland.

5. Recruitment to Training Programmes

Recruitment to both training programmes is carried out at UK level by the relevant Faculty within the Royal Colleges of Physicians/Surgeons. In the most recent round of recruitment in 2021 there were four new registrars appointed to the general public health training programme and one new registrar appointed to the dental public health training programme. It is unlikely there will be any further recruitment to the dental training programme for the foreseeable future.

Eligibility to apply to the general public health training programme in NI changed in 2021 and it is now open to both medical and non-medical applicants. This brings NI into line with other parts of the UK which have been recruiting people from a range of backgrounds to the training programme for a number of years. The first non-medical trainee commenced training with the PHA in April 2021.

In the absence of a functioning Executive in NI at that time, a temporary agreement was reached between the PHA, Department of Health and NIMDTA in July 2020 to enable the introduction of multidisciplinary public health training. The legislative changes are to be brought forward in due course.

Specialty Registrars in post (at April 2022)

Training programme	Staff in post	
General Public Health	12 (10.9 wte)	8 medical trainees 4 non-medical trainees (2 dentists + 2 AfC)
Dental Public Health	1 (1.0 wte)	

6. Employing organisation

The PHA is currently the lead employer for registrars in Public Health. However, going forward from August 2022 NIMDTA will take on the role of single lead employer for newly appointed medical and dental trainees, while new non-medical trainees will continue to be employed by the PHA. This is in line with wider changes across all medical specialties. This change will only impact new appointees, with the PHA remaining as the employer for existing trainees until they exit the programme.

7. Funding for specialist training posts

The PHA receives funding from NIMDTA for ten speciality registrar posts. NIMDTA provides the basic salary costs at mid-point of the scale. Registrars in Public Health deliver the first tier of the out–of-hours rota in Health Protection. Costs associated with the out-of-hours rota are not covered by NIMDTA and are borne by the PHA.

Due to anticipated retirements and the fact that there were several vacant consultant posts in the PHA, it was agreed with NIMDTA in 2019 that the PHA would re-direct funding from vacant consultant posts to temporarily increase the number of specialty registrars from 10 to 12 wte posts. In 2020 it was further agreed that the PHA would fund an eleventh post on a recurrent basis.

8. Pay parity for out-of-hours work

Since non-medical and medical registrars both carry out the same duties when covering the out of hours rota there is a reasonable expectation that they will be paid at a similar level. However, as non-medical trainees are on Agenda for Change contracts, their Terms and Conditions relating to out-of-hours work is significantly different to that of medical staff. In England there is a Departmental circular which addresses this issue but to date there has been no equivalent circular in NI. This issue has been highlighted to the Department of Health by Human Resources but has not yet been resolved satisfactorily. This issue is causing concern among the non-medical registrars who are not participating in the rota until this is resolved. Out-of-hours work is a key part of training, allowing trainees to gain valuable skills. . The resulting rota gaps has also placed additional pressures on those medical trainees who are covering the rota, so steps have been taken to train and recruit duty room locum doctors to provide some out of hours support. This issue needs to be resolved as soon as possible.

9. Quality Assurance of the Training Programme

NIDMTA's Public Health Specialty Training Committee oversees recruitment, annual assessment and placement of trainees and quality within the training programme. This involves reviewing feedback received from trainees and trainers as part of the national annual GMC surveys. The 2022 survey is currently open and results will be available later in the year.

The results of last year's GMC survey of trainees highlighted some concerns which are discussed below. The survey compares responses of trainees in NI to trainees nationally across the UK. Several issues of concern were raised by NI registars. These included overall satisfaction, supportive environment, regional teaching and

educational governance. Senior PHA staff have met with trainees to discuss the findings and identify measures to address these concerns.

The issues largely reflect the pressures experienced during COVID-19 by our small pool of registrars and consultants in NI who were at the front line of the COVID response. These pressures were compounded by the trainees feeling isolated when working remotely. Similar issues were reported by registrars across the UK but were likely felt more acutely in NI due to our smaller workforce and role in a regional organisation. Efforts have been made throughout the pandemic to support registrars and introduce arrangements to minimise the burden, particularly in the out-of-hours period. Some of the issues that have arisen in the survey reflect the fact that registrars predominantly do project work and are not formally attached to teams, apart from the Health Protection team, and can therefore feel disconnected from the wider organisation. New arrangements are being made for attachments to teams and these will be introduced shortly. A forum to raise concerns in Health Protection has also been re-established to strengthen the registrar voice. Formal attachments to teams and a return to working in the office in the near future should help registars feel better engaged.

With the recent closure of the Health and Social Care Board it is important that registrars can continue to gain experience and competency in all areas of the training curriculum. This will have to be monitored carefully going forward and appropriate placements arranged as required. Registrars need to be fully engaged across the full breadth of public health practice.

It is also important to ensure adequate attention to wellbeing and adequate capacity in the organisation to respond to future pandemics and similar scenarios to prevent burnout among this group of staff.

The findings of the 2022 GMC survey will be closely monitored and additional actions taken to address any outstanding concerns.

10. Future direction

The PHA Board will continue to be provided with an annual update going forward in relation to the specialist training programmes.

A workforce review is about to commence led by the Department of Health. It is likely that a substantial increase in funded training positions may be required.

While this paper focuses on training towards FPH ‘specialist/consultant’ status, it is likely that in coming years there will be demand from within the existing non-medical workforce in PHA for more defined career paths and the opportunity to work towards both practitioner and eventually specialist registration with the UKPHR and FPH.