agenda

Title of Meeting	150th Meeting of the Public Health Agency Board
Date	19 January 2023 at 1.30pm
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street

standing items

1 1.30	Welcome and apologies		Chair
2 1.30	Declaration of Interests		Chair
3 1.35	Minutes of Previous Meeting held on 15 December 2022		Chair
4 1.40	Matters Arising		Chair
5 1.45	Chair's Business		Chair
6 1.55	Chief Executive's Business		Chief Executive
7 2.15	Finance Report	**PHA/01/01/23**	Director of Finance
8 2.30	Health Protection Update		Dr McClean

items for approval

9 2.45	PHA Board Buddy Pilot Final Evaluation Report	**PHA/02/01/23**	Dr Keaney
10 3.00	Board Performance Framework	**PHA/03/01/23**	Mr Wilson

items for noting

11 3.15	Presentation on Serious Adverse Incidents	Chief Executive

12 3.35	Infectious Diseases in Pregnancy Screening Programme (IDPS) Annual Report 2018-2020	**PHA/04/01/23**	Dr McClean
13 3.50	Update on Accommodation	**PHA/05/01/23**	Mr Wilson
14 4.00	Presentation on Findings of PHA Reputation Survey		Mr Wilson

closing items

15 Any Other Business
4.10

16 Details of next meeting:

Thursday 16 February 2023 at 1.30pm

Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

minutes

Title of Meeting	149th Meeting of the Public Health Agency Board
Date	15 December 2022 at 1.30pm
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

Present

Mr Andrew Dougal	-	Chair
Dr Joanne McClean	-	Director of Public Health (*Joined at Item 7*)
Mr Stephen Wilson	-	Interim Director of Operations
Mr Craig Blaney	-	Non-Executive Director
Ms Anne Henderson	-	Non-Executive Director
Mr Robert Irvine	-	Non-Executive Director (*via video link*)
Professor Nichola Rooney	-	Non-Executive Director
Mr Joseph Stewart	-	Non-Executive Director

In Attendance

Ms Tracey McCaig	-	Director of Finance, SPPG
Mr Robert Graham	-	Secretariat

Apologies

Mr Aidan Dawson	-	Chief Executive
Dr Aideen Keaney	-	Director of Quality Improvement
Mr John Patrick Clayton	-	Non-Executive Director
Ms Deepa Mann-Kler	-	Non-Executive Director
Mr Brendan Whittle	-	Director of Social Care and Children, SPPG
Ms Vivian McConvey	-	Chief Executive, PCC

125/22	**Item 1 – Welcome and Apologies**
125/22.1	The Chair welcomed everyone to the meeting. Apologies were noted from Mr Aidan Dawson, Dr Aideen Keaney, Mr John Patrick Clayton, Ms Deepa Mann-Kler, Mr Brendan Whittle and Ms Vivian McConvey.
126/22	**Item 2 – Declaration of Interests**
126/22.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda.
127/22	**Item 3 – Minutes of previous meeting held on 17 November 2022**
127/22.1	The minutes of the Board meeting held on 17 November 2022 were

APPROVED as an accurate record of that meeting.

128/22 **Item 4 – Matters Arising**

128/22.1 The Chair went through the minutes noting the actions which had been completed as per the action log.

128/22.2 For action 4 relating to poverty, Mr Wilson gave a presentation setting out an overview of PHA's work in relation to the cost of living crisis. He explained how PHA uses its relationships to identify those at risk of poverty and seeks to signpost them to appropriate support. He said that PHA also provides financial support to relevant initiatives including Fareshare and the Keep Warm Pack scheme. He highlighted other areas in other Trusts and then gave an overview of the communications work being undertaken.

128/22.3 Mr Stewart expressed concern that all of this work is relatively invisible to the Board and he suggested that time should be set aside to determine PHA's priorities in this area as part of PHA's overall investment package. Professor Rooney said that this work will be more visible once PHA begins to present its work in terms of its statutory functions. She commented that this work is scattered between various directorates and therefore it is difficult to determine if the work that PHA is carrying out is sufficient.

128/22.4 Ms Henderson asked how difficult it had been to compile this information and Mr Wilson said that it had not been difficult as most of it fell within the domain of Health Improvement. He conceded that he was not aware of all of it so there remains some work for PHA to raise its profile.

128/22.5 Mr Blaney asked if the funding for Fareshare was given annually and when Mr Wilson said that it was issued on a year-by-year basis, Mr Blaney said that it more helpful for charities to implement their services if they knew they were guaranteed funding.

128/22.6 Ms McCaig said that this goes back to PHA determining its core purpose and what actions should be included in the Business Plan, then starting at that high level and working beneath that to ensure it has the right balance. She added that some contracts will be on a year-by-year basis, and others will be on a rolling basis. Mr Blaney agreed that PHA should look at its priorities, but noted that Fareshare does good work and charities would welcome clarity around funding.

128/22.7 Ms Henderson commented that she is now getting more of a handle on where PHA's priorities are and a sense that everything is beginning to come together. Professor Rooney said that there is a link with procurement and how PHA knows that it is spending its money in the right areas. The Chair commented that the cost of living and fuel poverty are now finally major talking points, but PHA should ensure that it is not duplicating what others are doing.

129/22 **Item 5 – Chair's Business**

129/22.1 The Chair presented his Report and said that following a Chairs and Chief Executives meeting he had attended at which the Head of the Civil Service was present, he had got the impression that there is an appetite for the possibility of being able to carry over underspends in the future. Ms McCaig noted that a 3-year budget had been planned, but carry forward can be difficult while there remains a need to break even to balance the Northern Ireland grant.

129/22.2 The Chair presented an overview of the most recent meeting of the Remuneration Committee. Ms Henderson commented that it would be interesting for the Board to see the workplan of the Organisation Workforce Development (OWD) group. The Chair asked about the workforce plan. Mr Wilson said that HR has been asked to bring this to the Agency Management Team (AMT) in the first instance before it comes to the Board **(Action 1 – Mr Wilson)**. The Chair said that a resume of the major issues from this Committee meeting was included with the Chair's Report.

129/22.3 The Chair advised that the first meeting of the Planning, Performance and Resources Committee had taken place. The Chair said that a resume of the major issues from this Committee meeting was included with the Chair's Report.

130/22 **Item 6 – Chief Executive's Business**

130/22.1 In the absence of the Chief Executive, Mr Wilson advised that PHA is seeking additional support from the Directorate of Legal Services (DLS) for Public Inquiries. He reported that PHA is working through Rule 9 requests for Modules 1 and 2a of the COVID Inquiry and has applied for core participant status for Module 3. He noted that each of these requests draws on the same individuals to provide the information. He added that this is now being placed on the Corporate Risk Register. He reported that PHA will be required to contribute to future modules. The Chair advised that this drain on staff resources was discussed at the Accountability Review meeting on 13 December.

130/22.2 Professor Rooney asked about psychological support for staff. She commented that following the Hyponatraemia Inquiry there were huge levels of staff sickness. Ms Henderson asked if an update on this could be given at the next meeting **(Action 2 – Chief Executive)**.

131/22 **Item 7 – Finance Report (PHA/01/12/22)**

131/22.1 Ms McCaig presented the Finance Report for the period up to 31 October and advised that she will meet with Ms Henderson early in the New Year once she had the latest financial information.

131/22.2 Ms McCaig said that PHA's current year end forecast is a surplus of

£443k. She reminded members that PHA had been asked by the Department about slippage and slowing other work down and had confirmed that it could release £500k. She said that the position has moved on and PHA had uncovered slippage within screening so the overall slippage figure had increased. She advised that PHA then received correspondence from the Department seeking a further £500k and PHA is able to respond to this without need to stop or curtail any of its programmes. The Chair sought clarity on this.

At this point Dr McClean joined the meeting.

131/22.3 Ms McCaig explained that PHA offered £500k of slippage and potentially other savings by pausing campaigns. She advised that PHA is now covering EY expenditure for this year to the sum of £370k and in addition has identified other areas of slippage totalling £500k. She added that PHA was then asked to contribute a further £500k which it was able to do from slippage. She advised that this means that PHA's forecast end of year position is now a surplus of around £250k. Ms Henderson asked if PHA will offer that up but Ms McCaig said that PHA would not be offering that up. Ms Henderson noted that PHA has had almost £5m worth of slippage this year. Ms McCaig advised that PHA still has unplanned slippage and this remains an issue.

131/22.4 Mr Stewart said that this is a significant amount of slippage and PHA needs to be on its mettle next year. Ms McCaig commented that this year PHA has managed its slippage differently so only this most recent slippage has been handed back. The Chair asked how PHA can avoid having so much slippage next year. Ms McCaig reiterated that PHA has managed this process this year, but it will need to manage it better next year. The Chair noted that there will always be slippage that is not anticipated. Dr McClean explained that for screening, there was funding for image storage that was not required and in some Trusts there was not the expected level of activity generated. She said that some flux in the system is to be expected.

131/22.5 Professor Rooney said that the lateness in the notification of these large amounts of slippage is alarming, but noted that this is not unusual. Ms McCaig acknowledged that these things do happen, and there is learning for next year.

131/22.6 Ms McCaig reported that the capital budget is on track.

131/22.7 Ms Henderson said she was content with the overview and noted that slippage is a perennial problem. Given that the work of HSCQI is funded from slippage, she asked if there were difficulties in that area. Ms McCaig reported that HSCQI has received the funding it has needed for this year and added that the Chief Executive and others are meeting with the Department to discuss how HSCQI is funded. The Chair noted that PHA was asked to take on the work of HSCQI without additional funding. Ms McCaig advised that there are some options and Ms

	Henderson asked if there could be an update on this in March **(Action 3 – Ms McCaig)**. Ms McCaig said the issue of HSCQI funding needs to be resolved one way or another. Mr Stewart commented that the only way to resolve this is if PHA is reshaped and only provides the functions which it is paid to undertake. Ms McCaig outlined that one potential option is for the various partners that work with HSCQI to provide funding, but she was did not think this would be resolved quickly.
131/22.8	The Chair commented that it was very useful to see the variances in these reports.
131/22.9	The Board noted the Finance Report.
132/22	**Item 8 – Health Protection Update**
132/22.1	Dr McClean began her overview of health protection matters by reporting that the number of cases of COVID has been coming down, but there is a slight indication of an increase.
132/22.2	Dr McClean reported that with regard to flu, PHA has advised the Department to issue a flu letter which tells GPs that if certain individuals present with flu-like symptoms they should get antivirals.
132/22.3	Dr McClean advised that the uptake of both the flu and COVID vaccine is tailing off and she expressed disappointment at the uptake in specific groups. Using the live data from the Vaccine Management System (VMS), she said that there is learning for PHA for next year in that it appears that the uptake slows after the school half term break. She noted that the figures for flu vaccines will be higher as data from schools can take time to get uploaded onto VMS.
132/22.4	For COVID vaccines, Dr McClean said that the uptake among the 50+ age category is 62%, among the 70-79 age category it is 80% and among the 80+ age category it is 86.6%. She advised that the uptake among pregnant women is 13.3%. Among care home residents, she said that the figure is 80% for residents and 15% for staff. She noted that healthcare workers may not be recorded as such on the system so their uptake may be higher.
132/22.5	For flu vaccines, Dr McClean said that the figures are slightly better with the uptake among the 65+ age category being 82%, the 50-64 age category being 50% and pregnant women 34%. For care home residents she reported that the uptake is 84% and for pre-school children it is 20%.
132/22.6	Dr McClean reported that cases of Respiratory Syncytial Virus (RSV) are decreasing.
132/22.7	Professor Rooney asked if there are targets for the vaccination programmes, but Dr McClean advised that while the Department did not

	set any specific targets, PHA set its own targets. She said that the arrangements for getting vaccines in care homes was successful.
132/22.8	Ms Henderson asked about the supply of COVID vaccine highlighting a personal example of an individual not being able to get one. Dr McClean said that supply should not be an issue and perhaps GP practices only offer certain vaccines at certain times. Ms McCaig advised that a pharmacy she knew of was carrying out vaccinations 3 mornings per week.
132/22.9	Ms McCaig asked if the uptake among frontline workers was tailing off, and if there was therefore an opportunity to go down the age range, but Dr McClean said that PHA would not go against JCVI advice.
132/22.10	The Chair asked what work can be done to improve the uptake among pregnant women and if PHA can influence healthcare professionals and midwives. Dr McClean advised that there is a low vaccine uptake group. She added that had spoken to midwives and while individuals may not see the risks, there is a lot of media coverage around possible effects like infertility.
132/22.11	The Chair asked that if in the case a parent withdraws consent for a child to receive a vaccine, would PHA write a letter to that parent, but Dr McClean advised that this would be an unusual circumstance. The Chair asked how the uptake of the flu vaccine compares with that before the pandemic. Dr McClean replied that the uptake is slightly better.
132/22.12	Ms Henderson commented that it is a very disparate system in that there are individuals who wish to get a vaccine but cannot because the information is too hard to navigate. Dr McClean said that there are channels, but as GPs and pharmacies are independent contractors, PHA cannot direct them. She said that the Trust centres will be open for another week so suggested that PHA should message out that this is potentially a “last chance”. The Chair asked about a press release. Mr Wilson agreed that the system is not uniform and so it is infuriating to manage from a communications perspective.
132/22.13	Mr Stewart said that a year ago he raised concerns about the delivery of vaccines and performance measures for delivering them. He advised that GPs are receiving up to £15 per shot and asked should not measures not be put in place. Dr McClean said that the amount paid to GPs was cut. Ms McCaig advised that a lot of work goes through SPPG and it is not as lucrative to do this work as it appears. Dr McClean added that some GP practices opted out and although there has been a lot of coverage about community pharmacies doing more, it is still GPs who do the vast bulk of the vaccinations.
132/22.14	Ms Henderson asked how much more delivery GPs will be expected to do. Dr McClean said that the programme runs until the end of December and there are still plenty of vaccines in the system. Ms

Henderson said that she would like to see some sort of system where, through technology, an individual can see where it is possible to get a vaccine on a given day, but Mr Blaney pointed out that this would be impossible to manage given there are so many moving parts.

133/22 **Item 9 – Update from Chair of Remuneration Committee**

133/22.1 This item had been covered in Item 5, Chair's Business.

134/22 **Item 10 – Update from Chair of Planning, Performance and Resources Committee**

134/22.1 This item had also been covered under Item 5, Chair's Business.

135/22 **Item 11 – PHA Procurement Board – Update Report (PHA/02/12/22)**

Mr Stephen Murray joined the meeting for Items 11 and 12.

135/22.1 Mr Wilson advised that this update was presented to the Planning, Performance and Resources Committee and is a summary of where PHA is with regard to the implementation of its Procurement Plan. He said that PHA has many rolling contracts and that following a review of the processes around these, a number of recommendations was made and there is an update on these. He explained that following a hiatus caused by the pandemic, there are now staff working full time in this area, but there remains a considerable amount of work to be done. He added that there is reference in the update to Strategic Planning Teams (SPTs) and said that there will be information on these in the next item. He said that the paper also highlights the role of social value procurement and there is an update on training on procurement across the whole of PHA.

135/22.2 Mr Stewart welcomed the update but said that 2026 for the completion of the work seems a long time. However, he noted that when he raised this with External Audit, it was pointed out to him that having this large number of contracts is not uncommon within the HSC. He queried how much change there will be in the workload for PHA if there is a change from procurement to grants. He expressed a concern that in Northern Ireland there is a situation where 60% of the population is obese, but yet PHA spends so much on mental health and suicide prevention which impacts on a smaller percentage of people. He said that was a different debate. Mr Wilson replied that while 2026 may seem a long way away, PHA will not be far off that given the work that is required to be undertaken. He added that PHA is in the process of looking to see where it can make the best use of its funding. He said that the point about grants is a relevant one given procurement can take a long time. He added that grants may be more sustainable. He said that he intends to keep the Board up to date and that this is opportune given PHA is looking at its corporate priorities.

135/22.3	The Chair commented that this work has been ongoing since 2015 and that the previous Chair of the Governance and Audit Committee had asked for a timeline for this work but was not given one. Ms McCaig noted that if a timeline had been given it would have changed and she cited the ability of organisations to submit tenders and a change in EU procurement rules as two main reasons. She said that PHA is in a relatively good position compared to other HSC bodies. She suggested that PHA should be looking at how it manages the number of contracts it has awarded as there are 72 contracts in suicide prevention.
135/22.4	Ms Henderson welcomed the update and said that this is a realistic workplan. She added that there is a lot to do and that this is fundamental to the governance of the organisation. She said that this is an area that needs more resources. Mr Murray noted that while this plan will help in terms of the way in which PHA is structured and the skills mix of staff, it is the process itself, and in particularly the pre-procurement stage that is the issue. However, he said that PHA now has a group of staff who are working with their colleagues in Health Improvement and he was confident that this work will progress.
135/22.5	The Chair said that when he first discussed this he asked if PHA needed more individuals with skills in procurement, but was advised that it was more to do with requiring individuals with skills in planning. He added that when these individuals were appointed, they immediately went to support the COVID response, and he asked if they were now back. Mr Murray confirmed that they were and are dedicated to working in the areas of mental health and drugs alcohol. The Chair asked if there was a third member and Mr Murray confirmed that there will be a third individual working in this area from January. He added that PHA also has the capacity to buy in additional support.
135/22.6	Ms Henderson noted that the £11.5m of contracts listed on the Operational Framework fall outside procurement regulations and the Board needs to recognise the risk involved in these. However, she said that she recognised PHA has a plan for dealing with those.
135/22.7	The Chair noted that there is a lot of fragmentation within the area of self-harm with different organisations offering different services and he asked if there was any way of having these co-ordinated in any way. Mr Murray said that the SPT on suicide prevention would look at that as self-harm is a single service.
135/22.8	Mr Blaney asked for more information on the Shared Reading Group. Mr Murray advised that this is a small group within the Criminal Justice System which encourages individuals who are illiterate to read and help them when they get out of prison. Mr Blaney asked if the Department of Justice would be better placed to support this. Mr Murray agreed that there would be some overlap. Mr Blaney said that he did not feel that this is a key duty of PHA. The Chair advised that he was aware of work that speech and language therapists have, in the past, carried out work

with younger offenders to help such prisoners who encountered communication problems. Mr Murray agreed that it is about that holistic approach. Mr Blaney commented that while he did not disagree with the concept, he did not think that it was PHA who should be doing it.

135/22.9 The Board noted the update on the PHA Procurement Board.

136/22 Item 12 – Mental Health, Emotional Wellbeing and Suicide Prevention Strategic Planning Team (SPT) Update and Action Plan 2022/23 (PHA/03/12/22)

136/22.1 Mr Wilson said that he thought it would be useful for the Board to get an overview of how PHA is seeking to establish SPTs and to look at the work of the first of these, which is in the area of mental health.

136/22.2 Mr Murray advised that this approach is an example of what PHA is aiming to achieve in other areas. He gave a presentation which he began by showing how there are many different strategies in the area of mental health with many different drivers, but PHA is aiming to have a "golden thread" that works through all of these different areas. He showed how there is overlap between the strategies in terms of recommendations.

136/22.3 Mr Murray outlined the aims and objectives of the SPT and showed how it links to other groups that have been established. He then gave an overview of some of the key achievements of the group, and said that there is also an action plan which shows the breadth of the work that PHA is trying to bring together.

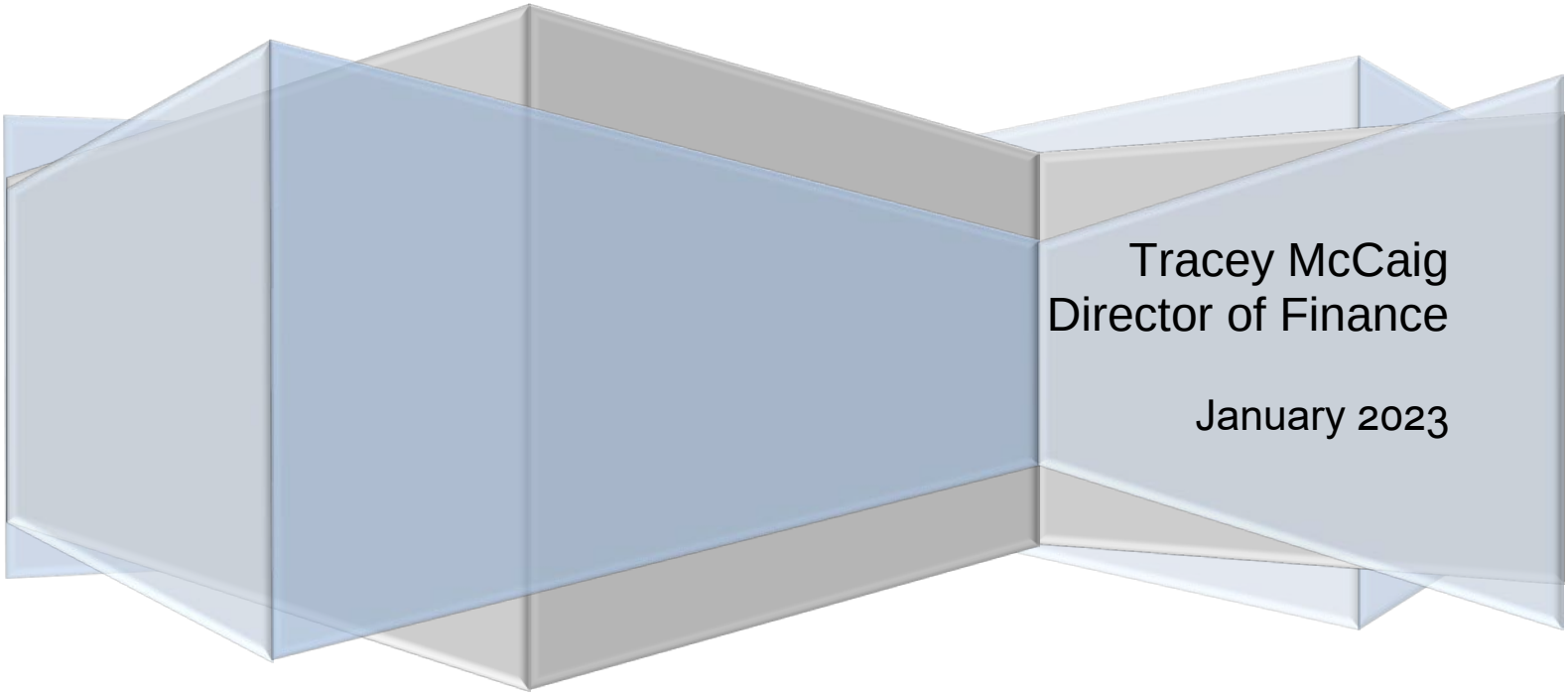
136/22.4 Professor Rooney said that she was very excited by this development and pleased to hear about the work that has been done. She added that this is difficult work to pull together and for PHA to achieve this is a huge step. She said that it is important that PHA is seen as a leader in this area and that this is a brilliant piece of work. Ms Henderson echoed these remarks. Mr Murray advised that PHA has made good connections and is working to bring together the different funding streams which relate to the Substance Misuse Strategy, Early Intervention Services and the Self-Harm Intervention Programme so that services are open to all clients. Professor Rooney commented that Early Intervention work is important for physical health as well as mental health.

136/22.5 Mr Stewart said that the work required to pull together is obvious, but what has to be done should inform the operating model for PHA and this type of approach could be replicated in about a dozen other areas, hence the need to get the reform work completed as soon as possible.

136/22.6 The Chair commented that it is frustrating that there are two different branches in the Department working on mental health and he asked whether they should be working together. Mr Murray said that this is a

	legacy arrangement with mental health sitting under the social care side and the Protect Life 2 Strategy falling under the remit of the Chief Medical Officer. It was noted that there can be tension between the policy side and the professional side. Professor Rooney noted that the policy work is being removed from the role of the new Chief Social Services Officer so the Department has recognised the difficulty in being organised along professional lines.
136/22.7	Ms Henderson asked if the work of this SPT is reflected in the Business Plan. Mr Murray said that it is, and it will be in the Business Plan for 2022/23. Professor Rooney said that it is important that PHA's work links with the work of the Department. Mr Murray advised that the Department has seen the value of PHA's model of working. For the Substance Misuse Strategy, he said that PHA has been working well with SPPG and inputting into a regional process. He added that there is a lot of learning and all organisations need to be part of a joint planning approach and support the thinking around the new ICS model.
136/22.8	The Board noted the update on the Mental Health, Emotional Wellbeing and Suicide Prevention Strategic Planning Team.
137/22	**Item 13 – Any Other Business**
137/22.1	There was no other business.
138/22	**Item 14 – Details of Next Meeting**
	Thursday 19 January 2023 at 1:30pm
	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast
	Signed by Chair:
	Date:

Finance Report
November 2022



Tracey McCaig
Director of Finance

January 2023

Section A: Introduction/Background

1. The PHA Financial Plan for 2022/23 set out the funds notified as available, the risks and uncertainties for 2022/23 and summarised the opening budgets against the high level reporting areas. It also outlined how the PHA will manage the overall funding available and enable it to support key programmes of work that will help achieve its corporate priorities. It received formal approval by the PHA Board in the June 2022 meeting.

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. On the basis of this approved Plan, this summary report reflects the latest position as at the end of November 2022 (month 8).

Section B: Update – Revenue position

4. The PHA has reported a year to date surplus at November 2022 of £1.3m (£1.2m, October 2022), against the annual budget position for 2022/23.

5. In respect of the year to date surplus of £1.3m:
    - The annual budget for programme expenditure to Trusts of £46.8m has been profiled evenly for allocation, with £31.2m expenditure reflected as at month 8 and a nil variance to budget shown.
    - The remaining annual programme budget is £57.3m. Programme expenditure of £32.1m has been recorded for the first eight months of the financial year with a small underspend to date of £0.2m. This budget has been separately reviewed and is currently anticipated to achieve planned spend in full by the end of the financial year. Budget holders are required to continually keep all programme budgets under close review and report any expected slippage or pressures at an early stage.
    - A year-to-date underspend of £1.1m is reported in the area of Management & Administration, primarily in the areas of Public Health and Operations, which reflects a high level of vacant posts in each area.

- There is annual budget of c£3.3m in ringfenced budgets, most of which relates to COVID funding for the Contact Tracing Centre for quarter 1 (£2.2m). A business case has been submitted to DoH for in year costs relating to the Vaccination programme and associated funding (£0.2m) has been assumed within this area. A small variance is reported on these areas to date, however they are largely expected to breakeven against funded budgets.

6. The month 8 position is summarised in the table below.

PHA Summary financial position - November 2022

	Annual Budget	Year to Date budget	Year to Date Expenditure	Year to Date variance	Projected year end Surplus / (Deficit)
	£'000	£'000	£'000	£'000	£'000
Health Improvement	12,663	8,442	8,442	0	
Health Protection	10,640	7,093	7,093	0	
Service Development & Screening	14,542	9,695	9,695	0	
Nursing & AHP	7,768	5,179	5,179	0	
Centre for Connected Health	1,476	984	984	0	
HSC Quality Improvement	23	15	15	0	
Other	(275)	(183)	(183)	0	
Programme expenditure - Trusts	**46,838**	**31,225**	**31,225**	**0**	**0**
Health Improvement	29,537	17,300	16,990	310	
Health Protection	18,364	12,949	12,994	(45)	
Service Development & Screening	3,359	1,474	1,500	(26)	
Research & Development	3,418	0	0	0	
Campaigns	1,741	148	243	(95)	
Nursing & AHP	781	196	148	48	
Centre for Connected Health	347	135	116	19	
HSC Quality Improvement	168	122	107	15	
Other	(441)	0	0	0	
Programme expenditure - PHA	**57,272**	**32,324**	**32,098**	**226**	**(1,761)**
Subtotal Programme expenditure	**104,110**	**63,549**	**63,323**	**226**	**(1,761)**
Public Health	16,659	11,106	10,347	759	
Nursing & AHP	5,050	3,369	3,295	75	
Operations	4,496	2,939	2,641	298	
Quality Improvement	653	396	390	6	
PHA Board	162	84	151	(67)	
Centre for Connected Health	421	280	291	(11)	
SBNI	850	566	500	66	
Subtotal Management & Admin	**28,291**	**18,741**	**17,615**	**1,126**	**1,993**
Trusts	0	0	0	0	
PHA Direct	2,393	2,213	2,184	29	
Subtotal Covid-19	**2,393**	**2,213**	**2,184**	**29**	**(50)**
Trusts	147	98	98	(0)	
PHA Direct	125	0	(0)	0	
Subtotal Transformation	**272**	**98**	**98**	**0**	**0**
Trusts	0	0	0	0	
PHA Direct	639	242	277	(35)	
Other ringfenced	**639**	**242**	**277**	**(35)**	**0**
TOTAL	**135,704**	**84,842**	**83,496**	**1,346**	**182**

Table subject to roundings

7. In October 2022, the Permanent Secretary was advised that there is a projected additional slippage of circa £0.5m in-year, the source of this primarily being windfall gains on additional vacant senior posts, return of funding from a provider due to non-delivery, Connected Health and other general slippage on demand led budgets. This was notified to the DoH in a response to the request, and funding retracted accordingly.

8. In addition, PHA was notified of an additional savings target for 2022/23 of £0.5m by the DoH on 1 December 2022. This requirement was to support the challenging in year budget position for the wider HSC and funding was retracted during December 2022. Actions have been identified to meet this additional requirement.

9. An updated forecast year-end surplus of £0.2m is currently shown (£0.4m, October 2022). This position remains under close review, and the financial forecasts will be updated accordingly in future reports, with DoH being kept informed where necessary.

Section C: Risks

10. Any significant assumptions, risks or uncertainties facing the organisation, and the management of these elements, are set out below.

11. **Impact of COVID-19 on Financial Planning:** The global pandemic and its impact on the HSC brings with it obvious challenges for predicting and managing budgetary resources as the service continues to respond during 2022/23. The cost of the Contact Tracing Service has been included for quarter 1 of the financial year, and at this stage it is assumed there will not be any requirement for the service to resume later in the financial year. As noted above, PHA have furnished DoH with a business case for the in-year forecasted costs of the Vaccination programme. The longer term requirements for the Vaccination Programme transfer to PHA are being considered for this service and will be kept under close review.

12. **Demand led services:** Whilst an initial estimate of funding was identified within the 2022/23 Financial Plan, to enable pressures or strategic developments to pass through an approval process, clarity on the financial impact of this could only be secured on conclusion of the process. This process was concluded in early Summer and confirmation received from operational management that plans have progressed in line with approvals. Additionally, business as usual Programme expenditure is monitored closely to ensure that planned expenditure is met. As in previous years, the PHA operational management will continue to review expenditure plans to identify any potential easements or inescapable pressures which may need to be addressed in-year.

13. **Annual Leave:** PHA staff are carrying a significant amount of annual leave, due to the demands of responding to the COVID-19 pandemic over the last two years. As at each financial year end, this is converted into a financial balance. This balance of leave is being managed to bring it down to a more normal level during the year, and this may present some risk to the delivery of organisational objectives. Based on current position of leave taken, an estimate of the partial release of the financial balance during 2022/23 is contributing toward the forecast available for deployment in-year.

14. **Funding not yet allocated:** there are a number of areas where funding is anticipated but has not yet been released to the PHA. These include AfC and Non-AfC Pay uplift for 2022/23, however no expenditure is currently being assumed for these areas.

15. **Future year's Budget**: The financial challenge facing HSC is significant in-year and will continue to present an ongoing challenge to manage. PHA will be required to work closely with DoH in the coming months, where required, to inform any assessment of options to address the wider HSC financial position.

16. **HSC wider financial position**: The impact of the wider HSC financial position has required actions to be taken by DoH in planning to achieve financial breakeven in 2022/23. PHA was required to meet an additional funding reduction of £0.5m, which was advised on 1 December 2022 and a subsequent funding retraction was processed later that month. HSC organisations have been advised to identify plans

for potential funding reductions in 2023/24 and work is ongoing internally to respond to this requirement.

17. Due to the complex nature of Health & Social Care, there may be further challenges with financial impacts which could present in year. PHA will continue to monitor and manage these with DoH and Trust colleagues on an ongoing basis.

Section D: Update - Capital position

18. The PHA has a current capital allocation (CRL) of £13.1m. The majority of this (£12.0m) relates to Research & Development (R&D).

19. The overall summary position, as at November 2022, is reflected in the following table.

Capital Summary	Total CRL £'000	Year to date spend £'000	Full year forecast £'000	Forecast Surplus / (Deficit) £'000
HSC R&D:				
R&D - Other Bodies	6,551	1,875	6,551	0
R&D - Trusts	8,208	6,206	8,208	0
R&D Capital Receipts	(2,759)	(142)	(2,759)	0
Subtotal HSC R&D	**12,000**	**7,939**	**12,000**	**0**
CHITIN Project:				
CHITIN - Other Bodies	0	0	0	0
CHITIN - Trusts	0	0	0	0
CHITIN - Capital Receipts	0	0	0	0
Subtotal CHITIN	**0**	**0**	**0**	**0**
Other:				
Congenital Heart Disease Network	436	54	436	0
Online Safety Project	15	0	15	0
Covid Wastewater	600	0	600	0
Subtotal Other	**1,051**	**54**	**1,051**	**0**
Total HSCB Capital position	**13,051**	**7,993**	**13,051**	**0**

20. 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.

21. 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. It should be noted that the values for CHITIN have not yet been fully confirmed by way of an CRL allocation letter. PHA R&D team are working with the DoH Capital Investment Team to finalise and any update will be noted, where required, in future finance reports.

22. PHA has also received a number of smaller capital allocations including the Congenital Heart Disease (CHD) Network (£0.4m), which is managed through the PHA R&D team, and a COVID-19 Wastewater project (£0.6m) which is a QUB project analysing wastewater to help with the tracking of outbreaks of COVID-19. A small CRL allocation has been received for an online safety project, which relates to SBNI, and is anticipated to be spent in quarter 4 of the financial year.

23. The capital position will continue to be kept under close review throughout the financial year.

Recommendation

24. The PHA Board are asked to note the PHA financial update as at November 2022.

Public Health Agency

Annex 1 - Finance Report

2022-23

Month 8 - November 2022

PHA Financial Report - Executive Summary

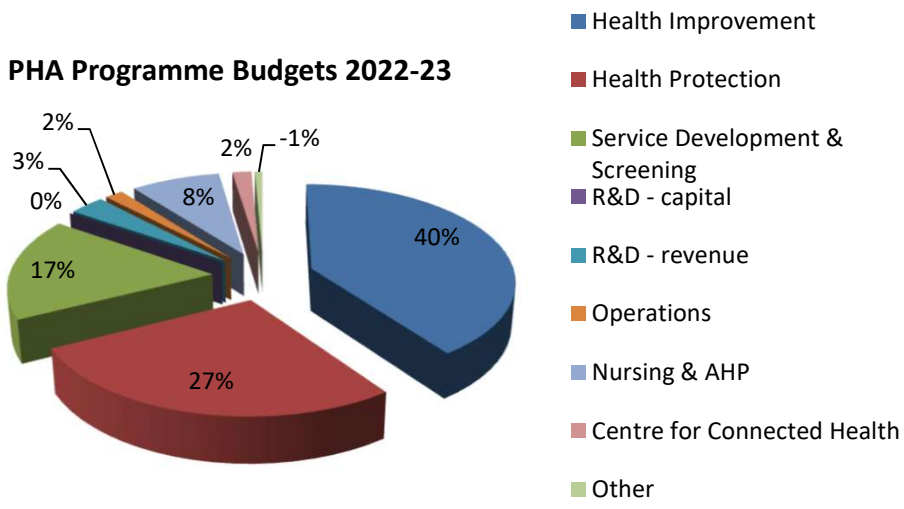
Year to Date Financial Position (page 2)

At the end of month 8 PHA is reporting an underspend of £1.3m against its profiled budget. This underspend is primarily the result of underspends on Administration budgets (page 6) and PHA Direct programme budgets, with expenditure running behind profiled budget in a number of areas.

Budget managers continue to be encouraged to closely review their profiles and financial positions to ensure the PHA meets its breakeven obligations at year-end.

Programme Budgets (pages 3&4)

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

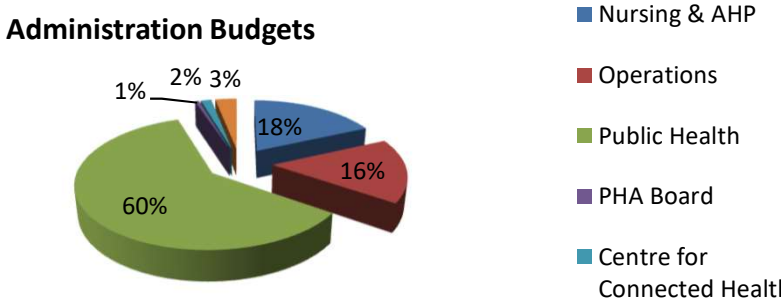


Administration Budgets (page 5)

The breakdown of the Administration budget by Directorate is shown in the chart below. Over half of the budget relates to the Directorate of Public Health.

A 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.



Full Year Forecast Position & Risks (page 2)

PHA is currently forecasting a small surplus of £0.2m for the full year.

The Administration and Programme budgets are being continually reviewed in order to update the full year forecast.

Public Health Agency
2022-23 Summary Position - November 2022

	Annual Budget					Year to Date				
	Programme		Ringfenced	Mgt &	Total	Programme		Ringfenced	Mgt &	Total
	Trust	PHA Direct	Trust & Direct	Admin		Trust	PHA Direct	Trust & Direct	Admin	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources										
Departmental Revenue Allocation	46,838	57,221	3,303	27,424	**134,786**	31,225	32,273	2,552	18,225	**84,275**
Revenue Income from Other Sources	-	51	-	867	**918**	-	51	-	517	**568**
Total Available Resources	46,838	57,272	3,303	28,291	**135,704**	31,225	32,324	2,552	18,741	**84,842**
Expenditure										
Trusts	46,838	-	147	-	**46,985**	31,225	-	98	-	**31,323**
PHA Direct Programme *	-	59,034	3,206	-	**62,240**	-	32,097	2,461	-	**34,558**
PHA Administration	-	-	-	26,297	**26,297**	-	-		17,615	**17,615**
Total Proposed Budgets	46,838	59,034	3,354	26,297	**135,522**	31,225	32,097	2,559	17,615	**83,496**
Surplus/(Deficit) - Revenue	0	(1,761)	(50)	1,993	**182**	-	226	(7)	1,126	**1,346**
Cumulative variance (%)						***0.00%***	***0.70%***	***-0.27%***	***6.01%***	***1.59%***

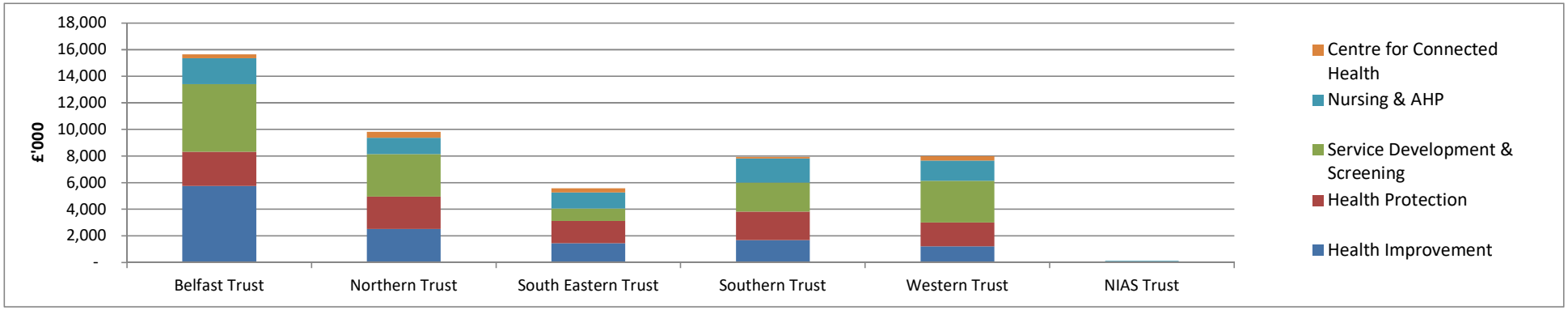
The year to date financial position for the PHA shows an underspend of £1.3m, which is a result of PHA Direct Programme expenditure being behind profiled budgets and a year-to-date underspend within Administration budgets.

A surplus of £0.2m is currently forecast for the year.

Please note that a number of minor rounding's may appear throughout this report.

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

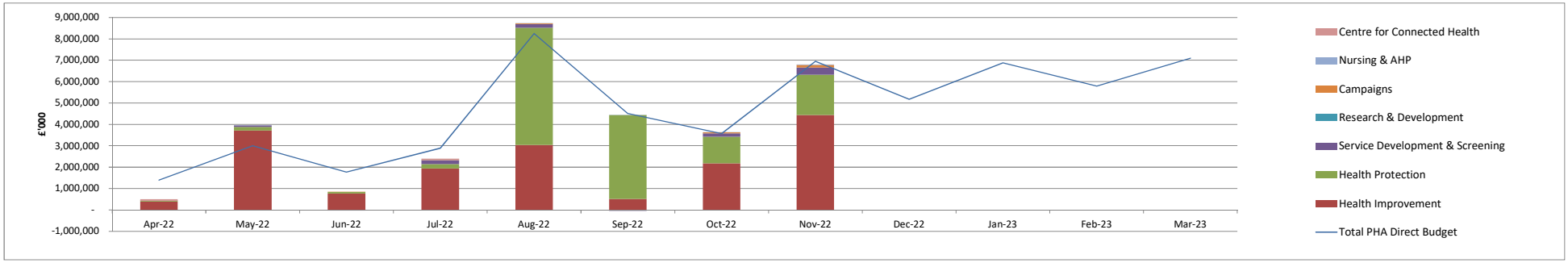
Programme Expenditure with Trusts



Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	NIAS Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	5,746	2,516	1,443	1,685	1,205	68	**12,663**	8,442	8,442	-
Health Protection	2,579	2,437	1,674	2,137	1,813	-	**10,640**	7,093	7,093	-
Service Development & Screening	5,091	3,207	941	2,188	3,116	-	**14,542**	9,695	9,695	-
Nursing & AHP	1,946	1,226	1,197	1,811	1,531	57	**7,768**	5,179	5,179	-
Centre for Connected Health	279	431	315	115	336	-	**1,476**	984	984	-
Quality Improvement	23	-	-	-	-	-	**23**	15	15	-
Other	(96)	(55)	(29)	(48)	(47)	0	**(275)**	(183)	(183)	-
Total current RRLs	**15,568**	**9,761**	**5,541**	**7,888**	**7,954**	**126**	**46,838**	**31,225**	**31,225**	-
Cumulative variance (%)										***0.00%***

The above table shows the current Trust allocations split by budget area. The negative figures in the *Other* line reflect the retraction of funds relating to the 1.25% NIC uplift when this increase was reversed during month 8.
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.

PHA Direct Programme Expenditure



	Apr-22 £'000	May-22 £'000	Jun-22 £'000	Jul-22 £'000	Aug-22 £'000	Sep-22 £'000	Oct-22 £'000	Nov-22 £'000	Dec-22 £'000	Jan-23 £'000	Feb-23 £'000	Mar-23 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000	
Profiled Budget																	
Health Improvement	1,268	2,538	1,454	2,248	2,621	646	2,284	4,242	1,146	3,510	3,582	3,999	**29,537**	17,300	16,990	310	*1.8%*
Health Protection	42	254	144	128	5,448	3,775	1,159	1,998	2,510	1,646	260	1,000	**18,364**	12,949	12,994	(45)	*-0.4%*
Service Development & Screen	79	144	102	489	53	11	22	574	272	317	553	742	**3,359**	1,474	1,500	(26)	*-1.7%*
Research & Development	-	-	-	-	-	-	-	-	1,000	1,000	1,000	418	**3,418**	-	-	-	*0.0%*
Campaigns	3	2	18	5	15	52	15	38	114	305	273	900	**1,741**	148	243	(95)	*-64.1%*
Nursing & AHP	2	3	50	14	19	19	43	47	45	68	117	354	**781**	196	148	48	*24.3%*
Centre for Connected Health	-	61	5	-	57	-	- 13	25	93	29	6	84	**347**	135	116	19	*14.0%*
Quality Improvement	-	-	-	-	38	-	58	26	-	-	-	46	**168**	122	107	15	*12.6%*
Other	-	-	-	-	-	-	-	-	-	-	-	(441)	**(441)**	-	-	-	*100.0%*
Total PHA Direct Budget	**1,393**	**3,001**	**1,772**	**2,884**	**8,252**	**4,503**	**3,568**	**6,950**	**5,180**	**6,876**	**5,791**	**7,101**	**57,272**	**32,324**	**32,098**	**226**	
Cumulative variance (%)																***0.70%***	
Actual Expenditure	**503**	**3,986**	**1,106**	**2,336**	**8,954**	**4,476**	**3,786**	**6,950**	**-**	**-**	**-**	**-**	**32,097**				
Variance	**890**	**(985)**	**666**	**548**	**(702)**	**27**	**(218)**	**0**					**226**				

The year-to-date position shows an underspend of approximately £0.2m against profile. A year-end overspend of £1.8m is anticipated, reflecting the plan to absorb anticipated underspends within Administration budgets.

Public Health Agency
2022-23 Ringfenced Position

	Annual Budget				Year to Date			
	Covid £'000	NDNA £'000	Other ringfenced £'000	Total £'000	Covid £'000	NDNA £'000	Other ringfenced £'000	Total £'000
Available Resources								
DoH Allocation	2,224	272	639	**3,135**	2,213	98	242	**2,552**
Assumed Allocation/(Retraction)	169	-	-	169	-	-	-	**-**
Total	2,393	272	639	**3,304**	2,213	98	242	**2,552**
Expenditure								
Trusts	-	147	-	**147**	-	98	-	**98**
PHA Direct	2,443	125	639	**3,206**	2,184	-	277	**2,461**
Total	2,443	272	639	**3,354**	2,184	98	277	**2,559**
Surplus/(Deficit)	**(50)**	**-**	**-**	**(50)**	**29**	**-**	**(35)**	**(6)**

PHA has received a COVID allocation totalling £2.4m to date, £2.1m of which is for Contract Tracing. A small overspend is forecast for the full year, which is currently being managed within the PHA's overall financial position.

Transformation funding has been received for a Suicide Prevention project totalling £0.3m. This project is being monitored and reported on separately to DoH, and a breakeven position is anticipated for the year.

Other ringfenced areas include Safe Staffing, NI Protocol and funding for SBNI. A small overspend has been shown for the year-to-date. This is a timing issue only, and it is expected that these areas will achieve a breakeven position for the year.

PHA Administration

2022-23 Directorate Budgets

	Nursing & AHP	Quality Improvement	Operations	Public Health	PHA Board	Centre for Connected Health	SBNI	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Annual Budget								
Salaries	4,887	641	3,492	16,336	115	379	619	**26,469**
Goods & Services	163	12	1,004	323	48	42	230	**1,822**
Total Budget	**5,050**	**653**	**4,496**	**16,659**	**162**	**421**	**850**	**28,291**
Budget profiled to date								
Salaries	3,260	388	2,270	10,890	58	252	413	**17,531**
Goods & Services	109	8	669	216	26	28	153	**1,210**
Total	**3,369**	**396**	**2,939**	**11,106**	**84**	**280**	**566**	**18,741**
Actual expenditure to date								
Salaries	3,172	382	1,945	10,091	132	280	414	**16,416**
Goods & Services	123	8	696	256	19	11	86	**1,199**
Total	**3,295**	**390**	**2,641**	**10,347**	**151**	**291**	**500**	**17,615**
Surplus/(Deficit) to date								
Salaries	88	6	325	799	(74)	(28)	(1)	**1,115**
Goods & Services	- 14	0	(27)	(39)	7	17	67	**11**
Surplus/(Deficit)	**75**	**6**	**298**	**759**	**(67)**	**(11)**	**66**	**1,126**
Cumulative variance (%)	*2.21%*	*1.45%*	*10.15%*	*6.84%*	*-79.70%*	*-3.93%*	*11.66%*	***6.01%***

PHA's administration budget is showing a year-to-date surplus of £1.1m, which is being generated by a number of vacancies, particularly within Health & Well-being Improvement and SDS. Senior management continue to monitor the position closely in the context of the PHA's obligation to achieve a breakeven position for the financial year. The full year surplus is currently forecast to be c£2.0m, which includes a release of the annual leave accrual and the cost of the EY Review.

The SBNI budget is ringfenced and any underspend will be returned to DoH prior to year end.

PHA Prompt Payment

Prompt Payment Statistics

	November 2022 Value	November 2022 Volume	Cumulative position as at November 2022 Value	Cumulative position as at November 2022 Volume
Total bills paid (relating to Prompt Payment target)	£9,082,051	692	£47,845,754	3,844
Total bills paid on time (within 30 days or under other agreed terms)	£9,053,928	676	£46,993,120	3,748
Percentage of bills paid on time	**99.7%**	**97.7%**	**98.2%**	**97.5%**

Prompt Payment performance for November shows that PHA achieved the 95.0% target on both volume and value. The year to date position shows that on both value and volume, PHA is achieving its 30 day target of 95.0%. Prompt payment targets will continue to be monitored closely over the 2022-23 financial year.

The 10 day prompt payment performance remains very strong at 85.5% on volume for the year to date, which significantly exceeds the 10 day DoH target for 2022-23 of 70%.

HSC Public Health Agency

item 9

Title of Meeting	PHA Board Meeting
Date	19 January 2023
Title of paper	PHA Board Buddy Pilot Final Evaluation Report
Reference	PHA/02/01/23
Prepared by	Clifford Mitchell, Anita Rowe, Domenica Gilroy, Dawn Clarke
Lead Director	Dr Aideen Keaney
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

In February 2022, HSCQI was tasked, on the request of the Chief Executive, with evaluating the effectiveness of the Board Buddy pilot, to understand the experience of the participants and provide recommendations on the future development of the PHA Board and the Agency. The final evaluation report is attached.

2 Background Information

A six-month "Board Buddy" pilot was proposed by the Chief Executive which commenced on 1st March 2022 and Executive and Non-Executive members of the Board were paired and asked to meet regularly over the subsequent six-month period. The aim of the pilot was to:

1. Develop a better understanding of Non-Executive and Executive roles across the Agency.
2. Develop a greater understanding of the work undertaken by the organisation.
3. Promote better working relationships through transparent and open discussions as relationships develop across the Board Room.

3 Key Findings

Overall, this evaluation has provided evidence that the Board Buddy pilot achieved its 3 stated aims.

4 Next Steps

Consider the list of recommendations regarding the Board Buddy pilot, the functioning of the PHA Board and the wider work of the Agency and where appropriate, agree an action plan for implementation.

PHA Board Buddy Pilot Final Report

1.0 Background

In accordance with the 2021/22 Annual Internal Audit plan, the BSO Internal Audit department reviewed the effectiveness of the PHA Board during October and November 2021. This identified a need to clarify the roles and responsibilities of Executive and Non-Executive Directors of the PHA Board and to enhance working relationships and collaboration. Consequently, a six-month "Board Buddy" pilot was proposed by the Chief Executive in a paper (Ref: PHA/03/02/22) which was approved by the PHA Board at their meeting on 17 February 2022. As stated in the paper, the aim of the pilot was to:

1. Develop a better understanding of Non-Executive and Executive roles across the Agency.
2. Develop a greater understanding of the work undertaken by the organisation.
3. Promote better working relationships through transparent and open discussions as relationships develop across the Board Room.

The Board Buddy pilot commenced on 1st March 2022 and Executive and Non-Executive members of the Board were paired and asked to meet regularly over the subsequent six-month period. Five pairs were created initially. Each pair were to agree informal agendas for their meetings and to discuss their own areas of work and the wider work of the Agency.

In February 2022, HSCQI was tasked, on the request of the Chief Executive, with evaluating the effectiveness of the Board Buddy pilot, to understand the experience of the participants and provide recommendations on the future development of the PHA Board and the Agency.

2.0 Aim

This final evaluation aimed to:

1. Understand the experience of the Executive and Non-Executive Director members of the PHA Board who participated in the Board Buddy pilot.
2. Determine whether the Board Buddy pilot achieved its stated aims (as outlined above).
3. Provide recommendations regarding the Board Buddy pilot, the functioning of the PHA Board and the wider work of the Agency.

3.0 Evaluation Process

Given the small number of participants engaged in the Board Buddy pilot at its outset (*n*=10), this evaluation sought to obtain the views of all of the participants, using two data collection methods:

1. **Questionnaires**

   Questionnaires (appendix 1) were distributed to all of the participants in the pilot at 3 time points: the start, the mid-point and the end of the pilot. This aimed to capture participants' experiences and views. It also sought to explore whether their understanding of each other's roles, the functioning of the PHA Board and the wider work of the Agency developed over time. The participants were asked to rate their views and understanding of various factors on a 5-point Likert scale, ranging from 'very poor' to 'excellent'.

2. **Appreciative Inquiry (AI) interviews**

   At the end of the pilot, interviews were carried out with participants using Appreciative Inquiry (appendix 2). The aim of these interviews was to facilitate a deep dive into participant experience and to capture high-point moments, lived values, unexplored potential and opportunities for improvement across the PHA Board and wider organisation. The interviews were recorded, transcribed verbatim and analysed using thematic analysis.

4.0 Results

One of the five identified Executive Director – Non-Executive Director pairs did not meet during the 6-month duration of the Board Buddy pilot. Therefore, this results

section refers to the data gathered from the remaining 8 participants. These 4 pairs all met at least once during the lifespan of the pilot and 7 meetings took place in total.

Questionnaire data (Quantitative)

At the start of the pilot, all of the participants (*n*=8) completed the questionnaire. At the end of the study, 4 questionnaires were returned and some questions had not been answered. Due to the low number of responses, it was not possible to carry out any statistical analyses of the data or to present clear results.

AI interview data (Qualitative)

AI interviews were carried out with a total of 7 participants, 4 Executive Directors and 3 Non-Executive Directors. All of the participants described positive experiences of the Board Buddy pilot and reported that the informal meetings helped to nurture and develop relationships and trust. All of the participants expressed a desire to continue with the scheme and it was suggested that people are given the opportunity to be paired with other members of the Board in the future, perhaps on a rotational basis to further broaden their experience.

Five key themes were identified in the data:

Theme 1: Benefits of informal, less time-constrained meetings

- The meetings offered a *"slightly more informal and relaxed way to do a bit of a deep dive."*
- The one to one conversations that took place in the meetings were described in positive terms and as *"an excellent way in which to develop relationships and to develop understanding of what's important."*
- The Board Buddy meetings provided an opportunity to look towards the future e.g., *"those moments when we were dreaming of the future together I think for me were peak experiences or high points within those conversations."*

Theme 2: Improved understanding of role and perspectives

- The meetings enabled participants to understand each other's perspectives, develop relationships and build mutual trust.

Theme 3: Better understanding of operational processes and challenges

- The participants, and the Non-Executive Directors in particular, gained a greater understanding of the operational processes that exist in the Agency and the factors that impact on them e.g., *"probably the most useful thing I have found, is I just think it has improved my understanding of how things operate currently within the directorate that [my buddy] has responsibility for and some of the challenges that that directorate faces which is important to know about."*

Theme 4: Generation of ideas for the future

- The Board Buddy meetings promoted positive, supportive conversations about the current structure of the PHA and how it might look in the future e.g., *"to better understand how the organisation is currently constituted and then, with a view to looking to the future."*
- Several participants discussed the need to clarify the overall vision of the PHA

Theme 5: Constructive Challenge

- Throughout the interviews, several participants discussed the centrality of offering constructive challenge to their role as board members. All of the participants referred to their wish to do this in a respectful manner and the data consistently indicated that this is viewed positively by board members and can build relationships, promote understanding and help to identify solutions.

5.0 Limitations

As stated above, due to the low number of questionnaire responses, it was not possible to carry out any statistical analyses of the quantitative data or to present clear results. When conducting future evaluations, HSCQI will consider alternative approaches, especially with small sample sizes, to capture meaningful qualitative data.

6.0 Conclusions

Whilst the data obtained via the questionnaire were limited, the AI interviews gleaned some valuable learning about the Board Buddy pilot, which was valued highly by all of the participants. Overall, this evaluation has provided evidence that the Board Buddy pilot achieved its 3 stated aims.

Both Non-Executive Directors and Executive Directors reported they had an increased understanding of each other's roles across the agency. The Non-Executive Directors appreciated the opportunity in the Board Buddy meetings to discuss the operational processes of the PHA Directorate with which they had been paired. The Executive Directors gained an understanding of the role and perspectives of Non-Executive Directors, including how their desire to offer constructive, respectful challenge at board meetings.

All of the participants reported a greater understanding of the work currently undertaken across the Agency and reported that the Board Buddy meetings also provided an opportunity to discuss new ways of working and to generate ideas that may enhance the effectiveness of the PHA board in the future. The participants also referred frequently to valuing the time to discuss the vision and future of the Agency and its wider work (figure 1).

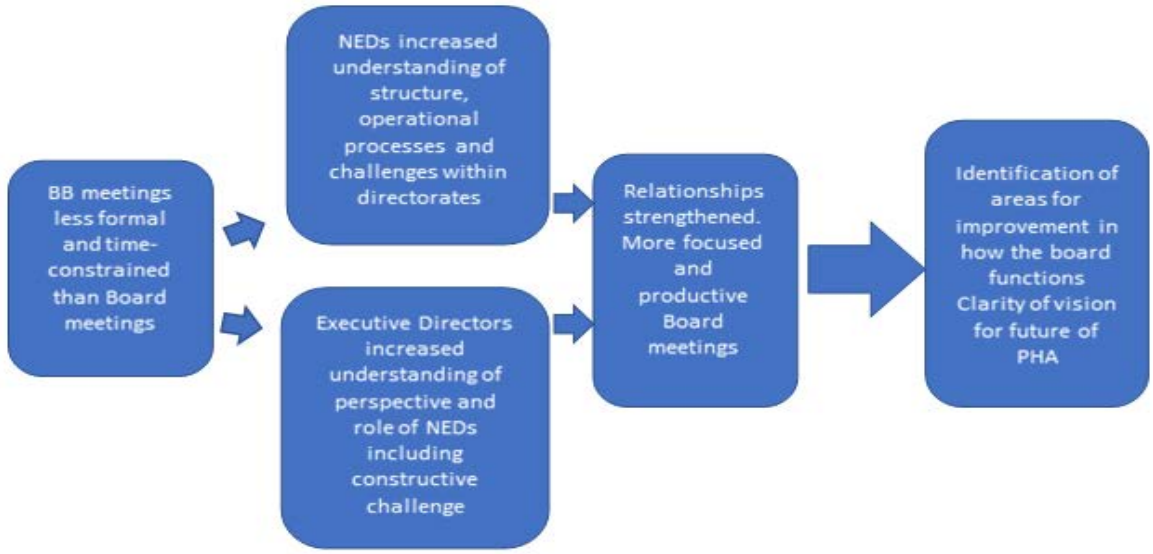


Figure 1

During the AI interviews, the participants all spoke enthusiastically and warmly about how the informal, transparent and open discussions they had in their Board Buddy meetings had enabled better working relationships that can further develop across the Board Room. Additionally, the AI interviews gave participants the opportunity to reflect on personal qualities that were important to them and the wider organisation (figure 2).

Figure 2: Qualities

7.0 Recommendations

The following list of recommendations regarding the Board Buddy pilot, the functioning of the PHA Board and the wider work of the Agency, includes points identified in the themes drawn from the qualitative data analysis and specific points raised by the participants.

1. Continue the Board Buddy scheme and maximise on its potential to deepen board members' experience and foster positive working relationships by rotating pairs.
2. Develop a clear vision for the PHA and clarify its role across the HSC system.
3. Promote collective decision making by PHA Board members, supported by robust feedback channels.

4. Raise the internal profile of the PHA Board and celebrate and promote what is already working well.
5. Develop closer working relationships between the PHA Board and the Executive team, with clarity of objectives and understanding around the work that the agency is involved in, how it commits its resources, the effectiveness of the approaches and the governance and control measures that are in place.
6. Continue with PHA Board workshops and consider specific themes e.g. how the Agency is demonstrating that it is focused on improving quality of care.
7. Develop a critical friend approach between Executive Directors and Non-Executive Directors that is focused on coaching, mentoring and supporting each other.
8. Consider the skill-mix of Board members to ensure that: a) the existing skills of members are valued appropriately and utilised fully; and b) there are no gaps in the collective skillset required for the Board to function effectively and efficiently
9. Create the conditions to help the PHA and PHA Board to learn, develop and get things right.
10. Develop a wider and deeper understanding of Quality Improvement (QI) across the PHA by providing leadership and support for QI training at various levels of the Quality 2020 Attributes Framework:

    a) Consider making Level 1 QI training mandatory for all PHA staff

    b) Provide and support Level 2 QI training for identified staff across the Agency

    c) Develop Level 4 QI training for Board members.

    d) Continue the involvement of Non-Executive Directors' involvement in QI e.g. via the HSCQI Awards.

Appendix 1: Questionnaires

Non-Executive Director Questionnaire (start, mid, end):

Table 1: Please rate your understanding of the role and function of the following PHA Directorates

Directorate	Very poor	Poor	Average	Good	Excellent
Finance					
HSCQI					
Operations					
Public Health					
Public Health Nursing, Midwifery and AHPs					

Non-Executive Director Questionnaire (start, mid, end):

You have been paired with (Please tick)

Executive Director	Tick
ED 1	
ED 2	
ED 3	
ED 4	
ED 5	

Table 2 What is your understanding of:

	Very poor	Poor	Average	Good	Excellent
The function of this Directorate					
The role of the Director					
The Directorate structure					

Directorate successes					
Directorate challenges					
What is your understanding of the function of the wider PHA					

Director Questionnaire (start, mid, end):

You have been paired with (Please Tick)

Non-Executive Director	Tick
NED 1	
NED 2	
NED 3	
NED 4	
NED 5	

Table 3 How would you rate your current understanding of the following:

	Very poor	Poor	Average	Good	Excellent
The role of the Non-Executive Director					
The challenges of the Non-Executive Director role					
The function of the PHA Board					
What is your understanding of the function of the wider PHA					

Appendix 2: Appreciative Inquiry

Appreciative Inquiry (AI) is a way of looking at organisational change which focuses on identifying and doing more of what is already working, rather than looking for problems and trying to fix them. It focuses on the core strengths of an organisation and then using those strengths to reshape the future.

The 4 D's of Appreciative Inquiry: Discovery, Dream, Design and Destiny.

Discovery: This phase is about discovering the organisations key strengths and appreciating the "best of what is".

Dream: This phase is focused on bringing out the dreams people have for their future within the organisation and also their dreams about the organisation's future.

Design: This phase is concerned with making decisions about the high-level actions which need to be taken to support the delivery of the dream.

Destiny: This phase is concerned with planning and forming action groups to take forward the actions identified during the discovery, dream and design phases. This involves celebration of both the learning identified so far and the start of the process to move forward.

(Appreciative Inquiry for change management: Using AI to facilitate organisational development. Lewis et al. 2016)

Board Buddy pilot participants were asked 3 AI questions:

Question 1.

Thinking about your board buddy meetings - can you describe a "peak experience" or "high point" during your board buddy meetings?

Question 2.

Imagine I had a conversation with your board buddy and asked them to share the three best qualities they see in you and the qualities that you bring to the PHA – what would they say and why are these qualities important to you?

Question 3.

If you think about the PHA operating at its best, where do you envision or see the PHA and the PHA Board five years from now?

HSC Public Health Agency

item 10

Title of Meeting	PHA Board Meeting
Date	19 January 2023
Title of paper	Board Performance Framework
Reference	PHA/03/01/23
Prepared by	Stephen Murray
Lead Director	Stephen Wilson
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to present the PHA Board Performance Framework to the Board for approval.

2 Background

One of the key recommendations from the PHA Performance Management Audit 2021/22 was for PHA board to agree a performance management framework that would define and formalise the PHA board performance management arrangements.

3 Summary

The attached Framework document sets out the current processes and management systems that are in place to provide PHA Board with assurance that the organisation is delivering effectively against the agreed strategic priorities and outcomes that have been set in the PHA Corporate Plan and against which specific actions have been agreed in the Annual Business Plan.

The Framework document has been reviewed by the PHA Planning, Performance and Resources Committee and approved by the Agency Management Team for consideration by PHA board.

4 Next Steps

Following approval by the Board the Framework will be reviewed on an annual basis.

PHA Board Performance Framework

1.0 Introduction

1.1 This Framework document sets out the current processes and management systems that are in place to provide PHA Board with assurance that the organisation is delivering effectively against the agreed strategic priorities and outcomes that have been set in the PHA Corporate Plan and against which specific actions have been agreed in the Annual Business Plan. It also identifies where there are opportunities to introduce new approaches that will improve the quality of information provided and take into account the new focus on assessing performance based on Outcomes Based Accountability (OBA) methodology.

1.2 It is important to highlight that further to the Covid Pandemic that started in 2020, some of the performance reporting systems previously in place were suspended, in agreement with the Department of Health (DoH), due to PHA operating in business continuity mode. This has resulted in some regular reporting systems in areas such as monitoring Commissioning Plan Directions targets and Making Life Better Strategy updates not being produced.

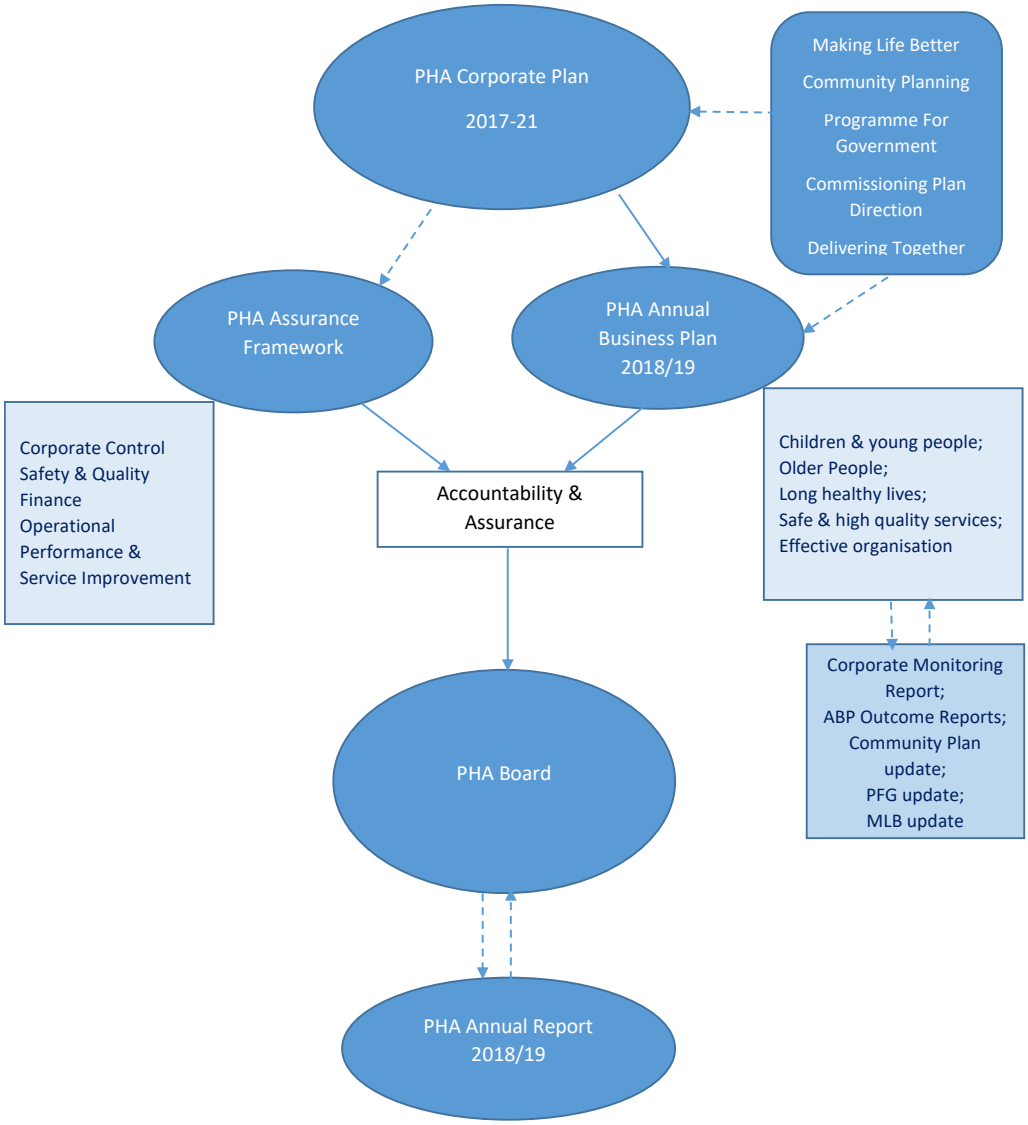
1.3 It is also important to recognise that the current processes and systems in place are likely to change and will need to be reviewed and e re-designed over the coming period in light of a number of key changes including:

- The on-going refresh and review of PHA
- the move towards an Integrated Care System (ICS) and the introduction of a new planning model
- the development of a new Strategic Outcomes Framework by DoH and the requirement to embed OBA methodology in how we report and measure progress
- the need to reflect a move toward multi-disciplinary working and the potential development of Strategic Planning Teams
- the closure of the Health and Social Care Board (HSCB) in April 2022 and the establishment of the new Strategic Planning and Performance Group (SPPG),

2.0 Corporate Governance Framework

2.1 When considering the specific processes and controls that are in place to monitor organisational performance in meeting agreed actions and targets, it is important to set this within the overall context of the Corporate Governance Framework that is in place and which provides PHA Board with assurance across the four performance and assurance dimensions of Corporate Control; Safety and Quality; Finance; and, Performance and Improvement. This is summarised in diagram 1 below.

PHA ACCOUNTABILITY AND REPORTING 2022/23



3.0 Corporate Planning Processes

3.1 The PHA sets its organisational priorities and associated actions and targets to be achieved through its Corporate Planning processes. These Plans are developed in line with DoH guidance as set out in the Management Statement.

3.2 The **Corporate Strategy** sets out the PHA's medium term (usually a 3-4 year period) direction and Goals / outcomes to be achieved, The strategy reflects the PHA's statutory duties and priorities set by the Minister. It sets out the purpose, vision and values of the organisation along with the specific priorities PHA should seek to progress over the following years.

3.3 The PHA **Annual Business Plan** (ABP) sets out how the goals / outcomes in the Corporate Strategy will be delivered in each year. It incorporates both organisational and service/programme delivery objectives and includes key targets and milestones for the year immediately ahead and shall be linked to budgeting information.

3.4 The PHA Corporate Strategy and the PHA Annual Business Plan are developed with the involvement of PHA board members and staff from all Directorates. Both documents are formally approved at a public board meeting.

4.0 Current Processes for Monitoring organisational Performance

4.1 Dimension 4 of the Assurance Framework - Operational Performance and Service Improvement – sets out the current reporting requirements that have been set by PHA board.

Performance Report (to include Commissioning Plan Directions (CPD) Targets)

4.2 The key mechanism for reporting on progress against the delivery of corporate outcomes and actions as set out in the ABP is via the Performance Monitoring report that is presented to PHA Board on a quarterly basis. This report provides PHA Board with an overview of the progress being made against the key individual actions and measurable targets set by the organisation and for which it has direct responsibility for achieving. A RAG rating assessment is provided, indicating where performance is not being achieved and outlining mitigating actions being taken to address any issues or to clarify why the action may not be achieved.

Commissioning Plan Directions Targets

4.3 In addition to the ABP actions and targets, the PHA is also accountable for the achievement of a number of long-term targets that have been set by the Minister in the CPD. Monitoring against these targets was suspended during the Covid pandemic but has recently been re-established. It is proposed that the PHA will provide an annual update report to PHA board on progress against the CPD targets and report by exception on a quarterly basis, in the Performance Report if there has been a significant change in the position, in year.

Procurement Plan Update

4.4 PHA board is to be provided with 6 monthly updates on progress with implementing the Procurement Plan. During the Covid Pandemic, all procurements were suspended, due to staff being re-deployed and no updates reports have been provided since March 2020. As business returns to normal, procurements are now being progressed by PHA staff.

Commissioning Plan

4.5 In line with DoH guidance, the Commissioning Plan 2019/20, has been rolled forward since April 2021 and therefore no updates have been presented to PHA board for approval. Once confirmation is provided by DoH on the process for agreeing commissioning priorities in 2023/24, PHA will engage with PHA board to

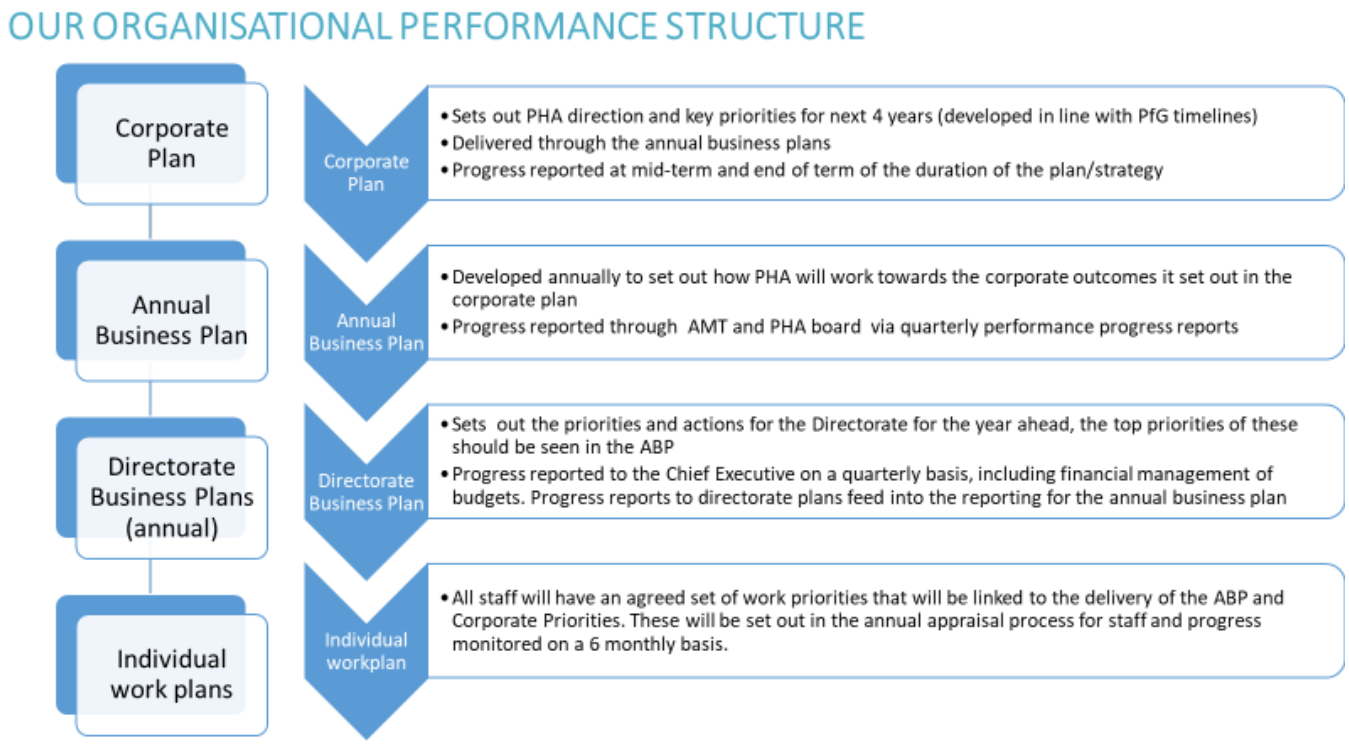
appropriately input to the process. DoH is currently in the process of revising the planning documentation, in line with the implementation of an ICS.

Programme Expenditure Monitoring System (PEMS)

4.6 The PEMS system provides a breakdown of how PHA allocates the programme funding that it has available to deliver on agreed Corporate priorities. A report from the PEMS system should be provided to PHA board on an annual basis. During Covid, the reports were suspended, as resources were being realigned.

5.0 PHA Management Systems for monitoring Performance

5.1 Internally within PHA, the CE has established a number of organisational management systems to ensure that the resources of the organisation are focused on achieving the corporate objectives and that performance against the achievement of these is appropriately managed throughout the organisation and reported through to PHA Board. A summary of the management processes in place is outlined in Diagram 2 below.



Directorate Business Plans

5.2 Each Directorate is required to produce a Directorate Business Plan that sets out in greater detail the particular actions that will be taken during the year to ensure that the agreed actions and targets in the ABP are being delivered and the staffing resources are focused on achieving these.

5.3 The Chief Executive and Director of Finance meet with Directors on a quarterly basis to review progress on delivering the actions set and to ensure that the financial resources available are being utilised effectively.

Individual Appraisals

5.4 Work priorities agreed in the annual individual performance reviews for staff should be linked to the delivery of the actions and targets that have been set in the ABP. Progress in meeting the individual actions agreed will be monitored on a bi-annual basis by managers.

6.0 Financial Planning and Performance Monitoring

6.1 Each year PHA will develop and agree a Financial Plan that sets out how the organisation will allocate the available funding to best met the organisational priorities and targets that have been set. It will also ensure that the organisation will achieve a financial breakeven position. The PHA Financial Plan will be approved by the board.

6.2 Monthly Finance reports are provided to PHA board providing an update on performance against the financial plan agreed, noting any significant variances or changes against planned spend, additional allocations received and any actions required to ensure a breakeven position will be achieved.

7.0 New Developments

Establishment of a Planning, Performance and Resource Committee

7.1 PHA board has agreed to the establishment of a new Planning, Performance and Resources Committee. The Terms of Reference for this Committee is attached as appendix 1.

It is intended that this new Committee will review the existing Performance Management arrangements that are in place and propose any new systems and processes required to ensure performance reporting is adequate to provide assurance, taking into account the changes outlined under 1.3.

Development of Strategic Planning Teams and Outcomes Frameworks

7.2 AMT has approved the piloting of Strategic Planning Teams (SPTs)

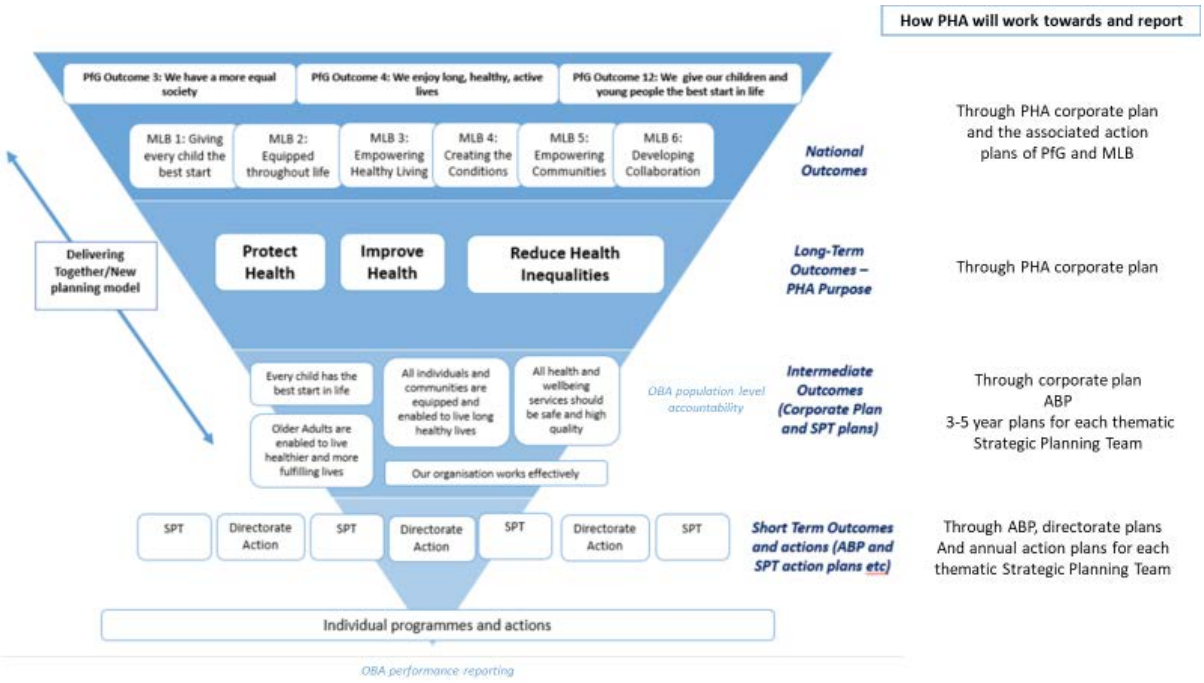
The aim of SPTs will be to:

- Develop the commissioning frameworks for key areas of work and ensure a population health approach and focus on health inequalities underpins all future plans
- ensure corporate oversight and performance accountability to AMT and PHA board in delivering against agreed outcomes,

- embed OBA approaches to demonstrate impact and progress in achieving outcomes
- ensure strategic priorities are agreed and available funding is targeted effectively

It is intended that each SPT will develop a outcomes-based planning and performance framework that will be monitored using OBA methodology and that regular update reports provided to AMT/PHA Board.

A summary of how the SPT approach will help to align strategic priorities is summarised below.



Appendix 1

PLANNING, PERFORMANCE & RESOURCES COMMITTEE

1.0 REMIT AND CONSTITUTION

1.1 Introduction

The Health and Social Care (Reform) Act (Northern Ireland) 2009 applies.

The PHA Board has a Governance and Audit Committee and a Remuneration and Terms of Service Committee. Under Standing Order 3.1.3 the PHA Board may establish other Committees as it deems appropriate.

1.2 Role

The primary responsibility of the Planning, Performance & Resources Committee is, in relation to the core functions of the Agency, to keep under review the financial position and performance against key non-financial targets of the Board, to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of all resources, and that Corporate/Business Planning arrangements are working effectively.

1.3 Terms of Reference

The main functions of the Committee are:

- To oversee the annual business planning process in accordance with DoH commissioning directives / Strategic Outcomes Framework;
- To monitor performance against annual business plan KPI's;
- To review the financial monitoring information in order to advise the board concerning the effective use of resources in-year;
- To review performance of key business supports /processes against SLA targets; (Human Resources / ITS / PALS);
- To undertake any other work delegated by the board.

The Terms of Reference for the Committee will be reviewed annually with an initial review taking place nine months after the establishment of the Committee.

1.4 Composition of the Planning, Performance and Resources Committee

The Committee shall comprise at least three Non-Executive Directors. If a member is not able to attend the PHA chair may appoint a deputy to attend in order to ensure that a quorum is achieved.

Senior staff in attendance will include the Director of Operations and the Director of Finance (or their deputies). The Chief Executive may attend at their own discretion. Other officers may be invited to attend as required.

A quorum shall be two Non-Executive Directors and one officer.

1.5 Establishment of the Planning, Performance and Resources Committee

The Committee shall be constituted as a Committee of the board but will not have the power to make decisions on behalf of the board of the Agency. Where appropriate it make recommendations to the board of the Agency. The Terms of Reference are to be approved by the board and recorded in the board minutes.

Committee meetings shall be conducted formally and minutes submitted to the board at its next meeting in accordance with the Policy set out in 5.2.21.

The Committee shall expect to meet at least four times per year. Agenda and briefing papers shall be prepared and circulated in sufficient time for members to give them due consideration.

2.0 CONDUCT OF BUSINESS

2.1 Attendance

Only the members of the Committee, the Director of Operations and the Director of Finance (or their deputies) shall attend meetings as a matter of course. Appropriate administrative support staff shall be in attendance to record the business of the meetings.

Other Executive or Non-Executive board Members and Officers may be invited to attend as required.

Any member of staff of the PHA may be required to attend a meeting of the Committee, as necessary.

The Committee Chair shall request fuller explanatory information in papers put before them, if there are any doubts or uncertainties and the issues discussed shall be summarised in the minutes.

The Assistant Director (Operations – Planning and Business Services) will be the lead officer to the Committee. The Corporate Secretariat shall service the Committee.

2.2 Agenda

Planning, Performance & Resources Committee meetings will include ‘conflict of interest’ as a standing item. In instances where there is a declaration of interest in any of the agenda items, members will be asked to leave the meeting while those items are being discussed. In instances where the conflict of interest is likely to be ongoing the member may be asked to stand down from the Performance Committee.

Items for ‘Any Other Business’ should formally be requested from the chair in advance of the meeting.

2.3 Frequency of Meetings

Routine meetings are to be held four times per year. Further meetings may be arranged at the discretion of the Chairperson, as necessary.

HSC Public Health Agency

item 12

Title of Meeting	PHA Board Meeting
Date	19 January 2023
Title of paper	Infectious Diseases in Pregnancy Screening Programme (IDPS) Annual Report 2018-2020
Reference	PHA/04/01/23
Prepared by	Lorna Hawe
Lead Director	Dr Joanne McClean
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Introduction

This Annual Report of the Northern Ireland Infectious Diseases in Pregnancy Screening (IDPS) Programme provides an overview of performance in relation to the UK national standards.[1] Performance data in relation to the screening offer, uptake and actions taken on receipt of positive/rubella susceptible results from 1st April 2018 to 31st March 2020 are detailed.

The programme is commissioned and quality assured by the Public Health Agency. Monitoring performance against nationally agreed standards for population screening programmes is part of the PHA's quality assurance function. Approval of the annual report by AMT is an important element of the governance of the programme.

2 Background

The IDPS Programme in Northern Ireland offers screening for: Human immunodeficiency virus (HIV); hepatitis B; syphilis; and rubella susceptibility.

The screening blood tests are routinely offered to pregnant women at the booking appointment, ideally by 10 weeks gestation, or at the earliest opportunity thereafter. The objective is to enable early identification of infections, allowing early intervention and reduction of the risk of mother to child transmission of the infection. Pregnant women identified as susceptible to rubella, with no documented evidence of two previous measles, mumps, and rubella (MMR) vaccinations are offered an MMR vaccination postnatally to prevent rubella infection in future pregnancies.

[1] https://www.gov.uk/government/publications/infectious-diseases-in-pregnancy-screening-programme-standards/infectious-diseases-in-pregnancy-screening-standards-valid-for-data-collected-from-1-april-2018

3 Summary of Performance

The report shows that for the period 2018-2020 Northern Ireland:

- Exceeded the achievable level for:
    - Standards 1-3 (in both years 2018-2020) for screening coverage for HIV, hepatitis B and syphilis.
    - Standard 4 (in 2019-2020) for test turnaround times of all samples (both positive and negative).
    - Standard 4 (in 2018-2019) for test turnaround times of confirmed screen positive HIV samples.
    - Standard 5 (in 2018-2019) for the review by maternity services of women confirmed screen positive for HIV and hepatitis B, within 10 working days.
    - Standard 5 (in 2019-2020) for the review by maternity services of women confirmed screen positive for HIV, hepatitis B and syphilis, within 10 working days
    - Standard 7 (in both years 2018-2020) for the vaccination of the babies at birth within 24 hours.

- Exceeded the acceptable level for:
    - Standard 4 (in 2018-2019) for test turnaround times for all samples (both positive and negative).
    - Standard 4 (in 2019-2020) for test turnaround times of confirmed screen positive HIV and hepatitis B samples.
    - Standard 6 (in 2018-2019) for the review by hepatology services of women testing positive for hepatitis B, within 6 weeks.

- Did not achieve an acceptable level in:
    - Standard 4 (in 2018-2019) for test turnaround times of confirmed screen positive hepatitis B and syphilis samples.
    - Standard 4 (in 2019-2020) for test turnaround times of confirmed screen positive syphilis samples.
    - Standard 5 (in 2018-2019) for the review by maternity services of women testing positive for syphilis, within 10 days (small numbers).
    - Standard 6 (in 2019-2020) for the review by hepatology services of women testing positive for hepatitis B, within 6 weeks.

This report provides evidence of a high level of programme performance against most of the national standards, whilst highlighting areas for improvement.

4 Next Steps

Following noting by the PHA Board the Report will be shared with relevant HSC Trust staff and published on the PHA website.

HSC Public Health Agency

Working together Excellence Openness & Honesty Compassion

Northern Ireland Infectious Diseases in Pregnancy Screening programme report

April 2018-
March 2020

Document Title	Northern Ireland Infectious Diseases in Pregnancy Screening Programme Performance Report April 2018 - March 2020
Author	**Lorna Hawe** - Regional Antenatal Infection Screening Programme Co-ordinator - Public Health Agency (PHA)
Owners	Northern Ireland Infectious Diseases in Pregnancy Screening Programme
Contributors	**Rachel Doherty**- Consultant in Public Health Agency responsible for the antenatal infectious diseases in pregnancy screening programme. **Jenny Gingles** - Locum Consultant in Public Health Agency responsible for the antenatal infectious diseases in pregnancy screening programme. **Sharon Rainey** - Transfusion Microbiology Laboratory Manager - Northern Ireland Blood Transfusion Service (NIBTS) **Alison Watt** - Consultant Virologist - Regional Virology laboratory (RVL) **Ruth Campbell** - Surveillance Officer - PHA **Trust Antenatal Screening Co-ordinators** **Roberta Carlisle** - Belfast Health and Social Care Trust (BHSCT) **Jenny Henderson** - South Eastern Health and Social Care Trust (SEHSCT) **Allison Wilson / Lorna Hawe** - Northern Health and Social Care Trust (NHSCT) **Kate Maxwell** - Southern Health and Social Care Trust (SHSCT) **Ceri Knobbs** - Western Health and Social Care Trust (WHSCT)
Approved by	Senior Management Team PHA on XXX

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1.0 Glossary

ANSC	Antenatal Screening Co-ordinator. There is an ANSC appointed in each of the five trusts across Northern Ireland who is responsible for co-ordinating the care of women screened positive for infection and their babies.
BHIVA	The British HIV Association is an organisation of healthcare professionals interested in the treatment and care of people with HIV.
BSO	The Business Services Organisation has been established to provide a broad range of regional business support functions and specialist professional services to the health and social care sector in Northern Ireland.
CBT	Cognitive behavioural therapy is types of talking therapy which can help people manage their problems by changing the way they think and behave. It's most commonly used to treat anxiety and depression, but can be useful for other mental and physical health problems. Women with needle phobias can benefit from this type of therapy.
HAART	Highly Active Antiretroviral Therapy is an aggressive treatment regimen used to suppress HIV viral replication and the progression of HIV disease. The usual HAART regime combines three or four different drugs.
HBeAg	The hepatitis e antigen, or HBeAg, is a marker of an actively replicating HBV virus infection. Those with a positive HBeAg have active replication in their liver cells i.e. more of the virus circulating in their blood and as a result they are more infectious, with a higher likelihood of transmitting HBV to others.
HBIG	Hepatitis B immunoglobulin is recommended as a post exposure prophylaxis for babies whose mothers are HBeAg positive and/or have a high hepatitis B viral load. It provides a temporarily induced immunity by the transfer of immunoglobulins.
HBV	Hepatitis B virus causes an infection in the liver. It can cause both acute and chronic infections.
HIV	Human immunodeficiency virus belongs to a group of viruses called retroviruses. HIV attacks the immune system leaving the infected person vulnerable to serious infections and cancers. HIV is present in blood, genital fluids and breast milk. One way of passing on the infection is from a mother to her baby during pregnancy, birth or through breast feeding.

IDPS	Infectious diseases in pregnancy screening programme - currently screens for HIV, hepatitis B, syphilis and rubella susceptibility in Northern Ireland.
MDT	Multidisciplinary team - obstetricians, ANSCs and the wider maternity team, GUM, hepatology, pharmacists and paediatricians all work together to ensure standards are achieved and women and their babies receive optimum care.
MMR	Measles, Mumps and Rubella vaccine.The MMR vaccine is a safe and effective combined vaccine. It protects against three serious illnesses: measles; mumps; rubella (German measles) These highly infectious conditions can easily spread between unvaccinated people. Rubella infection in early pregnancy can have serious implications for the baby.
MTCT	Mother to child transmission - also called perinatal or vertical transmission. It occurs when an infection is passed from a mother to her baby either during the antenatal period, intra-natal period or in the postnatal period through breastfeeding.
NIBTS	The Northern Ireland Blood Transfusion Service provides IDPS testing for women booked prior to twenty weeks gestation.
NICE	The National Institute for Health and Care Excellence - provides national guidance and advice to improve health and social care.
NIMATS	The Northern Ireland Maternity System is a web based electronic system used regionally to capture geographical and clinical data on pregnant women and their babies. This includes the offer and acceptance of screening tests and the test results.
PHA	The Public Health Agency is a multi-disciplinary, multi-professional body with a strong regional and local presence. It has four key functions: • Health and social wellbeing improvement. • Health protection. • Public health support to commissioning and policy development. • Health and social care research and development.
RVL	The Regional Virus Laboratory provides IDPS testing for women booked after twenty weeks gestation and also provide confirmatory testing for samples screened positive in the NIBTS.
TTT	Test turnaround time - the time from receipt of a blood sample in the laboratory until a result is reported. The National Standard states that the IDPS samples should be returned within 8 working days.
UKAS	United Kingdom accreditation service is the national accreditation body for the United Kingdom, appointed by government, to assess organisations that provide certification, testing, inspection and

	calibration services. Both the NIBTS and RVL laboratories are UKAS accredited.
WHO	The World Health Organisation’s primary role is to direct international health within the United Nations' system and to lead partners in global health responses.

Northern Ireland infectious diseases in pregnancy screening programme performance report.

1st April 2018 – 31st March 2020

2.0 Executive summary

This Annual Report of the Northern Ireland Infectious Diseases in Pregnancy Screening (IDPS) programme provides an overview of performance in relation to the UK national standards.[1] Performance data in relation to the screening offer, uptake and actions taken on receipt of positive/rubella susceptible results from 1st April 2018 to 31st March 2020 are outlined.

The programme is commissioned and quality assured by the Public Health Agency (PHA). Monitoring against nationally agreed standards for screening is an important element of quality assurance for the IDPS programme and allows those involved in its organisation and delivery to identify potential areas for improvement.

2.1 Background

The IDPS programme in Northern Ireland offers screening for: Human immunodeficiency virus (HIV); hepatitis B; syphilis; and rubella susceptibility.

In keeping with the National Institute for Health and Care Excellence (NICE) guidance,[2] the screening blood tests are routinely offered to pregnant women at the booking appointment, ideally by 10 weeks gestation or at the earliest opportunity thereafter where the woman presents to maternity services. The objective of the IDPS screening is to enable early identification of infections allowing early intervention and reduction of the risk of mother to child transmission (MTCT) of the infection. Pregnant women identified as susceptible to rubella with no documented evidence of two previous measles, mumps, and rubella (MMR) vaccinations are offered an MMR vaccination postnatally, prior to discharge from hospital, to prevent rubella infection in future pregnancies, and a second MMR if necessary by the GP at least 4 weeks later.

2.2 Headline results

Performance of the Northern Ireland IDPS programme between 1st April 2018 and 31st March 2020 against national standards is summarised below.

2.2.1 Standards 1-3: Identifying population and coverage

This standard measures the number of eligible pregnant women offered and accepting screening for HIV, hepatitis B, syphilis and rubella susceptibility and who have a confirmed result within the reporting period.

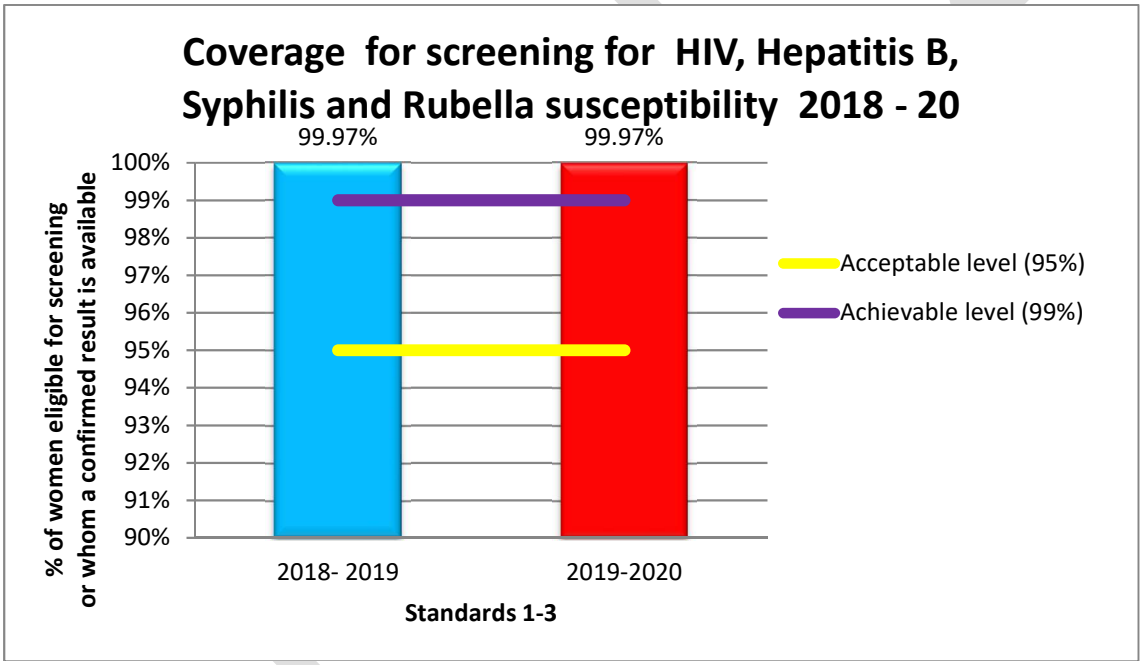
[1] https://www.gov.uk/government/publications/infectious-diseases-in-pregnancy-screening-programme-standards/infectious-diseases-in-pregnancy-screening-standards-valid-for-data-collected-from-1-april-2018
[2] www.nice.org.uk/guidance/cg62/chapter/appendix-d-antenatal-appointments-schedule-and-content

Table 1 and figure 1 below, show that Northern Ireland has achieved above the highest achievable level in this standard, with only a small number of women declining screening.

Table 1: Coverage: the proportion of women eligible for screening for whom a confirmed result is available at the end of the reporting period.

Year	Number of women screened	Percentage screened
2018-2019	23,123 / 23,131 (8 women declined screening)	99.97%
2019-2020	22,435 / 22,441 (6 women declined screening)	99.97%

Figure 1: Programme coverage 2018-20



2.2.2 Standard 4: Test turnaround time (TTT)

This standard measures the number of results for each infection (confirmed screen positive or negative) reported to maternity services within 8 working days of sample receipt in the laboratory.

The Northern Ireland Blood Transfusion Service (NIBTS) is United Kingdom Accreditation Service (UKAS) accredited and work to a standard of a 3-day turnaround time for all negative samples excluding samples where a repeat has been requested. Currently they cannot provide data for an 8-day turnaround for non - referred samples, however they can supply this data for screened positive samples referred from NIBTS to RVL for confirmation.

Data provided by the Regional Virology Laboratory (RVL) showed that they achieved 100% TTT for all late booking samples (defined as those taken after 20 weeks gestation) tested by them, both positive and negative. (Of note in early 2019 the late booking form was coded in order to allow data capture against this standard. Late booking data supplied by RVL for this report has not been included as the figures may be an underestimate.)

Table 2 below shows that Northern Ireland achieved the acceptable level of 95% for TTT of all HIV, hepatitis B and syphilis samples, positive and negative within 8 working days.

Table 2: Test turnaround time for all samples (both positive and negative) tested by NIBTS

	TTT all results positive and negative (% TTT <3 working days) *
2018-2019	22,196/22,949 (96.72%)
2019-2020	21, 709/22,277 (97.45%)

Source: NIBTS

*NIBTS work to a standard of a 3-day turnaround time. Currently they cannot provide data for an 8-day turnaround for non - referred samples

A review of the confirmed screen positive results separately see table 3 and figure 3 below demonstrate that: -

- 100% (above the achievable level of 97%) of samples confirmed screen positive for HIV in 2018-2019 had a TTT of within 8 working days and 95% (the acceptable level - 95%) in 2019-2020 had a TTT of within 8 working days.

- 87.5 % (below the acceptable level of 95%) of samples confirmed screen positive for hepatitis B in 2018-2019 had a TTT of within 8 working days and 96.2% (above the acceptable level of 95%) in 2019-2020 had a TTT of within 8 working days.

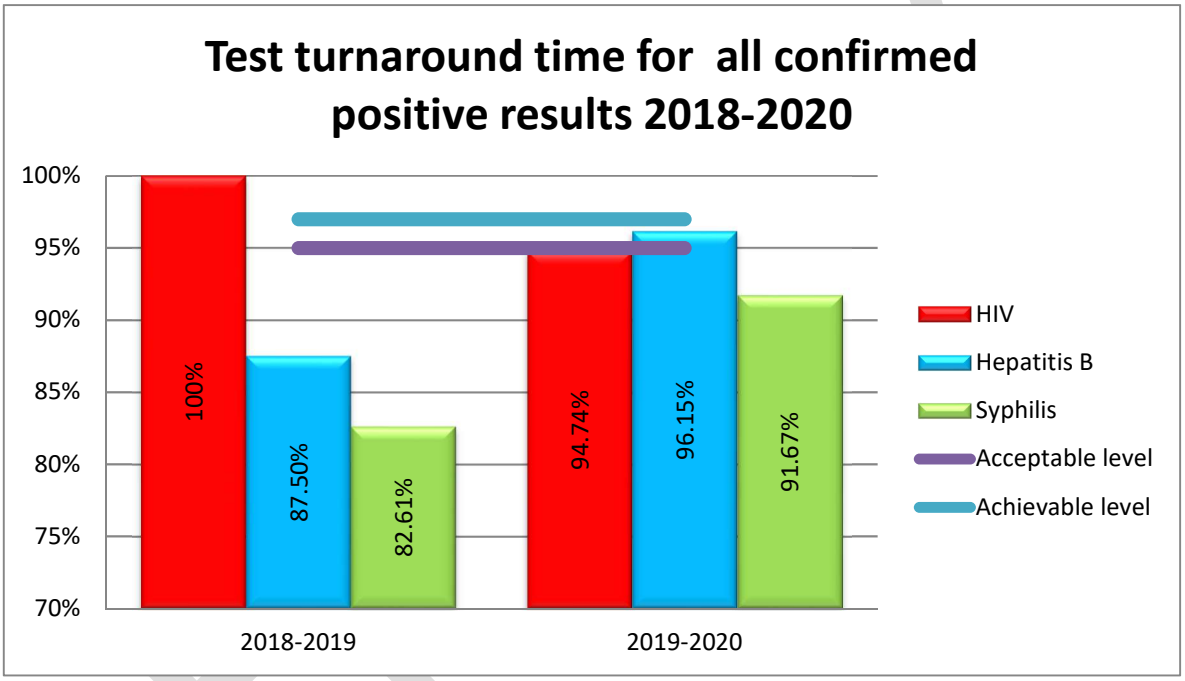
- 82.6% (below the acceptable level of 95%) of samples confirmed screen positive for syphilis in 2018-2019 had a TTT of within 8 working days and 91.7% (below the acceptable level of 95%) in 2019-2020 had a TTT of within 8 working days.

As the total numbers of samples here are relatively small (table 3), each sample's TTT has a bigger proportional impact on the collective performance against the standard.

Table 3: -Test turnaround time for samples confirmed screen positive

Test turnaround time for number (%) of confirmed screen positive samples reported within 8 working days from NIBTS / RVL	HIV	Hepatitis B	Syphilis
2018-2019	14/14 (100%)	28/32 (87.5%)	19/23 (82.6%)
2019-2020	18/19 (94.7%)	25/26 (96.2%)	11/12 (91.7%)

Figure 3: -Test turnaround time for confirmed screen positive samples



2.2.3 Standard 5: Timely assessment of women confirmed as screen positive.

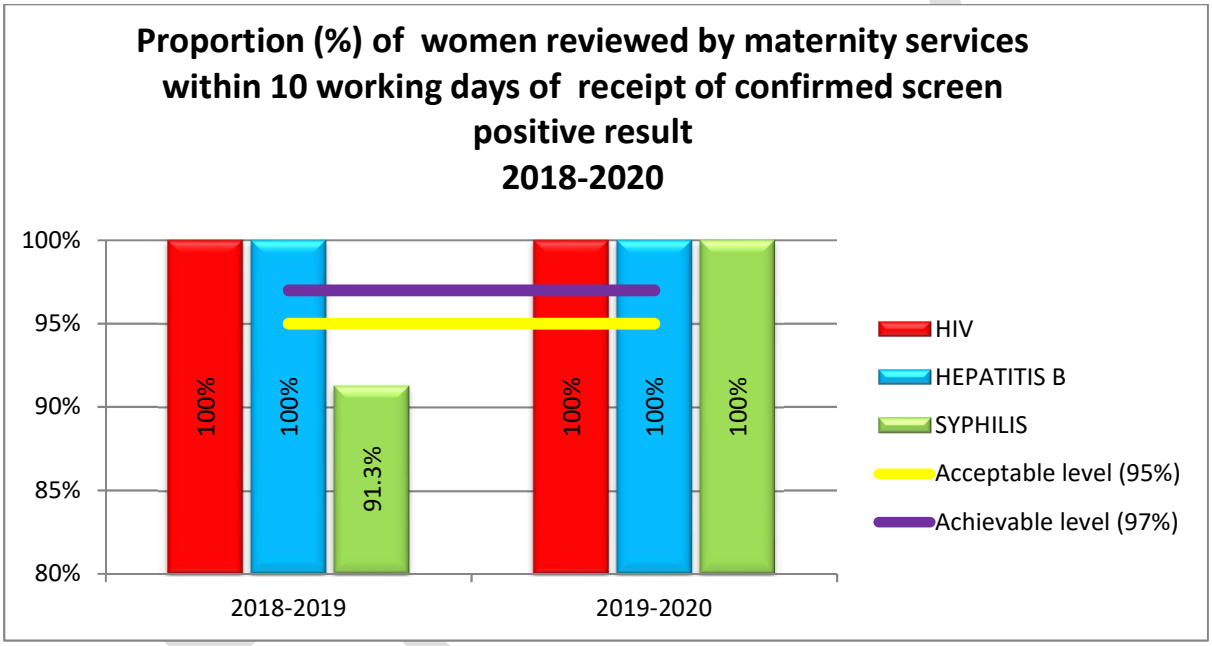
This standard measures the number of women with confirmed screen positive results for HIV, hepatitis B or syphilis who attended for a screening assessment appointment within 10 working days of the result receipt by maternity services.

Table 4 and figure 4 below demonstrate that Northern Ireland surpassed the achievable level for review of women testing positive for HIV and hepatitis B in both years, but in 2018-2019 fell under the acceptable level for the review of 2 women who tested positive for syphilis.
A review of these cases showed that all reasonable efforts had been made to arrange an appointment within the 10 days.

Table 4: Attendance at specialist maternity assessment

Number and proportion (%) of women confirmed as screen positive for infection, attending for assessment within 10 working days off result receipt.	HIV	Hepatitis B	Syphilis
2018-2019	14/14 (100%)	32/32 (100%)	21/23 (91.3%)
2019-2020	19/19 (100%)	26/26 (100%)	12/12 (100%)

Figure 4: Attendance at screening assessment appointment within 10 working days of receipt of confirmed screen positive result.



2.2.4 Standard 6: Diagnosis/intervention - Timely assessment of women with hepatitis B.

This standard measures the number of pregnant women who are confirmed as screen positive for hepatitis B positive attending for specialist assessment by a hepatologist within 6 weeks of the positive result being reported to the maternity service including:

- all women who are newly diagnosed hepatitis B positive.
- women already known to be hepatitis B positive with high infectivity markers detected in the current pregnancy.

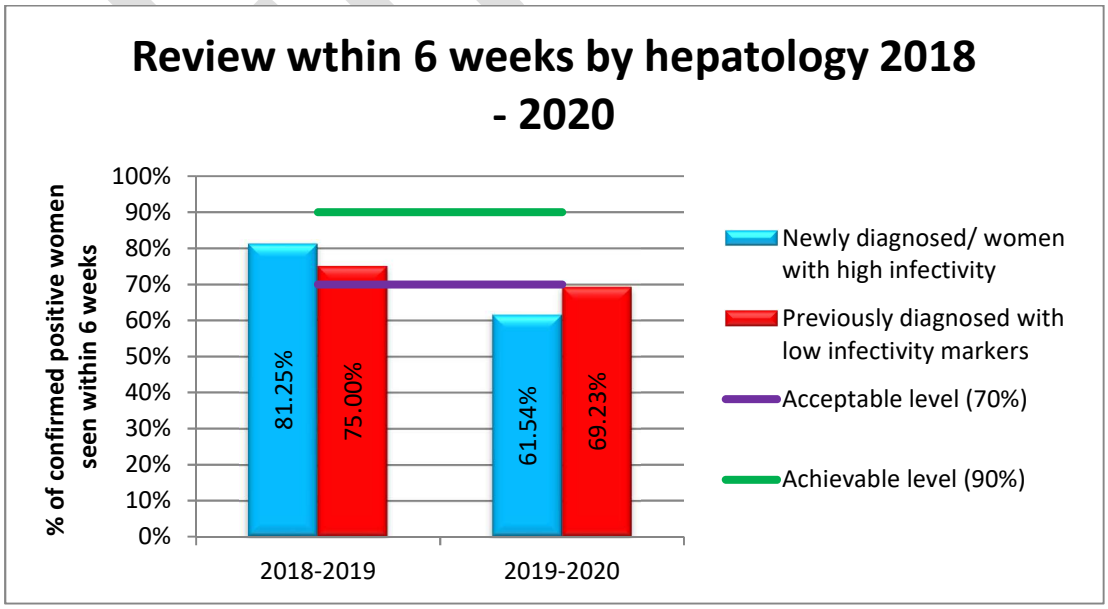
All women in Northern Ireland who are confirmed screen positive for hepatitis B are referred to hepatology even if previously known to have Hepatitis B. Although the national standard focuses on the timeliness of review by hepatology for women newly diagnosed or with high infectivity markers for hepatitis B, results for all women testing positive to hepatitis B are included in this report.

Table 5 and figure 5 below show that in 2018-2019 Northern Ireland achieved the acceptable level of 70% for all women, (either newly diagnosed or previously diagnosed), being reviewed within 6 weeks by hepatology. However, in 2019-2020 the acceptable level was not achieved for either those with new diagnosis/known diagnosis and high infectivity levels (61.5%) or for those who were previously diagnosed and had low infectivity markers (69.2%).
Review of the cases where the hepatology review exceeded 6 weeks showed that the reasons for not meeting the standard included service related and patient related factors. These included delayed appointment times, interpreting staff not available and non-attendance at appointments.

Table 5: Diagnosis / Intervention

Number (%) of women positive for hepatitis B seen by hepatology services within 6 weeks of receipt of result.	**2018-2019**	**2019-2020**
Eligible women, either with a new diagnosis of Hepatitis B or already known with high infectivity markers.	13/15 (86.67%)	8/13 (61.54%)
Eligible women testing positive for hepatitis B previously diagnosed and with low infectivity markers.	12/16 (75%)	9/13 (69.23%)

Figure 5: Diagnosis / Intervention



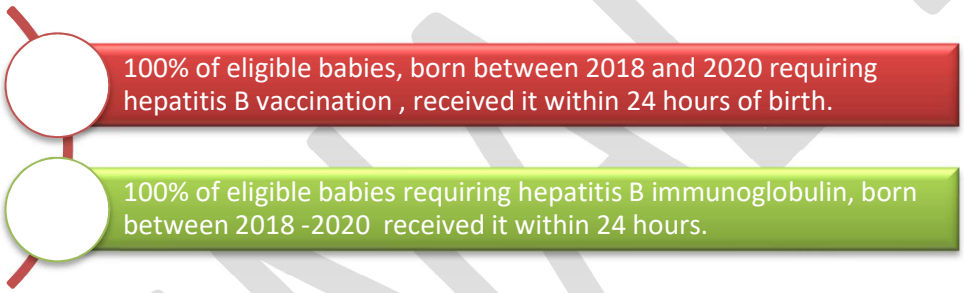
2.2.5 Standard 7: Intervention/treatment - Timely neonatal hepatitis B vaccination and immunoglobulin.

This standard measures the number of eligible babies born in the reporting period, to women with hepatitis B, receiving their first vaccination within 24 hours of birth and the percentage of eligible babies receiving the HBIG within 24 hours.

Table 6: Intervention/treatment of the neonate

Year	Number of eligible babies born receiving the hepatitis B vaccine within 24 hours of birth	Proportion of eligible babies receiving the HBIG within 24 hours.
2018-2019	35/35 (100%)	100%
2019-2020	27/27 (100%)	100%

Figure 6: -Intervention / treatment of the neonate



2.3 Conclusion

This report provides evidence of a very high level of programme performance against some standards, whilst also highlighting areas for improvement and recommendations have been made to progress against these. An audit of cases falling outside the acceptable standard levels should be reviewed in a regionally agreed process to improve performance against national standards and ensure accessibility of services for all women across Trusts and improvements in achievements against the National Standards. [1]

The national standard 4 relates to test turnaround times for reporting against all samples (both screen positive and negative). We have also specifically reviewed performance for the TTT of samples referred for confirmation from NIBTS- RVL and also all confirmed positive results, to identify potential delays which could impact upon timeliness of review and referral.

For the reporting period 2018-2020 Northern Ireland has: -

Exceeded the achievable (highest) levels in: -

- Standards 1-3 in both years 2018-2020 for screening coverage
- Standard 4 in 2019-2020 for TTT of all samples (both positive and negative)

- Standard 4 in 2018-2019 for the TTT of confirmed screen positive HIV samples.
- Standard 5 in 2018-2019 for the review by maternity services of women confirmed screen positive for HIV and hepatitis B, within 10 working days
- Standard 5 in 2019-2020 for the review by maternity services of women confirmed screen positive for HIV, hepatitis B and syphilis, within 10 working days
- Standard 7 for both years 2018-2020 for the vaccination of the babies at birth within 24 hours.

Exceeded the acceptable level in: -

- Standard 4 in 2018-2019 for the TTT for all samples (both positive and negative)
- Standard 4 in 2019-2020 for the TTT of confirmed screen positive HIV and hepatitis B samples.
- Standard 6 in 2018-2019 for the review by hepatology services of women testing positive for hepatitis B, within 6 weeks

Did not achieve an acceptable level in: -

- Standard 4 in 2018-2019 for the TTT of confirmed screen positive hepatitis B and syphilis samples.
- Standard 4 in 2019-2020 for the TTT of confirmed screen positive syphilis samples.
- Standard 5 in 2018-2019 for the review by maternity services of women testing positive for syphilis, within 10 days
- Standard 6 in 2019-2020 for the review by hepatology services of women testing positive for hepatitis B, within 6 weeks

3.0 Introduction

The Northern Ireland IDPS programme offers screening to all eligible pregnant women for HIV, hepatitis B and syphilis infections and for susceptibility to rubella infection. Achievement against National Standards 1, 2, 3 and 6 are the agreed Key Performance Indicators (KPI) for Northern Ireland currently.

This report provides an overview of the IDPS programme in Northern Ireland for the year from 1st April 2018 to 31st March 2020, including performance data in relation to National standards.

3.1 Aims of the screening programme

- To ensure that all eligible pregnant women in Northern Ireland are offered and recommended screening for HIV, syphilis and hepatitis B infections and rubella susceptibility.

- To ensure that high quality up to date information on infection screening in pregnancy is given to all eligible women, in the appropriate easy to understand

language, to enable them to make an informed choice about their screening options.[3]

- To ensure early detection and treatment of HIV and syphilis infection in pregnancy in order to significantly reduce the risk of MTCT during pregnancy, at birth or postnatally.
- To ensure early detection of hepatitis B in pregnancy so that onward referral to specialist services can happen in a timely manner and treatment commenced if necessary to reduce the risk of MTCT.
- To ensure that babies born to mothers screened positive for hepatitis B are vaccinated within 24 hours of birth and hepatitis B immunoglobulin (HBIG) given if necessary.
- To ensure that rubella susceptible mothers are adequately informed that they should avoid rubella contact in pregnancy and that they are offered MMR vaccination postnatally unless they have been previously adequately vaccinated, in order to protect against rubella infection in future pregnancies.

3.2 Rationale for the screening programme.

3.2.1 HIV

HIV infection can be transmitted from an infected mother to her baby during pregnancy, at the time of birth or by breast feeding. The risk of transmission in the absence of intervention ranges from 15 - 45%.[4] The risk of MTCT of HIV can be reduced to less than 5% through appropriate interventions. Screening in pregnancy aims to identify HIV infected mothers and, with early treatment and management, reduce the risk of MTCT.

Currently the World Health Organisation (WHO)[5] and the British HIV Association (BHIVA)[6] recommend that all pregnant women should be commenced on Highly Active Antiretroviral Therapy (HAART) as soon as possible after diagnosis, in the second trimester (or earlier if the viral load is very high) and that they should continue on the treatment for life. Correct management of the mother following diagnosis in pregnancy, and of the baby following delivery, is imperative in order to prevent MTCT. Breastfeeding is still not recommended for affected women.

Care is provided by a multidisciplinary team (MDT) encompassing obstetricians, ANSCs and the wider maternity team, genito-urinary medicine (GUM) consultants and their teams, neonatologists, paediatric infectious disease specialists and pharmacists. At the time of this report the majority of HIV positive pregnant women

[3] https://www.publichealth.hscni.net/sites/default/files/2019-06/ante%20natal%20blood%20screening%202019%20Final.pdf
[4] http://www.who.int/hiv/topics/mtct/about/en/
[5] http://apps.who.int/iris/bitstream/handle/10665/186275/9789241509565_eng.pdf;jsessionid=8DF7A3839376199A6F5DFA2034A31FC1?sequence=1
[6] https://www.bhiva.org/pregnancy-guidelines

were being delivered in the BHSCT. However, in cases where a woman has requested to deliver in her own Trust, this has been facilitated.

3.2.2 Hepatitis B

Hepatitis B infection in a baby can occur at or around the time of birth (perinatal transmission). Babies acquiring infection at this time have a high risk of becoming chronically infected with the virus (carriers). As well as being infectious to others, they are at increased risk of developing chronic liver disease and some will die prematurely from cirrhosis or hepatocellular (liver) cancer. The development of the carrier state after perinatal transmission can be prevented in over 90% of cases by appropriate vaccination, starting within four hours of birth.[7]

3.2.3 Syphilis

Syphilis infection readily crosses the placenta and may be transmitted to the foetus at any stage of pregnancy. The risk of transmission varies with syphilis stage and is greatest in early disease. Infection during pregnancy can result in miscarriage, stillbirth or congenital syphilis. Maternal infection is detectable and treatable so, with early detection in pregnancy, transmission to the baby can be prevented. See attached guidelines for management of syphilis in pregnancy.[8] [9]
Babies born with congenital syphilis may have an early manifestation of the disease (within the first two years of life) or a later manifestation (after two years of life), including stigmata of congenital syphilis.

3.2.4 Rubella

Rubella is generally a mild disease caused by a togavirus. However, rubella during pregnancy can be serious, especially in early pregnancy, as infection may cause abnormalities in the unborn baby known as congenital rubella syndrome (CRS). These can include mental impairment, cataract, deafness, cardiac abnormalities, intra–uterine growth retardation and inflammatory lesions of the brain, liver, lungs and bone marrow.[10]

Screening maternal blood for rubella susceptibility allows identification of rubella susceptible women who can then be advised to avoid rubella contact in pregnancy and can be offered the Measles, Mumps and Rubella (MMR) vaccination after delivery. Of note, vaccination during the current pregnancy is not possible given that MMR, is contraindicated during pregnancy.[11] Giving MMR postnatally provides protection against rubella in future pregnancies.

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[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/628602/Greenbook_chapter__18.pdf

[8] https://www.bashhguidelines.org/media/1053/syphilis-2015.pdf

[9] http://www.publichealth.hscni.net/sites/default/files/Regional%20syphilis%20guidelines.pdf

[10] https://www.gov.uk/government/publications/vaccine-in-pregnancy-advice-for-pregnant-women/mmr-measles-mumps-rubella-vaccine-advice-for-pregnant-women

[11] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/147968/Green-Book-Chapter-21-v2_0.pdf

As per the Green Book Chapter 28 [12] "All seronegative women of childbearing age who need to be protected against rubella should be offered MMR vaccine. Satisfactory evidence of protection would include documentation of having received two doses of rubella-containing vaccine or a positive antibody test for rubella."

In May 2018 the NIMATS antenatal and postnatal letters were revised to reflect the fact that if a mother had documented evidence of having received two previous MMR vaccinations that she should be adequately protected against rubella and would not require any further MMR vaccinations regardless of her rubella screening test result.

Women screened susceptible to rubella without evidence of two previous MMR vaccinations are still offered the MMR vaccination postnatally before discharge from hospital, with their GP giving the second one, if necessary, at least 4-6 weeks later.

3.2.5 Positive results

For HIV and hepatitis B results, all confirmed screen positive results are counted even for women previously known to be positive.

It should also be noted that a confirmed screen positive result for syphilis will reflect all stages of disease, as well as a previous infection that has been successfully treated. Further diagnostic testing and clinical assessment is required to ascertain the stage of infection and whether treatment is required.

All screening blood samples taken before 20 weeks gestation are sent to NIBTS for testing and if the initial screening result is positive the sample is sent to RVL for a confirmatory test.
In the event of an initial screen positive result on the first testing assay, which is not then confirmed as screen positive in the second confirmatory test, the result will appear on the mismatch report and the ANSC will review and counsel the woman and arrange a repeat test in 3-4 weeks' time.

- If this results in a negative screen this will be classified as a false positive result and no further action will be required unless risk factors are identified.

- If the repeat result is positive the normal process for a confirmed screen positive screening result will be followed.

- If the repeat sample is also inconclusive then advice and/or referral should be sought from the infectious disease clinicians for future management.[13]

[12] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/148498/Green-Book-Chapter-28-v2_0.pdf

[13] NHS Infectious Diseases in Pregnancy Screening Programme Laboratory Handbook 2016 to 2017 (publishing.service.gov.uk)

All screening blood samples taken ≥ 20 weeks gestation are sent directly to RVL using the late booking form.[14] If the initial screening result is positive a confirmatory test will be performed in RVL using a different testing assay.

4.0 IDPS programme delivery

IDPS is a complex programme involving a wide range of professionals working in maternity units, laboratories, pharmacy, hepatology, genito-urinary medicine, neonatology and paediatric services. Along with the PHA, these partner organisations work closely together to ensure that pregnant women have access to safe, effective, high quality and equitable screening.

Screening tests for HIV, hepatitis B and syphilis infections and rubella susceptibility are routinely offered to all pregnant women at the maternity booking appointment, or at the earliest opportunity when a pregnant woman presents to maternity services. A blood sample is taken by a health professional, usually a midwife or maternity support worker.
The lead ANSC in each Trust, with support from at least one deputy ANSC, oversees the screening programme and ensures that positive results are followed up and appropriate referrals made. The lead/deputy ANSC arrangement ensures that essential duties are addressed continually e.g. if the lead ANSC is absent.

At a regional level, within the PHA, there is a regional antenatal infection screening programme co-ordinator and a consultant in public health who oversee quality assurance of the programme.

4.1 Failsafes

A failsafe is a backup mechanism, in addition to usual care, which ensures that if something does not go according to plan in the screening pathway, processes are in place to identify what has happened and thereafter action is taken to ensure a safe outcome.
Failsafe processes minimise the risks in the screening pathways used by population screening programmes. There are a number of failsafe processes within the IDPS programme in Northern Ireland.

4.1.1 The failsafe report

A failsafe is operational in each Trust to identify pregnant women who have not completed the antenatal infection screening (AIS) including rubella susceptibility. The failsafe report is produced electronically from the Northern Ireland Maternity System (NIMATS) on a weekly basis and is sent from Business Services Organisation (BSO) to the Trust ANSCs or their deputy for review and appropriate action. It identifies all women booked for care where:

- The screening bloods have not been initiated on NIMATS

[14] http://www.rvl-belfast.hscni.net/wp-content/uploads/2020/07/Antenatal-Screening-Request-form-M-1872-v2.pdf

- They have declined the AIS tests
- Results from the AIS tests are missing >14 days from the booking date

4.1.2 The mismatch report

Since the establishment of an electronic link between NIMATS and the NIBTS IT system, a “mismatch report” is now available on NIMATS. This report highlights all:

- Positive results
- Rubella susceptible results
- Rhesus negative blood group results and any positive antibody screens
- Rejected tests which need repeated
- Results where there is no Health and Care (H&C) number for the mother
- Results where the details on NIMATS do not match those on NIBTS
- Tests that have not been initiated on NIMATS and therefore cannot cross the systems electronically

This allows the ANSCs or their deputies to identify the above women and take appropriate action to ensure that these women are followed up in a timely manner.

4.1.3 Generic email accounts

Generic email accounts have been set up for all Trust antenatal screening teams, so that when a positive result for HIV, hepatitis B or syphilis is identified in either NIBTS or RVL, a secure email is sent to these email addresses alerting the ANSC or their deputy of the positive result and the need for action to be taken.

4.2 Programme developments

The key developments within the IDPS programme during 2018- 2020 include: -

- In April 2018 the antenatal and postnatal NIMATS letters were changed to reflect the fact that a previous history of two MMR vaccinations should be sufficient to provide immunity against rubella. Women testing susceptible to rubella were encouraged to obtain their MMR vaccination history prior to delivery so that they wouldn’t need any further MMR vaccinations and the GPs were advised further MMR vaccinations were not required if they had evidence of two previous MMR vaccinations on their system.
- The RVL late booking form was revised in March 2019 to include a code to enable accurate late booking data to be collected in the future.

5.0 Programme standards and performance

Public Health England (PHE) published revised standards for the Infectious Diseases in Pregnancy Screening Programme for data collected from April 2018.[15]

Table 6: Northern Ireland performances against National IDPS programme standards April 2018 – March 2020

Northern Ireland Performance Against National Standards for Antenatal Infectious Disease Screening Programme, April 2018 - March 2020				
	Standard	**Northern Ireland 2018/2019**	**Northern Ireland 2019/2020**	**England[16] 2018/2019**
1-3	**Coverage: -** The total number of pregnant women booked for antenatal care during the reporting period, or presenting in labour, without previously having booked for antenatal care, for whom a confirmed screening result was available for HIV, hepatitis B or syphilis. Excluding women who: • miscarry between booking and testing • opt for termination between booking and testing • transfer out between booking and testing (do not have a result) • transfer in who have a result from a screening test performed elsewhere in the NHS in this pregnancy **Acceptable level** ≥ 95.0% **Achievable level** ≥ 99.0%	23,123 / 23,131 (99.97%)	22,435 / 22,441 99.97%	99.7%

[15] https://www.gov.uk/government/publications/infectious-diseases-in-pregnancy-screening-programme-standards/infectious-diseases-in-pregnancy-screening-standards-valid-for-data-collected-from-1-april-2018

[16] https://www.gov.uk/government/statistics/antenatal-screening-standards-data-report-2018-to-2019/antenatal-screening-standards-data-report-1-april-2018-to-31-march-2019--2

	Standard	Northern Ireland 2018/2019	Northern Ireland 2019/2020	England 2018/2019
4	**Test turnaround times: HIV, hepatitis B, syphilis: -** The number of results for each infection (confirmed positive or negative) reported to maternity services ≤ 8 working days of sample receipt in the laboratory, excluding samples received that are not fit for analysis and a repeat sample is requested from the screening team. (NIBTS data is reported as a 3-day turnaround). **Acceptable level** ≥ 95.0% **Achievable level** ≥ 97.0%	**NIBTS: -** 22,196/22,949 (96.72%) RVL: - 249 / 249 (100%) **Confirmed screen positive samples: -** HIV: - 14/14 (100%) Hepatitis B: - 28/32 (87.5%) Syphilis: - 19/23 (82.6%)	**NIBTS: -** 21,709 / 22,277 (97.45%) RVL: - 640 / 640 (100%) **Confirmed screen positive samples: -** HIV: - 18/19 (94.74%) Hepatitis B: - 25/26 (96.15%) Syphilis:- 11/12 (91.67%)	99.3%
5	**Referral: timely assessment of screen positive and known positive women:-** The number of women with confirmed positive results for HIV, hepatitis B or syphilis who attend a screening assessment appointment ≤ 10 working days of result receipt by maternity services. **Acceptable level** ≥ 95.0% **Achievable level** ≥ 99.0%	**HIV** 14/14 (100%) **Hep B** 32/32 (100%) **Syphilis** 21/23 (91.3%)	**HIV** 19/19 (100%) **Hep B** 26/26 (100%) **Syphilis** 12/12 (100%)	**HIV** 89.3% **Hep B** 80% **Syphilis** 81.2%

	Standard	Northern Ireland 2018/2019	Northern Ireland 2019/2020	England 2018/2019
6	**Diagnosis/intervention: timely assessment of women with hepatitis B:-** the number of eligible pregnant women with hepatitis B who are booked in the reporting period, who have been seen by a hepatologist within 6 weeks, including:- • all women who are newly diagnosed with hepatitis B. • women already known to have hepatitis B with high infectivity markers detected in the current pregnancy, with high infectivity as defined as:- ➢ HBsAg positive and HBeAg positive ➢ HBsAg positive, HBeAg negative and anti-HBe negative ➢ HBsAg positive where e-markers have not been determined ➢ having acute hepatitis B during pregnancy ➢ HBsAg seropositive and known to have an HBV DNA level equal or above 1x10^{6}IUs/ml in an antenatal sample **Acceptable level** ≥ 70.0% **Achievable level** ≥ 90.0%	13/16 (81.25%)	8/13 (61.54%)	86.2%
7	**Intervention/treatment: timely neonatal hepatitis B vaccination and immunoglobulin: -** The number or percentage of babies born in the reporting period to women with hepatitis B receiving first dose of vaccination +/- immunoglobulin within 24 hours of birth. (Due to small number data this is only reported as a percentage). **Acceptable level** ≥ 97% **Achievable level** ≥ 99%	35/35 (100%) of eligible babies received their Hep B vaccination . 100% of babies requiring HBIG received it.	27/27 (100%) of eligible babies received their Hep B vaccination . 100% babies requiring HBIG received it.	98.9% 96.6%

6.0 Coverage data for all infections.

All women whether they are known to be positive for HIV, hepatitis B or syphilis are offered screening in each pregnancy.

In Northern Ireland there is no difference in the acceptance of testing for HIV, hepatitis B, syphilis or rubella. Data from 2018-2020 shows that women, who declined screening, declined all the tests- see below. Over the last two years the number of eligible women who were offered and accepted screening for HIV, hepatitis B, syphilis or rubella susceptibility, and had a reported result within the reporting period, has remained consistently high with only a small number of people declining screening.

2018/2019 coverage data

- 23,123 / 23,131 (99.97%) of eligible women were screened for all four infections
- 8 women declined screening for all four infections

2019/2020 coverage data

- 22,435 / 22,441 (99.97%) of eligible women were screened for all four infections
- 6 women declined screening for all four infections

7.0 HIV performance data

7.1 HIV confirmed screen positive samples

2018-2019

- 14 women were confirmed screen positive for HIV infection during 2018/2019
- 13/14(93%) women with a confirmed screen positive samples for HIV were women previously known to have HIV.

2019-2020

- 19 women were confirmed screen positive for HIV infection during 2019/2020
- 16/19 (84%) women with a confirmed screen positive samples for HIV were women previously known to have HIV.

7.2 Test Turnaround Time for all screen positive HIV samples referred from NIBTS to RVL for confirmation

2018/2019

- 29/34 (85.29%) of samples initially screened positive in NIBTS and referred to RVL for confirmatory testing had a TTT of within 8 working days
- The median TTT for all referred samples was 9 working days (range 3-11 working days)

2019/2020

- 40/43 (93.02%) of samples initially screened positive in NIBTS referred to RVL for confirmation had a TTT of within 8 working days
- The median TTT for all referred samples was 6 working days (range 3-10 working days)

7.3 Test Turnaround Time for samples confirmed screen positive for HIV.

2018/2019

- 14/14 (100%) of confirmed screen positive for HIV results were reported to maternity services within 8 working days.
- The median TTT for samples confirmed screen positive for HIV was 5 working days (range 3-8 days)

2019/2020

- 18/19 (94.74%) of confirmed HIV positive results were reported to maternity services within 8 working days.
- The median TTT for samples confirmed screen positive for HIV was 4working days (range 3-9 days)

7.4 HIV referral: timely assessment of women who screen positive for HIV

During 2018 - 2020 100% of women confirmed screen positive for HIV were seen by maternity services for initial assessment within 10 working days from receipt of a positive result. This exceeds the achievable level standard of 97% and compares favorably with performance in England in 2018-2019 (89.3%).

8.0 Hepatitis B performance data.

8.1 Hepatitis B confirmed screen positive samples.

2018/2019

- 32 women in total were confirmed screen positive for hepatitis B infection.
- There were 8 late booking samples (>20 weeks gestation) tested and confirmed positive in RVL.
- 16/32 (50%) women with a confirmed screen positive hepatitis B sample were women who were newly diagnosed and/or women who had high infectivity markers.

2019/2020

- 26 women in total were confirmed screen positive for hepatitis B infection.
- There were 5 late booking samples (>20 weeks gestation) confirmed positive in RVL.
- 13/26 (50%) women who were confirmed screen positive were either newly diagnosed and/or women who had high infectivity markers.

8.2 Test Turnaround Time for all screen positive hepatitis B samples referred to RVL for confirmation.

2018/2019

- 53/58 (91.38%) of samples initially screened positive in NIBTS and referred to RVL for confirmatory testing were turned around within 8 working days.
- Median TTT for all referred samples was 6 working days (range 2-10 working days)

2019/2020

- 54/56(96.43%) of samples initially screened positive in NIBTS and referred to RVL for confirmatory testing were turned around within 8 working days.
- Median TTT for all referred samples was 5 working days (range 2-11 working days)

8.3 Test Turnaround Time for confirmed screen positive hepatitis B samples.

2018/2019

- 24/58 referred samples were confirmed as screen positive for hepatitis B by RVL
- 20/24 (83%) had a TTT of within 8 working days.

- The median TTT for samples confirmed as screen positive for hepatitis B was 6 working days (range 2-10 working days)

2019/2020

- 20/56 referred samples were confirmed as screen positive for hepatitis B by RVL
- 19/20 (95%) had a TTT of within 8 working days.
- The median TTT for samples confirmed as screen positive for hepatitis B was 6 working days range (3-11 days)

8.4 Hepatitis B referral: timely assessment by maternity services of women who screen positive for hepatitis B.

During 2018-2020 all women (100%) confirmed as screen positive for hepatitis B were seen by maternity services for initial assessment within the standard of 10 working days from receipt of the positive result. This is an improvement from 80% in 2017-18 and compares favorably with performance in England during 2018-2019 (80%).

8.5 Diagnosis/intervention: timely assessment by hepatology of women who screen positive for hepatitis B.

All women in N Ireland who are confirmed as screen positive for hepatitis B are referred to hepatology, even if previously known to be positive for the condition. In relation to referral to specialist services, the national standard focuses on the timeliness of review by hepatology for newly diagnosed women or women previously known to have hepatitis B if they have high infectivity markers for hepatitis B. However, within this report data is included for all women confirmed as screen positive for hep B.

2018/2019

- 13/16(81.25%) of eligible women newly diagnosed or women with high infectivity markers in Northern Ireland were seen by hepatology within 6 weeks
- 12/16(75%) of eligible women confirmed as screen positive for hepatitis B, previously diagnosed and who have low infectivity markers, were seen within 6 weeks

2019/2020

- 8/13 (61.54%) of women newly diagnosed in Northern Ireland or women with high infectivity markers were seen by hepatology within 6 weeks.

- 9/13 (69.23%) of eligible women confirmed as screen positive for hepatitis B, previously diagnosed and who have low infectivity markers, were seen within 6 weeks.

Performance in this area in 2019/2020 did not meet the acceptable standard of 70%. Review of the cases that didn't meet the standard showed there were a range of service and patient related factors for not meeting the 6 week review. These included delayed appointment times (4 cases), interpreters not being available (2 cases), and non-attendance at appointments (4 cases).

8.6 Vaccination of babies at birth.

The PHA Health Protection Service monitors vaccine coverage for the neonatal hepatitis B vaccination programme for infants born to hepatitis B positive mothers.

2018/2019

- 35/35 (100%) eligible babies born to women who tested positive for hepatitis B received a first dose of monovalent hepatitis B vaccine within 24 hours of birth.

- 100% of those babies who also required the hepatitis B immunoglobulin (HBIG) at birth received it within 24 hours.

2019/2020

- 29/29 (100%) eligible babies born to women who tested positive for hepatitis B received a first dose of monovalent hepatitis B vaccine within 24 hours of birth.

- 100% of those babies who also required the hepatitis B immunoglobulin (HBIG) at birth received it within 24 hours.

8.7 Follow on vaccinations of babies after discharge.

Coverage of hepatitis B vaccine is measured at 12 months and 24 months.

2018/2019

- In 2018/2019(12-month age birth cohort Apr 2017- Mar 2018), 96.0% of babies born to mothers testing positive for hepatitis B, received a hepatitis B containing vaccine. Depending on when they were born they were given it under 2 different schedules, so received either three or five doses of hepatitis B vaccine by 12 months.

- In 2018/2019 (birth cohort April 2016 - Mar 2017), 92.0% of babies born to mothers testing positive for hepatitis B received four doses of hepatitis B vaccine by 24 months.

2019/2020

- In 2019/2020(birth cohort April 2017 - Mar 2018), 76.0% of babies born to mothers testing positive for hepatitis B received a hepatitis B containing vaccine. Depending on when they were born, they received it under 2 different schedules and would have received either four or six doses of hepatitis B vaccine by 24 months.

- In 2019/2020(12-month age birth cohort Apr 2018 - Mar 2019), 82.9% of babies born to mothers testing positive for hepatitis B, received five doses of hepatitis B vaccine (either monovalent or hexavalent) by 12 months.

9.0 Syphilis performance data.

9.1 Syphilis confirmed screen positive samples.

2018/2019

- 23 samples in total were confirmed as screen positive for syphilis infection

- 6 of these were late booking samples taken >20 wks gestation and tested in RVL

- 13/23 (56.52%) of the women were known to have a previous syphilis infection

2019/2020

- 12 samples in total were confirmed as screen positive for syphilis infection

- 10/12 (83.33%) of the women were known to have a previous syphilis infection

9.2 Test turnaround time for screen positive syphilis samples referred to RVL for confirmation.

2018/2019

- 34/41 (82.93%) of samples initially screened positive for syphilis in NIBTS and referred from NIBTS to the RVL for confirmatory testing had a TTT of within 8 working days of receipt.

- The median TTT for all referred syphilis samples was 7 working days (range 4-10 working days)

2019/2020

- 25/26 (96.15%) of samples initially screened positive for syphilis in NIBTS and referred to the RVL for confirmatory testing had a TTT of within 8 working days of receipt

- The median TTT was 5 working days (range 3- 10 working days).

9.3 Test turnaround time for confirmed positive syphilis samples

2018/2019

- 13/17 (77%) of confirmed screen positive syphilis samples tested in NIBTS had a TTT of within 8 working days
- The median TTT for samples confirmed as screen positive for syphilis was 8 days (working days range 5-10)

2019/2020

- 9/10 (90%) of confirmed screen positive syphilis samples tested in NIBTS had a TTT of within 8 working days

- The median TTT for samples confirmed as screen positive for syphilis was 6 working days (range 4-10)

9.4 Syphilis -Time to intervention.

2018/2019

21/23 (91.30%) of women confirmed as screen positive for syphilis were seen by maternity services within 10 working days of the result being received by maternity services. A review of women who were confirmed as screen positive for syphilis and did not meet the 10-day standard showed that all efforts were made to arrange an appointment within the 10 days, but due to patient related factors this was not possible.

2019/2020

12/12 (100%) of women confirmed as screen positive for syphilis were seen by maternity services within 10 working days of the result being received by maternity services.

9.5 Rubella performance data

The proportion of women identified as susceptible to rubella in both years was 21% and although steps were taken to try to encourage women to present their MMR vaccination history to avoid further vaccinations, anecdotal evidence suggests that this did not happen often. The regional annual audit of the offer and uptake of MMR postnatally revealed that only 66 - 68% of women who had tested susceptible to rubella actually received the MMR vaccination postnatally prior to discharge, with most women either declining it or deferring it to get it with their GP.

2018/2019

- 4,857/23,123 (21%) women tested susceptible to rubella.

- 3,186/4,674 (68%) of women who delivered during 2018/2019 and tested susceptible to rubella were given the MMR vaccination prior to discharge from hospital following delivery.

2019/2020

- 4,679 / 22,435 (20.86%) women tested susceptible to rubella.
- 3,141 / 4,751 (66%) of women who delivered during 2019/2020 and tested susceptible to rubella were given the MMR vaccination prior to discharge from hospital following delivery.

The most common reason identified for the MMR not being given postnatally by maternity services was that it was deferred for the GP to give and the second most common reason was that the patient declined the vaccine.

10.0 Trends

Infection rates for HIV, hepatitis B and syphilis

Antenatal infection rates for HIV, hep B and syphilis for 2018 - 2020 are shown below. All rates in Northern Ireland for HIV, hepatitis B and syphilis are lower than reported rates in England for the same time period.

2018/2019

- 0.61 per 1,000 eligible pregnant women screened had a confirmed screen positive result for HIV
- 1.38 per 1,000 eligible pregnant women screened had a confirmed screen positive result for hepatitis B
- 1.0 per 1,000 eligible pregnant women screened had a confirmed screen positive result for syphilis

2019/2020

- 0.85 per 1,000 eligible pregnant women screened had a confirmed screen positive result for HIV
- 1.19 per 1,000 eligible pregnant women screened had a confirmed screen positive for hepatitis B
- 0.54 per 1,000 eligible pregnant women screened had a confirmed screen positive result for syphilis

Figure 6 Antenatal Infection rate for HIV, hepatitis B and syphilis in Northern Ireland from 2016-2020.

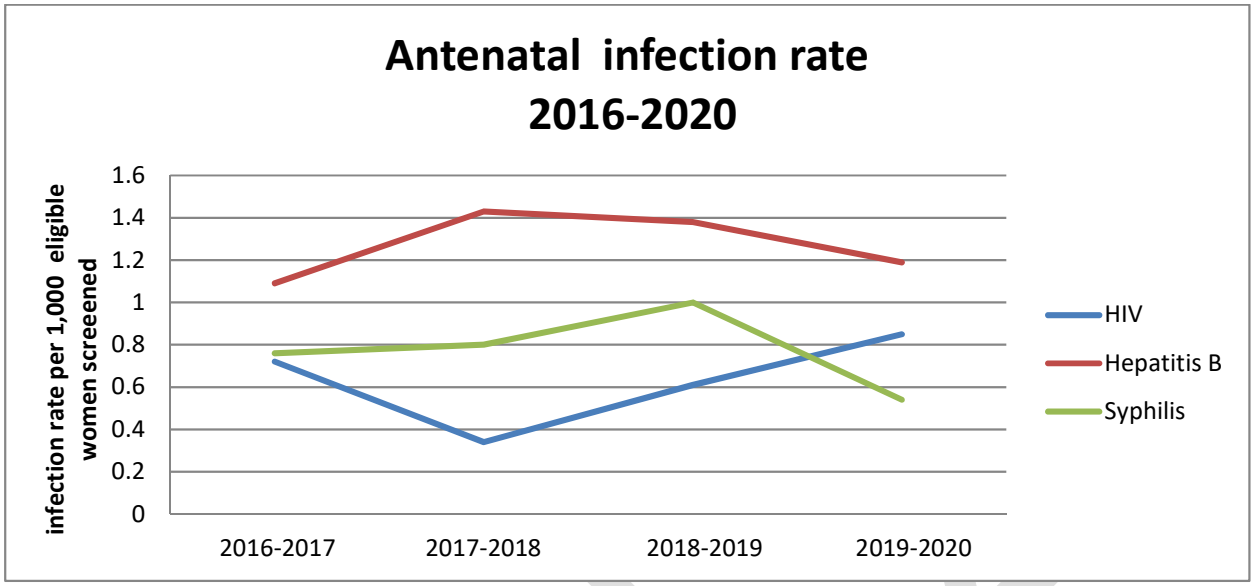

Figure 6 shows there has been slight fluctuations in the infection rates across all 3 infections in the last four years in Northern Ireland.

11.0 Conclusions

In Northern Ireland, pregnant women are offered screening for HIV, hepatitis B and syphilis infection, regardless of their previous history of infection, as well as testing for rubella susceptibility, early in pregnancy or as soon as possible after presenting to maternity services. Pathways are in place for women with positive screening results to reduce the risk of MTCT of HIV, hepatitis B and syphilis. Women who are susceptible to rubella are identified and offered MMR vaccination postnatally to protect future pregnancies, unless they can provide evidence of two previous MMR vaccinations.

This report provides evidence of a very high level of programme performance against some of the national standards, whilst highlighting areas for improvement in other standards.

For the reporting period 2018-2020 Northern Ireland has: -

Exceeded achievable (highest) levels in: -

- Standard 1- 3 for screening coverage for HIV, hepatitis B, syphilis and rubella.
- Standard 4 in 2019-2020 for TTT of all samples positive and negative
- Standard 4 in 2018-2019 for the TTT of confirmed screen positive HIV samples.
- Standard 5 in 2018-2019 for the review of women confirmed screen positive for HIV and hepatitis

- Standard 7 in both years 2018-2020 for the vaccination of the babies at birth

Reached the acceptable level in: -

- Standard 4 in 2018-2019 for the TTT for all samples positive and negative.
- Standard 4 in 2019-2020 for the TTT of confirmed screen positive HIV and hepatitis B samples.
- Standard 5 in 2018-2019 for review by hepatology of women confirmed screen positive for hepatitis B.
- Standard 6 in 2018-2019 for the review by hepatology within 6 weeks of women testing positive for hepatitis B.

Did not achieve an acceptable level in: -

- Standard 4 in 2018-2019 for the TTT of confirmed screen positive hepatitis B and syphilis samples.
- Standard 4 in 2019-2020 for the TTT of confirmed screen positive syphilis samples.
- Standard 5 in 2018/2019 for the 10-day review and referral of women testing positive for syphilis.
- Standard 6 in 2019-2020 - for the review by hepatology within 6 weeks of women testing positive for hepatitis B.

The RVL reported a 100% TTT within 8 working days for the late booking samples tested by them, in both years.

Standard 4 – Although the national standard only measures the TTT for all samples both positive and negative we have also looked at the TTT for confirmed positive samples and this has shown an improvement over the two years 2018-2020 for confirmed screen positive hepatitis B and syphilis samples. Although, there was a slight drop in the TTT for the confirmed screen positive HIV samples in 2019-20 and this equates to one sample not meeting the standard.

Standard 5 - the timely assessment of confirmed screen positive women by maternity services has shown an excellent improvement since 2017- 2018 when 80% of women testing positive for hepatitis B were seen within the 10 days, to 100% of women testing positive for hepatitis B being seen within 10 days in 2018-2020.

As the total numbers of confirmed screen positive cases are relatively low each individual case has a greater proportional impact on the collective performance against the standard, e.g. 21 women testing positive for syphilis out of 23 were

followed up within 10 days in 2018-19 giving a rate of 91.3% which was below the acceptable standard of 95 %. A review of these cases showed that all reasonable efforts were made to arrange an appointment within the 10 days.

Standard 6 – In 2018 -19 (86.67%) of women testing positive for hepatitis B who were newly diagnosed or previously known to have hepatitis B and had high levels of infectivity were reviewed by hepatology services within 6 weeks which meets the acceptable standard of 70%. Unfortunately, in 2019 - 2020 this decreased to 61.54% and did not meet the acceptable standard. This was mainly due to issues with availability of interpreters or women not attending appointments. The reasons for this need to be better understood to further improve the accessibility of the service for these women.

Although the proportion of women susceptible to rubella in 2018-19 and 2019-20 (21%) has not changed much since the last report in 2017/2018 when it was 20%, the uptake of the MMR vaccination postnatally has decreased from 73% in 2017/2018 to 66 - 68% in 2018/2020. Women have been encouraged to present evidence of previous MMR vaccinations; however related data from NIMATS does not suggest that this has had an impact on the reasons for women not taking the MMR postnatal prior to discharge. The main reasons given for not having an MMR before discharge are either deferral or refusal. Further information should be sought to understand the reasons why vaccinations are being deferred and/or declined.

12.0 Recommendations

12.1 Timely review of women who are confirmed screen positive for infection

A process of continuous audit should be in place to review cases where a woman falls outside the national standard for review within 10 working days of a confirmed screen positive result being received by maternity services. This can help to identify potential barriers, help efforts to improve service accessibility and ensure that all women are reviewed in a timely manner.

12.2 Timely assessment of women confirmed screen positive for hepatitis B

A process of continuous audit should be in place to review cases where a woman confirmed screen positive for hepatitis B, falls outside the national standard of review by hepatology within 6 weeks of the positive result being received by maternity services. Liaison with hepatology services and identifying potential barriers can help efforts to improve service accessibility and allow all women to be reviewed in a timely manner.

12.3 Test turnaround times

Where a positive result does not meet the TTT of 8 working days a review should take place to identify areas of potential delay, or if improvements could be made.

12.4 MMR vaccinations post-delivery

Reasons for deferral of the MMR vaccination at delivery should be investigated to see if improvements could be made on the uptake of the MMR vaccination prior to discharge for women identified as susceptible to rubella.

HSC Public Health Agency

item 13

Title of Meeting	PHA Board Meeting
Date	19 January 2023
Title of paper	Update on Accommodation
Reference	PHA/05/01/23
Prepared by	Karen Braithwaite / Stephen Murray
Lead Director	Stephen Wilson
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to provide Board members with an update on a range of matters relating to accommodation.

2 Update on Hybrid Working

Since 1st September 2022, staff who applied for hybrid working have been required to work for two days per week in the office. The Hybrid Working Policy envisioned a move to three days working in the office from 1st January 2023, but this has been deferred until 1st March 2023 while work is ongoing on a desk booking system.

3 Desk Booking System

Based on current staff numbers, it has not yet been possible to move to 3-day office based working arrangements for all staff, if staff are to remain in their existing work location and continue to have access to an individual desk until a desk booking system is put in place.

A Desk Booking System is currently being piloted in one location, however a number of issues need to be addressed before a desk booking system approach can be fully implemented. These include:

- The introduction of a desk booking system will mean that staff would no longer have their own desk and would be required to book desks within designated 'zones'. Whilst this is possible to implement, the PHA does not have appropriate supporting infrastructure / working environment in place to facilitate this model of

working such as personal locker space, break out rooms / pods for on-line meetings etc. Introducing such working arrangements in the current conditions is likely to require formal agreement with Staff Side representatives as it will not be in line with expected standards as set out in the Department of Finance published "Central Government Office Accommodation General Standards" October 2017.

- The approach for zoning and booking desks will need to be agreed on a Directorate / Divisional basis. If there is to be an immediate move to implement a desk booking system, this will not allow any time to reconfigure existing accommodation space. The most practical approach is to zone the desks based on existing Directorate / Divisional boundaries and teams agree internal arrangements for booking desks. Staff working 5 days per week in the office would need to retain a designated desk. Access to offices to provide some break out space could be agreed based on Divisional needs.
- Desk management procedures will need to be introduced with respect to issues such as cleaning down desks and provision of key boards / mouse etc.

Office Configuration / Standards

The Department of Finance published "Central Government Office Accommodation General Standards" in October 2017. This document lays out the standards for equipping and laying out modern office buildings. Whilst the current PHA offices bear little comparison to the standards outlined in the document, the stipulation that there should be 8 workstations for 10fte staff members is an underlying guideline and a core issue when looking at future accommodation needs.

Moving to this model of working entails a huge change in office culture and a move away from the concept of personal desks for the majority of staff. With the pressures on existing office accommodation and the implementation of hybrid working, this may be an opportune time to start working toward a 8/10 desk policy.

In moving back to office based working, the need for break out areas, meeting rooms and dining areas are key issues that have been highlighted by staff.

The current office layouts and number of staff in post across all sites makes these issues very difficult to address without undertaking a significant re-design of the respective office configurations. Any physical changes to accommodation layout will take significant time to implement and would need to be planned and costed in liaison with BSO Estates and SPPG.

Potential Winter Surge Planning Response

In considering the move to 3 day per week office-based working, it was prudent for PHA to assess the potential impact of 'seasonal viruses' in circulation over the coming months and the impact the impact this could have on staff capacity to discharge key functions e.g. health protection response. Given the critical role that

PHA staff have in helping to manage the on-going pandemic response and dealing with other prevalent wider health protection issues, AMT determined that it would be advisable to extend the current grace for moving to a 3 day per week office-based working arrangement until the end of February at the earliest.

Feedback on Current model of Working

General feedback on the current 2 days in the office arrangements is positive and the hybrid working approach has been welcomed by staff. Line managers are currently engaged on ensuring that the policy is being applied and that staff are complying. There is no evidence to suggest that overall staff productivity has been impacted.

Capacity in Linum Chambers

Linum Chambers has 60 workstations and is currently under-utilised. Whilst there are nominally 56 posts attached to these offices, only 44 staff are in post currently.

With the introduction of a desk booking system and hybrid working there are options to address some of the pressures in Linenhall Street by reviewing how Linum Chambers is utilised. This could involve simply moving more staff into Linum Chambers or a larger exercise to reconsider which Directorates should have staff based there.

Any potential review of the use of Linum needs to take into account that the lease expires in September 2026 and that there is a break option in March 2024. DoH would be supporting an end to private sector leases where possible.

4 Longer Term Accommodation Needs

The SIB “Review of Accommodation” that was presented to AMT in April 2021 and shared with Board members in August 2022, did not fully account for the future expansion in PHA staff numbers and whilst the impact of a hybrid working pattern was considered, the focus of the recommendation was more on a geographical solution with local hubs. The SIB report and recommendations need to be reviewed, particularly in regard to staff numbers and possible options.

When the SIB report was presented it was agreed that a programme board needed to be established to take forward the accommodation review and strategy. This board was to include Directorate level staff from the PHA and BSO as well as from Property Management Branch in the Department of Health and from the Department of Finance. It was deemed essential that the PHA was represented at a senior, strategic level to ensure that the needs of the organisation were understood and considered alongside those of the wider HSC bodies.

Discussions are currently underway to establish the programme board in the very near future and it is proposed that regular updates will be reported into the newly formed PHA PPR committee.

5. Recommendation

Board members are asked to note the update.