

## AGENDA

**66<sup>th</sup> Meeting of the Public Health Agency board to be held on  
Thursday 19 June 2014, at 1:30pm,  
Public Health Agency, Conference Rooms,  
12/22 Linenhall Street, Belfast, BT2 8BS**

No	Time	Item	Paper	Sponsor
1.	1:30	Welcome and Apologies		Chair
2.	1:30	Declaration of Interests		Chair
3.	1:30	Minutes of the PHA board Meeting held on 15 May 2014		Chair
4.	1:35	Matters Arising		Chair
5.	1:40	Chair's Business		Chair
6.	1:45	Chief Executive's Business		Chief Executive
7.	1:50	Finance / Operations Update <ul style="list-style-type: none"> <li>• Investment Plan 2014/15 – Final Draft</li> <li>• PHA Budgets 2014/15</li> </ul>	<b>PHA/01/06/14 (for Approval)</b>  <b>PHA/02/06/14 (for Approval)</b>	Mr McClean  Mr Cummings
8.	2:10	Governance and Audit Committee Update <ul style="list-style-type: none"> <li>• Minutes of 10 April 2014 meeting</li> <li>• Verbal briefing from Chair</li> </ul>	<b>PHA/03/06/14 (for Noting)</b>	Mr Coulter
9.	2:20	Corporate Risk Register	<b>PHA/04/06/14 (for Noting)</b>	Mr McClean

- |     |  |  |  |                    |
|-----|--|--|--|--------------------|
| 10. | 2:30   | Remuneration Committee Update <ul style="list-style-type: none"> <li>• Minutes of 4 December 2013 meeting</li> <li>• Verbal briefing from Chair</li> </ul> | <b>PHA/05/06/14<br/>(for Noting)</b>   | Chair              |
| 11. | 2:40   | Project Initiation Document:<br>Development of PHA Strategic<br>Priorities 2015/20   | <b>PHA/06/06/14<br/>(for Approval)</b> | Chief<br>Executive |
| 12. | 3:00   | Programme Report: Health<br>Protection   |  | Dr Harper          |
| 13. | 3:25   | Northern Ireland Abdominal Aortic<br>Aneurysm (AAA) Screening<br>Programme Annual Report 2012/13   | <b>PHA/07/06/14<br/>(for Noting)</b>   | Dr Harper          |
| 14. | 3:45   | DPH Annual Report 2013   | <b>PHA/08/06/14<br/>(for Noting)</b>   | Dr Harper          |
| 15. | 3:55   | Personal and Public Involvement<br>Report  | <b>PHA/09/06/14<br/>(for Noting)</b>   | Mrs Cullen         |
| 16. | 4:20   | Annual Progress Report 2013/14 to<br>the Equality Commission   | <b>PHA/10/06/14<br/>(for Approval)</b> | Mr McClean         |
| 17. | 4:35   | Any Other Business   |  |                    |
| 18. | <b>Date, Time and Venue of Next Meeting</b><br>Thursday 21 August 2014<br>1:30pm<br>Conference Rooms 3/4<br>Public Health Agency<br>12-22 Linenhall Street<br>Belfast<br>BT2 8BS |  |  |                    |

## MINUTES

**Minutes of the 65<sup>th</sup> Meeting of the Public Health Agency board  
held on Thursday 15 May 2014 at 1:30pm,  
in Public Health Agency, Conference Rooms,  
12/22 Linenhall Street, Belfast, BT2 8BS**

**PRESENT:**

Ms Mary McMahon	- Chair
Dr Eddie Rooney	- Chief Executive
Mrs Pat Cullen	- Director of Nursing and Allied Health Professionals
Dr Carolyn Harper	- Director of Public Health/Medical Director
Mr Edmond McClean	- Director of Operations
Alderman William Ashe	- Non-Executive Director
Mr Brian Coulter	- Non-Executive Director
Mrs Julie Erskine	- Non-Executive Director
Dr Jeremy Harbison	- Non-Executive Director
Mrs Miriam Karp	- Non-Executive Director
Mr Thomas Mahaffy	- Non-Executive Director
Alderman Paul Porter	- Non-Executive Director

**IN ATTENDANCE:**

Mr Simon Christie	- Assistant Director of Finance, HSCB
Mr Tony Rodgers	- Assistant Director of Social Services, HSCB
Mr Robert Graham	- Secretariat

**APOLOGIES:**

Mr Owen Harkin	- Director of Finance, HSCB
Mrs Joanne McKissick	- External Relations Manager, Patient Client Council

		<b>Action</b>
<b>63/14</b>	<b>Item 1 – Welcome and Apologies</b>	
63/14.1	The Chair welcomed everyone to the meeting and noted apologies from Mr Owen Harkin and Mrs Joanne McKissick.	
<b>64/14</b>	<b>Item 2 - Declaration of Interests</b>	
64/14.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. None were declared.	

<b>65/14</b>	<b>Item 3 – Minutes of the PHA Board Meeting held on 17 April 2014</b>	
65/14.1	The minutes of the previous meeting, held on 17 April 2014, were approved as an accurate record of the meeting, subject to one amendment. In paragraph 56/14.1, the minute should read, “...there <u>was a year to date</u> surplus of £1.3m”. The minutes were duly signed by the Chair.	
<b>66/14</b>	<b>Item 4 – Matters Arising</b>	
<i>46/14</i>	<i>Update on Inter-sectoral Programme Boards</i>	
66/14.1	The Chair advised that Mr McClean had circulated dates for a proposed first meeting of the Local Government group. Mrs Cullen advised that she would finalise a date for the first meeting of the Older People’s group. Dr Harper requested that the membership and terms of reference of each group be circulated, and it was agreed that this would be done.	Mrs Cullen  Secretariat
<b>67/14</b>	<b>Item 5 – Chair’s Business</b>	
67/14.1	The Chair advised that she had attended a recent NICON event where the new Chief Executive of the NHS Confederation had given a talk and had highlighted the significant issues facing the NHS in England. At the same event, the Chair said that, as part of the round table discussions, she had heard positive feedback on the 10,000 voices project.	
<b>68/14</b>	<b>Item 6 – Chief Executive’s Business</b>	
68/14.1	The Chief Executive advised that the PHA had appointed an Assistant Director of Public Health Nursing, Una Turbitt, and that this appointment would strengthen PHA’s work in the area of public health nursing.	
68/14.2	The Chief Executive said that he had recently attended a session of the Education Committee at Stormont which focused on the area of special needs schools.	
68/14.3	The Chief Executive advised that he was involved in a workshop regarding a cancer prevention campaign and he commended the work of the PHA staff who had been involved in the organisation	

of this and for their inputs.

68/14.4 The Chief Executive said that he had visited the Balmoral Show to support the PHA staff who had organised a stand regarding PHA's Organ Donation campaign.

**69/14 Item 7 – Finance Report  
PHA Financial Performance Report (PHA/01/05/14)**

69/14.1 Mr Christie was asked whether he was aware of any issues regarding staff payments to PHA staff following recent technical issues which had affected staff in some of the HSC Trusts. Mr Christie assured members that he was not aware of any issues regarding any members of PHA staff.

69/14.2 Mr Christie presented the end of year finance report and said that for the year 2013/14, PHA had a total expenditure of £95.2m against an income of £95.3m, thus ending the year with a surplus of £160k. He said that the anticipation that the surplus at the end of February would be spent before the year end had proved to be correct. He said that the final Annual Report and Accounts would be brought to the Board for approval in June.

69/14.3 Mr Christie drew members' attention to two issues within the non-Trust expenditure. He said that there had been overspends on the Lifeline contract and on campaigns, however these had been compensated by an underspend within management and administration.

69/14.4 Mr Christie said that the prompt payment statistics for March had shown a slight dip in performance, but this was mainly due to the transfer of payments to shared services. He noted that 74% of PHA invoices had been paid within 10 days, and he commended this outcome.

69/14.5 Mrs Erskine said she was surprised that the prompt payments figures were so high, given that there had been issues in other organisations. Mr Christie said that this showed that PHA's systems were working well.

69/14.6 Alderman Porter raised a concern that if PHA had not funded the pressure on Lifeline the year end surplus could have been greater. However, he queried whether in fact the pressure was

met by taking away funding from other projects. The Chief Executive assured members that PHA would not run with a financial underspend as there is a list of reserve projects should additional funding be identified. He added that there is significant work undertaken in terms of planning at the start of each year so that when a potential underspend or overspend is identified, action can be taken. He acknowledged that there is a risk with there being a large “tail” of expenditure projected in the last quarter, but he was content that there were no gaps and no unmet needs identified.

69/14.7 The Chief Executive advised members that a full Investment Plan would be brought to the next Board meeting.

69/14.8 Mrs Karp commended the work of the Finance department and PHA staff for achieving this outcome.

69/14.9 Members noted the Financial Report.

#### **70/14 Item 8 – HCAI Target Monitoring Report (PHA/02/05/14)**

70/14.1 Dr Harper introduced Dr Lourda Geoghegan and Mr Gerry McIlvenny to the meeting and invited Dr Geoghegan to present to members the HCAI report.

70/14.2 Dr Geoghegan began her presentation by giving members an overview of the number of cases of C Diff in Northern Ireland during 2013/14. She said that improvements had been made and that the target reduction of 22% in the number of cases had been exceeded.

70/14.3 Dr Geoghegan said that, although the Northern and South Eastern Trusts had missed their target for 2013/14, there had still been a significant reduction in numbers of cases since 2009. She said that the performance of the Belfast Trust compared favourably with comparable Trusts in England.

70/14.4 Dr Geoghegan moved on to give an overview of MRSA cases and said that the regional target for 2013/14 had not been met. She said that the Belfast Trust had met its target, and although the Southern Trust had not met its target, it had achieved a significant reduction in the number of cases in recent years. She added that discussions were on-going with Trusts regarding the

numbers of cases.

- 70/14.5 Dr Geoghegan advised that in England, there are Trusts where no cases of MRSA are recorded, but she said that Trusts in England were much further on in their work to achieve this zero position. She said that PHA will continue to work with Trusts and highlighted areas where Trusts can improve. She added that a workshop is being arranged for June 2014 on MRSA.
- 70/14.6 Dr Harbison asked whether it was possible to do comparisons with Scotland and Wales. Dr Geoghegan advised that there are differences in terms of how each country collects its data. She said that as Northern Ireland uses the same surveillance system as England, it is easier to do comparisons with England. In summary, she said that Northern Ireland fares reasonably well in comparison.
- 70/14.7 Dr Harbison asked about MSSA. Dr Geoghegan said that this PHA also looks at cases of MSSA, and that there was a slight reduction in the number of cases in 2013/14.
- 70/14.8 Mr Coulter queried whether there were any issues relating to the governance arrangements within Trusts, in case there was under-reporting of cases. Dr Geoghegan said that in England there has been proactive work in reducing the numbers of cases, and there are good systems in place, for example undertaking root cause analysis and sharing learning.
- 70/14.9 The Chair asked about infection control procedures within the Northern Ireland Ambulance Service. Dr Geoghegan said that NIAS are required to have procedures in place, and she added that NIAS attends the quarterly HCAI forum.
- 70/14.10 Members noted the HCAI report.
- 71/14 Item 9 – HALT Report 2013: Healthcare Associated Infections and Antimicrobial Use in Long-Term Care Facilities in Northern Ireland (PHA/03/05/14)**
- 71/14.1 Mr McIlvenney outlined to members the background to the HALT report and advised that 31 nursing homes and 11 residential homes in Northern Ireland had taken part. He said that the aim of the study was to evaluate the prevalence of HCAs and to look

at the use of antibiotics in long term care facilities. He outlined the characteristics and care needs of residents within the facilities that had taken part in the study.

- 71/14.2 In terms of the main HCAs identified, Mr McIlvenney said that for both nursing and residential homes the main HCAs related to urinary tract and respiratory tract. The overall prevalence of HCAs was 5.5% which was above the median. In terms of antimicrobial prevalence, Northern Ireland was also above the median with a rate of 10.6%, compared to the median of 9.5%.
- 71/14.3 Mr McIlvenney highlighted issues regarding antimicrobial prescribing, specifically relating to uroprophylaxis, which accounted for half of the prescribing in nursing homes.
- 71/14.4 Dr Geoghegan said that each facility that had taken part in the survey had received a report on their own facility in order to help make improvements. She said that reports were also shared with the pharmacy division within HSCB. She added that there is learning within the report, both in terms of TYC and for RQIA, as part of its inspection process.
- 71/14.5 Dr Geoghegan gave an overview of the recommendations from the report which fell into three broad categories – HCAs, leadership and stewardship.
- 71/14.6 Mrs Karp said that the work undertaken was important but noted that the responsibility for implementing the recommendations fell on a lot of organisations and asked how PHA could be assured that they would be implemented. Dr Geoghegan acknowledged that a joined-up approach is needed but she said that PHA is taking a role in this and is working with HSCB, who will in turn provide support to nursing homes. She said that it is ultimately the responsibility of the homes to take forward the recommendations. In response to a query from Dr Harper, Dr Geoghegan confirmed that a follow up survey would be undertaken every five years.
- 71/14.7 Alderman Porter queried the logic of comparing nursing and residential homes, given the needs of the service users of each facility. Dr Geoghegan acknowledged this, but said that it was useful to have data from both types of facility.



- 71/14.8 Dr Harbison asked whether the results of the survey were expected. Dr Geoghegan said that, with respect to HCAs, the outcome was expected, but not with regard to the rates of antimicrobial prescribing. Dr Harbison was disappointed at the low response rate from residential homes and also said that the rate of prescribing was very high. He asked about the role of RQIA in terms of picking up some of the issues highlighted in the report. Mr Coulter highlighted the same issue and asked about the role of PHA.
- 71/14.9 Dr Geoghegan said that the role of PHA is to advise and provide support for improvement and specialist expertise. She added that in the case of a major incident or outbreak PHA would chair the outbreak control team. Furthermore, if PHA felt that a nursing home was not taking account of PHA's advice, PHA would highlight this to RQIA.
- 71/14.10 Mr Coulter said he was concerned that the value of antibiotics would be diminished through overuse and inappropriate use. Dr Geoghegan advised that PHA would support an approach where pharmacies are aligned to GP practices which would pick up on these issues.
- 71/14.11 Mrs Cullen gave an overview of the role of RQIA and said that it is required to carry out reviews of medicines management. She said that within nursing and residential homes, each individual has a care plan and there should be a registered nurse responsible for that plan. She added that the nurse is responsible for ensuring that the management of medicines is part of the overall management of the home.
- 71/14.12 Mrs Cullen noted that it is not only GPs who prescribe antibiotics, these could be prescribed by an out of hours doctor or a prescribing nurse, but she added that it was important that the right call was made on behalf of the patient.
- 71/14.3 Members noted the HALT Report.

*At this point Alderman Porter left the meeting.*

**72/14 Item 10 – Performance Management Report – Corporate Business Plan and Commissioning Plan Direction Targets for Period Ending 31 March 2014 (PHA/04/05/14)**

- 72/14.1 Mr McClean presented the end of year Performance Management Report and advised that of the 93 targets, 80 had achieved a “green” rating, 10 an “amber” rating and 3 a “red” rating. The three rated red related to community capacity building, smoking cessation and telemonitoring.
- 72/14.2 Mrs Erskine said that it was disappointing that PHA had been unable to meet its target due to factors outside its control and proposed that a different colour be used to indicate those actions which fall outside PHA’s control.
- 72/14.3 The Chair said that in relation to those targets about healthy choices, there was a need to consider not commissioning these on an annual basis as results could only be measured over a longer time period. She said that some of these areas would be more likely to be squeezed if cuts had to be made.
- 72/14.4 Dr Harper said that all services are currently squeezed but PHA’s influence on the Commissioning Plan can ensure that funding can be secured in important areas, for example the rollout of FNP and the alcohol substance misuse liaison service.
- 72/14.5 Mr Coulter suggested that, with regard to capacity building, PHA should commission a third party to undertake this as there would be no element of prejudice and it would be open for all organisations to attend. Mr Coulter asked about PHA’s position in relation to e-cigarettes, an issue also raised by Alderman Ashe.
- 72/14.6 Dr Harper advised that discussions are taking place at UK-level regarding e-cigarettes and a position paper will be available shortly. In response to Mrs Karp’s query, she confirmed that the quit rates are for individuals who have quit smoking altogether, and have not moved on to the use of e-cigarettes.
- 72/14.7 The Chief Executive assured members that the objectives rated as red would continue to feature within PHA’s priorities moving forward – capacity building, telemonitoring and smoking cessation.

72/14.8 Mrs Erskine thanked the work of all staff for achieving this outcome at the end of the year.

72/14.9 Members noted the Performance Management Report.

*During this item Mrs Erskine left the meeting.*

**73/14 Item 11 – Health and Social Wellbeing Improvement Update (PHA/05/05/14)**

73/14.1 Dr Harper introduced Mary Black to the meeting and said that this presentation was an end of year report on the range of initiatives undertaken within health and social wellbeing improvement.

73/14.2 Mrs Black began by highlighting the context within which health and social wellbeing improvement directorate operates and some of the key challenges. In particular, Mrs Black identified procurement as a challenge going forward.

73/14.3 Mrs Black updated members on initiatives under the banner of “building sustainable communities”, and drew particular attention to Resurgam, MARA and the community allotments programme. She also highlighted work in relation to BME, older people and LGBT.

73/14.4 Mrs Black moved onto “make healthy choices easier” and highlighted work done with regard to suicide prevention and mental health and wellbeing. She cited work PHA does in partnership with sporting bodies.

73/14.5 Mrs Black informed members about PHA’s smoking cessation campaign and its obesity prevention campaign.

73/14.6 Mrs Black finished her presentation by giving members an overview of PHA’s work with the Belfast Strategic Partnership under the banner of “Active Belfast”.

73/14.7 Dr Harbison said that a huge amount of work had been achieved, but he asked how PHA can quantify its impact, for example in areas such as MARA. He asked whether baselines had been set against which PHA can measure activity to see whether PHA’s work is making a dent in the areas it is working in. Mrs Black

said it is not an exact science and baselines had been developed for some areas. Dr Harbison said in terms of future planning, PHA needs to ensure that it uses its resources where they are most needed, by being able to identify where the problem areas are.

73/14.8 Mrs Karp noted that this update is presented annually, and she asked whether it would be possible to facilitate opportunities for individuals to come to the Board and present their stories in the same way as patients have done their experiences. Mrs Black said that this was something that could be done at a future meeting and cited an example of an individual who had benefitted from the MARA programme.

73/14.9 Mr Coulter asked how PHA maps its activity against social inequalities and how PHA knows if it is making a difference. Mrs Black said that PHA's work is largely based on the areas highlighted in the Marmot Review and as part of this work, it is important that PHA seeks to leverage resources from other government departments. She added that PHA will always seek to push on with its initiatives and regularly evaluate its progress.

73/14.10 Members noted the health and social wellbeing improvement update.

#### **74/14 Item 12 – Child Development Programme Board Update (PHA/06/05/14)**

74/14.1 Dr Harper advised members that the Child Development Programme Board (CDPB) has been running since 2010 and she introduced Maurice Meehan to the meeting and invited him to give members an overview of the recent work of the Board.

74/14.2 Mr Meehan said that one of PHA's objectives under "Building Blocks for a Healthy Life" is to work with others to ensure that every child and young people has the best start in life, thus the creation of the CDPB. He gave an overview of the different elements of the Board and some of the programmes.

74/14.3 In terms of looking forward, Mr Meehan said that PHA would seek to continue to inform policy through initiatives like Delivering Social Change and the Early Intervention Transformation Programme. He added that PHA will continue to analyse what

works best and said that the secret of the success of the CDPB is working together.

74/14.4 Mrs Karp thanked Mr Meehan for the presentation and said that she was heartened by the amount of work that had been achieved thanks to the enthusiasm and hard work of all of those sitting on the CDPB.

74/14.5 The Chief Executive noted that as the work of the CDPB develops the interface with education will be important. Dr Harper said that the 5 Education and Library Boards are members of the Roots of Empathy Project and that there is a proposal to develop a strategic liaison with education. The Chief Executive added that the Education Committee at the Northern Ireland Assembly is becoming interested in PHA's work.

74/14.6 Dr Harbison noted the large membership of the Group and asked whether there was a good attendance at each meeting. Dr Harper said there is usually a very good turnout at each meeting and that there is a lot of energy and enthusiasm within the group.

74/14.7 Members noted the Child Development Programme Board update.

### **75/14 Item 13 – Development of the PHA Corporate Strategy 2015-19**

75/14.1 The Chief Executive explained to members that a full proposal outlining the proposed development of the next PHA Corporate Strategy will be brought to the Board in June.

75/14.2 Reflecting on the range of presentations that had been brought to the Board meeting today, the Chief Executive said that this demonstrated the breadth of the work undertaken by PHA and it was now timely for PHA to consider the impact it was having and also to think about areas where PHA needed to make more impact.

75/14.3 The Chief Executive said that the next Corporate Strategy will run from 1 April 2016 as DHSSPS has allowed the current Strategy to run for another year, given that in the next few months, the Public Health Strategy will be launched and there will be a new Programme for Government. The Chief Executive

said that PHA needed to consider these in the development of its future core activities and align itself in order to make the desired impact.

75/14.4 The Chief Executive said that the Plan will be developed with input from non-executives and that there will be a formal project plan, with key milestones, developed. There will also be significant discussion at the away day later in the year.

75/14.5 Members noted the update on the development of the new Corporate Strategy.

**76/14 Item 14 – ALB Self-Assessment Action Plan (PHA/07/05/14)**

76/14.1 The Chair said that the Action Plan highlighted the actions that PHA is committed to following the completion of the ALB self-assessment questionnaire.

76/14.2 Members noted the Action Plan.

**77/14 Item 15 – Draft Investment Plan (PHA/08/05/14)**

77/14.1 Mr McClean said that this Plan was a high level summary in advance of the full Investment Plan being brought to the Board in June. It indicates areas of growth and where PHA is anticipating in-year funding.

77/14.2 The Chair stressed that PHA has a responsibility to ensure that it utilises its additional funding appropriately.

77/14.3 Members noted the draft Investment Plan.

**78/14 Item 16 – Any Other Business**

78/14.1 The Chair advised members that the OFMDFM Active Ageing Strategy was out for public consultation and a copy of PHA's draft response was circulated. Members were asked to forward any comments to Chris Totten by Friday 23 May.

78/14.2 Mrs Karp asked whether a date for an away day had been confirmed. The Chair said that a date would be finalised in advance of the June Board meeting.

**79/14 Item 17 – Date and Time of Next Meeting**

Date: Thursday 19 June 2014

Time: 1:30pm

Venue: Public Health Agency

Conference Rooms

2<sup>nd</sup> Floor

12-22 Linenhall Street

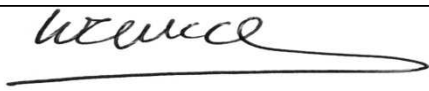
Belfast

BT2 8BS

Signed by Chair: \_\_\_\_\_

Date: \_\_\_\_\_

**PUBLIC HEALTH AGENCY BOARD PAPER**

<b>Date of Meeting</b>	19 June 2014
<b>Title of Paper</b>	Investment Plan 2014/15 – Final Draft
<b>Agenda Item</b>	7
<b>Reference</b>	PHA/02/06/14
<b>Summary</b>	
<p>The PHA Investment Plan sets out how the overall funding available to the Public Health Agency (PHA) in 2014/15 will be deployed to advance its work in improving and protecting health and well-being. In particular it focuses on how additional programme funding will be invested and identifies changes that are being made in how the baseline budgets are used.</p> <p>It also outlines how the PHA has delivered a broad range of efficiencies within its baseline budget to help fund the expansion of a number of programmes as well as new developments.</p> <p>The Plan reflects and advances the priorities outlined in the PHA Corporate Strategy 2011-15, the Executive's Programme for Government, as well as in DHSSPS Commissioning Directions for 2014/15 and sits within the PHA's annual business and investment planning process.</p>	
<b>Equality Screening / Equality Impact Assessment</b>	N/A
<b>Audit Trail</b>	This report was brought to AMT on 10 June 2014.
<b>Recommendation / Resolution</b>	For Approval
<b>Director's Signature</b>	
<b>Title</b>	Director of Operations
<b>Date</b>	10 June 2014



## Investment Plan 2014/15

### 1.0 Introduction

1.1 This Investment Plan sets out how the overall funding available to the Public Health Agency (PHA) in 2014/15 will be deployed to advance its work in improving and protecting health and well-being. In particular it focuses on how additional programme funding will be invested and identifies changes that are being made in how the baseline budgets are used. It also outlines how the PHA has delivered a broad range of efficiencies within its baseline budget to help fund the expansion of a number of programmes as well as new developments.

1.2 The Plan reflects and advances the priorities outlined in the PHA Corporate Strategy 2011-15, the Executive's Programme for Government, as well as in DHSSPS Commissioning Directions for 2014/15 and sits within the PHA's annual business and investment planning process. This takes into account the need for innovation and reform in meeting the changing needs and expectations of our population, as well as requirements set by DHSSPS in driving efficiency and taking account of cost pressures. The Investment Plan is agreed by the board of the PHA and is a key document in ensuring good stewardship of public funds.

### 2.0 Baseline Allocation 2014/15

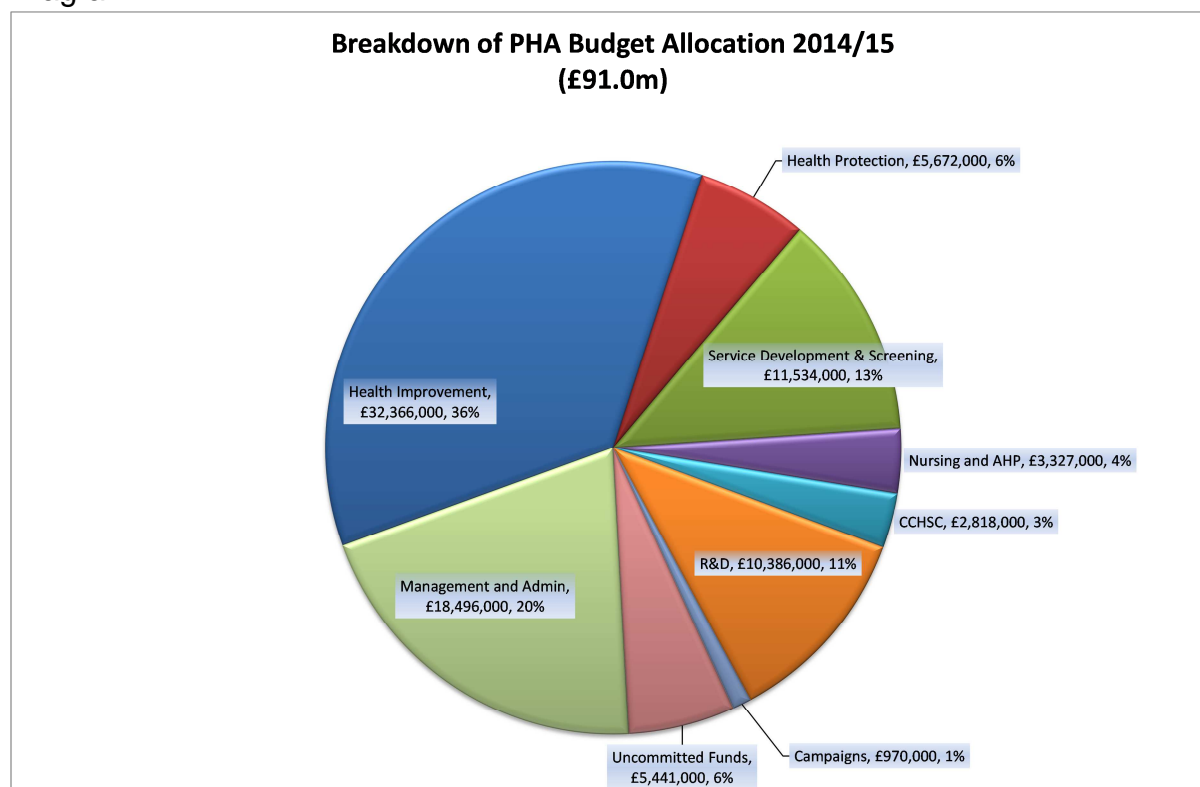
2.1 The allocation provided by DHSSPS to the PHA provides an opening budget for 2014/15 of £91.0m. This is an increase of £5.44m from 2013/14. The majority of this - £72.4m - is for expenditure on the programmes and activities we conduct and support, with the balance, £18.6m, covering running and related costs. A more detailed breakdown of the new baseline budget is provided below.

*Table 1: Baseline Budget 2014/15*

Budget Area	Budget (£000s)
Opening Allocation	85,568
2014/15 pay and price uplift	2,139
New Development funding	1,438
Rotovirus / 2 <sup>nd</sup> phase Children's Flu programme	1,864
<b>Total</b>	<b>£91,009</b>

A breakdown of how the £91.0m is currently allocated across budget areas is outlined in diagram 1 below.

Diagram 1



Additional details on how the programme funding is allocated is provided in appendix 1.

2.2 The opening allocation excludes additional funding that will be allocated to the PHA during the year by other Government Departments to take forward initiatives such as *Delivering Social Change*, *MARA* and the *Farm Families* project. It also excludes funding of circa £3.0m to be allocated for the National Institute for Health Research.

### 3.0 Recurrent Funding for New Developments

3.1 In total, £5.441m of new funding has been allocated to PHA in 2014/15, of which £1.864m has been earmarked specifically for new vaccination programmes. In seeking to maximise the amount of funding available for new investments, PHA has applied a pay and price uplift of 1.5% to core service contracts. This is consistent with the HSCB uplift for similar services. By doing this, it is possible to release £1.238m of the pay and price allocation to progress new developments. In addition, the PHA has also identified a further £0.545m from within the existing baseline budget that can now be allocated to new developments on a recurrent basis. In total, PHA has been able to create an investment fund of £3.221m for 2014/15. This is summarised in table 2 below.

*Table 2: Recurrent Funds for New Developments*

Area of Funding	Allocated (£000's)	Available for Investment (£000's)
New Vaccination Programmes	£1,864	£0
New Development funding 2014/15	£1,438	£1,438
Pay and Price uplift (2014/15)	£2,139	£1,238
Funding released from 2013/14 baseline	-	£545
Total	£5,441	£3,221

3.2 In February 2014, the PHA agreed an initial package of new developments to the value of £2.113m. A breakdown of the new investments approved is set out in appendix 2.

3.3. In addition to the above developments there is a further £1.108m that remains available for prioritisation. A number of high priority developments including the development of health support workers in primary care; expansion of the New Entrants service and additional support for young people not in education or training have been identified against this funding and business cases are currently being finalised. A final list of developments to be supported with the £1.108m will be considered by the PHA board and take account of final decisions on the 2014/15 Commissioning Plan and outcome of the June monitoring round.

3.4 A summary breakdown of how the new programme funding available for 2014/15 has been allocated to date across budget areas is set out in diagram 2 below. In allocating the additional funding PHA is mindful of the need to ensure that resources are distributed on an equitable basis and will continue to keep this position under review.

Diagram 2

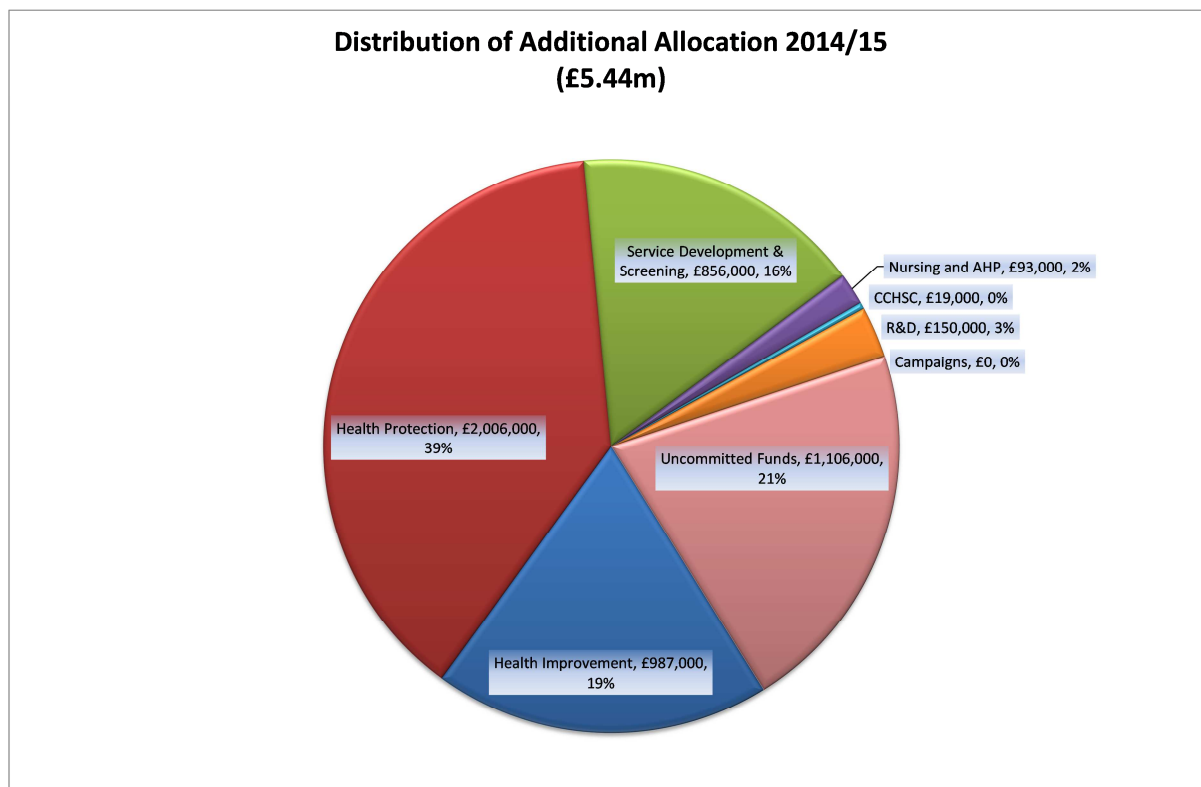
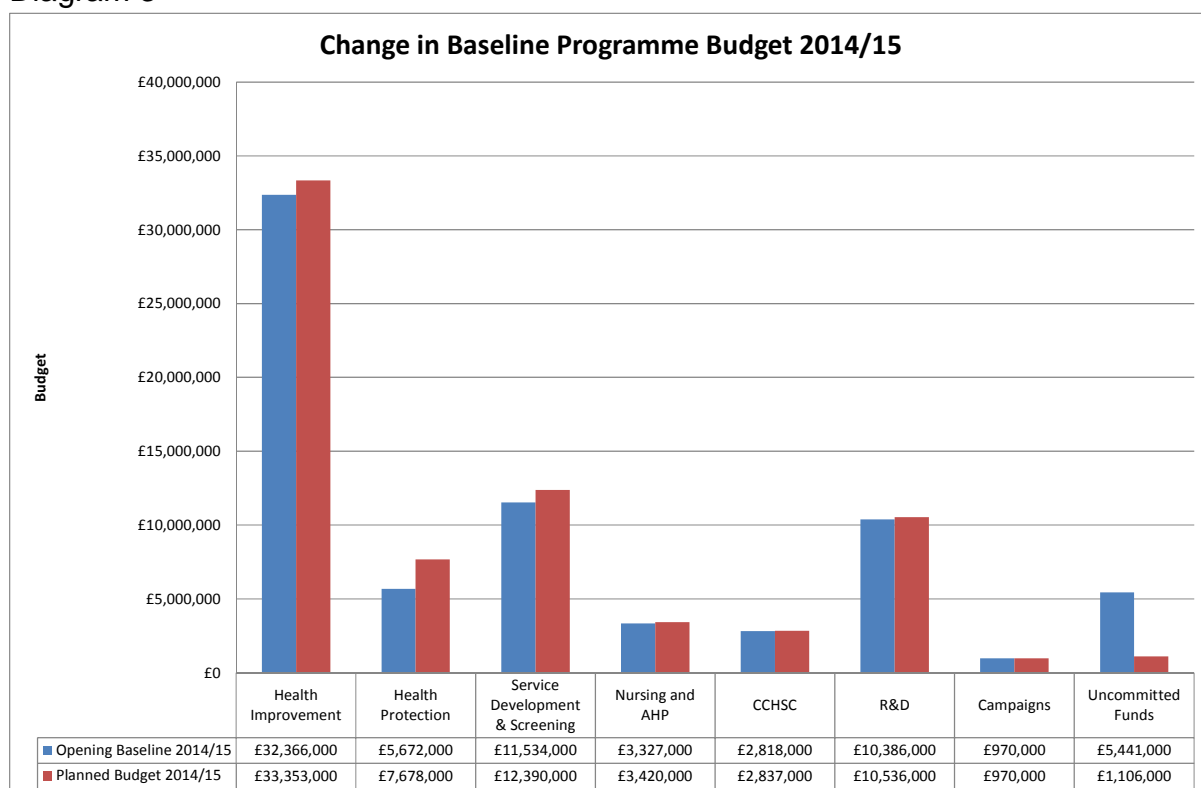


Diagram 3



#### 4.0 Review of Baseline Budgets

4.1 In addition to new funding available to PHA, a review of how all baseline funding has also been undertaken. This is to ensure that all available programme funding is being targeted effectively and, if advantageous, reprioritised to allow new developments to be progressed that will deliver on the PHA's core objectives. A total of £0.248m will be released on a recurrent basis from baseline budgets to support new developments (see appendix 3 for breakdown). In addition, circa £3.7m is being re-prioritised within the baseline on a recurrent or non-recurrent basis to meet core PHA objectives and priorities. A summary of the changes being taken forward is outlined in appendix 4.

#### 5.0 In Year funding

5.1 For each of the investments agreed to date a planned lead in time has been identified. In addition, there will be a full in-year commitment available against the £1.108m of new funding still to be finalised. In total there is £1.711m of in-year funding available. PHA board has already approved in-year developments amounting to £1.144m. A breakdown of these is outlined in appendix 2. There remains a total of £0.567m to be allocated to support further in-year investments. A list of possible proposals is currently being considered and will be submitted to PHA Board for approval.

*Table 3: Summary of In-year Funding Available*

In year Funds	£000s
Total available 2014/15	3,221
In year requirement against £2.113m	(1,510)
Additional Non Recurring pressures approved February 2014	(949)
Additional Non Recurring for consideration	(195)
Balance of In- year funding remaining for allocation	<b>567</b>

#### 6.0 Efficiency Savings 2014/15

6.1 Within the Commissioning Plan for 2014/15, it was highlighted that PHA would deliver £2m in efficiency savings to help address the service pressures identified. Whilst some of the pressures identified have not materialised as anticipated, there is still an expectation that PHA will deliver efficiencies of £2m.

6.2 Based on the information outlined above in table 2, the PHA has realised efficiencies of circa £1.238m from reviewing the application of pay and price uplifts and releasing £0.545m from the baseline budget.

6.3 In addition, new developments to the value of £0.248m have been funded by re-focusing funding within existing baseline budgets. In total, efficiencies of £2.031m will be achieved.

## 7.0 Monitoring and and Review

7.1 The financial performance of the PHA is a standing item on the agenda of the Agency's Management Team meetings and reported on a monthly basis to the PHA board.

7.2 The operational financial policies of the PHA are contained within its Standing Financial Instructions (SFI). As well as being subject to Internal Audit Reviews, the actions and expenditure of the PHA is subject to an annual external audit on behalf of the Department of Health, Social Services and Public Safety. The PHA's current external auditors are PriceWaterhouseCoopers. The Annual report and final accounts for the PHA are public documents and are available on its website.

\*\*\*\*\*

## Appendix 1

## Breakdown of PHA Programme Budgets 2014/15

Area of Spend	Opening Baseline Budget 14/15	Planned Budget 14/15
<b>HEALTH &amp; SOCIAL WELLBEING IMPROVEMENT</b>		
Breastfeeding	£80,071	£91,351
Drugs and Alcohol	£5,941,299	£6,019,169
Food & Nutrition/Obesity/Fit Futures/Physical Activity/Education	£3,178,739	£3,604,173
Healthy Living Centres	£1,407,177	£1,433,470
Hidden Harm	£306,576	£310,902
Accident Prevention	£452,597	£482,823
Inequality Funding	£299,160	£303,999
Investing for Health	£2,644,541	£2,684,314
LGBT	£30,000	£30,000
Local Gov't Allocation	£483,273	£490,110
Mental Health Promotion	£1,155,185	£1,117,668
Older People	£592,386	£572,872
One Stop Shop	£887,726	£887,726
Smoking Cessation	£4,690,577	£4,586,535
Suicide Prevention Strategy / Lifeline	£7,242,823	£7,284,151
Sustainable Communities	£238,401	£241,452
Teen Pregnancy/Sexual Health	£1,612,614	£1,803,303
Travellers	£77,000	£228,000
Workplace Health	£68,597	£44,109
New Parent Programme	£175,000	£175,000
Early Years (Regional)	£396,180	£460,122
Arts and Health (Regional)	£101,459	£30,459
Poverty	£150,000	£250,000
Melanoma Network	£34,280	£34,280
Fareshare (Regional)	£35,595	£36,307
Migrant HSWI (Regional)	£85,000	£150,300
<b>Total</b>	<b>£32,366,255</b>	<b>£33,352,594</b>
<b>HEALTH PROTECTION</b>		
HCAI	£498,809	£499,890
Immunisation	£1,873,391	£2,053,857
Flu vaccination	£3,078,545	£4,901,498
National Poisons Information Service	£146,720	£147,451
Support to Hep C Clinical Network	£15,000	£15,000
HIV Surveillance	£60,000	£60,000
<b>Total</b>	<b>£5,672,465</b>	<b>£7,677,696</b>

<b>SCREENING &amp; SERVICE DEVELOPMENT</b>		
Abdominal Aortic Aneurysm	£483,049	£490,181
Cervical Screening Programme	£689,209	£833,723
Bowel Cancer Screening Programme	£2,765,108	£3,032,149
Breast Screening Programme	£5,638,591	£5,662,774
Digital mammography	£462,000	£462,000
High Risk Screening	£155,000	£290,000
Diabetic Retinopathy Screening Programme	£40,181	£120,669
New Born Screening Programme	£264,284	£348,259
Cancer Registry	£770,244	£802,094
Cerebral Palsy	£93,560	£94,963
Screening & Service Development (Other)	£172,806	£252,806
<b>Total</b>	<b>£11,534,032</b>	<b>£12,389,618</b>
<b>NURSING / AHP / CCHSC</b>		
CCHSC	£2,818,150	£2,837,289
Ward Sister Initiative	£2,102,559	£2,133,599
Family Nurse Partnership	£1,011,865	£1,026,390
Nursing & AHP (Other)	£0	£60,000
Public Health Nursing	£213,000	£200,000
<b>Total</b>	<b>£6,145,574</b>	<b>£6,257,278</b>
<b>CAMPAIGNS</b>	<b>£970,481</b>	£970,481
<b>RESEARCH &amp; DEVELOPMENT</b>	<b>£10,386,000</b>	£10,535,804.00
Uncommitted Programme Funds	£5,438,193	£1,105,528
Management and Admin	£18,496,000	£18,720,000
<b>TOTAL BASELINE BUDGET</b>	<b>£91,009,000</b>	<b>£91,009,000</b>



11<sup>th</sup> June 2014

## Appendix 2

### Summary of Investments Approved 2014/15

## Summary of Additional PHA Investments 2014/15 Supported Through Efficiency Savings

Proposed Investment	Funding Required	Source of Funding	Outcomes Expected
To appoint a dedicated officer to work across the local councils in the western area to promote accessibility for people with disabilities.	£63,510	This funding was previously used to support initiatives under the City of Culture.	Increased accessibility to facilities; encourage more older people to use recreational and leisure services; help reduce social exclusion.
Match funding required to establish an Early Years post in each Trust area to maximise the impact of various initiatives being implemented to support young families. (125k allocated under the PfG funding)	£125,000	Funding has been re-directed from a variety of local budgets. This funding was being used to support a range of non-recurrent investments in 2013/14.	This post will provide leadership, support and capacity within each Trust area to ensure optimum local coordination and implementation of a core portfolio of parenting support programmes being commissioned by and through the Public Health Agency.
Benzo Project (Western Trust) - to provide support to people who are prescribed anti-depressants and reduce dependency by promoting healthier lifestyle choices.	£59,000	Funding was retracted from Western Trust due to the existing programme underperforming over a number of years.	Target 100 patients and reduce dependency on anti-depressants through completion of the programme. Promote increased levels of physical activity and referral into other support programmes such as smoking cessation
	<b>£247,510</b>		

11<sup>th</sup> June 2014

## Appendix 4

### Breakdown of Changes in Baseline Programme Budgets 2014/15

11<sup>th</sup> June 2014

### Summary of Additional PHA Investments 2014/15 Supported through Efficiency Savings

Proposed Investment	Funding Required	Source of Funding	Outcomes Expected
To appoint a dedicated officer to work across the local councils in the western area to promote accessibility for people with disabilities.	£63,510	this funding was previously used to support initiatives under the City of Culture.	Increased accessibility to facilities; encourage more older people to use recreational and leisure services; help reduce social exclusion.
Match funding required to establish an Early Years post in each Trust area to maximise the impact of various initiatives being implemented to support young families. (125k allocated under the PfG funding)	£125,000	funding has been re-directed from a variety of local budgets. This funding was being used to support a range of non-recurrent investments in 2013/14.	This post will provide leadership, support and capacity within each Trust area to ensure optimum local coordination and implementation of a core portfolio of parenting support programmes being commissioned by and through the Public Health Agency.
Benzo Project (Western Trust) - to provide support to people who are prescribed anti-depressants and reduce dependency by promoting healthier lifestyle choices.	£59,000	Funding was retracted from Western Trust due to the existing programme underperforming over a number of years.	target 100 patients and reduce dependency on anti-depressants through completion of the programme. Promote increased levels of physical activity and referral into other support programmes such as smoking cessation
	<b>£247,510</b>		

<Amend Appendix no >

# **PHA Budgets 2014/15**

**For Approval**

### Introduction

This paper sets out the total resources which the PHA has available in 2014/15. These funds have been set out in their high level summary areas including, Health and Social Care services provided by other organisations, Commissioning with HSC Trusts and the Management and Administration costs of the PHA.

The figures build on the detail provided by Budget Managers and the Programme Expenditure Monitoring System (PEMS) and contain assumed resources as detailed in the section below.

### Resources

The PHA receives an allocation from the DHSSPS and this is supplemented by incomes from other sources, e.g. Income for Research and Development projects and receipts for PHA staff on secondment to other organisations.

A summary of the total resources available for 2014/15 is set out in the table below.

Source of Funding	£k
DHSSPS allocation	91,009
Assumed DHSSPS allocation (Safeguarding Board for Northern Ireland(SBNI)) *	797
Assumed Allocation for Clinical Excellence Awards	134
Income from Secondments	179
Income from Research & Development	661
Income for Community Engagement Project	61
Income from Barnardo's	40
<b>TOTAL BUDGET</b>	<b>92,881</b>

\* Please note the funding for SBNI is included within this paper as it is consolidated within the PHA Financial Accounts. However, the responsibility for financial breakeven lies between the Chair of SBNI and the DHSSPS.

### Summary of Additional Allocations made available 2014/15

	FYE £k	CYE £k
Total Additional Allocations	5,441	5,441
Funding Utilised and Built into Budgets		
- Vaccination Programme	( 1,864)	( 1,864)
- Pay & Price (Man & Admin)	( 224)	( 224)
- Pay & Price (Trusts & BSO)	( 358)	( 358)
- Pay & Price (Non - Trust Programme)	( 319)	( 319)
New Recurrent Developments Approved	( 2,113)	( 1,510)
New Non-Recurrent Developments	-	( 1,144)
Sub-total Funds Available	563	22
Additional Funding Released from Baseline	545	545
<b>Total Balance Still Remaining to be Allocated</b>	<b>1,108</b>	<b>567</b>

The PHA has yet to approve developments against the balance of £1.1m Full Year Effect and £0.6m Current Year Effect as set out in the table above. These funds are held on the Non Trust Programme section of this report.

### Conclusion

The Board is asked to approve the 2014/15 proposed budgets as set out within this paper, the detailed deployment of which is summarised in the separate 2014/15 Investment paper.

## Available Resources

	<u>Page</u> <u>Reference</u>	Year End Position £000s
Department Allocation*		91,940
Income from Other Sources		941
<b>Total Available Resources</b>		<b>92,881</b>

## Proposed Budgets

Non-Trust Programme	3	38,031
Trusts & BSO	4	35,280
PHA Administration	5	19,570
<b>Total Proposed Budgets</b>		<b>92,881</b>
<b>Surplus/(Deficit)</b>		<b>-</b>

\* Includes assumed allocations.

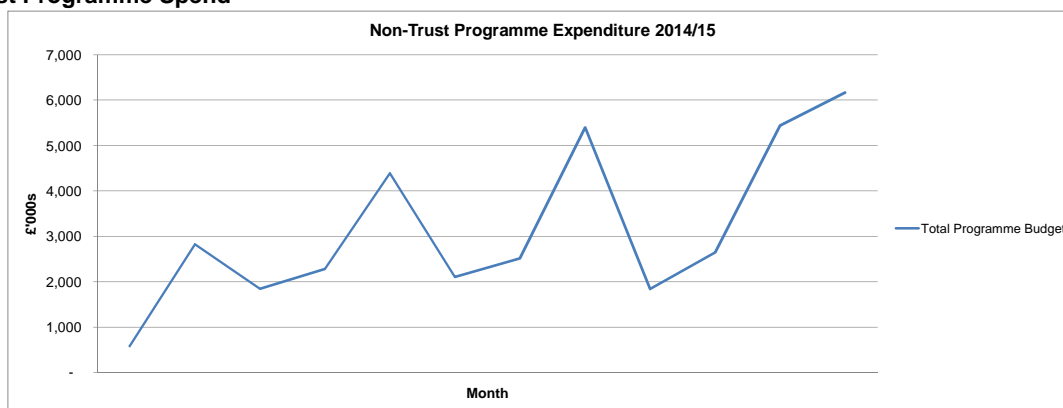
### **Position Synopsis:**

The above allocation for PHA includes £797k for the Safeguarding Board for Northern Ireland (SBNI) and £134k for Clinical Excellence Awards which have not yet been received.

The income of £941k above relates to programme income in respect of Research & Development and a two projects for South Eastern Health Improvement team funded by Department of Social Development and Barnardo's. It also includes anticipated income relating to staff on secondment to other organisations.



Non-Trust Programme Spend



£'000s £'000s £'000s £'000s £'000s £'000s £'000s £'000s £'000s £'000s £'000s £'000s £'000s

Apr-13 May-13 Jun-13 Jul-13 Aug-13 Sep-13 Oct-13 Nov-13 Dec-13 Jan-14 Feb-14 Mar-14 Total

Budget

Health Improvement - Belfast LCG	4	492	609	314	1,038	297	215	1,071	299	155	1,196	270	5,961
Health Improvement - South East LCG	1	69	38	695	71	7	677	87	1	677	87	822	3,233
Health Improvement - North LCG	61	501	81	301	621	69	277	532	72	240	518	830	4,103
Health Improvement - South LCG	163	536	418	355	295	574	397	445	184	476	445	497	4,784
Health Improvement - West LCG	0	637	25	81	635	46	52	654	36	75	674	81	2,995
Health Improvement - Lifeline Contract	292	292	292	292	292	292	292	292	292	292	292	292	3,500
Health Improvement - Smoking Cessation*	-	-	-	-	-	-	-	-	-	-	-	-	-
Health Protection	-	12	-	9	19	634	306	656	546	219	340	620	3,359
Service Development & Screening	50	275	75	50	275	75	50	275	99	50	302	156	1,732
Research & Development	-	-	2	22	1,098	14	71	1,071	95	273	1,225	1,193	5,064
Campaigns	8	14	155	63	45	45	152	192	83	153	291	447	1,647
Nursing & AHP	-	-	5	5	-	-	2	-	9	21	66	4	111
Regional Obesity	2	0	145	96	0	53	29	125	122	9	4	225	811
Procurement	-	-	-	-	-	-	-	-	-	-	-	165	165
Unallocated Programme Funds	-	-	-	-	-	-	-	-	-	-	-	567	567
<b>Total Programme Budget</b>	<b>581</b>	<b>2,827</b>	<b>1,845</b>	<b>2,282</b>	<b>4,388</b>	<b>2,105</b>	<b>2,518</b>	<b>5,400</b>	<b>1,837</b>	<b>2,641</b>	<b>5,439</b>	<b>6,169</b>	<b>38,031</b>

**Position Synopsis:**

The Public Health Agency non programme budgets are those funds which are provided to community groups, voluntary organisations and local Councils to assist the PHA in the delivery of its Programme for Government targets.

This budgeted profile set out above has been provided by Budget Managers and includes income of £661k for R&D and £101k for South Eastern Health Improvement programmes.

Unallocated funds of £567k above have a full year effect of £1,108k, when PHA approves the use of these funds they will be built into the relevant budgets and shown within the monthly financial report.

\* Funds for Smoking Cessation are currently held within local Health Improvement lines.

## Revenue Resource Limits (RRLs) June 2014 to Trusts

	Annual Budget (per SBA) £'000's
Western Trust	5,113
Northern Trust	6,129
Belfast Trust	11,178
South Eastern Trust	2,889
Southern Trust	4,595
BSO	625
Balance of Funding Identified to Trusts (awaiting completion and approval of Business Cases)	4,751
<b>Total</b>	<b>35,280</b>

These are the indicative budgets held for Trusts and the Business Services Organisation.

The balance of funds identified above have been held for distribution to Trusts in 2014/15 pending agreement and approval of Business Cases for essential developments.

	<b>Budget</b> £'000's	<b>Income</b> £'000's	<b>Total Budget</b> £'000's
Salaries & Wages	17,173	179	17,353
Goods & Services	2,217	-	2,217
<b>Total Administration</b>	<b>19,390</b>	<b>179</b>	<b>19,570</b>

### ***Position Synopsis:***

The Management and Administration Budgets are for all staff and building related costs associated with the Public Health Agency.

This budget contains anticipated income relating to staff on secondment to other organisations and funding anticipated from DHSSPS for Clinical Excellence Awards for Medical Staff.

Inflation has been indicatively profiled to budgets however, as final decisions on pay awards has not yet been made these amounts are subject to change during 2014/15.

**MINUTES****Minutes of the Governance and Audit Committee  
Thursday 10 April 2014 at 10 am,  
held in 5<sup>th</sup> Floor Meeting Room,  
Linenhall Street, Belfast, BT2 8HS****PRESENT:**

Mrs Julie Erskine	(Chair)
Alderman Paul Porter	Non-Executive Director
Mr Brian Coulter	Non-Executive Director
Mrs Miriam Karp	Non-Executive Director

**IN ATTENDANCE:**

Mr Edmond McClean	Director of Operations
Miss Rosemary Taylor	AD Planning & Operational Services
Mr Simon Christie	AD Finance, HSCB
Mr Gary Christie	Northern Ireland Audit Office
Ms Laura Allen	Pricewaterhouse Coopers
Mrs Catherine McKeown	Internal Audit, BSO
Mr David Charles	Internal Audit, BSO
Mr Mark Anderson	Sponsor Branch, DHSSPSNI
Ms Sharon Beattie	SBNI (For Item 13)
Mrs Oriel Brown	PHA, (For item 14)
Mrs Cathy McAuley	Secretariat

**APOLOGIES:**

Mr Thomas Mahaffy	Non-Executive Director
-------------------	------------------------

**23/14 | Item 1 – Welcome and Apologies**

Mrs Erskine welcomed everyone to the meeting and noted apologies from Mr McMahafty.

**24/14 | Item 2 – Declaration of Interests**

Mrs Erskine asked if anyone had any interests to declare relevant to any items on the agenda.

None were declared.

**25/14 Item 3 – Chair’s Business**

Mrs Erskine said HSC 17/2014 circular HSC Audit and Risk Assurance Committee Handbook was available for information.

Mrs Erskine said she had attended the IGSG meeting on 26 March 2014.

Mrs Erskine said she had attended a meeting with Internal Audit earlier today re: IA Plans for 2014/15.

**26/14 Item 4 – Minutes of the GAC Meeting held on 5 December 2014**

Members agreed the minutes of the GAC meeting held on 6 February 2014 as an accurate record of the meeting.

**27/14 Item 5 – Matters Arising**

19/4: All items were brought to the PHA Board meeting for approval.

**28/14 Item 6.1 – Assurance Framework**

Mr McClean presented the PHA Assurance Framework report 2013/15 as reviewed at April 2014 to members. Members were asked to approve the amendments to the Assurance Framework 2013-15 as at 1 April 2014.

Members approved the amendments to the PHA Assurance Framework.

**29/14 Item 6.2 – Risk Management Strategy and Policy**

Miss Taylor presented the strategy and policy and said updates made included strengthening the risk appetite section and updating the regional HSC matrix and impact table.

Members approved the strategy and policy.

*Alderman Porter arrived at 10.15 am.*

**30/14 Item 6.3 – CAS Compliance Report**

Miss Taylor advised the process was now complete for 2014/15 and presented draft scores along with comparisons for the previous three years. She added the CAS assessment scores would be submitted to the DHSSPS and would also be included in the PHA Governance Statement.

Mrs Erskine thanked Miss Taylor and her team in achieving substantive compliance.

Members noted the report.

**31/14 Item 7 – Information Governance Update**

Controls Assurance Standard (CAS) – Miss Taylor updated members on the new information governance CAS. A self-assessment has been carried out against the standards, achieving 78% compliance. She added that confirmation is awaited from DHSSPS on exemption from criteria 18-27 (relating to clinical records). An action plan will be developed to address gaps in compliance.

E-Learning Training - Miss Taylor said the PHA was advised at the last Regional Information Advisory Group that the pass mark should be 80% (not 100%). The remaining modules will be rolled out when the Leadership Centre amends the programme.

FOI Request – Miss Taylor said 16 new FOI requests had been received between 6/9/13 – 20/3/14. Mrs Karp asked if comparative data for FOIs was available. Miss Taylor replied the numbers are similar to last year, 39 requests during 2013/14 compared to 27 in 2012/13.

Miss Taylor said one FOI had been made to the Information Commissioners Office (ICO) following their

investigation the ICO found that the PHA had responded to the initial request appropriately given the sensitive nature of the complaint. The complainant subsequently withdraw their complaint. Mr McClean said the learning and findings report from this would be brought to the PHA Board meeting.

Members noted the update.

### **32/14 Item 8.1 – Internal Audit Progress Report**

Mr Charles gave an overview of the progress report against the 2013/14 Internal Audit Plan and audit summaries of the final audit reports since the last meeting; this included Governance: Board Effectiveness and Gifts and Hospitality and Financial Review.

Report 1 – Board Effectiveness and Gifts and Hospitality 2013/14.

No priority 1 weaknesses were identified. Four priority 2 weaknesses were identified during the audit. A satisfactory level of assurance was provided and all recommendations have been accepted by management.

Mrs Erskine expressed her concern about the lack certificates for attendance at “On Board” training courses. Mr Coulter said following his recent training as a new member he did receive a certificate of attendance, indicating this was now resolved.

Mr Coulter asked why the issue of the MOU between the PHA and the HSCB has yet to be completed. Mr McClean said the groundwork had been completed and the PHA were awaiting the HSCB to sign the document.

Mr Coulter asked the importance of finalising this document to the auditors. Mrs McKeown said the relationships of the services and roles provided by both organisations with HSCB/PHA did have the potential to overlap and stressed the importance of finalising and agreeing the draft MOU.

Mr McClean

Members agree they would ask for this document to be finalised. Mr McClean will raise this matter with the Chief Executive.

Members noted the report.

Report 2 – Financial Review 2013/14.

One priority 1 and seven priority 2 weaknesses were identified.

Mrs Erskine expressed her concern that the priority 1 weakness identified (procurement of training for delivery of SBNI Learning Together Foundation Course) was outside the remit of the PHA. It was clarified SBNI finances come through PHA and Mr S Christie assured the committee that operations colleagues continue to work closely with SBNI to ensure that they are aware of all relevant policies and procedures.

Mrs Erskine expressed her concern and frustration about the lack of guidance being made available to staff in relation to staff travel claims. Miss Taylor advised members that new arrangements had become effective in July 2013 but despite repeated requests updated guidance has not been received from BSO.

Mrs McKeown said that Internal Audit had recognised the situation, and noted this was partially implemented and that the PHA had endeavoured to rectify this matter in the year-end follow-up report.

Mrs Erskine expressed her concern regarding the tax implications this would have upon staff.

The committee agreed that Mr McClean would raise this at AMT with the Director of HR, BSO.

Mr McClean

**33/14 Item 8.2 – Year End Follow Up 2013/14**

Mr Charles advised that progress has been made and 90% of the recommendations have now been implemented.



Members noted the report.

**34/14 Item 8.3 – Strategy Incorporating the Proposed Internal Audit Plan for 2014/15**

Mrs McKeown presented the proposed Internal Audit plan for 2014/15 and gave an overview of the proposed work schedule.

Members approved the Internal Audit Plan.

**35/14 Item 9.1 – Finance: Report To Those Charged With Governance Progress Report.**

Mr Christie presented the progress report on the implementation of recommendations of the report to those charged with governance and said two observations were partially implemented and these would be addressed in the BSTP update.

Members noted the report.

**Item 9.2 – Fraud Liaison Officer Update Report**

Mr S Christie advised there were no new or live cases to report.

**35/15 Item 9.3 – BSTP Update**

Mr Christie presented the BSTP update. He said that progress is being made although there were some inaccuracies in reports from the systems. He outlined the continuous review of the quality of financial information.

Mr S Christie said there continues to be issues with the timely interface of the FPL system which includes delayed interfacing, accuracy and incorrect coding. He added this was formally escalated to the Director of BSO Customer Care & performance, and as the reply did not address all the issues raised this was followed up and a response is awaited.

During a discussion regarding shared services Mr Porter asked if the PHA was at risk as a small organisation. Mr S Christie responded by assuring members that he was mindful of this, but content that the systems were now embedded within HSCB/PHA, and that good working relationships and networks have been built with BSO colleagues over the past year and that BSO are aware of the high standards expected by PHA.

Mrs Erskine thanked Mr S Christie and his team for the volume of work undertaken throughout the past year.

Members noted the BSTP update.

**37/14 Item 10 – Draft Governance Statement**

Mr McClean presented the draft Governance Statement highlighting section 9: Internal Governance Divergences. Mr G Christie suggested that Board performance and the management of conflicts of interest are should be strengthened in the document.

Subject to minor amendments members approved the draft statement and recommended it for approval to the next PHA confidential board meeting.

Mr McClean

**38/14 Item 11 – GAC Annual Report**

Mrs Erskine presented the GAC Annual Report which outlined the key activities of the Committee during 2013/14.

Members noted the report.

**39/14 Item 12 – Draft Annual Report**

Mr McClean shared the draft Annual Report with members and said the report would then go to the confidential session of the next PHA Board meeting on 17<sup>th</sup> April.

Members approved the draft report subject to minor

Mr McClean

amendments.

### **Item 13 – SBNI Declaration of Assurance**

Mrs Beattie joined the meeting and gave members a summary of the SBNI Declaration of Assurance. She began by saying the purpose of the assurance statement is to attest the effectiveness of the internal controls system in accordance with Departmental guidance. She said the Minister made a statement in the Assembly in late September 2013 of his intention to direct the SBNI to undertake the Thematic Review.

Mrs Karp asked about the undertaking of the Thematic Review and the possibility of this happening again. Mrs Beattie said it was possible but highly unlikely that the SBNI would be asked to undertake another Thematic Review under similar circumstances.

Mrs Karp asked a question relating to concerns of perceived membership which had been noted at the Health Committee and the importance of mitigating the reputational risk in the future. Mrs Beattie said the SBNI had sought independent legal advice on the perceived conflict and a small sub group had been set up to review the findings and that this information had been shared with the Department.

Members noted the report.

*Mr Anderson left the meeting at 11.45am.*

### **Item 14 - Review of Venous Thromboembolism (VTE) Incidents Reported to Health and Social Care Board as Serious Adverse Incidents**

Mrs Brown joined the meeting and gave members an overview of the main findings of the VTE report, the key regional learning and actions taken. She began by noting a review of reported SAI's in which patients suffered VTE was requested by the PHA/HSCB, Quality Safety and Experience Group on 6 December 2013. She said a review of all SAI's reported to the HSCB and recorded in Datix System for Acute POC from 1 May

2010 to 22 November 2013 was conducted and the review had identified three reported SAI's reporting to VTE and that all three patients had died. In conclusion all 3 reports showed that either a risk assessment had not been undertaken or appropriate prophylactic treatment was not prescribed in line with NICE Guidelines.

*Mr Porter left the meeting at 11.50am.*

Mr Coulter asked a question relating to the monitoring systems for families. Mrs Brown advised trusts are required to involve and communicate with families. Documentation has been updated to enable PHA/HSCB to monitor this.

Mrs Karp asked if Mrs Brown was content with the current staffing levels. Mrs Brown replied that she would welcome more staff, as this would enable the team to spend more time on the analysis, overview and management of the SAI's process.

Members noted the report.

**40/14 Item 15 – Items to be brought to PHA Board**

GAC/10/04/14 - Draft Governance Statement

GAC/12/04/14 – Draft Annual Report

Mr McClean

**41/14 Item 16 – Date of next meeting**

Date: 11 June 2014

Time: 1:00 pm

Venue: Conference Room 2 & 3  
2<sup>nd</sup> Floor, 12-22 Linenhall Street  
Belfast  
BT2 8HS

**PUBLIC HEALTH AGENCY BOARD PAPER**

<b>Date of Meeting</b>	19 June 2014
<b>Title of Paper</b>	Corporate Risk Register
<b>Agenda Item</b>	9
<b>Reference</b>	PHA/04/06/14

**Summary**

**Context**

In line with the PHA's system of internal control, a fully functioning risk register has been developed at both directorate and corporate levels. The purpose of the corporate register is to provide assurances to the Chief Executive, AMT, the Governance and Audit Committee and the PHA board that risks are being effectively managed in order to meet corporate objectives and statutory obligations.

**Process**

To support these assurances, a process has been established to undertake a review of both directorate and corporate risk registers on a quarterly basis i.e. the end of each financial quarter.

The previous review was undertaken as at 31 December 2013 and was approved by AMT on 28 January 2014 and forwarded to the Governance and Audit Committee for approval at its next meeting which took place on 6 February 2014.

The attached Corporate Risk Register reflects the review as at 31 March 2014 and has been carried out in conjunction with individual directorate register reviews for the same period.

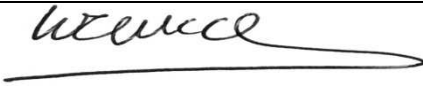
The next review will be undertaken as at 30 June 2014.

**Outcome**

This quarter saw changes to the Corporate Risk Register as follows:

**2 risks were removed:**

Ensuring continuity of website communication  
(de-escalated to Operations Directorate Risk Register)  
Implementation of new Information Management Controls Assurance Standard  
(de-escalated to Operations Directorate Risk Register).

<b>Equality Screening / Equality Impact Assessment</b>	N/A
<b>Audit Trail</b>	This report was brought to AMT on 20 May 2014.
<b>Recommendation / Resolution</b>	For Noting
<b>Director's Signature</b>	
<b>Title</b>	Director of Operations
<b>Date</b>	20 May 2014



Public Health  
Agency

---

# PHA Corporate Risk Register

**Date of Review:  
March 2014**

## Introduction

Managing risk is a key component of the wider governance agenda for the PHA. It is therefore essential that systems and processes are in place to identify and manage risks as far as reasonably possible.

The purpose of risk management is not to remove all risks but to ensure that risks are identified and their potential to cause loss fully understood. Based on this information, action can then be taken to direct appropriate levels of resource at controlling the risk or minimising the effect of potential loss.

The PHA has recognised the need to adopt such an approach and has commenced a systematic and unified process to develop a fully functioning risk register at both corporate and directorate levels that complies with the Australian/New Zealand (AS/NZS) 4360:2004 standard.

The Corporate Register that follows identifies corporate risks, all of which have been assessed using a 'five by five' risk grading matrix (see below) which is in line with DHSSPS guidance. This ensures a consistent and uniform approach is taken in categorising risks in terms of their level of priority so that appropriate action can be taken at the appropriate level of the organisation.

IMPACT	Risk Quantification Matrix				
5 - Catastrophic	High	High	Extreme	Extreme	Extreme
4 - Major	High	High	High	High	Extreme
3 - Moderate	Medium	Medium	Medium	Medium	High
2 - Minor	Low	Low	Low	Medium	Medium
1 - Insignificant	Low	Low	Low	Low	Medium
LIKELIHOOD	A Rare	B Unlikely	C Possible	D Likely	E Almost Certain



## Overview of Risk Register Review as at 31 March 2014

Number of new risks identified	0
Number of risks removed from register	2 CR18 Ensuring continuity of website communication (de-escalated to Operations Directorate Risk Register)  CR29 Implementation of new Information Management Controls Assurance Standard (de-escalated to Operations Directorate Risk Register)
Number of risks where overall rating has been reduced	0
Number of risks where overall rating has been increased	0

## CONTENTS

Corporate Risk		Lead Officer/s	Risk Grade		Page
<del>18</del>	<del>Ensuring continuity of website communication</del>	<del>Director of Operations</del>		<b>MEDIUM</b>	
25	PHA Belfast Accommodation	Director of Operations	→	<b>HIGH</b>	5
26	Lack of market testing for roll forward contracts	Chief Executive	→	<b>HIGH</b>	7
<del>29</del>	<del>Implementation of new Information Management Controls Assurance Standard</del>	<del>Director of Operations</del>		<b>MEDIUM</b>	
30	Management of Lifeline Contract	Medical Director/Director of Public Health	→	<b>HIGH</b>	9

Key:

Risk rating:

- ↑ increased from previous quarter
- ↓ decreased from previous quarter
- remained the same as previous quarter

Corporate Risk 25				
<b>RISK AREA/CONTEXT:</b> PHA Belfast Accommodation				
<b>DESCRIPTION OF RISK:</b> PHA staff based in Belfast are in unsuitable accommodation (PHA staff in Linenhall street are in an increasingly over-crowded environment – communications staff, previously in Ormeau avenue have had to be relocated to floor 4 south, with access to specialised IT equipment compromised; no space is available for additional staff recruited to Nursing/AHP, Public Health and Operations; lack of meeting rooms and breakout space), compromising privacy and confidentiality, smooth operation of business and resulting in poor staff moral and complaints. While the business case has been approved, the lease needs to be agreed with the landlord before this can be implemented. There is a risk that the lease for the identified building may not be finalised				<b>DATE RISK ADDED:</b> June 2012
<b>LINK TO ASSURANCE FRAMEWORK:</b> Corporate Control Dimension				
<b>LINK TO CORPORATE ANNUAL BUSINESS PLAN 2014/15:</b> Corporate Objective 6				
GRADING	LIKELIHOOD	IMPACT	RISK GRADE	
	Likely	Major	HIGH	
<b>LEAD OFFICER:</b> Mr E McClean, Director of Operations				
Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
<ul style="list-style-type: none"> <li>Communications staff have been set up with IT connections to enable routine functionality;</li> <li>Issue has been highlighted to Health Estates;</li> <li>Health Estates have established a Steering Group to look at accommodation – (Sept 2012) <del>(contract now ceased)</del></li> <li>Following submission of revised business case</li> </ul>	Regular reports to Chief Executive Business case approved at PHA board confidential session, September 2013	Lack of suitable accommodation for number of staff based in Belfast; Lease not signed Contracts and facilities arrangements to be agreed.	<ul style="list-style-type: none"> <li><del>Heads of Terms to be agreed and lease signed (by 31 January 2014);</del></li> <li>Implementation plan to be agreed <del>(31 Jan 2014)</del> (May 2014);</li> <li>Procurement and works carried out by <del>31 March 2014</del> 30 September 2014</li> <li>Lease to be finalised and signed (early May 2014)</li> <li>Meeting with PALS regarding facilities contracts (2 May 2014)</li> </ul>	June 2014

<p>(September 2013), conditional approval given;</p> <ul style="list-style-type: none"><li>• Sponsorship Branch support provided as part of DHSSPS advisors comments.</li><li>• Affordable rent agreed with landlord.</li><li>• Business case approved by DHSSPS (19 Nov 2013).</li><li>• Project manager appointed by Health Estates</li><li>• Design team appointed through HEIG</li><li>• Heads of Terms agreed with landlord</li></ul>				
--	--	--	--	--

<b>Corporate Risk 26</b>				
<b>RISK AREA/CONTEXT:</b> Lack of market testing for roll forward contracts and introduction of new EU procurement requirements and lack of staff capacity to procure services in line with this.				
<b>DESCRIPTION OF RISK:</b> Due to roll forward of many legacy contracts, PHA has not undertaken market testing of all baseline contracts as required under procurement regulations. This primarily impacts on the community and voluntary sector contracts under Health Improvement. PHA staff do not have the capacity (time) or skills, knowledge and experience in what is a technically specialist area, and also requires significant management of the process. Need to have shared understanding with BSO of procurement mechanisms and respective roles. Risk of PHA being in breach of procurement regulations.				<b>DATE RISK ADDED:</b> September 2012 (Amalgamated with Corporate Risk 28, September 2013)
<b>LINK TO ASSURANCE FRAMEWORK:</b> Operational Performance and Service Improvement Dimension				
<b>LINK TO CORPORATE ANNUAL BUSINESS PLAN 2014/15:</b> Corporate Objective 6				
<b>GRADING</b>	<b>LIKELIHOOD</b>	<b>IMPACT</b>	<b>RISK GRADE</b>	
	Likely-Possible	Major	<b>HIGH</b>	
<b>LEAD OFFICER:</b> Dr E Rooney, Chief Executive				
<b>Existing Controls</b>	<b>Internal and External Assurances to the Board</b>	<b>Gaps in Controls and Assurances</b>	<b>Action Plan/Comments/ Timescale</b>	<b>Review Date</b>
<p>Reports on social care procurement requirements brought to AMT.</p> <p>Procurement Plan has been developed and agreed by AMT setting out the timescales for achieving the re-tendering of baseline contracts.</p> <p>Revised processes and documentation-developed for PHA in liaison with PALS to ensure tender process is applied where required in line with</p>	<p>Performance Expenditure Management System Reports brought to AMT and PHA board regularly</p> <p>Progress reports on implementing the Procurement Plan will be provided to AMT</p> <p>Leadership at AMT and Assistant Director level via a Procurement Steering Group.</p>	<p>Legacy contracts may not be providing value for money</p> <p>Lack of capacity within BSO PALS</p> <p>Lack of skills, knowledge and expertise within PHA staff in respect of social care procurement.</p>	<p><del>Monitoring</del> Continue to monitor input of additional capacity through PALS framework (<del>March</del> June 2014)</p> <p><del>Contract terms to be agreed by project board (31 Jan 14)</del></p> <p><del>RSE tender to be advertised Feb 14.</del></p> <p>Tender documentation to be finalised by Legal (April 2014)</p> <p>RSE Tender and Mental Health phase 1 tenders to be issued (June</p>	June 2014

<p>Procurement regulations</p> <p>Training has been provided for relevant staff, including legal aspects of procurement.</p> <p>Additional staffing resource to provide dedicated support for procurement within PHA. (Sept 2013)</p> <p>External support secured by PALS to provide dedicated resource to PHA. (August 2013)</p> <p>Internal management structures established to oversee implementation of the Procurement Plan.(August 2013)</p> <p>Suite of documentation and guidance for tendering developed. (Sept 2013)</p> <p>Review of Procurement Plan and wider support requirements on agenda of Procurement Board that meets monthly.</p> <p>Procurement awareness briefing sessions held (Nov 2013)</p>			<p>2014)</p>	
--	--	--	--------------	--

Corporate Risk 30				
RISK AREA/CONTEXT: Management of Lifeline Contract				DATE RISK ADDED: December 2013
DESCRIPTION OF RISK: : Reported demand for the lifeline service has increased considerably, exceeding the designated budget. Additionally analysis of data download has raised a number of questions about the invoiced activity. The management of the new Lifeline Contract requires ongoing attention, to deal with the above and to ensure that the key performance indicators(KPIs) are delivered within all Trust areas and that appropriate arrangements are in place for signposting or referral where appropriate to other statutory or non-statutory providers.				
LINK TO ASSURANCE FRAMEWORK: Operational Performance and Service Improvement Dimension				
LINK TO CORPORATE ANNUAL BUSINESS PLAN 2014/15: Corporate Objective 2				
GRADING	LIKELIHOOD	IMPACT	RISK GRADE	
	Possible	Major	HIGH	
LEAD OFFICER: Dr C Harper, Medical Director/Director of Public Health				
Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
<p>Existing monitoring of Lifeline Contract.</p> <p>Lifeline Steering Group (chaired by Assistant Director of Public Health) meets regularly.</p> <p>Regular meetings between the provider and commissioner to monitor all aspects of the contract, through the following sub-groups:</p> <ul style="list-style-type: none"> <li>• Clinical and Social Governance</li> <li>• Performance management and Evaluation</li> <li>• Communications</li> </ul>	<p>Rigorous monitoring of performance.</p> <p>Detailed analysis of performance including data categorisation.</p> <p>Clear communication channels and reporting to CE, Directors and AMT.</p> <p>Plan has been developed to ensure continuity of service and regular meetings held with provider and Communications Staff, PHA.</p>	<p>Difficulty in data analysis due to changes in categorisation fields.</p> <p>Delays in response from provider to issues raised by PHA.</p> <p>Deficiencies in original contract controls.</p>	<p>Further analysis of data to be considered by senior management of PHA, Legal and Finance and actions agreed. (January 2014 April 2014).</p> <p><del>Meeting with provider scheduled for Jan 2014 to agree way forward.</del></p> <p>Findings of independent clinical audit will be shared with Contact regarding accuracy. An action plan will be prepared on basis of findings for implementation</p>	<p>June 2014</p>

<p>PHA internal Lifeline Project Management Group meets regularly to co-ordinate management and monitoring of all aspects of the contract</p> <p>Regular meetings of senior staff (PHA and Contact) to ensure management of the new contract and building relationships and clear communication with other key providers.</p> <p>Letter issued to provider in respect of demand management and data quality issues.</p> <p>DHSSPS has been advised of issues.</p>	<p>Ongoing monitoring and regular interchange between senior staff of both organisations on a regular basis.</p> <p>Decision <del>to be</del> taken, based on outcome from above, regarding potential clawback <del>(Feb 2014)</del> and correspondence issued re; same.</p> <p>Further correspondence <del>to be</del> issued to provider to seek further information.</p>		<p>from 1 May 2014.</p> <p><del>PID to be brought to AMT setting out process and timetable for the development of business case and Consultation commenced on the procurement process in respect of re-tendering for Lifeline service (June 2014).</del> <del>(end January 2014)</del></p>	
---	---	--	--	--



# **APPENDIX**

## **Risks Removed from Register as at 31 March 2014**

De-escalated to Operations Risk Register:

Corporate Risk 18				
<b>RISK AREA/CONTEXT:</b> Ensuring continuity of website communication				
<b>DESCRIPTION OF RISK:</b> PHA corporate website resilience level falling below demand experienced, and subsequent risk of damage to PHA reputation through unavailability of website.				<b>DATE RISK ADDED:</b> September 2011
<b>LINK TO ASSURANCE FRAMEWORK:</b> Corporate Control Dimension				
<b>LINK TO CORPORATE ANNUAL BUSINESS PLAN 2014/15:</b> Corporate Objective 6				
GRADING	LIKELIHOOD	IMPACT	RISK GRADE	
	Possible	Moderate	<b>MEDIUM</b>	
<b>LEAD OFFICER:</b> Mr E McClean, Director of Operations				
Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
<ul style="list-style-type: none"> <li>Website continuity – external cover arranged in event of loss of service during absence of web developer.</li> <li>Close monitoring of potential surges in traffic to health protection information on websites during health emergencies.</li> <li>Arrangements in place to deliver key public health messages through NI Direct and OFMDFM call centre</li> </ul>	<ul style="list-style-type: none"> <li>Action Plan agreed and under leadership at Assistant Director level reporting back to Director of Operations.</li> </ul>	<ul style="list-style-type: none"> <li>Delays in implementation of ICT arrangements</li> <li>No internal cover for maintenance in event of loss of service during absence of web developer</li> <li>Current payment system does not allow for online renewal of domains.</li> </ul>	<ul style="list-style-type: none"> <li>Web hosting requirements put out to tender in Oct to enhance capacity and resilience. Contract awarded. Mitigation of sites to new hosting arrangement a priority, may require third party input. (Review end March 2014)</li> <li>Funding for extra web developer post approved by DHSSPSWeb developer post advertised and shortlisted.. (Review end March 2014)</li> </ul>	31 March 2014

<ul style="list-style-type: none"> <li>Contract awards for new web hosting arrangements to enhance capacity and resilience</li> </ul> <p>Migration of sites to new Memset server underway. Additional level of protection being applied to all sites.</p> <p>Extra web developer post recruited and in place since March 2014.</p>			<ul style="list-style-type: none"> <li>Work ongoing to screen IPs accessing the PHA site limiting it to local IPs. Delay in progressing, to be resolved by mid-Jan.</li> </ul>	
--	--	--	--	--

De-escalated to Operations Risk Register:

<b>Corporate Risk 29</b>				
<b>RISK AREA/CONTEXT:</b> Implementation of new Information Management Controls Assurance Standard				<b>DATE RISK ADDED:</b> September 2013
<b>DESCRIPTION OF RISK:</b> A new Information Management Controls Assurance Standard (CAS) has been introduced from 2013/14 onwards. PHA is required to meet substantive compliance (or moderate compliance in a few sub-criterion identified) in this CAS. Given the lack of clarity received from DHSSPS, the lack of a regional toolkit, the amount of work required and the lack of resources within Information Governance to implement the standard, there is a risk is that the organisation will not achieve the required level of compliance.				
<b>LINK TO ASSURANCE FRAMEWORK:</b> Corporate Control Dimension				
<b>LINK TO CORPORATE ANNUAL BUSINESS PLAN 2014/15:</b> Corporate Objective 6				
<b>GRADING</b>	<b>LIKELIHOOD</b>	<b>IMPACT</b>	<b>RISK GRADE</b>	
	Possible	Moderate	<b>MEDIUM</b>	
<b>LEAD OFFICER:</b> Mr E McClean, Director of Operations				
<b>Existing Controls</b>	<b>Internal and External Assurances to the Board</b>	<b>Gaps in Controls and Assurances</b>	<b>Action Plan/Comments/ Timescale</b>	<b>Review Date</b>
Information Governance Manager has been attending meetings and briefings organised by DHSSPS.  Work within Information Governance in PHA has been undertaken to scope the extent of this standard (Aug 13)  Chair of GAC, Director of Operations and Information Governance Manager attended a	Substantive compliance has been achieved in the previous CAS (Information Governance) during 12/13. Much of this work will carry forward into the new standard.  Internal structures for the management of Information Governance/Information Management are well established in the organisation	Lack of clarity from DHSSPS on the extent of many of the sub-criterion.  Lack of a regional toolkit  Lack of staff within Information Governance to absorb the additional workload this standard will create  Impact on all staff within the	Liaison with other HSC organisations, esp HSCB ongoing re interpretation of standard and actions required for implementation. (will continue until Mar 14)  Work within the Directorate has commenced and will continue towards the achievement of this standard. (progress ongoing	31 March 2014

<p>one-day event (Sept 13) organised by DHSSPS</p>	<p>(Records Management Working Group; Information Governance Steering Group).  GAC receives regular updates on Information Governance</p>	<p>organisation to take cognisance of this new standard and implement changes within their area of work.</p>	<p>– will be reviewed at CAS self assessment meeting Jan/Feb 2014)  Exemption from non applicable criteria to be requested (31 January 2014)</p>	
--	---	--	--	--

**MINUTES**  
**OF REMUNERATION COMMITTEE MEETING**  
**ON 4 DECEMBER 2013**  
**In Mary McMahon's Office, 4<sup>th</sup> Floor, 12-22 Linenhall Street, Belfast**

Present: Mary McMahon, Jeremy Harbison, Cllr Billy Ashe  
In attendance: Hugh McPoland

1. The minutes of the previous meeting were approved.
2. Matters Arising: The Chair advised that C Executive personal responsibilities on inequalities had not yet been agreed but would be circulated to Remuneration Committee members early in the New Year for approval and subsequent inclusion in Appraisal template.
3. The template, with Chair's comments, having been previously circulated to members, was discussed. Members agreed that the focus of today's discussion would be PHA Impact on Inequalities, subsequent to Away Day deliberations, addressing the gap on Pay Differentials within SMT and issues around Governance.

**Inequalities** - members believed that the Away Day had assisted in providing a renewed focus on this distinctive and unique PHA role. While there was agreement that smoking was the biggest single contributory factor in health inequalities, it was not evident that PHA was being particularly successful in addressing this matter. Members would ask Chief Executive for his view on how better PHA could tackle this issue.

**Job Evaluation** -Mr Mc Poland advised members that a Job Evaluation process had been activated with regard to the responsibilities of Director of Operations post, following the previous meeting. He further identified that exit interviews with departing HSC staff had identified pressure of work as the biggest single reasons for leaving. This was not PHA specific but he advised members that it could pose a threat to the stability of the HSC system if it were not properly addressed.

**Governance**- Difficulties had arisen within PHA about planning processes and Chief Executive had initiated action to address these. The Committee agreed that this was a matter of considerable importance in the context of a new Corporate Strategy being developed for the next 5 years.

The Chief Executive joined the meeting.

## **1 Impact on Inequalities**

The Chief Executive agreed that smoking cessation was one of the most important areas on which to demonstrate progress. Smoking comprises 50% of the inequalities gap, smoking cessation and media campaigns are essential tools to having an impact. Constraints on media campaigns will impact the number trying to stop. He believed that there is strong international evidence from the World Health Organisation, as well as DHSSPSNI Strategy on Tobacco control and quit smoking features heavily in new public health policy. He identified for members that smoking cessation is amongst the largest investment areas for PHA. He agreed that a key challenge lies in trying to get the message out that smoking is not normal activity, especially among young people and preventing people from taking up smoking. There were still areas of policy and legislation which needed to be addressed to help improve public health including plain packaging for cigarettes and minimum pricing for alcohol.

In terms of PHA focus on key areas of investment to tackle inequalities he referenced the creation of 3 Programme Boards, modelled on the Child Development Programme Board which had been established early in the organisation's existence. The Local Government Programme Board would be convened following the appointment of Chief Executive's to new Shadow Councils and it was anticipated that this would be complete early in 2014. Cllr Ashe asked about evidence of good Local Government/PHA work outside of Belfast and the potential impact of community planning on that work. The Chief Executive recognised that there were particular difficulties in some areas but pointed out that this process could only work on a voluntary and agreed basis. He assured members that PHA was ready and willing to engage with all Councils as and when they were ready to participate.

With regard to the Older People's agenda, the Chief Executive reminded members that the Nursing Directorate was being assisted through a change process and that a little more time was needed to establish an Older People's Programme Board but he was confident it would be realised in 2014.

Dr. Harbison asked about the continued delay in the publication of a Draft Research and Development Strategy and the potential impact of such a delay on HSC evidence based studies as well as wider collaboration with our Universities. The Chief Executive recognised the continuing difficulties such delays at Departmental level created for the perception of the organisation but advised that as broad outlines were known we proceeded as best as possible.

## **Job Evaluation**

Chief Executive advised members that he was working with Mr Mc Poland on a Job Evaluation review of the responsibilities of Director of Operations post, following the previous meeting. Members asked that this work be completed thoroughly and within a reasonable time frame. Members were reminded that secondment arrangements for Senior staff were due to end in 2014 but there was no indication from the Department of the time scale or certainty of this happening.

Mr Mc Poland left the meeting

## **Governance and Forward Planning**

The Chief Executive advised members of the steps he had taken, and on which work was on-going, to address flaws in PHA planning processes which impacted on some aspects of programme delivery. External assistance had been sought and provided to assist this process which was critical to the development of a new 5 year corporate strategy in 2014-2015. He was satisfied that PHA Governance arrangements generally were robust and effective.

## **Other**

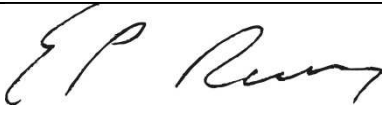
The Chief Executive reported on steps he had taken with DHSSPSNI and HSCB following on from the Away Day discussions on Health Inequalities and PHA role in Commissioning.

The Chief Executive left the meeting

The Committee considered the Chief Executive responses to matters raised and were satisfied that this mid-year appraisal was satisfactory in all respects.



**PUBLIC HEALTH AGENCY BOARD PAPER**

<b>Date of Meeting</b>	19 June 2014
<b>Title of Paper</b>	Project Initiation Document: Development of PHA Strategic Priorities 2015/20
<b>Agenda Item</b>	11
<b>Reference</b>	PHA/06/06/14
<b>Summary</b>	
<p>Attached for members is a draft Project Initiation Document outlining the process of the development of PHA's strategic priorities for the period 2015/20.</p>	
<b>Equality Screening / Equality Impact Assessment</b>	N/A
<b>Audit Trail</b>	This PID was brought to AMT on 10 June 2014.
<b>Recommendation / Resolution</b>	For Approval
<b>Director's Signature</b>	
<b>Title</b>	Chief Executive
<b>Date</b>	10 June 2014

## **Project Initiation Document: Development of PHA Strategic Priorities 2015/20**

### **Introduction**

In the five years to April 2014, the Public Health Agency has gone on a significant journey from its inception, taking on board a wide range of functions, to building over those years its own focus and voice and delivering on priorities with the aim of improving and protecting the health and well-being of the population, improving quality and safety in service delivery, as well as tackling wider inequalities in health and well-being status across groups and communities.

In the five years of our existence we have had the most significant recession since the 1930's and the impact this has had on our society and its well-being. The policy landscape will also develop and change: "Making Life Better", Delivering Social Change, Early Interventions, Community Planning will be important as will the continued outworking of change within health and social care through Transforming Your Care (TYC) and e-health.

The next five years will bring new challenges and opportunities and we must ready ourselves to make best use of the resources, relationships and opportunities we have at our disposal.

DHSSPS requires that HSC Arm's Length Bodies (ALB) Corporate Strategies should align with the period of the Executive and its Programme for Government (PfG), and have advised that the current PHA Corporate Strategy 2011 – 2015 should be extended to cover 2015/16, in line with the extension of the Assembly session and development of the next PfG. This will mean that the next PHA Corporate Strategy should cover the period 2016 to 2020.

This provides the PHA more time to review the existing Strategy and consider what its priorities should be to inform the next Strategy. It will provide an opportunity to take a fresh look at the direction of the PHA and how it addresses the full range of functions set out in the Health and Social Care (Reform) Act (Northern Ireland) 2009 and the DHSSPS Framework Document (2011).

It is anticipated that by reviewing achievements and challenges to date, engaging widely and taking account of the wider strategic context, as well as utilising other internal reviews and reports, the PHA will develop a set of vibrant and challenging, but realistic, strategic priorities for the foreseeable future. These, along with other requirements coming from the next PfG will determine the content of the next PHA Corporate Strategy.

### **Purpose**

The purpose of this document is to:

- Set out the aims and objectives of the project
- Define the scope of the project
- Set out the management structure and governance for the project and
- Set out the key activities, resources and responsibilities

## **Project Definition**

### **Aim**

The development of PHA Strategic Priorities for the next five years from 2015-2020, contributing to informing PHA Corporate Strategy within that period.

### **Objectives**

- To reviewing the current corporate objectives for 2011 – 2015 and take stock of the achievements and challenges over this period;
- To reflect full and extensive engagement with a wide range of stakeholders and 'critical friends';
- To involve staff in the development of the priorities and strategy, ensuring their ownership;
- To identify and consider the PHA priorities for the next 5 years across all our functions, taking account of the above engagement, regional strategies and internal reviews as well as the new PfG requirements;
- To set out clear corporate objectives for the next 5 years that can be translated into meaningful strategic and annual plans and provide context for staff objectives and organisational development;
- To consider our longer term relationships and partnerships with other HSC and non HSC organisations in light of the above;
- To assess and analyse how we utilise our resources (human, financial, IT and physical assets), our culture and working arrangements to deliver these objectives;
- To consider how we plan, deliver, monitor and evaluate our work to enable the Corporate Strategy to be taken forward and achievement monitored, ensuring that effective, appropriate and accountable systems are in place for planning, procuring, approvals and reporting (including KPIs).

It is anticipated that this work will also inform a number of other products and work, including

- Organisational Development Strategy
- IT Strategy
- Asset Management Plan
- Finance/budget management
- Procurement (including social procurement)

### **Scope**

This project initiation document is a high level document, setting out the overarching aim and objectives and some of the key actions and deliverables. As the project management structure is established the detail of how this will be delivered will be fleshed out. The PID will also be reviewed and developed over the course of the project.

## **Project Management and Governance**

### **PHA board**

The development of the PHA Strategic Priorities and Corporate Strategy is mandated by the PHA board. The project structures will ultimately take direction from and be accountable to the PHA board.

### **Project Board**

The project board will be comprised of Non-Executive and Executive members of the PHA board. *It will be chaired by Dr Jeremy Harbison.* The project board will provide direction and leadership, monitoring progress by the project team, and providing advice. The project board may seek assistance and take advice from other external experts as required (in line with PHA Standing Orders)

### **Project Sponsor**

The project sponsor is the PHA Chief Executive, Dr E Rooney. He will provide overall direction to the project, and will have overall accountability for the delivery of the project aims and objectives and of the delivery of the resulting products.

### **Project Director**

The project director is the Director of Operations, Mr E McClean.

### **Project Manager**

The project manager is Assistant Director Planning & Operational Services, Miss R Taylor.

### **Project Support Officer**

A dedicated project support officer will be appointed to support the work of the project board and project team.

### **Project Team**

The project team will be comprised primarily of the PHA Assistant Directors, ensuring representation across all PHA functions. *It will be chaired by xxx.* The project team will support the project director and project manager in taking forward the practical actions and day to day co-ordination of the project. The project team will involve other PHA staff as required and may seek assistance and take advice from other external experts as required (in line with PHA Standing Orders).

## **Reporting**

The project team will report to the Project Steering Group on a monthly basis.

The project steering group will report to the PHA board on a monthly basis.

## Key Tasks and Timescales

Key task	Timescale (provisional)	Comments
Establishment of project structures	July 2014	
Appointment of project support officer	August 2014	
Agreement of engagement process and plan	July and August 2014	Who? How (individual, round table, larger event etc)? PPI role
Development of a Communication Strategy	July and August 2014	To be monitored over the course of the project
Engagement process	September – December 2014	
Board workshop	September 2014?	Key element of annual board workshop
Staff event?		To inform staff To focus staff input to the development of aims, values and objectives
Health Intelligence/Research	September – November 2014	PHA health intelligence analysis of key trends etc; Collating internal PHA reviews Departmental and other strategies etc
Review of information gathered and draft strategic priorities	January – March 2015	
Report to PHA board on draft Strategic Priorities	March 2015	
Development of PHA Corporate Strategy based on Strategic Priorities and new PfG	April 2015 – January 2016	

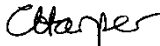
## Resources

Project support officer – band 7 – approximately £44,487 per annum

Costs of hosting larger engagement events, board workshop and staff event

Costs of facilitation (including using expert facilitators through the HSC Leadership Centre consultants and associates).

**PUBLIC HEALTH AGENCY BOARD PAPER**

<b>Date of Meeting</b>	19 June 2014
<b>Title of Paper</b>	NI Abdominal Aortic Aneurysm (AAA) Screening Programme Annual Report 2012/2013
<b>Agenda Item</b>	13
<b>Reference</b>	PHA/07/06/14
<b>Summary</b>	
<p>The PHA is responsible for commissioning and quality assuring the NIAAASP while the Belfast Health and Social Care Trust is responsible for providing and managing the programme.</p> <p>This inaugural annual report for AAA screening in Northern Ireland (produced jointly by the PHA and the Belfast H&amp;SCT) looks back on a successful first year.</p> <p>Following significant planning, AAA screening was introduced on time in June 2012, as required by the Government's 'Priorities for Action' target.</p> <p>Key points to note from the first full year of AAA Screening include:</p> <ul style="list-style-type: none"> <li>i) Uptake of 83%</li> <li>ii) 74 AAAs detected in total</li> <li>iii) 10 referrals made to the Vascular Team at BH&amp;SCT (for large AAAs)</li> <li>iv) 64 men participating in the Surveillance Programme (for small or medium-sized AAAs)</li> <li>v) 17 different screening locations in place during 12/13</li> <li>vi) First PPI event held in April 2013 where nine men and their wives attended a half day workshop to feed back their individual experiences of screening to Programme staff to facilitate development and on-going improvement to the programme.</li> </ul>	
<b>Equality Screening / Equality Impact Assessment</b>	N/A
<b>Audit Trail</b>	This report was brought to AMT on 20 May 2014.
<b>Recommendation / Resolution</b>	For Noting
<b>Director's Signature</b>	

<b>Title</b>	Director of Public Health
<b>Date</b>	20 May 2014

---

**Northern Ireland  
Abdominal Aortic Aneurysm (AAA)  
Screening Programme**



**Abdominal Aortic  
Aneurysm Screening**

*(Final Draft)*

**Annual Report  
2012-13**



---

2<sup>nd</sup> May 2014  
Version: 8.2



<b>Contents</b>	<b>Page</b>
<b>1 Summary</b>	<b>3</b>
<b>2 Introduction</b>	<b>4</b>
<b>3 Background to the Programme</b>	<b>5</b>
<b>4 Programme Delivery</b>	<b>8</b>
<b>5 Programme Performance</b>	<b>12</b>
<b>6 Personal and Public Involvement (PPI)</b>	<b>15</b>
<b>7 Governance and Accountability</b>	<b>17</b>
<b>8 Future Development</b>	<b>20</b>
<b>Appendices</b>	
<b>1 All Belfast Health and Social Care Trust Staff</b>	<b>23</b>
<b>2 Map of Screening Locations</b>	<b>24</b>
<b>3 The Screening Pathway</b>	<b>25</b>
<b>4 Governance and Accountability: Public Health Agency</b>	<b>26</b>
<b>5 Governance and Accountability: Belfast Health and Social Care Trust</b>	<b>27</b>

## Section 1:

### Summary

---

This inaugural annual report for the Northern Ireland Abdominal Aortic Aneurysm (AAA) Screening Programme (produced jointly by the Public Health Agency and the Belfast Health and Social Care Trust) looks back on a successful first year for the programme. The Public Health Agency (PHA) is responsible for commissioning and quality assuring the programme. The Belfast Health and Social Care Trust is responsible for providing and managing the programme.

Following significant planning, AAA screening was introduced on time in June 2012, as required by the Government's 'Priorities for Action' target. There is no doubt that this was due to sustained partnership working across a wide range of health and social care services within Northern Ireland.

All men are invited to attend for screening in the year they turn 65. Men over 65 are encouraged to contact the programme office to request an appointment. The programme has now completed its first year of screening with all men who turned 65 between 1 July 2012 and 31 March 2013 having received an invitation for their first screening appointment. Uptake was high at 81% and the programme has already started to make a difference to the lives of those who have had aneurysms detected. Seventy-four AAAs were detected in men screened during 2012-13. Ten men had large aneurysms which required surgery. The remaining 64 had small or medium sized aneurysms and are being monitored through the surveillance programme.

Highlights for the programme during 2012-13 included:

- **Programme staff appointed and trained** (including six screening technicians who completed an accredited training programme)
- **Seventeen screening clinic venues** across Northern Ireland identified and quality assured
- **2,000 Information Packs** distributed to GPs and pharmacies across Northern Ireland
- Implementation and Adoption of **National Quality Assurance Standards**
- **16 training sessions delivered to GPs** across Northern Ireland to promote and raise awareness of the Programme
- 2012-13 screening cohort **uptake rate of 81%**
- **224 men over 65 who self-referred** to the programme were screened.

## Section 2:

### Introduction

---

I am very pleased to be able to present the first NI AAA Screening Programme annual report, in partnership with colleagues from the Belfast Trust. This report provides information on the programme and its performance during its first year. It shows that the programme is working well and providing a high quality service for eligible men. It is particularly pleasing to note the good uptake rate of 81%.

In 2010, the Department of Health, Social Services & Public Safety (DHSSPS) tasked the Public Health Agency, working with the Health and Social Care Board and Health and Social Care Trusts, to begin preparatory work for the phased introduction of AAA screening. It is thanks to the hard work and professionalism of a wide range of individuals and partner organisations across Northern Ireland and the UK that AAA screening was implemented on time, as per DHSSPS requirements, in June 2012.

Since the programme started, thousands of men have benefitted from this quick, simple, free and potentially life-saving scan.

The focus now for the PHA is to build on the already high standards of programme delivery, address any barriers to accessing the programme and encourage all eligible men to seriously consider the offer of screening.

I look forward to continuing to work in partnership with Trust colleagues and other stakeholders to ensure delivery of a safe, effective, equitable and high quality AAA Screening Programme for Northern Ireland.

**Dr Adrian Mairs**  
**Consultant in Public Health Medicine /**  
**Project Lead**  
**NI AAA Screening Programme**



As Director of Vascular Surgery within the Belfast Trust I was delighted to be appointed Clinical Lead for the NI AAA Screening Programme.

The first year of the programme has been a successful one. As you will see in the report we have much to celebrate. Before commencing the programme a significant quality improvement initiative took place to ensure a high standard of care for men diagnosed with an AAA. This required significant co-operation from clinicians, a wide range of health care professionals and patient feedback. I am indebted to the hard work and co-operation of my clinical colleagues, the Public Health Agency and NI AAA Screening Programme staff for the introduction of such a successful programme. The programme has undoubtedly led to an improvement in the quality of care for patients diagnosed with an AAA and I would encourage all men, aged 65, to take part in the programme. I would similarly encourage those men aged over 65 to consider self-referral to the programme.

Finally, I am particularly grateful to colleagues in the English National Programme. They have been very generous with their assistance and advice.

**Mr Paul Blair**  
**Consultant Vascular Surgeon /**  
**Clinical Lead**  
**NI AAA Screening Programme**



## Section 3:

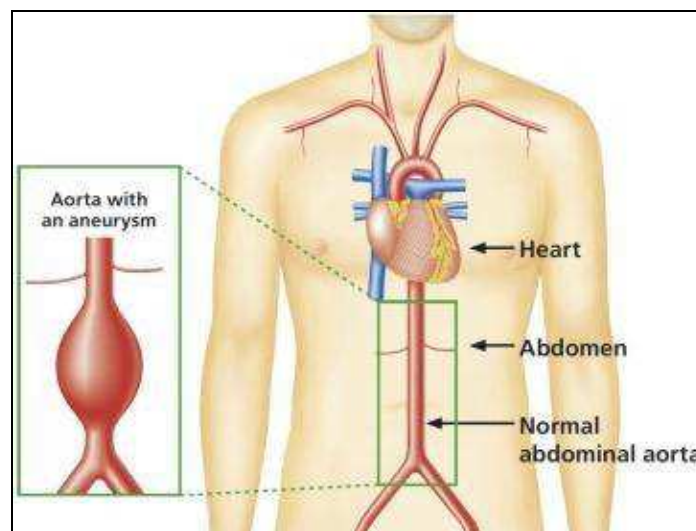
# Background to the Programme

---

### What is an AAA?

An abdominal aortic aneurysm (AAA) is a swelling of the main artery in the body as it passes through the abdomen. The walls of the artery weaken, causing it to balloon out. AAAs are more common in men aged 65 and older. Other factors known to increase the risk of developing an AAA are smoking, high blood pressure and high blood cholesterol. Close relatives of someone who had, or has, an AAA are also more likely to develop one.

AAAs usually cause no symptoms, therefore most people who have one will not feel anything. As the aneurysm grows so too does the risk of it rupturing if left untreated. Rapidly expanding or ruptured aneurysms do produce symptoms (typically severe abdominal, back or flank pain; low blood pressure or shock and mass in the abdomen which pulsates, but only a minority of patients have all of these features). Patients with a ruptured AAA have a very low chance of survival; while those who undergo planned surgery for a non-ruptured AAA have an excellent rate of survival. Each year 80–100 people in Northern Ireland die from a ruptured AAA.



*Image courtesy of English AAA Screening Programme*

## ***Rationale for Screening***

In 2004, the results of the largest ever randomised trial into the merits of AAA screening (the Multi-centre Aneurysm Screening Study - MASS) showed that, after ten years, screening reduced AAA mortality by 40%.

The UK National Screening Committee subsequently recommended implementation of AAA screening provided:

- ***Invited men were given clear information about the risks of elective surgery; and***
- ***Vascular networks were in place to treat individuals referred from the Screening Programme.***

Research has shown that women are six times less likely than men to have an AAA and, on average, women tend to develop AAAs ten years later than men. The NI AAA Screening Programme is therefore aimed at men in keeping with the recommendations of the UK National Screening Committee.<sup>1</sup>

In Northern Ireland, the key milestones which led to the implementation of the programme in 2012 were:

- November 2009 – direction by the Chief Medical Officer to introduce an AAA Screening Programme.
- 2010-2011 – The Public Health Agency in collaboration with the Health and Social Care Board and the Trusts, commenced preparatory work – including consultation with key stakeholders to identify the appropriate service model.
- 2011 - Public Health Agency commissioned the Belfast Health and Social Care Trust to provide the Northern Ireland Abdominal Aortic Aneurysm Screening Programme.
- July 2012 - programme launched and fully implemented across all five Trust areas in Northern Ireland.

## ***Aim of the Northern Ireland AAA Screening Programme***

The overall aim of the Northern Ireland AAA Screening Programme is to reduce deaths from ruptured abdominal aortic aneurysms through early detection, monitoring and treatment.

---

<sup>1</sup> Abdominal aortic aneurysm: the UK NSC policy on abdominal aortic aneurysm screening in men over 65. UK Screening Portal. Available at: [www.screening.nhs.uk/aaa](http://www.screening.nhs.uk/aaa) Accessed 10 December 2012.

All men in Northern Ireland are invited for screening in the year they turn 65; men over the age of 65 can self-refer by contacting the screening programme office.

### ***National Abdominal Aortic Aneurysm Screening Programme (NHS)***

The Northern Ireland AAA Screening Programme benefits from close alignment with the English NHS AAA Screening Programme. Some of these benefits include:

- Adoption of the same call / recall information system (the Northgate SMaRT database); this is also used to manage the ongoing surveillance programme for men with small or medium sized aneurysms.
- Use of the same training provider (Salford University) for the training and accreditation of the Screening Technicians and the Lead Screening Sonographer.
- Procurement of the same portable ultrasound scanning equipment.
- Adoption of the same Quality Assurance standards, which will allow comparison across the two programmes.

It is planned to further develop and improve AAA screening within Northern Ireland through benchmarking of data, operational procedures and other relevant areas with the English NHS AAA Screening Programme. Sharing of best practice and participation in each other's external Quality Assurance visits will help to improve the quality of the programme.

The Northern Ireland AAA Screening Programme has also benefitted from joint promotional initiatives with our English colleagues, including a recent parliamentary reception at Westminster to officially mark full roll-out of AAA screening in England and in Northern Ireland.

## **Section 4:**

### ***Programme Delivery***

---

The Public Health Agency is responsible for commissioning and quality assuring the programme. The Belfast Health and Social Care Trust is responsible for the management and delivery of the programme. The two organisations work closely together to provide an effective, safe and accessible service.

#### ***Programme Staff and Clinic Locations***

There are seven full-time screening technicians who run clinics across Northern Ireland on a daily basis. The programme also employs both a Clinical Lead and an Imaging Lead, together with a range of other staff making up the multi-disciplinary team. (See **Appendix 1** for a full list of the staff.)

The programme office is based in the Royal Victoria Hospital in Belfast. The clinics however are distributed throughout Northern Ireland in 17 different locations. These include health and wellbeing centres, primary care centres and community hospitals. (See **Appendix 2** for a map of current screening locations.) The programme is continuing to identify suitable new clinic locations to ensure that screening is provided as locally as possible, particularly in areas where uptake rates are below the regional or national average.

Screening has also recently taken place for eligible men within Magilligan prison. The programme continues to liaise with health leads within Maghaberry prison with a view to running a similar screening clinic.

#### ***The Screening Pathway***

Pathways have been developed for each part of the programme. **Appendix 3** provides an overview of each of the key stages. These are:

- Screening Invitation
- The Scan
- The Result
- Surveillance
- Referral and Treatment

## Screening Invitation

The programme office sends an initial screening invitation letter to all men during the year in which they turn 65. All eligible men registered with a GP are invited to attend a local screening clinic; men over 65, who have not previously been scanned as part of the programme, can self-refer by calling the programme office (*Tel: 02890 631828*).

Invitation letters are sent together with:

- information on the informed consent process; and
- a leaflet which explains the condition, the screening process and the benefits and risks of screening.

## The Scan

On arrival at the clinic, the screening technician will explain the screening process and the possible outcomes. The technician then advises the man of the consent process, explains that his personal information will be retained securely within the programme system and that the man's GP will be informed of the outcome of the scan. The screening technician is available to answer any questions that the man may have to enable the informed consent process to be completed before the scan takes place.

The screening test involves a simple ultrasound scan of the abdomen. It is quick and painless. The screening technician measures the widest part of the aorta and saves a minimum of two images per scan. The whole process usually lasts less than fifteen minutes.

## The Result

All men will be informed of their results verbally at the clinic. Both the man and his GP will then be sent a letter confirming the result.

There are **FIVE** possible results from screening:

- **NORMAL:** **aortic diameter less than 3cm**

Around 98% of men will have a normal result. This means that the aorta is not enlarged (there is no aneurysm). No treatment or monitoring is needed and the man will be discharged from the screening programme. He will not need to be screened again.



- **SMALL AAA:** aortic diameter measuring between 3cm and 4.4cm

Men who have a small aneurysm detected will be invited back every twelve months for a surveillance scan to monitor the size of the aneurysm. Some small aneurysms will grow in size over time and become medium or large aneurysms.

- **MEDIUM AAA:** aortic diameter measuring between 4.5cm and 5.4cm

Men who have a medium aneurysm detected will be invited back every three months for a surveillance scan to monitor the size of the aneurysm. Some medium-sized aneurysms will grow over time to become large aneurysms.

- **LARGE AAA:** aortic diameter measuring 5.5cm or over

Men who have a large aneurysm detected are referred to a vascular surgeon for further investigation and to discuss treatment options.

- **NON-VISUALISATION:** If an aorta cannot be fully visualised at the initial scan, a man will be invited back for a further scan at another clinic.

The programme also stores details of men in whom a focal bulge – or localised swelling of the abdominal aorta - is detected. These men will be offered a rescreen by the programme five years after their initial screen. A record will also be kept of all men who are detected with an aorta measuring between 2.6cm and 2.9cm should further research deem a rescreen in later years appropriate.

## Surveillance

If a man has either a small or medium-sized aneurysm he will be invited back for surveillance appointments on a regular basis to monitor its size as follows:

- Men with small AAAs will be invited for **annual** surveillance scans.
- Men with medium AAAs will be invited for surveillance scans every **three months**.

Men under surveillance are also offered an appointment with a vascular nurse specialist for additional support and advice. The nurse will contact every man who has an AAA detected within two working days and offer either a face to face appointment or a telephone consultation. The nurse will explain the significance of having an AAA and offer lifestyle advice (including advice on smoking cessation) and advice on blood pressure control (if relevant) to help decrease the risk of the aneurysm growing. The man will also be asked to attend his GP to have measurements taken for height, weight and blood pressure and to discuss any appropriate medication.

## **Referral & Treatment**

The Northern Ireland AAA Screening Programme refers all men with a large aneurysm to the vascular service within the Belfast Health and Social Care Trust. Vascular units are required to meet national standards set by the English NHS AAA Screening Programme and the Vascular Society of Great Britain and Ireland (VSGBI). The regional vascular service in the Royal Victoria Hospital within the Belfast Trust meets these standards.

All men referred to the vascular service are seen by a consultant vascular surgeon within two weeks of the initial scan. During this period, the man will have a CT scan to confirm the size of the aneurysm. The vascular consultant will discuss options available to the man following assessment and discussion at a multi-disciplinary team meeting. The two main treatment options are open surgery or endovascular (EVAR) surgery. The consultant will discuss both options with the man to enable him to make an informed choice.

## Section 5:

### Programme Performance

---

The Northern Ireland AAA Screening Programme's first screening year started in July 2012. Therefore only men who turned 65 between 1 July 2012 and 31 March 2013 were included in the 2012-13 cohort and invited to attend for screening. Future cohorts will include all men who turn 65 between 1 April and 31 March each year.

The current population of Northern Ireland is just over 1.8 million. Within this the number of men aged 65 and over in 2012 was 119,466; while there were 8,894 men aged 65.

This report focuses on the performance of the programme for the 2012-13 cohort<sup>2</sup>, the self-referrals and others offered screening through the programme as at end of March 2013.

The table below shows the total number of men added to the information system for whom screening appointments were generated.

**Table 1: Numbers and categories of men offered screening in 2012-13**

<b>Men:</b>	
Screening Cohort 2012-13 - all men in their 65 <sup>th</sup> year (July 12 – March 13 only) <sup>2</sup>	6,803
Self Referrals – men over 65 who were screened	224
Transfers into the NI programme – men over 65 who were screened	25
Prison setting - men 65 and over who were screened	9
<b>TOTAL:</b>	<b>7,061</b>

---

<sup>2</sup> Data for the 2012-13 cohort is as at 30/06/2013 to allow time for screening episodes to be completed; all other data is as at 31/03/2013

## Overall Performance:

As outlined in the table below, the Northern Ireland AAA Screening Programme has a (detection) prevalence rate of 1.4% for the 2012-13 cohort, which is similar to a number of AAA Screening Programmes across the UK.

**Table 2: Programme performance 2012-13**

	<b>2012-13 cohort</b>	<b>Other men screened</b>	<b>TOTAL<sup>3</sup></b>
<b>Men aged 65 and over</b>	<u>6,803<sup>4</sup></u>	<u>258</u>	<u>7,061</u>
<b>Number of men 65 and over screened for the first time</b>	5,323	258	5,581
<b>Aneurysms detected</b>	-	-	74
<b>Prevalence</b>	1.4%	-	-
<b>Number of men on surveillance</b>	-	-	64
<b>Referrals to the Vascular Unit</b>	-	-	10
<b>30 day post-operative mortality for NI AAA Screening Programme referrals</b>	0	0	0

<sup>3</sup> A detailed breakdown of some data is not provided to ensure no patient is identifiable

<sup>4</sup> Of the 6,803 men in the 2012-13 cohort, 47 men died before being offered a screening appointment; 80 men were not eligible for screening as they were either no longer registered with a GP in NI or they informed the programme of (a) a previously detected AAA (b) previous imaging confirming they did not have an AAA; and 58 men had deferred their screening appointment. A further 43 men still required a screening outcome as at the end of June 2013. The total men eligible for screening with a completed outcome therefore was 6,575 – this is the figure used to calculate the uptake rate.

**Abdominal Aortic Aneurysms detected**  
(from 2012-13 cohort and others screened as at 31 March 2013)

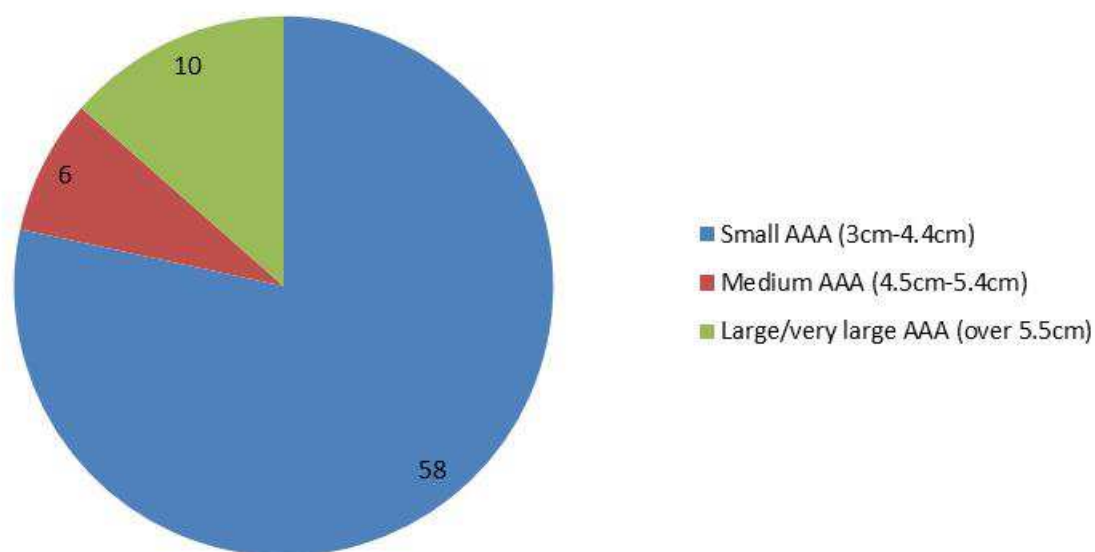


Table 3: Performance against Quality Assurance Standards for 2012-13:

	Programme Performance	Quality Standard - Acceptable	Quality Standard - Achievable
<b>Uptake (initial screening)</b>	81%	≥ 60%	≥ 85%
<b>Uptake (surveillance)</b>	100%	≥ 90%	≥ 95%
<b>Timely referral (subjects with AAA ≥ 5.5cm referred within one working day)</b>	100%	≥ 95%	≥ 97%
<b>Minimise Harm (men with ruptured aneurysm between first screen positive and referral)</b>	0%	≤ 3%	≤ 1%
<b>Timely Intervention (men with AAA ≥ 5.5cm seen by vascular specialist within eight weeks)</b>	100%	≥ 95%	100%

The programme is meeting the 'Achievable' level in all but one of the above Quality Assurance standards; uptake for initial screening is however well above the 'Acceptable' standard at 81%. This compares favourably with the uptake of the English programme, which was 75% in 2011/12.<sup>5</sup>

<sup>5</sup> <http://aaa.screening.nhs.uk/annualreport>

## **Section 6:**

### ***Personal and Public Involvement (PPI)***

---

Personal and Public Involvement (or PPI) is about people and communities influencing the planning, commissioning and delivery of health and social care (HSC) services. It means actively engaging with the public and, specifically, those who use services such as screening.

The Public Health Agency is the lead organisation responsible for the implementation of PPI policy across all HSC organisations within Northern Ireland.

With this in mind, the Northern Ireland AAA Screening Programme instigated a number of initiatives during 2012-13 to help tailor the programme to the needs of its eligible population. Specifically, the following events have actively sought feedback from service users and suggestions for potential enhancements to the current quality of delivery:

- Men's Health Event April 2013 (where men who had undergone AAA surgery or were under surveillance were invited to attend a morning event to meet each other and members of the Programme Team to share their screening experiences and advise on ways in which programme delivery might be improved).
- An awareness raising session delivered to leaders of Men's Health Groups across Greater Belfast.
- Development of the Northern Ireland AAA Screening Programme Website, with visitors being encouraged to feedback on any aspect of the site or programme.

The programme is also in the process of producing a PPI Action Plan to consider short, medium and long-term strategies to facilitate ongoing engagement with service users and other key stakeholders. In particular, the programme is keen to address any perceived health inequalities associated with men aged 65 or over being able to:

- make an informed decision about whether or not to be screened.
- attend for screening.

To this end, the following are just two of a number of exercises to be undertaken within 2013-14:

- pilot of an equality monitoring questionnaire.
- work with local ethnic minority groups to ensure all men who are eligible for AAA screening can access all relevant information in their first language.

### **Northern Ireland AAA Screening Programme Men's Health Event: 25th April 2013**

#### **David and Helen McIntyre (below)**

David underwent an AAA repair in February 2013



**Sandra Byrne, Paul Blair** Clinical Lead (Belfast Trust), **Vaughan Byrne, Dr Adrian Mairs** Programme Lead (PHA) & **Dr Peter Ellis** Imaging Lead (Belfast Trust)

Vaughan underwent an AAA repair in November 2012

## **Section 7:**

### ***Governance and Accountability***

---

#### ***The Public Health Agency***

The Public Health Agency has a number of key functions in relation to screening programmes including:

- Leading on the implementation of screening policy, including the introduction of new screening programmes and any required changes to existing screening programmes.
- Ensuring the delivery of high quality, safe, effective and equitable screening programmes for people in Northern Ireland.
- Supporting continuous quality improvement through programme monitoring and evaluation, and adverse incident investigation and management.

Having successfully led on the implementation and roll-out of AAA screening across the region, the PHA has now entered a new phase of consolidation and development of the existing service. Specifically, the Agency will take lead responsibility for external quality assurance of the programme, focussing on the establishment of a robust QA structure and function to ensure it meets the responsibilities outlined above.

To help fulfil the PHA's core function of monitoring, maintaining and continuously improving upon acceptable standards of service, performance and quality across all elements of the Northern Ireland AAA Screening Programme, the PHA has ensured:

- The timely appointment of QA leads (namely a clinical lead and imaging lead) through a formalised process.
- The establishment of an AAA Screening Co-ordinating Committee, chaired by the Public Health lead, including PHA staff and all relevant members of Belfast Health and Social Care Trust NI AAA Screening Programme staff.
- Regular monitoring of QA data is undertaken by the QA team.
- That appropriate fail-safe mechanisms are in place to ensure screening is



offered to all eligible men and that those men requiring surveillance and referral are followed up in a timely and appropriate way.

- There is an agreed programme of equipment monitoring.
- A programme of formal, external Quality Assurance visits will be established in collaboration with the English NHS AAA Screening Programme.

Members of the PHA will also develop and facilitate audit and research activities related to the programme.

### *The Belfast Health and Social Care Trust*

The Belfast Health and Social Care Trust is responsible for the operational management and delivery of the NI Abdominal Aortic Aneurysm Screening Programme.

The Trust ensures all eligible men are invited to attend for screening in their 65<sup>th</sup> year and that they are provided with appropriate information, support and advice, particularly those men who have an AAA detected through the programme.

Staff who have responsibility for the operation of the programme are employed by the Trust and carry out all of the scans including re-scans and surveillance scans.

The surveillance programme for men identified with a small or medium AAA is provided by the Trust as part of the NI AAA Screening Programme. Similarly, those men who are identified with a large AAA are referred to the vascular surgery team at the Royal Victoria Hospital within the Belfast Trust to discuss potential treatment options.

The Trust also has responsibility for:

- Setting operational policy for the programme.
- Liaising with GPs regarding secondary care, particularly when a man is detected as having an aneurysm.
- Local quality assurance of the screening process.
- Providing reports on the performance of the programme and data for quality assurance purposes.
- Engaging with stakeholders regarding development of the programme.
- Organising and taking part in promotional activities for the programme.

**Appendix 4** details the PHA's governance and accountability reporting arrangements.

**Appendix 5** details the Belfast Trust's governance and accountability reporting arrangements.

***Some members of the AAA Screening Team at the Belfast Health and Social Care Trust***



***From left: Linda Wisdom, Deirdre Kearns, Judith Holmes, Diane Stewart, Sarah Hughes and Pauline McMahon***

## **Section 8:**

### ***Future Development***

---

To ensure the programme continues to meet the needs of its service users both organisations will work on a number of key areas. Some of these areas for future development will be organisation specific, while other objectives will benefit from partnership working. One theme common to all, however, is that both the PHA and the Belfast Health and Social Care Trust are committed to providing a safe, high quality, equitable and easily accessible AAA screening programme for all eligible men in Northern Ireland.

#### **Northern Ireland AAA Screening Programme Objectives 2013-14**

The Public Health Agency and the Belfast Health and Social Care Trust will continue to work together, each taking the lead as appropriate, to:

- Monitor delivery of the programme against national quality standards, taking appropriate action on areas where performance is not on target.
- Ensure appropriate failsafe systems are in place at each stage of the screening process.
- Ensure all staff are appropriately trained on all relevant aspects of the programme, including the Health and Social Care organisations' mandatory training.
- Develop and formalise an appropriate quality assurance structure and function in collaboration with the English NHS AAA Screening Programme.
- Build on existing relations with the other four UK AAA Screening Programmes, specifically with regard to: a review of current QA Standards, updating programme leaflets and re-tendering for the Programme's IT solution.
- Actively engage with stakeholders at relevant events and opportunities, particularly in those areas where uptake rates are lower than the programme average.
- Identify and address health inequalities to ensure all eligible men can make an informed decision about whether or not to attend for screening.
- Develop a Personal & Public Involvement (PPI) Action Plan.

- Develop the Northern Ireland AAA Screening Programme website, engaging with stakeholders as appropriate.
- Review information materials, with a particular emphasis on promoting the self-referral process for men aged 65 or over who have never attended for AAA screening.
- Identify and disseminate examples of regional and national best practice with regard to all elements of programme delivery.
- Promote and participate in research initiatives.

## ***Appendices***

---

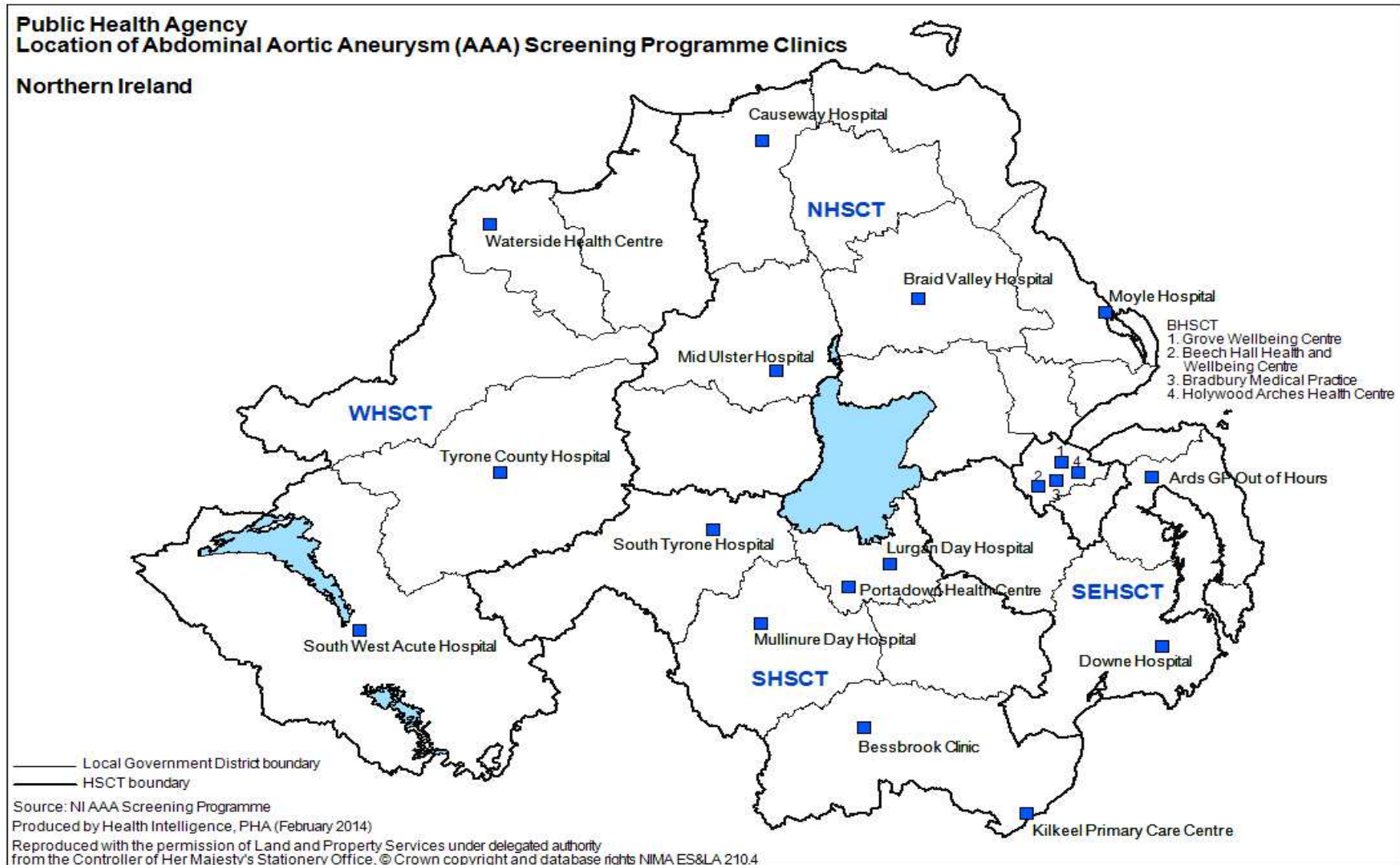
- 1 All Belfast Health and Social Care Trust Staff**
- 2 Screening Locations and Map**
- 3 Overview of Screening Pathway**
- 4 Governance and Accountability Chart for PHA**
- 5 Governance and Accountability Chart for Belfast Health and Social Care Trust**

## *Appendix 1 – Belfast Trust Staff*

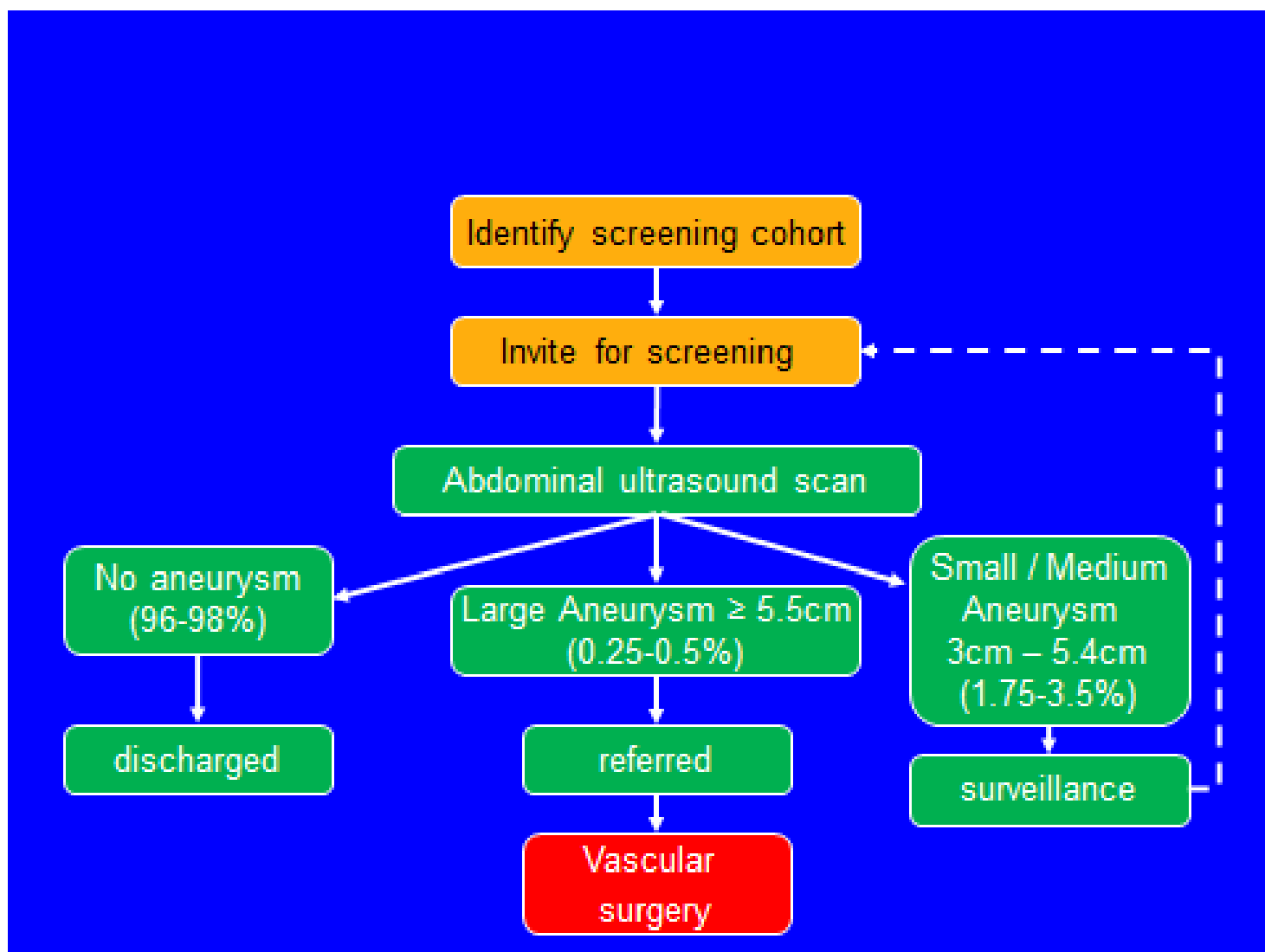
---

Paul Blair	Clinical Lead
Janet Callaghan	Clinical Co-ordinator
Lisa Campbell	Administrative Assistant
Ciara Conway	Screening Technician
Sarah Davidson	Administrative Assistant
Trez Dennison	Vascular Nurse Specialist
Elaine Donnelly	Screening Technician
Peter Ellis	Imaging Lead
Judith Holmes	Screening Technician
Sarah Hughes	Screening Technician
Deirdre Kearns	Lead Screening Sonographer
Pauline McMahon	Screening Technician
Roisin Monan	Deputy Programme Manager
Karen McClenaghan	Specialist Surgery Services Manager
Kathy McGuigan	Vascular Nurse Specialist
Gillian Newell	Screening Technician
Diane Stewart	Programme Manager
Gill Swain	Vascular Nurse Specialist
Linda Wisdom	Screening Technician

## Appendix 2 – Map of Screening Locations



## Appendix 3 – The Screening Pathway



NB: Percentage figures in brackets in the above diagram are predictions based on previous research and therefore differ slightly from actual figures obtained from the NI AAA Screening Programme's first year of screening.



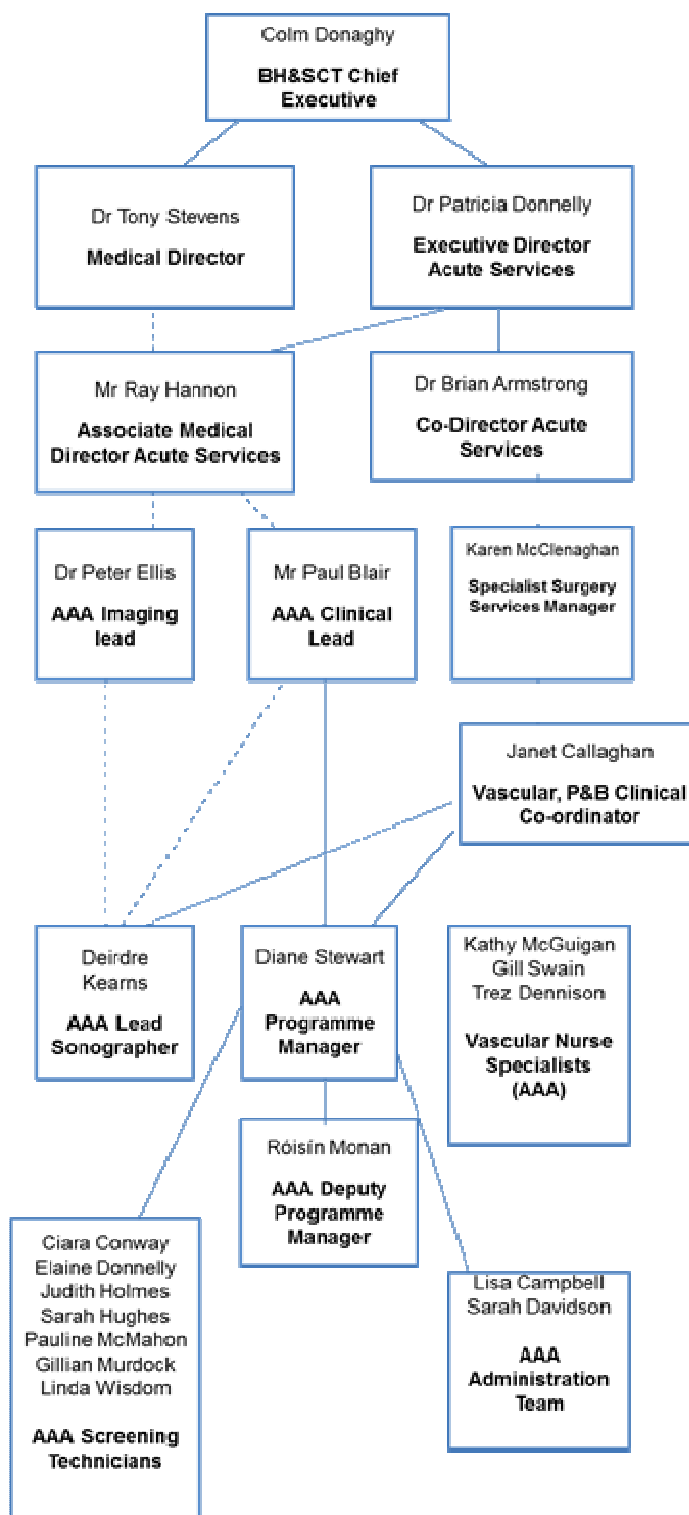
**Appendix 4 – Northern Ireland AAA Screening Programme Governance and Accountability Structure (PHA)**

---



## *Appendix 5 – Governance and Accountability Arrangements for the Northern Ireland AAA Screening Programme within the Belfast Health and Social Care Trust*

---

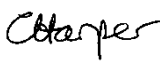


---

If you are interested in finding out more about being screened please contact the Programme Screening Office on 02890 631828.

---

**PUBLIC HEALTH AGENCY BOARD PAPER**

<b>Date of Meeting</b>	19 June 2014
<b>Title of Paper</b>	DPH Annual Report 2013
<b>Agenda Item</b>	14
<b>Reference</b>	PHA/08/06/14
<b>Summary</b>	
<p>The Board are asked to note the 2013 DPH Annual Report. The Report was launched at the Public Health Annual Scientific Conference on Monday 16 June.</p>	
<b>Equality Screening / Equality Impact Assessment</b>	N/A
<b>Audit Trail</b>	This report was brought to AMT on 3 June 2014.
<b>Recommendation / Resolution</b>	For Noting
<b>Director's Signature</b>	
<b>Title</b>	Director of Public Health
<b>Date</b>	3 June 2014

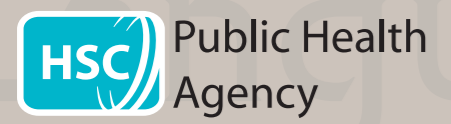
Poverty

Drugs and alcohol

Director of Public Health

Annual Report 2013

# Director of Public Health Annual Report 2013



Public Health Agency, 12-22 Linenhall Street, Belfast BT2 8BS.  
Tel: 0300 555 0114 (Local rate)  
[www.publichealth.hscni.net](http://www.publichealth.hscni.net)





<b>Foreword</b> .....	4
<b>Introduction</b> .....	6
<b>Overview – Diversity: redefining difference</b> .....	7
<b>Improving health and reducing inequalities</b> .....	20
<b>Overview</b> .....	21
E-learning aims to promote workplace LGB&T inclusion .....	22
LGB&T staff forum advocates diversity within HSC .....	24
Northern Ireland New Entrant Service established .....	26
Service users lead creation of addictions network .....	28
PHA health checks for our farming communities .....	30
People with disabilities empowered by Fit 4 U project .....	32
Understanding Traveller attitudes towards breastfeeding .....	34
<i>Cook it!</i> programme reaches out to local BME groups .....	36
Raising awareness of STIs among MSM community .....	38
Guidelines to support the needs of older LGB&T people .....	40
<b>Improving health through early detection</b> .....	42
<b>Overview</b> .....	43
Screening for women at higher risk of breast cancer .....	44
Informed choice to improve cancer screening uptake .....	46

<b>Improving health through high quality services</b> .....	48
<b>Overview</b> .....	49
Providing high-quality maternity services for everyone .....	50
<b>Improving health through research</b> .....	52
<b>Overview</b> .....	53
Community support models address the transition of adults with intellectual disabilities into old age .....	54
Mobility aids for children with physical impairments .....	56
Eyecare for children with developmental disability .....	58
Mortality patterns among Section 75 equality groups .....	60
<b>Protecting health</b> .....	62
<b>Overview</b> .....	63
Regional plan ensures coordinated approach to managing incidents and outbreaks across Northern Ireland .....	64
Meeting the public health challenges of the G8 Summit .....	66
Focusing on the health needs of migrant populations .....	68
<b>List of core tables 2012</b> .....	70
<b>List of figures and tables</b> .....	71
<b>References</b> .....	72
<b>Abbreviations and acronyms</b> .....	82



## Foreword

## Foreword



*“There are not more than five musical notes, yet the combinations of these five give rise to more melodies than can ever be heard.*

*There are not more than five primary colours, yet in combination they produce more hues than can ever be seen.*

*There are not more than five cardinal tastes, yet combinations of them yield more flavours than can ever be tasted.”*

### Sun Tzu

Welcome to the *Director of Public Health Annual Report 2013*.

The theme of this year’s report is to celebrate diversity in our population. Diversity is about people and how we value and appreciate those who are not like us. The ways in which we define ourselves are complex. We are all constantly defining and redefining different aspects of ourselves in the context of our physical characteristics, histories, influences, behaviours, cultures and subcultures.

### Dr Carolyn Harper

When we talk about diversity we mean respecting and valuing all forms of difference in individuals. People differ in all sorts of ways which may not always be obvious or visible. These differences might include race and ethnicity, culture and belief, gender and sexuality, age and social status, ability, and use of health and social care services.

A deep association exists between diversity and our work in public health. It is well recognised that some people find it more difficult to enjoy their full health. It is also evident that minority groups experience poorer health outcomes and have significantly lower access to services.



## Meeting the challenges

Understanding the distribution of the determinants of health within these groups is essential if we are to reduce health inequalities. Without this, it would be impossible to create services that address the real needs of our population. Northern Ireland has well-developed health information systems and significant work is underway to improve data that will allow us to analyse and monitor the differences in health status between groups.

Health inequality is a complex issue and many factors influence the differences in health status between population groups. The public health interventions employed to improve the population's health are wide-ranging and cross-cutting. It is therefore essential to continue effective partnership working to address these issues. There are a range of initiatives in place and we are working closely with many strategic partners to develop new, and expand existing, programmes for all subgroups within the population of Northern Ireland.

Our public health programmes are based on robust evidence where it is available and seek innovation where evidence is limited. The redesign of patient care pathways with a focus on prevention empowers people to manage their own health and avoid needing hospital care. It also offers a local approach different to traditional medical models, whilst operating under difficult financial conditions.

The report sets out some new public health priorities for Northern Ireland, as well as reiterating priorities in my previous reports for the period 2010 to 2012, around early years and elderly health.

My report recognises the opportunities and challenges posed by population diversity and highlights some of the key programmes introduced to meet these needs. The main purpose of public health is to protect and improve health and social wellbeing and to tackle health inequalities through strong partnership with individuals, communities, and other key public, private and voluntary organisations. Central to our ambition is to place the patients and the public at the heart of everything we do.

I hope you enjoy reading this report and want to thank you all for your commitment and enthusiasm for improving health in Northern Ireland, for making sure that we focus on reducing health inequalities and for putting working programmes in place that make a real difference. To inform future reports, I would also be pleased to receive feedback on this report's content, presentation and usefulness.



Dr Carolyn Harper  
Director of Public Health

### Further information

**Dr Carolyn Harper**  
**Director of Public Health**  
[carolyn.harper@hscni.net](mailto:carolyn.harper@hscni.net)

# Introduction

## Report structure

This is the fifth *Director of Public Health Annual Report*, detailing the main public health challenges in Northern Ireland. It also provides information on the wide variety of work undertaken by the Public Health Agency (PHA) and its partners during 2013 to improve the health and social wellbeing of the population. Each year, the Director of Public Health (DPH) report focuses on an overarching theme, and this year the theme is 'Population diversity'.

The report structure reflects the main areas of public health action:

- improving health and reducing inequalities;
- improving health through early detection;
- improving health through high quality services;
- improving health through research;
- protecting health.

For ease of reference, the sections are colour coded.

On page 70, the report also lists core tables for 2012 relating to key statistical data on, among others, population, birth and death rates, mortality by cause, life expectancy, immunisation and screening. In addition to the core tables, a specific set of tables relating to various aspects of diversity are published alongside this report.

Both sets of tables are available as a portable document format (PDF) file on the PHA website at: [www.publichealth.hscni.net](http://www.publichealth.hscni.net)

## Background

The PHA was established to:

- protect public health and improve the health and social wellbeing of people in Northern Ireland;
- reduce inequalities in health and social wellbeing through targeted, effective action;
- build strong partnerships with key stakeholders to achieve tangible improvements in health and social wellbeing.

The PHA takes direct public health action and commissions or facilitates action by others, including a wide range of community, voluntary and statutory partners across all sectors.

## Diversity: redefining difference

Diversity literally means difference. When it is used as a contrast or addition to equality, it involves:

- recognising individual as well as group differences;
- treating people as individuals;
- placing positive value on differences in the community and population.

Although there have been improvements in the overall health of the Northern Ireland population, these have not been experienced by all groups at the same rate. The economic downturn is a further risk factor with a disproportionate impact likely to be experienced by those already disadvantaged.

It is therefore important that public health principles, core services, research and programmes take into account the diversity in communities and the population. There is no single way to divide the population into specific sub-groups. However, for the purpose of this report, we have looked in detail at 12 groups.

There are opportunities and challenges for public health posed by diversity within the Northern Ireland population. The health problems faced by different population groups are immensely varied and this overview highlights some of the most important public health issues experienced by these diverse groups.

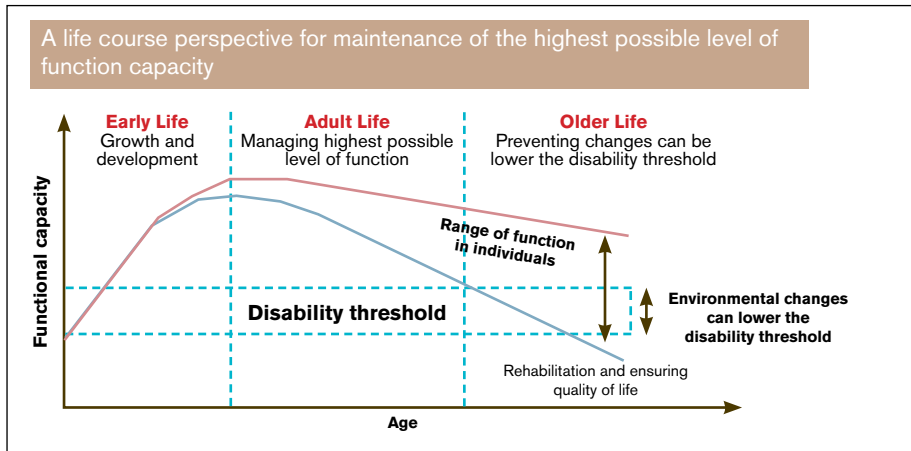
### 1. Public health and age

Age is one of the most important characteristics of health.<sup>1</sup> The current life course approach in public health refocuses our attention on the importance of age as a fundamental characteristic of individuals and society.<sup>1,3</sup>

Public health programmes cover the full life course from pre-conception to end of life care. The early years of life are a vital stage as they establish the foundations for later health, while the ages between 10–24 cover the key changes that pave the way to adulthood and reinforce many of the values and behaviours that will impact on health throughout the rest of life.<sup>1,2,3</sup>

In line with recommendations in *Fair society, healthy lives*, the Marmot Review of health inequalities in England, the PHA has a strategic goal to give every child and young person the best start in life. Investment in early years of life brings significant benefits later across a wide range of outcomes in relation to health and wellbeing, education and employment.<sup>4</sup>

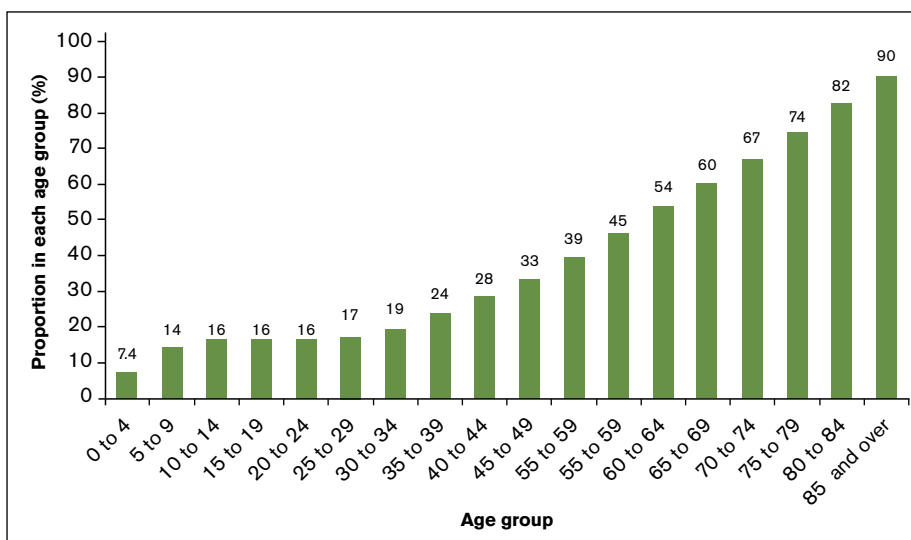
**Figure 1: Life course approach in public health**



Middle age is characterised as the time when the aggregated harms of the previous decades of life start to have their impact on health and, therefore, it is a time of greater concentration on healthier behaviours.<sup>2,3</sup> On the other hand, in older age, the focus is more on maintenance of functions and reduction of the gap between life expectancy and healthy life expectancy.<sup>2</sup>

The fall in fertility rates and the significant improvement in life expectancy have inevitably resulted in an older population overall in Northern Ireland.<sup>5</sup> As illness is more common in later life, it follows that the incidence of illness and disability will also increase.

**Figure 2: Proportion of those in each age group with at least one long-term condition**



Based on the 2011 Census, the proportion of the population who assess their general health as 'bad' or 'very bad' increases with age, from less than 1% among those aged 0–9 years to 10% among those in their 50s and 17% among those aged 85 and over.

In a similar way, the proportion of the population who have at least one long-term condition increases from 11% among children aged 0–9 years to 42% among those in their 50s and 90% among those aged 85 and over.<sup>5</sup>

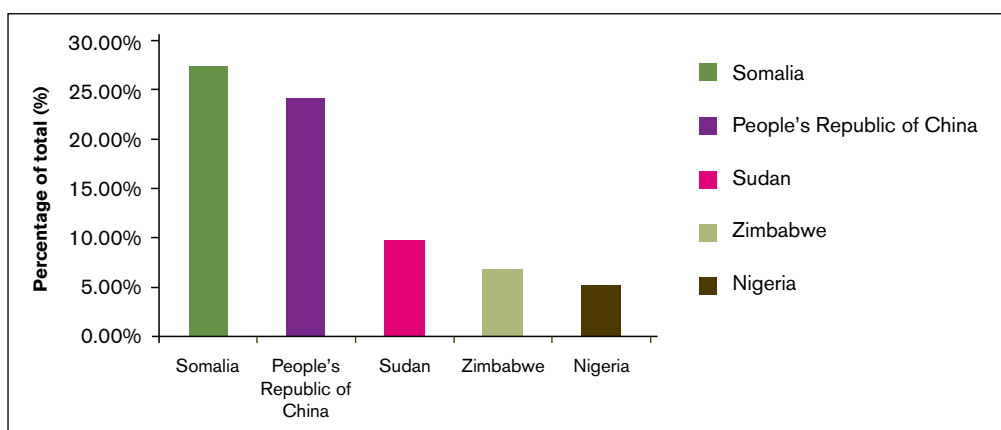
An active, secure and healthy older population can bring huge benefits to families, friends, workplaces and society as a whole. Given that the number of people of current pensionable age in Northern Ireland is projected to increase by around 40% by 2023, it is important to have in place a range of comprehensive programmes to ensure fair, high quality, integrated Health and Social Care (HSC) services for older people.<sup>6</sup>

The PHA has put in place a range of programmes to address the needs of all life course stages. Examples of these have been highlighted in previous DPH reports.<sup>7,8</sup>

## 2. Asylum seekers and refugees

It is difficult to accurately assess the number of asylum seekers and refugees in Northern Ireland. A small but growing number of people are seeking asylum in Northern Ireland, entering through one of the Northern Ireland ports or the Republic of Ireland.<sup>9</sup> The report *Forced to flee* published by the Refugee Action Group estimated that around 2,000 refugees from about 30 different countries currently reside in Northern Ireland.<sup>9</sup>

**Figure 3: Five most common countries of origin for first-time asylum applicants between 1 January 2011 and 31 October 2012**



Source: Northern Ireland Strategic Migration Partnership

The Northern Ireland Strategic Migration Partnership reported 115 first-time asylum applicants in Northern Ireland in 2011 and 140 between January and October 2012 (10 months).<sup>10</sup>

Aggregated data for first-time asylum applicants between 1 January 2011 and 31 October 2012 show that five countries (Somalia, China, Sudan, Zimbabwe and Nigeria) accounted for 73% of applications (Figure 3).<sup>10</sup>

It is important to note that, by virtue of their history and experiences, the health needs of asylum seekers and refugees are different to those of the indigenous population. Many may have endured acute hardship, abuse and persecution in their country of origin, and have multiple health and social care problems. As a result, they may require a broader range of health services, particularly in the area of psychology and mental health. There may also be added trauma for asylum seekers due to detention or delays in processing their claims.<sup>11</sup>

The PHA is working closely with organisations such as the Northern Ireland Council for Ethnic Minorities (NICEM), the National Asylum Support Service (NASS) and other related organisations to address these issues. In addition, the PHA, in collaboration with the Health and Social Care Board

(HSCB) and Belfast Health and Social Care Trust (HSCT), has established the Northern Ireland New Entrant Service (NINES) to offer a regional, holistic service and facilitate access to mainstream Health and Social Care for new entrants, including migrants, asylum seekers and refugees.

### 3. Public health and carers

Carers are a socially and demographically diverse group and, as the demand for care is projected to grow, people are increasingly likely to become informal providers of care at some point in their lives. The importance of unpaid care was reflected by its inclusion as an item in both the 2001 Census and 2011 Census. *Valuing care*, a report published in 2011, estimated that carers save the Northern Ireland economy over £4.4 billion a year.<sup>12</sup>

In the 2011 Census, approximately one in eight people living in household in Northern Ireland (12%) provided unpaid care to family members, friends, neighbours or others.<sup>13</sup> The provision of unpaid care was related to age, increasing from under 1% among children aged 5–9 to a peak of 23% among those aged 50–54, and thereafter declining to 6.7% among those aged 85 years and over. The number of people providing unpaid care in Northern Ireland has increased from 185,000 to 214,000 between 2001 and 2011.<sup>13</sup>

Current evidence suggests that caring is more commonly undertaken by women and is more intensive in deprived areas.<sup>14</sup> Carers are put under significant constraints through the physical and emotional demands of caring. The evidence also suggests the physical and mental health of those providing high levels of care is worse than that of non-carers.<sup>15,16,17</sup> The PHA is engaged with other strategic partners to provide support, training and educational programmes for carers in Northern Ireland.

### 4. Public health and disability

The population of disabled people is heterogeneous, not only in terms of impairments but also demographically, socially and economically.

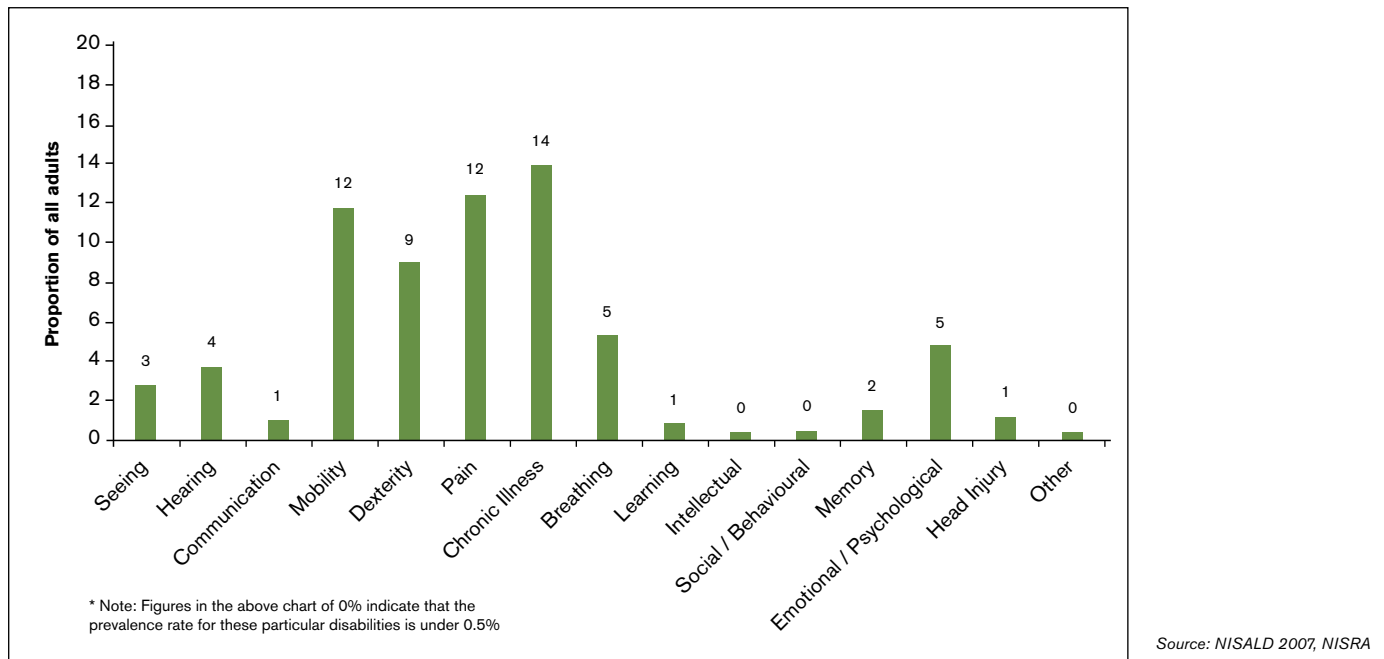
Good quality information on people in Northern Ireland with a disability is limited, especially in terms of their multiple identities and their experiences across a range of social and economic contexts, such as education, employment, transport and claiming of benefits.

In 2007, the Northern Ireland Statistics and Research Agency (NISRA) reported that nearly one in five people (18%) in households in Northern Ireland are limited in their daily activities for reasons associated with disability.<sup>18</sup> The 2011 Census included a new question about the nature of any long-term condition or disability that respondents experienced, including, for example:

- deafness;
- blindness;
- a mobility or dexterity difficulty;
- shortness of breath or difficulty breathing;
- a chronic illness.

People experiencing any such long-term condition or disability were less likely than those without such a long-term condition to assess their general health as 'very good' (12% compared with 64%). Broadly similar proportions among those with or without a long-term health problem or disability assessed their general health as 'good' (31% and 32% respectively).

Figure 4: Prevalence of different disabilities among adult household population in Northern Ireland



There is evidence that people with serious mental health problems are at high risk of coronary heart disease and stroke before the age of 55.<sup>19,20</sup> Similarly, people with learning difficulties are at high risk of respiratory disease, malnutrition and obesity.

Cervical and breast screening uptake rates are lower among people with learning disabilities.<sup>20</sup> There is also evidence that suggests people with disabilities are more likely to be living in poverty.<sup>21</sup> In addition, people with mental health problems and learning disabilities are more likely to experience social stigma and discrimination, which put them at greater disadvantage.<sup>22,23</sup>

Disability is not a simple reflection of an individual impairment or function, but a reflection of both physical and social environments that act as a barrier or facilitator in individual life. The PHA, in collaboration with partner organisations, is involved in improving the range and quality of services for people of all ages with disabilities across Northern Ireland.

## 5. Public health and ethnicity

Ethnicity reflects social differences between people and communities which may change over time. People may want to identify themselves with more than one ethnic group, which is why a new ethnic category 'Mix' was introduced in the 2011 Census.

Ethnic groups are non-homogenous, reflecting a highly diverse range of cultures and languages. On Census day 2011, 1.8% (32,400) of the Northern Ireland population were from ethnic minority groups, more than double the proportion in 2001 (0.8%). The main, non-white minority ethnic groups were Chinese (6,300 people), Indian (6,200), mixed (6,000) and other Asian (5,000), each accounting for around 0.3% of the resident population. A further 0.1% (1,300) were Travellers. Belfast (3.6%), Castlereagh (2.9%) and Dungannon (2.5%) had the highest proportions of residents from minority ethnic groups.



Table 1: Minority ethnic groups in Northern Ireland, 2001–2011

Ethnic group	Census 2001		Census 2011		Difference
	Count	Per cent of total population	Count	Per cent of total population	Count
<b>Total residents</b>	1,685,267	100	1,810,863	100	125,596
<b>White</b>	1,670,988	99.2	1,778,449	98.2	107,461
<b>Chinese</b>	4,145	0.2	6,303	0.4	2,158
<b>Indian</b>	1,567	0.1	6,198	0.3	4,631
<b>Mixed</b>	3,319	0.2	6,014	0.3	2,695
<b>Irish Traveller</b>	1,710	0.1	1,301	0.1	-409
<b>Other</b>	1,290	0.1	2,345	0.1	1,063
<b>Pakistani</b>	666	0	1,091	0.1	425
<b>Black African</b>	494	0	2,345	0.1	1,851
<b>Black other</b>	387	0	899	0.1	512
<b>Black Caribbean</b>	255	0	372	0	117
<b>Bangladeshi</b>	252	0	540	0	288
<b>Other Asian</b>	194	0	4,998	0.3	4,804

Source: NISRA

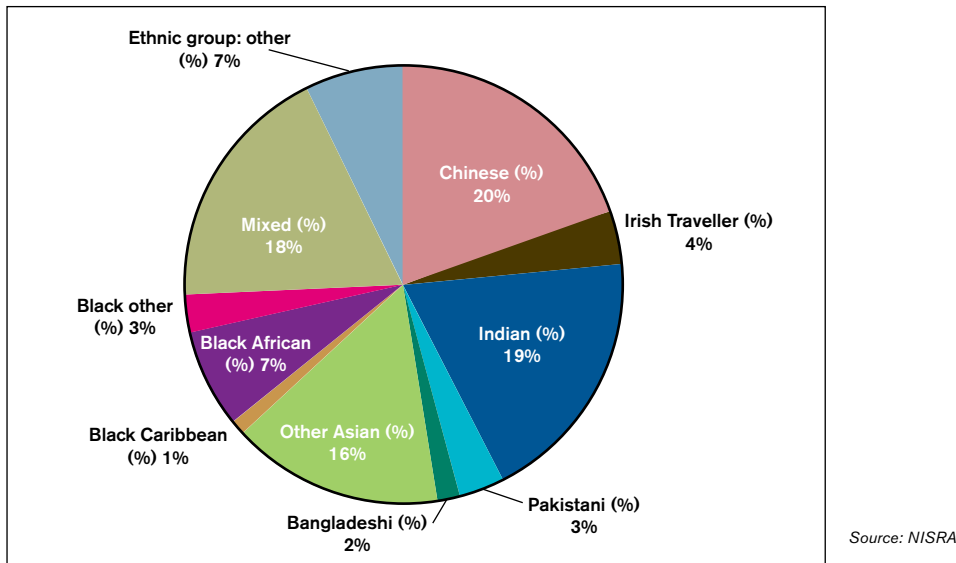
In the last few decades, the Northern Ireland population has become more ethnically diverse. It is clear that net inward migration during the last decade has supplemented existing minority ethnic communities and changed the ethnic mix of many places, both urban and rural. Ethnic minorities, however, have persistent barriers to healthy living, such as language, relatively lower socioeconomic class, inferior working and living conditions, lack of cultural awareness, and lack of understanding of HSC systems.

Ethnic groups within the Northern Ireland population bring different opportunities as well as challenges. These include:

- issues around health protection (eg hepatitis B, hepatitis C, HIV);
- vulnerability to non-communicable diseases;
- experience of health care (immunisation, prevention, screening, treatment);
- cultural beliefs about health/illness;
- acceptability of treatments.

There are also major challenges in the areas of education, employment, housing, poverty, racism and discrimination.<sup>20,21,24,25,26</sup>

Figure 5: Northern Ireland minority ethnic population, by ethnic group, 2011



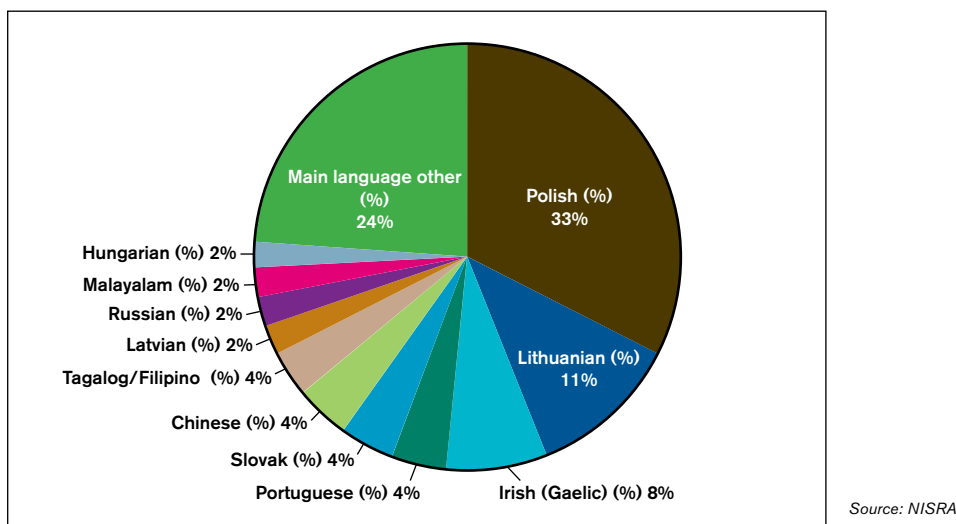
The PHA recognises the great wealth of experience and culture the minority ethnic population brings to Northern Ireland and is well aware of their specific needs as they can also represent one of our most vulnerable groups. The PHA is working in partnership with the Department of Health, Social Services and Public Safety (DHSSPS), HSCB, HSCTs, voluntary organisations and other strategic partners to address these needs.

### 6. Public health and language diversity

English is the main language in Northern Ireland and a lack of English language skills can therefore prevent or obstruct participation in society at the most basic level.

The 2011 Census found that English was not the main language for 3.1% (54,500) of Northern Ireland residents aged three years and over.<sup>25</sup> The most prevalent main language other than English was Polish (17,700 people). Other main languages spoken included: Lithuanian (6,300 people), Irish (4,200), Portuguese (2,300), Slovak (2,300), Chinese (2,200), Tagalog/Filipino (1,900), Latvian (1,300), Russian (1,200), Malayalam (1,200) and Hungarian (1,000).<sup>27</sup>

Figure 6: Northern Ireland minority ethnic population, by main language, 2011



Little or no knowledge of English is considered the most significant barrier to accessing HSC, as well as service delivery. This can lead to an over-reliance on friends, family and minority ethnic support organisations to provide information on services.

Current evidence suggests that people who are not fluent in English:

- have less access to healthcare;
- receive fewer preventive measures;
- may have poor experience of service.<sup>28,29,30</sup>

On the other hand, competency in English:

- is linked to quality of life improvements;
- enables people to secure employment;
- contributes to inclusion, integration and active citizenship.

Many people whose first language is not English are migrants, asylum seekers, refugees or from ethnic minorities, so it is plausible that some of the health issues faced by non-English speakers are similar to those groups.<sup>24,25,26</sup> Communication barriers within HSC:

- prolong appointments;
- take up more staff time;
- increase the risk of misdiagnosis, misunderstanding and non-consent to examination, treatment or care.

The PHA supports other organisations working to improve English language skills and access to HSC for people who do not speak English. For example, the Northern Ireland Health and Social Care Interpreting Service (NIHSCIS) provides free interpreting to those who do not speak English as a first or competent second language.

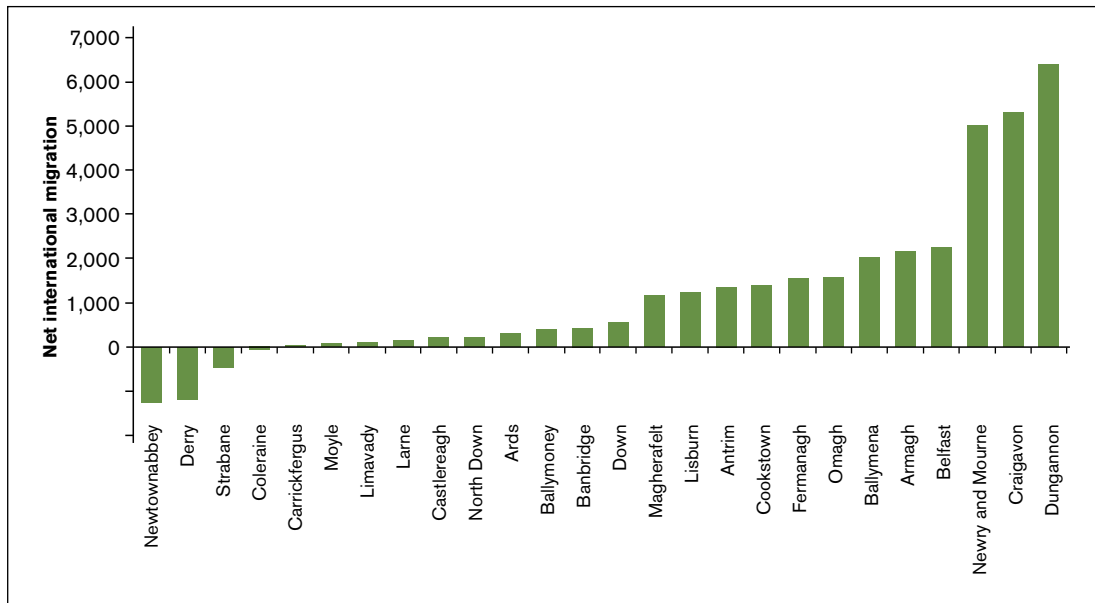
## 7. Public health and migrants

Migration has significant implications for all areas of public health practice. Patterns of disease, health needs and the type of health services required are different for migrant populations.

Between 2001 and 2009, it is estimated that around 110,000 migrants came to Northern Ireland. Previous immigrants to Northern Ireland tended to be from China and India, but more recently, eastern European migrants increased in number. During the tenure of the Worker Registration Scheme, figures showed relatively high numbers of migrants to Northern Ireland from A8 countries (eight eastern European countries that joined the European Union in 2004), compared with the UK as a whole. More than half of those migrants were from Poland, which continues to be the largest national minority group in Northern Ireland.<sup>31,32</sup>

Since 2009, migration figures in Northern Ireland have started to stabilise and most recent figures indicate a slight decrease. NISRA figures show a total of 12,900 people came to live in Northern Ireland from outside the UK in the period from mid-2011 to mid-2012, with migrants from outside the UK and Republic of Ireland making up approximately 4.5% of the overall population. Only 2% of the overall population – about 36,000 people – are migrants from outside the European Union.<sup>32,33</sup>

Figure 7: Estimated net international migration, by Local Government District



Source: NISRA

There is evidence that mental and social health problems are an issue for many migrants.<sup>33</sup> In general, the physical health of migrants is likely to be similar to the local population of the same age, but there are some differences, eg the smoking levels among Polish migrants in other countries were found to be higher than the local population.<sup>34</sup>

Access to and knowledge of the health systems among migrant populations is reported to be limited, with language as a recurring barrier.<sup>28,29</sup> The PHA is working on a number of programmes in partnership with the DHSSPS, HSCTs, voluntary organisations and other partners, to address the key challenges faced by migrant populations.

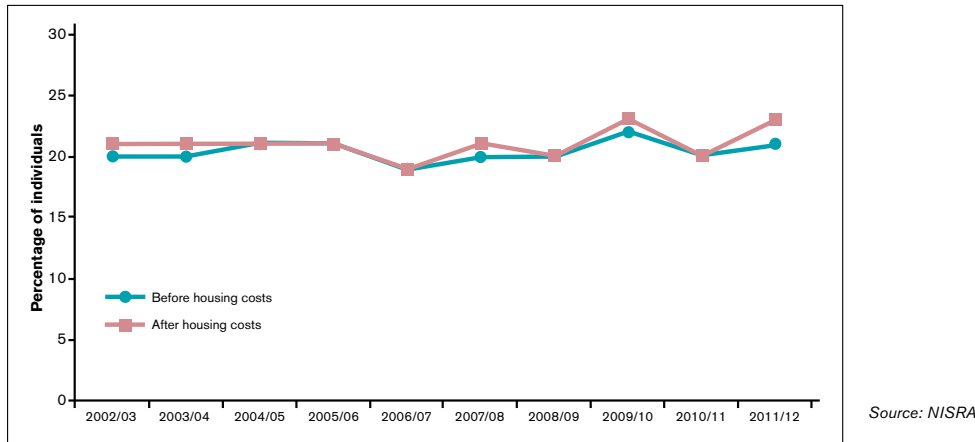
## 8. Poverty and public health

Poverty affects health throughout the life course. Evidence suggests that poverty can continue through generations with today's children who are living in poverty often going on to have children of their own who in turn experience poverty.<sup>35</sup> In addition, adults who experienced poverty in adolescence are more likely to be poor in their early 30s, with the association stronger than that seen for childhood poverty.<sup>36</sup> Similarly, events in later life – the onset of retirement, loss of a spouse and onset of disability – are the three most commonly studied life events affecting later life poverty and low income.<sup>37</sup>

The overall level of relative poverty in Northern Ireland has increased between 2010/11 and 2011/12.<sup>38</sup> This increase was more marked for some population groups. Approximately one fifth of the population (21%, 379,000 people) were in relative poverty and almost a quarter (24%, 422,000 people) were in absolute poverty before housing costs.<sup>38</sup>

In 2011/12, 22% of the child population (almost 95,000 children) were in relative poverty and 25% (109,000 children) were in absolute poverty before housing costs.<sup>38</sup> The latter represents a 4% increase on the previous year.<sup>38</sup> Similarly, a fifth of working age adults (20%, 213,000 people) were in relative poverty and more than a fifth (22%, 235,000) were in absolute poverty before housing costs.<sup>38</sup>

**Figure 8: Relative poverty in Northern Ireland, 2002/03–2011/12**



In 2011/12, a quarter of pensioners (25%, 72,000 people) were in relative poverty and more than a quarter (27%, 79,000 people) were in absolute poverty before housing costs. The latter figure represents a 5% increase on the previous year.<sup>35</sup>

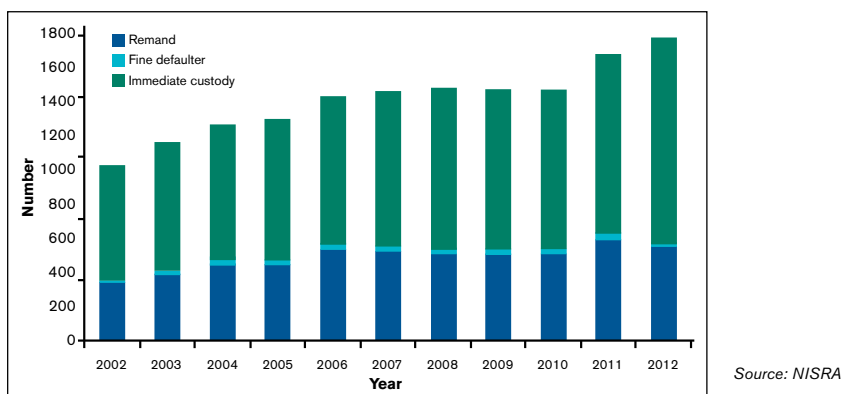
There is growing evidence that poverty is associated with high levels of poor health and increased HSC needs. Children’s early experience of poverty affects their health, not only when they are young, but also later in life. Adult health-related behaviours like smoking and poor diet are also strongly linked to poverty, with clear gradients from high to low income households.<sup>39,40</sup> Similarly, mental health problems, obesity and sexual health problems are linked to poverty.<sup>41,42</sup>

Across Northern Ireland, the PHA is working with voluntary and statutory partners on a range of initiatives to support vulnerable groups and address the wider and more complex determinants of health.

### 9. Prisoner population

Prisoners are a unique population that present distinct health challenges and exceptional health improvement opportunities. In 2012, there were an average 1,774 prisoners in Northern Ireland, 97% of whom were male. Fifty two percent of the immediate custody prison population were between the ages of 17 and 29 years at the time of entry. Life sentence prisoners made up 17% of the average immediate custody population in 2012.<sup>43</sup>

**Figure 9: Average number of prisoners in Northern Ireland, by prisoner type, 2002–2012**



There is growing evidence that the physical, mental and social wellbeing of prisoners is poor compared to people of the same age in the general population.<sup>43,44</sup> There are also high rates of blood-borne

diseases, asthma, epilepsy, sexually transmitted infections and dental decay. Drug and alcohol misuse and smoking are also more prevalent among prisoners than the general population.<sup>44</sup>

Evidence suggests that prisons can make a major contribution to improving the health of some of the most disadvantaged and excluded individuals in society, tackling health inequalities in the process.<sup>44</sup>

The PHA has recently completed a comprehensive health needs assessment of the prison population in Northern Ireland and is working with partner organisations on the implementation of resultant recommendations.<sup>44</sup>

### 10. Religion and beliefs

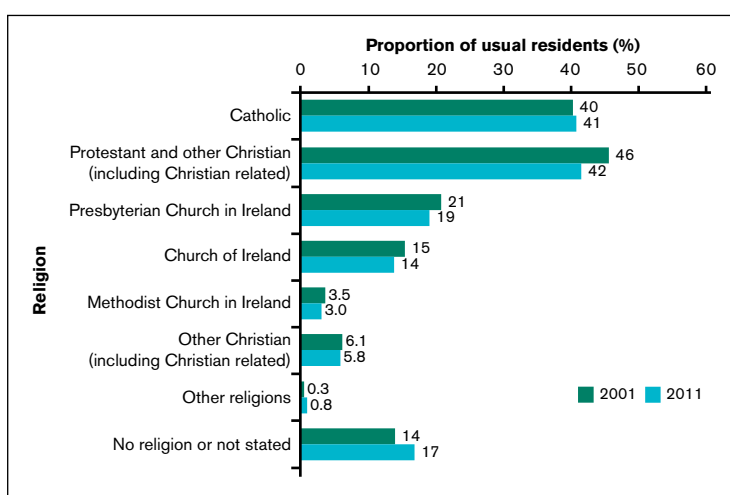
There are a diverse range of religious beliefs in Northern Ireland. It is likely that these beliefs have a role in and impact on people’s health.<sup>45</sup> Religion and beliefs may also affect the acceptability of certain medical practices, eg diagnostic procedures, certain types of treatment, organ donation, blood transfusion.<sup>45</sup>

Current evidence suggests religious beliefs may have both positive and negative impacts on health and morbidity. Religious involvements may increase physical, mental and social wellbeing.<sup>46</sup> On the other hand, discrimination based on religion and beliefs can contribute to poor health.<sup>46,47</sup>

The Census in 2001 and 2011 asked ‘What religion, religious denomination or body do you belong to?’ The main aim of this question was to determine religious affiliation, ie whether or not someone belongs to or identifies with a religion, irrespective of actual practice or belief.

Between 2001 and 2011, the proportion of people who belonged to Protestant or other Christian (including Christian-related) denominations fell from 46% to 42%, while the proportion of Catholics increased from 40% to 41%.<sup>45</sup>

Figure 10: Reported religious affiliation of Northern Ireland population, 2001 and 2011 Census



Source: NISRA

On Census day 2011, the largest other Christian (including Christian-related) categories were: Baptist (1% of usual residents), Christian (0.8%) and Pentecostal (0.7%). The most prevalent other religions were: Muslim (0.2%), Hindu (0.1 %) and Buddhist (0.1%).<sup>45</sup>

Some of the healthy behaviours of different religions and beliefs may provide a meaningful entry point into people’s lives to address some of the key public health issues in Northern Ireland.<sup>46,47</sup>

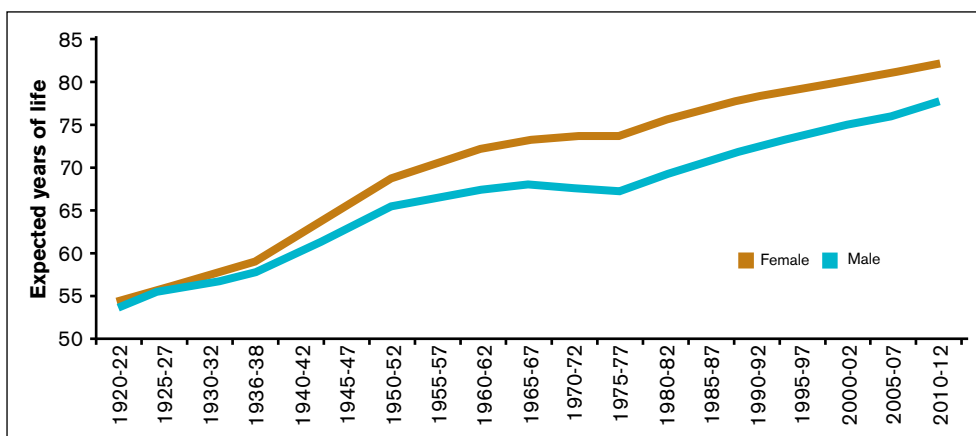
## 11. Sex and gender identity

Although the terms sex and gender are often interchanged, they have distinct meanings. Sex is a classification based on biological differences, while gender is a classification based on social construct. The differences in the health of males and females often reflect the simultaneous influences of both sex and gender.<sup>5</sup>

NISRA data from 2011 show there were more females (51%) than males (49%) in Northern Ireland.<sup>5</sup> In contrast, no reliable information is available on the number of transgender people living in Northern Ireland. In the UK, it is estimated the number of transgender people ranges from about 1 in 100 to as many as 1 in 20.<sup>48</sup>

Based on current death rates, males born between 2010 and 2012 could expect to live until they are 77.7 years and women could expect to live until they are 82.1 years. While women aged 65 years today can expect to live another 20.1 years, their male counterparts can expect to live another 17.3 years.<sup>5</sup>

Figure 11: Expected life years of the Northern Ireland population, by gender, 1920–2012



Source: NISRA

The largest contributor to the gap in life expectancy between genders was the higher mortality rate among men for coronary heart disease (1.3 years). Suicide and accidents (including transport accidents) each contributed 0.5 years to the gap, while cancer (other than breast and prostate cancer) contributed 1.2 years.<sup>49</sup> Breast cancer in women subtracted 0.5 years from the gender gap; however, this was largely offset by prostate cancer in men, which added 0.4 years to the gap.<sup>49,50</sup>

Recent research evidence highlighted that women generally have better health-related behaviours than men with regard to dietary habits, alcohol consumption and smoking. However, sub-groups within the population vary significantly between males and females.<sup>51,52</sup>

Challenges for women's health include cardiovascular diseases, cancer and osteoporosis. In contrast, men are characterised by their shorter lifespan and the fact that they do not use the health services, health improvement programmes or screening programmes as much as women.<sup>52</sup>

There is limited information available on transgender health. A survey conducted in the UK reported that 34% of transgender people attempted suicide and about 50% experienced discrimination at work.<sup>49,50,51</sup>

The PHA is working with strategic partners, including transgender sector organisations to address the wider determinants of health and wellbeing that will promote societal change, with a view to eliminating gender-based barriers to good health.

## 12. Sexual orientation

There are no robust data on the number of lesbians, gay men and bisexuals in Northern Ireland. However, research in the UK estimates that around 5–7% of the population is lesbian, gay, or bisexual (LGB).<sup>51,53</sup> This equates to about 65,000–90,000 of the Northern Ireland population. Although the acronym LGB is used as an umbrella term and the health needs of this community are often grouped together, each of these groups represents a distinct population with its own health concerns.

The availability of general health information on LGB people is patchy. Recent research concluded that LGB people are at significantly higher risk of mental disorders, suicidal thoughts, substance misuse and deliberate self-harm. Local evidence from Northern Ireland shows that 82% of LGB people have experienced harassment and 55% have experienced homophobic violence.<sup>53,54</sup> LGB people's experience of healthcare suggests there are numerous barriers, including:

- homophobia and heterosexism;
- lack of appropriate protocols;
- an absence of LGB-friendly resources.<sup>55,56,57</sup>
- misunderstandings and lack of knowledge;
- poor adherence to confidentiality;

Local research evidence also suggests substance misuse and risky sexual behaviours are more prevalent among the LGB population. Individuals of alternate sexual orientation are over-represented among patients with sexually transmitted infections, including syphilis and HIV.<sup>58,59</sup>

The PHA is responsive to the fact the LGB community, like other disadvantaged groups, has a higher incidence of physical, mental and social health problems, which are likely to have substantial, negative impacts on their life. The PHA is working in a lead role and in partnership with LGB sector organisations to help address these issues.

### The aim of public health programmes

Public health programmes aim to:

- prevent ill health;
- detect and treat diseases early;
- address health inequalities;
- improve the health and wellbeing of the whole population.

The PHA's challenge is to:

- increase awareness of the significance of health diversity;
- highlight the impact of health diversity on the population as a whole;
- lead on the actions necessary to improve health outcomes;
- broaden leadership for addressing health inequalities at all levels.

Public health programmes in Northern Ireland are based on scientific and economic evidence where it exists, or on innovative practice if evidence is limited. This report highlights some examples from our range of public health programmes, particularly those that have led to significant improvements in the health and wellbeing of population sub-groups in Northern Ireland.

#### Further information

**Dr Muhammad Sartaj**  
Public Health Registrar  
(Health Improvement)

[muhammad.sartaj@hscni.net](mailto:muhammad.sartaj@hscni.net)



# Improving health and reducing inequalities

## Overview

E-learning aims to promote workplace LGB&T inclusion

LGB&T staff forum advocates diversity within HSC

Northern Ireland New Entrant Service established

Service users lead creation of addictions network

PHA health checks for our farming communities

People with disabilities empowered by Fit 4 U project

Understanding Traveller attitudes towards breastfeeding

*Cook it!* programme reaches out to local BME groups

Raising awareness of STIs among MSM community

Guidelines to support the needs of older LGB&T people

## Overview

# Overview

Improving health and reducing inequality requires coordinated action across many different sections of government and delivery organisations. Action is required to embed health and social wellbeing improvement into the commissioning of HSC services alongside developing effective partnerships with other sectors that can influence the wider determinants of health.

Professor Sir Michael Marmot's review has highlighted that inequalities in health and wellbeing are avoidable and socially unjust.<sup>60</sup> He has also reinforced the fact that action must be universal and at a scale and intensity proportionate to the level of disadvantage.

In Northern Ireland, there is a strong pattern of inequalities in health and wellbeing at a geographic level, which is persistent over time. However, it is also recognised that some groups experience increased inequality and marginalisation, which contributes significantly to poorer health outcomes.

It is for this reason that the PHA has sought to develop actions to meet the needs of groups that are at greater risk of inequality. This section of the report focuses on actions to promote health and wellbeing, taking these particular needs into account.

Throughout the year, the PHA has continued to focus on four building blocks:

1. Give every child and young person the best start in life.
2. Ensure a decent standard of living for all.
3. Build sustainable communities.
4. Make healthy choices easier.

The following articles are illustrative of a range of work being undertaken to respond to the specific needs of groups experiencing inequalities. An important principle is direct engagement with those who are most affected in order to shape and design services that will best meet those needs and which empower individuals and communities.

### Further information

**Ms Mary Black**  
**Assistant Director Public Health**  
**(Health and Social Wellbeing Improvement)**  
 mary.black@hscni.net

## E-learning aims to promote workplace LGB&T inclusion

### Public health challenge

Addressing the health and social wellbeing inequalities of lesbian, gay, bisexual and transgender (LGB&T) people is a key priority for the PHA. A regional thematic action plan has been developed, which includes the following objectives:

- Reduce stigma and discrimination by increasing public awareness, understanding and skills, and create a safe and open environment for people who are LGB&T.
- Ensure HSC and related services are accessible and sensitive to the needs of LGB&T people.

### Actions

In July 2013, as part of the PHA's support for Belfast PRIDE, a new e-learning programme was launched, aimed at raising awareness and understanding of LGB&T issues in the workplace.

The e-learning programme entitled 'Lesbian, Gay, Bisexual and Transgender Creating Inclusive Workplaces' supports the PHA in addressing health and social wellbeing inequalities, while enabling staff members to safely explore LGB&T issues in a confidential and secure way. The programme was developed in partnership with the Southern HSCT and members of LGB&T sector organisations. It aims to educate staff so they better understand the difference between sexual orientation and gender identity, and the equality implications from both an employer and employee perspective.



Members of the writers group pictured at the launch of the LGB&T e-learning programme with (second left) Mary Black, Assistant Director of Public Health (Health and Social Wellbeing Improvement) and (right) Hugh McPoland, Director of Human Resources, PHA.

## Impact

Research suggests that creating a workforce that is more engaged enables organisations to gain through:

- increased productivity;
- lower staff turnover;
- better recruitment and retention of staff;
- enhanced reputation.<sup>61</sup>

The programme is open to all workplaces and will help staff recognise the barriers associated with disclosure of sexual orientation and/or gender identity in the workplace. It will also help staff understand how LGB&T awareness within the workplace can help create a more welcoming, safe and productive work environment.

The programme offers staff working across a range of HSC and other settings the flexibility to engage in ongoing learning and development at a time that suits them. It is designed to be used by individuals working in any setting and has relevance to a wide audience, including staff with management or recruitment roles within organisations. It is hoped the programme will be seen as complementary to face-to-face interactive training.

The e-learning programme is available at: [www.lgbtelearning.hscni.net](http://www.lgbtelearning.hscni.net)

## Next steps

The PHA continues to promote the programme within HSC and more widely afield. The programme is also promoted within HSCTs as part of ongoing equality and diversity training for new and existing staff. Significantly, the PHA is using this development to promote good practice and influence other parts of the public sector.

### Key facts



- Having LGB&T supportive policies in the workplace is associated with reduced incidence of discrimination, and less discrimination is associated with better psychological health and increased job satisfaction among LGB&T employees.
- A workplace climate that includes LGB&T supportive policies and more broad support from co-workers and supervisory staff is associated with a greater likelihood that LGB&T employees feel comfortable disclosing their sexual orientation at work.
- Increased disclosure of sexual orientation is related to improved psychological health outcomes among LGB&T employees.<sup>62</sup>

### Further information



**Ms Deirdre McNamee**  
**Health and Social Wellbeing**  
**Improvement Senior Officer**  
[deirdre.mcnamee@hscni.net](mailto:deirdre.mcnamee@hscni.net)

## LGB&T staff forum advocates diversity within HSC

### Public health challenge

In 2011, The Rainbow Project research report *Through our eyes: Experiences of lesbian, gay and bisexual people in the workplace* highlighted that:

- nearly 25% of respondents working in the public sector had concealed their sexual orientation;
- 40% of respondents working in the public sector had heard negative comments about LGB&T people from a colleague or colleagues in the workplace.<sup>63</sup>

### Actions

The PHA has worked in partnership with unions and other healthcare organisations to help establish an LGB&T forum for staff working across all HSC settings. To help inform this process, an online survey was conducted with LGB&T staff and a number of focus group discussions were held to ascertain views on the establishment of a forum. The main messages that emerged were:

- There are LGB&T staff within the HSC organisations who are not 'out' due to fear of potential discrimination.
- There is a need to increase visibility of LGB&T issues throughout the HSC organisations. This could be done through effective and relevant diversity training, which all staff, including senior management, would attend.
- Visibility of LGB&T issues could be increased through information in induction packs, staff intranet sites and staff bulletins.
- There must be a zero tolerance approach if staff are subject to homophobic/transphobic comments, harassment and bullying.

### Impacts

A member of the forum outlines her personal experience of being involved:

*The HSC LGB&T staff forum has provided the opportunity to have conversations about diversity and its inclusion in the workplace, and the opportunity to create a reality where all sorts of differences are valued and around which we feel comfortable.*

*The forum has given some of us the opportunity to step forward and talk about our interaction in our working and personal lives – in the workplace and as service users. It has given us a place to interact, be heard, access peer support, acknowledge the support of our organisations, and discuss issues around being a member of a minority group and the many and varied experiences within this group. The forum members have the opportunity to be involved in creating an inclusive working environment for all who perceive themselves to be contextually different within the HSC organisations, and the existence of the forum confirms that LGB&T employees are members of the HSC organisations.*

## Next steps

A website has been developed, which will provide an opportunity for staff who are not 'out' in the workplace to have access to a range of information, including links to organisations that can provide support on issues relating to health and wellbeing.



## Key facts

- The Equality Commission's most recent *Equality awareness survey* in 2011 found that while there was a decline in negative attitudes towards LGB people since 2008, there was not a corresponding increase in positive attitudes.<sup>64</sup>
- The survey showed high levels of negative attitudes towards LGB people in specific scenarios, such as in the workplace or in the local community.<sup>64</sup>
- Public bodies can make a significant contribution to LGB interaction, including taking measures to promote positive attitudes towards LGB employees, office holders and customers.<sup>65</sup>

## Further information

**Ms Deirdre McNamee**  
**Health and Social Wellbeing**  
**Improvement Senior Officer**  
 deirdre.mcnamee@hscni.net

## Northern Ireland New Entrant Service established

### Public health challenge

New immigrants often have complex health needs. They can have a higher incidence of communicable diseases such as tuberculosis (TB), HIV, hepatitis B and C, and they may not be fully vaccinated, making them more vulnerable to vaccine preventable diseases. They may also experience a higher prevalence of long-term conditions such as hypertension, cardiovascular disease and cancer.<sup>66</sup>

Many new entrants to Northern Ireland have difficulty engaging with health professionals due to:

- language barriers;
- cultural differences;
- understanding HSC services;
- lack of entitlement to HSC services.<sup>66</sup>

### Actions

In 2012, the PHA, in collaboration with Belfast HSCT, HSCB and other key stakeholders, established a regional service for migrants called NINES.

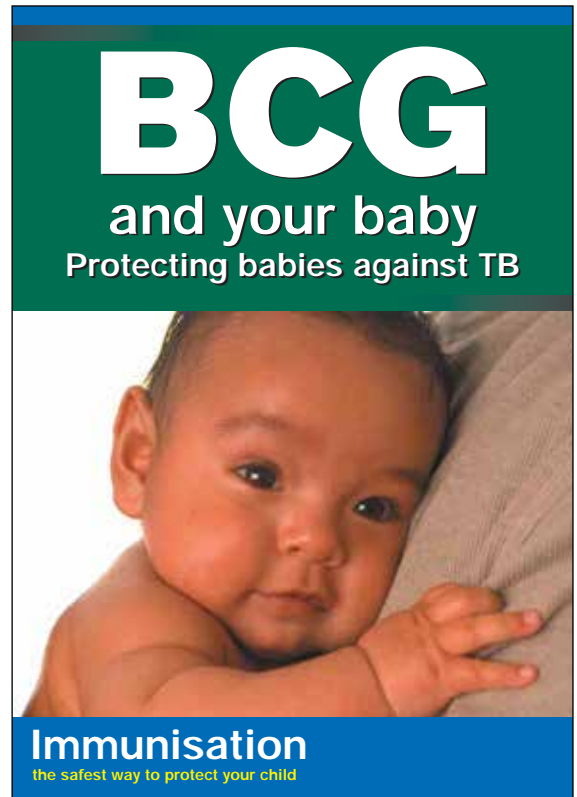
NINES allowed for the expansion and enhancement of existing TB screening services within Belfast HSCT, including:

- a comprehensive health assessment;
- health promotion;
- immunisation services;
- screening for communicable diseases such as HIV.

### Impacts

- A client-held passport has been developed in five languages to enhance communication between primary and secondary care. Service users carry their health passports to appointments with NINES, allowing a more complete health record.
- Communication networks have improved the transition for clients from emergency housing to Northern Ireland Housing Executive NASS Housing. They are the providers for asylum clients going through the process to gain refugee status.
- Information flyers have been developed by NINES. These have been specifically targeted at emergency department (ED) clinical managers and lead nurses, thereby raising staff awareness of how they can access NINES, and highlight why the client group may attend the emergency department for medical care.
- Direct referral pathways have been established between NINES and Belfast City Hospital x-ray, Genito Urinary Medicine (GUM), chest clinic, sexual and reproductive health, and dental services.
- Referral pathways to health services provide better health outcomes for the client group. Fast-tracking for chest x-rays allows early detection of TB and onward referral to the chest clinic for investigation and treatment if required.

- NINES can make referrals to the midwifery booking clinic in Royal Jubilee Maternity Hospital (RJMh) for any asylum seekers that arrive pregnant and requiring urgent referral. Clients are seen within 48 hours, therefore reducing any potential risk to mother and baby.
- The Health for Youth through Peer Education (HYPE) team is facilitating a relationship and sexual health education programme for Roma women. Negotiation is ongoing with other relevant partners to facilitate further group work.
- A weekly Roma clinic with input from a consultant paediatrician is provided for Roma families. The clinic is targeted at children aged up to five years and facilitates the commencement of family health assessments and growth parameters.
- NINES facilitates registration with GPs for those who are eligible. These clients can now obtain a medical card to allow registration with dentists and opticians.
- Blood testing for hepatitis B and C, and HIV, commenced in July 2012. Clients who test positive are referred to hepatology/GUM.



### Next steps

Subject to a favourable review, NINES will be widened through inter-sectoral partnership working to include more multi-sector elements, such as housing, poverty, community relations and education.

#### Key facts

- 1,367 appointments were booked for the client group to attend a range of clinics.
- 365 health passports have been distributed to the client group.
- 174 children and 306 adults attended NINES for Mantoux (TB) testing and 94 children were given a BCG vaccination.
- 75 clients required onward referral to the chest clinic.
- 585 clients were assisted to register with a GP.

#### Further information

**Ms Nuala C Toner**  
**Children's Services Manager, Belfast Health and Social Care Trust**

nualac.toner@belfasttrust.hscni.net

**Ms Elaine O'Doherty**  
**Health and Social Wellbeing Improvement Manager**

elaine.odoherty@hscni.net



## Service users lead creation of addictions network

### Public health challenge

People with alcohol or drug addictions come from a range of backgrounds and have diverse needs when it comes to services. It is sometimes said that existing drug and alcohol services are more attractive to men than women. There is also evidence of an increased need for drug and alcohol services among ethnic minorities, who may find traditional services have not been designed with them in mind. The only effective way to ensure our services meet the needs of the diverse range of users is to ask them what they require.

### Actions

In 2012, the PHA invited drug and alcohol service users from across Northern Ireland to oversee the development of a regional service user network (SUN). The purpose of the network is to strengthen the involvement of service users in the development of drug and alcohol services and policy. SUN members are adults who have current or past experience of using drug or alcohol services, or people with experience of addictions who have not used services. The latter group's inclusion is important, as they offer valuable insight into the reasons why some people do not use services.

The SUN was designed and agreed by service users across Northern Ireland. It focuses on supporting service users and organisations to work together. The Council for the Homeless NI (CHNI) was awarded the contract in May 2013 and appointed two full-time staff to take this work forward, along with their manager. The first challenge was to develop and provide a range of specific training programmes for service users and this has successfully taken place.

### Impacts

This is a long-term approach, as it requires capacity-building among service users and the organisations they need to influence. However, we have already seen a number of short-term impacts:

- The SUN has provided representatives for a range of decision-making groups, including the Bamford drug and alcohol subgroup, and the DHSSPS New Strategic Direction steering group, chaired by the Chief Medical Officer.
- Awareness of service user groups has grown, and service users are increasingly the first to be consulted about services, as should always be the case.
- Increased information sharing and support among groups across the region has led to feelings of empowerment.



Extern's service user group 'Suitcase' with PHA Chief Executive Eddie Rooney (left) at the launch of a new pocket pack for homeless people. The packs were distributed to vulnerable people sleeping rough or in crisis accommodation around Belfast by members of Suitcase, who have close contact with various homeless people and the local organisations who support them, including outreach services.

One service user, Stephen Patterson, said: “Service users have sought and fought for an identity and role in Northern Ireland society for years... more importantly, to be recognised as valid participants, advisors, and experts by experience, leading to essential partnerships with service and treatment providers. Through the support of the PHA and the development of the regional service user network, we are representing our peers on decision-making bodies to inform, input and consult on the future of addiction services at a local and regional level. Without CHNI and the regional SUN, I believe service user involvement would be struggling with no direction, support or purpose.”

### Next steps

The next challenge is to build capacity and willingness in drug and alcohol services to engage with service users, and help those services recognise the value of service user input.



 **Belfast Experts By Experience (BEBE)** members (from left) Stuart Fowler, Deborah Tully, Terry Sheils, Darryl Cuthbertson, Dennis Carson, Nicola Keegan and Jonathan Lacey speaking at the first regional SUN conference at Grosvenor House in Belfast. The event was organised by CHNI and attended by around 100 people, including service users from all parts of Northern Ireland. BEBE is an activist group working out of Belfast HSCT’s Drug Outreach Team who aim to challenge negative stereotypes of drug users and promote harm reduction principles.

### Key facts

- It is estimated that 1 in 20 people in Northern Ireland drink at dangerous levels.
- More than a quarter of those aged 16–59 years have used illicit drugs or drugs not prescribed for them.
- Around 500 people are receiving treatment in statutory addiction services at any one time.
- 2,100 visits were made to a needle exchange last year.

### Further information

**Ms Victoria Creasy**  
**Health and Social Wellbeing**  
**Improvement Senior Officer**  
 victoria.creasy@hscni.net

## PHA health checks for our farming communities

### Public health challenge

The farming community is particularly susceptible to poor health and wellbeing, partly because of the various demands impacting on farmers across a range of social and economic factors.<sup>67</sup> They often work long and anti-social hours, which can lead to isolation, and often have difficulty accessing traditional healthcare services.<sup>68</sup> The PHA has responsibility for improving people's health and wellbeing and reducing health inequalities, so the Farm Families Health Checks programme plays an important role in helping us do this in rural areas.


### Actions

The Department of Agriculture and Rural Development (DARD) joined forces with the PHA and the Northern HSCT to develop and implement the Farm Families Health Checks programme.

The on-going three year programme will see a specially developed health check van visit all rural markets on a bi-annual basis and also a number of rural community venues. The trained nursing staff on board carry out a detailed health assessment of those who consent to a check. This consists of:

- blood pressure monitoring;
- body mass index (BMI) reading;
- cholesterol check;
- diabetic risk assessment screening.



 A local farmer receives a health check at the launch of the Farm Families Health Checks programme, which was attended by the Health Minister Edwin Poots and Dr Eddie Rooney, Chief Executive of the PHA.

In addition, individual lifestyle advice is given on a range of health and safety issues.

After the assessment, clients are presented with a record of the findings and, where necessary, advised to attend their GP or signposted to other support services. Those who are advised to visit their GP will get a call from a nurse approximately six to eight weeks later to provide further advice or support.

### Impacts

Since the programme was launched in July 2012, the health check van has attended 170 events, with more than 3,600 clients accessing the service. Just over 50% of clients have been advised to see their GP following their check. Almost 1,000 clients have been referred to the Maximising Access in Rural Areas (MARA) project to help them access local services, grants or benefits, and more than 400 clients have been signposted to farm safety training funded by DARD.

Norman Henning, a dairy farmer from the Newry area, has benefited from the programme. Norman explained: “One day when visiting Camlough Mart, my wife encouraged me to visit the health check mobile as I hadn’t been feeling very well. I had my blood sugar taken and it was found to be high. I was referred to my GP where I was diagnosed with type 2 diabetes.”

Norman is managing his diabetes without the help of medication and it is under control. He is now looking after his health and diet. He added: “I have cut out sugar in my tea, changed my eating habits, and I am being more physically active, such as walking to the cattle instead of driving the tractor. I have lost 12 kilos in weight.”



 Agriculture Minister Michelle O’Neill (left) and Health Minister Edwin Poots (second right) launch the Farm Families Health Checks programme at Ballymena Market.

## Next steps

The programme is exploring options for extending the service to target other members of the agricultural workforce, such as workers in the agri-food industry.

### Key facts

Data gathered from clients who attended the health checks programme during the evaluation period (January–April 2013) show that:

- 82% of clients were given advice, signposted to other services and/or advised to see their GP;
- 37% were categorised as being at moderate or high risk of developing diabetes within the next 10 years;
- 47% of clients had a cholesterol level outside normal ranges;
- 30% of clients had high blood pressure.

Three months after the evaluation period, using a matched sample of clients who completed screening and the follow-up questionnaire (n=54):

- 42% were eating more healthily as a result of their health check;
- 28% were trying to lose weight;
- 24% were being more active.

### Further information

**Ms Diane McIntyre**  
**Health and Social Wellbeing Improvement Senior Officer**  
 diane.mcintyre@hscni.net

## People with disabilities empowered by Fit 4 U project

### Public health challenge

Across HSC, greater emphasis is being placed on the promotion of health and wellbeing and the reduction of health inequalities among all people, including those with disabilities.

People with disabilities are susceptible to the same chronic illnesses experienced by the general population (eg cardiovascular disease, respiratory disease, poor mental health), very often in addition to conditions secondary to their disabilities.

Creating equality of choice and opportunity for people with disabilities to adopt a healthier lifestyle is a key factor in promoting improved health and wellbeing.

### Actions

The PHA provides funding for a unique intervention in the Southern area, which offers physical activity and leisure opportunities for people with physical and/or sensory disabilities.

The 'Fit 4 U' project is delivered in partnership with the Southern HSCT, local councils, Active Community coaches, voluntary organisations and other volunteers.


The project aims to empower people with physical and/or sensory disabilities to improve their health through participation in a range of physical activity and leisure opportunities. Fit 4 U promotes independence and citizenship by providing safe, accessible programmes within a range of settings and supporting participants in accessing local leisure services.

Fit 4 U delivers the following core activities:

- weekly core exercise programmes – boxercise, fitness suite and group activities;
- inclusive sports – boccia and new age kurling;
- other sports and activities – archery, badminton, golf, swimming and walking;
- southern area/regional events – Southern area boccia competition, Southern area archery competition, Disability Sports NI boccia.

Fit 4 U works with existing support services in the area and utilises external funding opportunities as appropriate to meet gaps in provision. The project adopts a person-centred approach to meet the needs of both service users and local communities.



 Fit 4 U service users (from left) Gareth Heslip, Mary Bodel, Patricia McMahon and Mark Doran, participants at New Age Kurling in Newry Sports Centre.

## Impacts

Each year, more than 230 people from local communities and day care centres have the opportunity to engage with the Fit 4 U project. These are people with physical and/or sensory disabilities, who are leading sedentary lifestyles and at increased risk of obesity, diabetes or cardiovascular disease.

Through Fit 4 U, service users are supported to improve their physical and mental health and wellbeing by socialising and competing in a range of games and activities. People with physical and/or sensory disabilities gain increased independence, become more integrated into their communities and experience reduced feelings of isolation.

As a result of the Fit 4 U project, local leisure facilities have become aware of the needs of disabled users. Specific access issues have been raised with leisure service providers and training has been delivered to staff on visual awareness and all-inclusive activities.

## Next steps

The PHA Southern office continues to support the provision of physical activity and leisure opportunities for people with physical and/or sensory disabilities in the Southern area, and will explore ways to further enhance these services in partnership with other key stakeholders.



Fit 4 U service users and winners of the Southern Area Boccia Competition (from left) Paul Careless, Eric Flowers and David Wylie are presented with awards from Mayor Sean McGuigan, Dungannon and South Tyrone Borough Council.

## Key facts

NISRA produced estimates in 2007 that show:

- 18% of all people living in private households in Northern Ireland have some degree of disability (21% of adults and 6% of children have a disability);
- the prevalence of disabilities increases with age, ranging from 5% among young adults to 67% among those who are very old (85+ years).<sup>69</sup>

The Department of Culture, Arts and Leisure (DCAL) has set a target of a 6% increase in people with a disability participating in sports and physical recreation by 2019.<sup>70</sup>

## Further information

**Ms Orlaith Moley**  
**Health and Social Wellbeing**  
**Improvement Senior Officer**  
 orlaith.moley@hscni.net

## Understanding Traveller attitudes towards breastfeeding

### Public health challenge

The 2010 *All Ireland Traveller Health Study* (AITHS) highlighted that Travellers are the group most unlikely to breastfeed in Northern Ireland, with only 7.1% of Traveller children having been breastfed.<sup>71</sup> Figures for the Southern area, in particular, showed that Traveller mothers were not breastfeeding at discharge from hospital.<sup>72</sup> However, statistics for the settled community demonstrated a steady increase between 2001 and 2011/12 in mothers breastfeeding at discharge.<sup>72</sup>

### Action

In response to findings in the AITHS and Children and Young People's Strategic Partnership (CYPSP) *Outcome monitoring report* for 2011, the PHA's Southern office commissioned a scoping exercise among the Traveller community to ascertain awareness of, and attitudes towards, breastfeeding.

The scoping exercise was undertaken by Uplift breastfeeding counsellors. Uplift consulted with 40 local Travellers to identify:

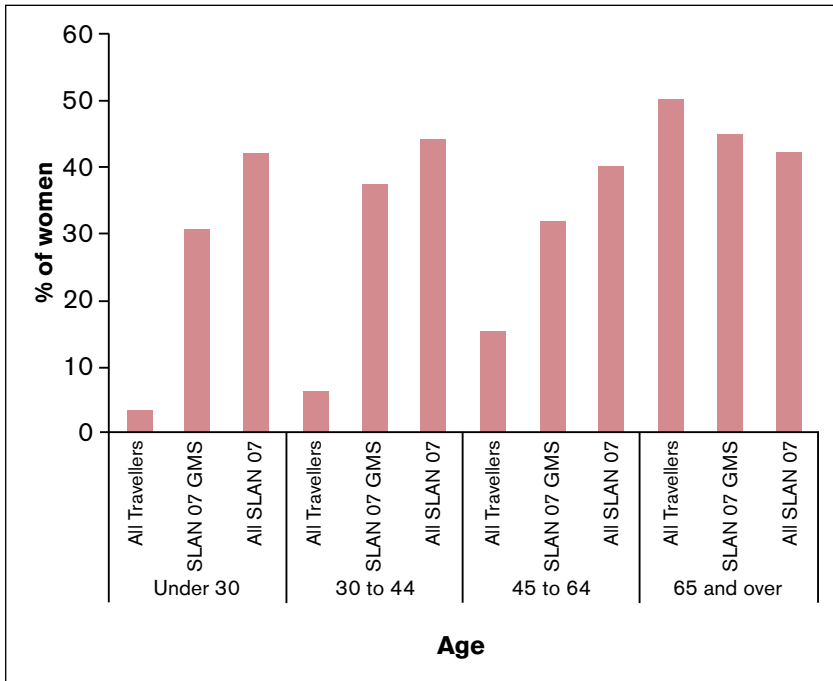
- why they do not breastfeed;
- the barriers currently in place;
- their awareness of the health benefits of breastfeeding.

Uplift also visited Dublin to explore how the Pavee Point Traveller organisation has worked with Travellers to deliver health information and training within their own communities. Uplift also produced a report on the scoping exercise, with a number of key recommendations to raise awareness of breastfeeding among the Traveller community.

### Impact

The scoping exercise was conducted through five focus groups and one-to-one interviews, which resulted in the following:

- Increased understanding of the reasons why Irish Travellers prefer to use formula rather than breastfeeding, a finding also true of the settled community in Northern Ireland (responses from Travellers included 'lack of antenatal education' and 'unaware of the protective qualities of breast milk to a mother and baby').
- Highlighting the most appropriate methods and supportive environments for Travellers to receive education and support (responses from Travellers included 'current literature is not focused towards the literacy levels of the Traveller community, unlike black and minority ethnic (BME) groups who have specific literature available to them').
- Increased understanding among the Traveller community of the preferred support mechanisms to encourage Travellers to consider breastfeeding (responses from Travellers included 'unaware of most of the protective qualities of breast milk and feel let down and frustrated about this' and 'non-attendance at antenatal classes should not preclude us from finding out the facts').



**Figure 12: Breastfeeding rates in the AITHS and Survey of Lifestyle, Attitudes and Nutrition (SLAN) studies, by age at the time of interview**

### Key facts

- The PHA *Breastfeeding Action Plan 2013–2014* states that ‘A number of factors including birth order, education level, age of mother and socioeconomic status influence breastfeeding rates.’<sup>73</sup>
- The highest incidences of breastfeeding are found among mothers from managerial and professional backgrounds, those with the highest educational levels, those aged 30 or over, and first-time mothers.<sup>73</sup>
- Research by the Department of Health (DH) in 2009 shows that public health initiatives that target pregnancy and the first few years of a child’s life are known to be more effective, as during this period, adults are more receptive to learning and making changes.<sup>74</sup>

### Further information

**Ms Lucille Lennon**  
**Health and Social Wellbeing**  
**Improvement Officer**  
 lucille.lennon@hscni.net



## Cook it! programme reaches out to local BME groups

### Public health challenge

The population of BME groups has increased substantially in recent years, from 1% (14,279) in the 2001 Census to 1.7% (31,113) in the 2011 Census.<sup>75,76</sup>

During that time, the population profile of BME groups has shown marked changes, which are largely reflective of the European Union's expansion and the increased ease of movement.

In the 2001 Census, the BME groups living in Northern Ireland were mainly Chinese, Vietnamese, Indian, Pakistani and Irish Traveller communities.<sup>75</sup> More recently, immigrants have been from Poland, the Czech Republic, Slovakia, Slovenia, Hungary, Latvia, Lithuania, Estonia, Bulgaria and Romania.<sup>77</sup> There have also been increasing numbers of immigrants from Portuguese speaking countries such as Portugal, East Timor, Brazil, Mozambique, Goa and Angola.<sup>77</sup>

Responding to the needs of this increasing immigrant population is an important public health challenge. It is acknowledged that people from BME groups are at increased risk of poverty and social exclusion.<sup>78</sup> Experience of racism and discrimination can contribute to further social isolation and these circumstances, along with language and cultural barriers, may further compromise health and wellbeing.<sup>78,79</sup>

### Actions

*Cook it!* is a nutrition education programme, which is delivered in local communities by facilitators who are specially trained by *Cook it!* teams based within the HSCTs. The programme:

- provides practical hands-on experience of preparing and cooking healthy, low-cost meals from scratch;
- increases knowledge of healthy eating;
- builds awareness about handling food safely.

During 2013/14, work has been undertaken to develop a new module for the *Cook it!* programme, which meets the specific needs of the main BME groups living in Northern Ireland.

The new draft module includes background information on the cultural norms relevant to the main BME groups, as well as a selection of 'traditional' recipes from each BME population. The recipes have been adapted in discussion with the groups to ensure they meet the healthy eating guidelines.



↑ Colette O'Brien (left), a dietitian with Southern HSCT, alongside Laila Damani and Mr & Mrs Ilya testing Indian recipes for the new *Cook it!* module

Training workshops have equipped *Cook it!* teams with the necessary knowledge and skills to pilot the draft materials with groups of single and mixed ethnicities.

## Impacts

The new module will allow locally-based *Cook it!* teams and facilitators to respond to the needs of BME groups within their areas by providing nutrition information and basic cooking skills sessions in an enjoyable, interactive and social environment.

Participants will benefit from enhanced knowledge about healthier eating and good food hygiene, and increased confidence in cooking meals from their own and other cultural backgrounds.

Perhaps more importantly, the BME module of the *Cook it!* programme will lead to increased social interaction within and between ethnic groups. This will reduce isolation, promote integration and improve health and wellbeing.

## Next steps

Following the pilot with each of the BME groups to inform final amendments, the new module will be printed and made available in 2014/15.

### Key facts



- The population profile of BME groups in Northern Ireland has changed in recent years, with the largest BME communities now Eastern European (Polish and Lithuanian), followed by Chinese, Indian, Irish Travellers and migrants from Portugal and the Philippines.<sup>76,77</sup>
- English is not the main language for 3.1% (54,500) of the population and English proficiency varies by age, gender, country of origin, education and social class.<sup>76</sup>
- Limited English is the most significant barrier to accessing HSC.<sup>78</sup>
- Mental health is an important issue for many BME groups living in the UK and Ireland, who are more likely to be prescribed the wrong medication or placed in institutionalised care.<sup>80</sup>

### Further information



**Ms Angela McComb**  
**Health and Social Wellbeing**  
**Improvement Manager**  
 angela.mccomb@hscni.net

## Raising awareness of STIs among MSM community

### Public health challenge

Surveillance data from GUM clinics in Northern Ireland have shown an increase in diagnoses of gonorrhoea, syphilis and HIV in men who have sex with men (MSM). Surveillance reports show that MSM remain disproportionately affected by sexually transmitted infections (STIs) and HIV.

Analysis of results for Northern Ireland from the 2010 *European MSM Internet Sex Survey* (EMIS) shows that half of respondents had never been tested for HIV and around one third had been tested in the last year.<sup>81</sup>

### Actions

A campaign aimed at raising awareness of the increase in STI diagnoses has been developed in partnership with The Rainbow Project and the regional GUM service. The campaign entitled 'Don't leave it to chance' was launched at the Annual Regional Sexual Health Conference in November.

The key messages of the campaign are that:

- MSM, like all sexually active people, need to consistently use condoms to prevent the spread of STIs and HIV;
- sexually active MSM need to be tested at least once a year, or once every three months if changing partners on a regular basis.

MSM should be aware that HIV has not gone away and that infection with syphilis, gonorrhoea and other STIs can lead to increased risk of acquiring HIV.

A suite of three posters that include the key campaign messages has been developed and distributed to a number of venues. The campaign also includes a range of online messages developed for social networking sites, dating sites, and peer and social support services targeting MSM.



## Impacts

Collaborative work with The Rainbow Project on the development and implementation of the campaign has ensured the key messages target the priority group through a range of formats, including posters and online messaging. Reports show an increase in the number of MSM accessing the rapid testing service offered by The Rainbow Project and an increase in referrals of MSM to GUM services.

## Next steps

A key action within the *Sexual health promotion: Strategy & action plan 2008–2013* relating to public information campaigns is:

“To develop a phased sexual health public information campaign which is accessible to all groups and aims to: promote sexual health and wellbeing; raise awareness of specific sexual health issues, including HIV/AIDS with particular focus on those most at risk and; tackle discrimination and stigma associated with HIV, STIs and sexual orientation.”<sup>82</sup>

The PHA recognises the importance of this campaign for raising awareness of the increase in gonorrhoea, syphilis and HIV in MSM in Northern Ireland, and for reinforcing the need to reduce risky sexual behaviours by taking greater personal responsibility and practicing safer sex. This campaign was phase one of a wider sexual health campaign that the PHA plans to develop in the future.

### Key facts

- HIV is still on the increase among MSM in Northern Ireland. Only a third of MSM have been tested for HIV in the last year.<sup>83</sup>
- Gonorrhoea cases in MSM have more than trebled since 2010.<sup>84</sup>
- 9 out of 10 syphilis cases last year occurred in MSM.<sup>84</sup>

### Further information

**Ms Deirdre McNamee**  
**Health and Social Wellbeing  
 Improvement Senior Officer**  
 deirdre.mcnamee@hscni.net

**Dr Neil Irvine**  
**Consultant in Health Protection**  
 neil.irvine@hscni.net

## Guidelines to support the needs of older LGB&T people

### Public health challenge

Northern Ireland has the fastest ageing population in the UK and this will continue to increase every year as the number of older people continues to grow. It is estimated that there are 24,012 men and women of pensionable age in Northern Ireland who will identify as something other than heterosexual.<sup>85</sup>

There are 80 to 100 transgender people known to, or who are accessing, support services within Northern Ireland. However, it is widely known that transgender people remain invisible and the numbers are estimated to be much higher. Older people who identify as LGB&T are likely to have a greater need for HSC services.

Compared to their heterosexual peers, LGB&T people are:

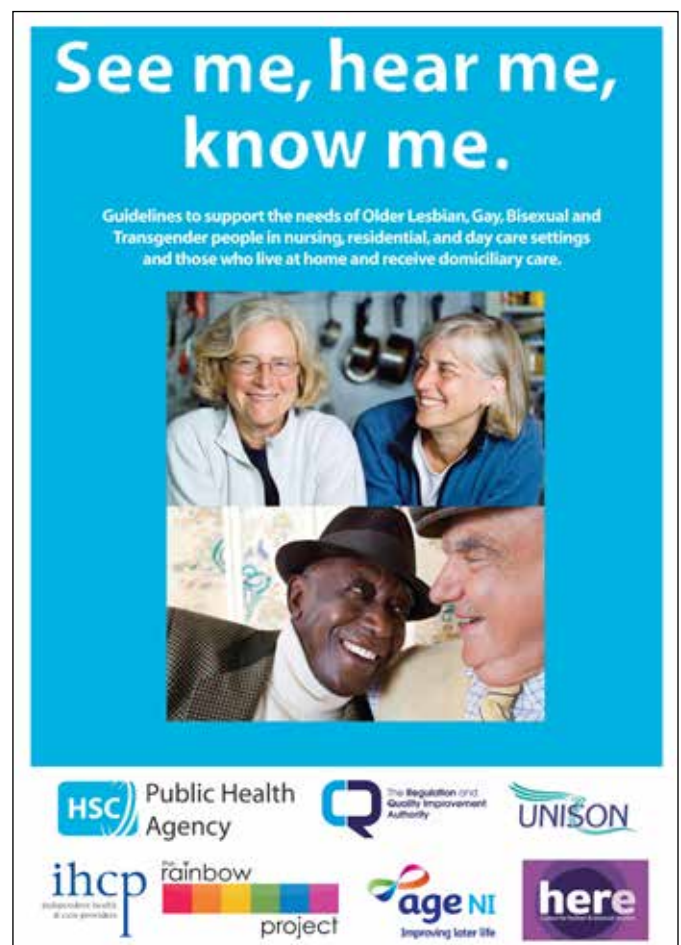
- two and a half times more likely to live alone;
- twice as likely to be single;
- four and a half times more likely to have no children to call on in times of need.<sup>86</sup>

### Actions

The needs of older people who identify as LGB&T are a key priority area within the PHA's regional thematic action plan for LGB&T. Informed by a scoping exercise carried out in 2011 by AgeNI and The Rainbow Project, the PHA worked in partnership with AgeNI, The Rainbow Project, HereNI, Unison, the Regulation and Quality Improvement Authority (RQIA) and independent healthcare providers to develop guidelines to support the needs of older LGB&T people in nursing, day care, residential and domiciliary care settings.

### Impacts

The guidelines, entitled *See me, hear me, know me*, are a practical resource to help those involved in the development and delivery of care better understand the needs of older people who identify as LGB&T, and respond to these needs in a range of care settings. The guidelines are a tool that we hope will help all staff strive to improve the delivery of person-centred care to older LGB&T people in Northern Ireland.



It is also hoped that the guidelines will help address the issue of invisibility experienced by many LGB&T older people and their carers, and encourage staff to reflect on their practice.

### Next steps

The guidelines were launched in March 2014 for all registered nursing, day care, residential and domiciliary care settings.

### Key facts



- Research has indicated that people from the LGB&T community generally have poorer health. This manifests in higher rates of cervical, breast and anal cancers, as well as increased drug, alcohol and tobacco misuse.<sup>87,88,89,90</sup>
- In a survey of LGB&T people aged 40 years and over:
  - 18% had self-harmed;
  - 39% had experienced suicidal thoughts;
  - 21% had attempted suicide;
  - 60% had experienced depression.<sup>91</sup>
- In a recent Northern Ireland survey of LGB&T people, more than 20% of respondents identified as living with a disability. The most common forms of disability were physical (64.4%) and mental (57.8%).<sup>92</sup>

### Further information



**Ms Deirdre McNamee**  
**Health and Social Wellbeing**  
**Improvement Senior Officer**  
 deirdre.mcnamee@hscni.net

# *Improving health through early detection*

---

## **Overview**

Screening for women at higher risk of breast cancer

Informed choice to improve cancer screening uptake

## Overview

## Overview

Early detection of disease often produces better outcomes for patients. At this stage, treatment may be more effective and may prevent significant ill health or, in some cases, premature death.

Population screening programmes have a key role to play in the early detection of disease. A range of programmes are available in Northern Ireland and the PHA has responsibility for commissioning, coordinating and quality-assuring them.

However, screening is not suitable for every condition. Organised screening programmes are only established on the recommendation of the UK National Screening Committee (NSC) and according to the best available evidence. Any proposed screening programme must meet a number of stringent criteria before it is recommended by the NSC.

The bowel cancer screening programme is available to all men and women aged 60–74 years after it was extended in April 2014.

Screening for abdominal aortic aneurysm (AAA) is also now an established programme with high uptake rates.

In 2013, the cancer screening programmes developed an action plan to improve informed choice and introduced a screening surveillance programme for women at higher risk of breast cancer.

This section focuses on:

- the introduction of a screening surveillance programme for a small group of women who are at higher risk of breast cancer because of their genetic characteristics or a specific radiotherapy treatment they have received;
- the work undertaken to improve informed choice for cancer screening, with particular emphasis on those groups who find services harder to reach.

### Further information

**Dr Janet Little**  
**Assistant Director Public Health**  
**(Service Development and Screening)**  
janet.little@hscni.net



## Screening for women at higher risk of breast cancer

### Public health challenge

A small number of women are at much higher risk of developing breast cancer than the majority of the female population. This may be because they have been diagnosed with a particular genetic disorder that can cause the disease, eg the BRCA1 or BRCA2 gene, or because they had radiotherapy treatment that included the breast area before the age of 30.

Some of these women decide to have a bilateral mastectomy to reduce their risk of breast cancer. Others decide not to have surgery and attend a number of hospital clinics for surveillance, including mammography, to detect any early signs of cancer.

The challenge was to identify all women in Northern Ireland who are at higher risk of breast cancer and ensure their surveillance is managed to new national standards.<sup>93</sup>

### Actions

The PHA introduced a screening surveillance programme for women at higher risk of breast cancer on 1 April 2013. It is closely linked to the Northern Ireland Breast Screening Programme. However, there are significant differences between the two programmes.

The higher risk screening surveillance programme is available only to those women who are known to be at higher risk and these women are normally invited for breast screening every year rather than every three years. They are also invited from a much earlier age (usually from the age of 30) and can have breast magnetic resonance imaging (MRI) and/or mammography.



Breast MRI is a painless test that involves lying face down on the scanning bed.

Because of the relatively small numbers, and the need to maintain expertise and quality in the use of these tests in this group of women, the service is based at a single site - Antrim Area Hospital.

### Impacts

More than 300 women at higher risk of breast cancer have been identified so far. All of these women will be invited to attend for regular breast surveillance screening in accordance with national standards. This will ensure the women have access to a breast imaging service that is quality assured to the same high standards as the regular breast screening programme.

### Next steps

The work to identify women at higher risk of breast cancer is continuing. A quality assurance process will be established to ensure this new programme meets the national quality standards.

#### Key facts



- Around 50% of women with the BRCA1 or BRCA2 genetic defect decide to have bilateral mastectomy to reduce their risk of getting breast cancer.
- An MRI scan is an imaging procedure that uses magnetic fields and radio waves to take pictures of the body.
- Breast MRI is better at detecting breast cancer in younger women.
- Mammography is better at detecting breast cancer in older women.
- A breast MRI scan usually takes between 30 minutes and an hour.

#### Further information



**Dr Adrian Mairs**

**Consultant in Public Health Medicine**

adrian.mairs@hscni.net

## Informed choice to improve cancer screening uptake

### Public health challenge

The Quality Assurance Reference Centre (QARC) of the PHA is responsible for commissioning and quality assuring the bowel, breast and cervical cancer screening programmes.

It is acknowledged that not everyone who receives an invite will participate in screening. There are many reasons why individuals do not take up their invitation, and for some this will be a fully informed choice. However, for many the decision may not be conscious or well-informed, and others may not find the programmes accessible to them. In addition, some population groups are less likely to attend.

While uptake of screening in Northern Ireland is largely in line with that seen elsewhere in the UK, there is always room for improvement.

The challenge is to promote informed choice of cancer screening with a view to increasing uptake of each programme.

### Actions

The QARC established a strategy group to explore why some groups of people found screening less accessible and to propose ways of removing any obstacles. The focus of this work was on:

- LGB&T people;
- BME groups;
- Travellers;
- prisoners;
- people with physical or sensory disabilities;
- people with learning disabilities;
- people living in deprived communities.

A series of meetings were held with voluntary organisations that represent each of these population groups. The work culminated with a workshop to identify proposals to make screening more accessible and acceptable.

A four year *Informed Choice Action Plan (2012–15)* was developed and agreed following the workshop.



## Impacts

The action plan coordinates work being done to promote informed choice in relation to the three cancer screening programmes. One of the key outcomes is that the PHA has now established common objectives with many stakeholders in the community and voluntary sectors, and with HSC organisations. Some examples of progress so far are outlined below:

- The Women's Resource Development Agency (WRDA) delivers a peer facilitator programme to educate and raise awareness of breast and cervical cancer screening with community groups. During 2013, this service was extended to include promotion of bowel screening. The trained facilitators delivered awareness sessions to 50 community groups throughout the year. The WRDA also arranged for women from the community groups to attend special breast screening clinics. This means a group of women with a learning disability, for example, can attend for screening together at a specially organised clinic.
- Work has been undertaken to review patient information resources, including leaflets and the website, and these have been updated where appropriate to meet the needs of different groups of people.
- An online training toolkit, developed by the Lesbian and Gay Foundation, was disseminated to GP practices and smear takers.<sup>94</sup> The toolkit enables cervical screening practitioners to improve the patient experience for lesbian and bisexual women.
- Breast screening information is now being disseminated via social media and a pilot has been undertaken for women to receive text reminders for their breast screening appointment.
- The QARC now confirms at quality assurance review visits that staff providing screening services have completed equality and diversity training.

## Next steps

The action plan runs through to 2015, so work is ongoing on a range of issues. The QARC will continue to work with the various stakeholders to take forward the remaining actions and promote uptake of the three screening programmes among diverse communities.

### Key facts

- 70 people from 16 organisations attended the workshop and contributed to the formation of the action plan.
- There are 52 recommendations to be delivered in the action plan.
- 13 special breast screening clinics were arranged in 2013/14, each accommodating screening for eight women.

### Further information

**Mr Colin McMullan**  
**Cancer Screening Programmes Manager**  
 colin.mcmullan@hscni.net

**Dr Tracy Owen**  
**Consultant in Public Health Medicine**  
 tracy.owen@hscni.net

# *Improving health through high quality services*

---

## **Overview**

Providing high-quality maternity services for everyone

## Overview

# Overview

It is recognised that the provision of high quality antenatal and obstetric care is important for improved outcomes for both mother and baby.

The health of a mother is very important for the outcome of a pregnancy and the health of a newborn infant. National reports show that outcomes for pregnant women from minority groups are worse than those for the general population, which is now being addressed as a health priority.

In this section, we outline the challenges to the HSC system in meeting the maternity needs of migrant and minority ethnic women and the most vulnerable sub-groups.

### Further information

**Dr Janet Little**  
**Assistant Director Public Health**  
**(Service Development and Screening)**  
janet.little@hscni.net

## Providing high-quality maternity services for everyone

### Public health challenge

In the last decade, Northern Ireland has experienced an increase in immigration, resulting in a growth in the number of births to non-UK and non-Republic of Ireland (ROI) born mothers.

In accordance with *A strategy for maternity care in Northern Ireland 2012–2018*, the DHSSPS aims to provide high-quality, safe, sustainable and appropriate maternity services to ensure the best outcome for all women and babies.<sup>95</sup> National reports on maternal and perinatal deaths have shown worse outcomes for migrant and minority ethnic women, including Irish Travellers, than white women.<sup>96,97,98,99</sup>

As a result, minority ethnic and migrant women were identified as a priority in the *Maternity Service Team equality/inequalities action plan 2013/2014*.

### Actions

The Maternity Service Team commissioned a scoping review to gain a better understanding of the issues and needs of such women when accessing maternity services. Maternity issues were identified from available published literature, local unpublished reports and anecdotal views of individuals working in the statutory and voluntary sectors.

### Impacts

Research carried out by the Northern Ireland Council of Ethnic Minorities (NICEM) on the experiences of more than 400 minority ethnic women living in Northern Ireland shows that the majority of women are satisfied with their experiences of childbirth.<sup>100</sup>

The findings also highlight issues that present challenges for HSC services in meeting the maternity needs of the growing number of migrant and minority ethnic women. In particular, sub-groups of vulnerable women are at higher risk of poorer maternity outcomes and have specific maternity needs. These include women from the Roma community, Irish Travellers, asylum seekers, refugees and undocumented migrants.

Black African and Caribbean women have maternity mortality rates more than three times that of white women. Indian and Pakistani women also have higher mortality rates than their white counterparts.<sup>99</sup> Mothers of black and Asian origin are more likely than mothers of white origin to have a stillbirth or neonatal death.<sup>101</sup>

Barriers to accessing maternity services include:

- speaking little or no English;
- lack of awareness of the local health system;
- confusion over entitlements;
- difficulty registering with primary care;
- different expectations of healthcare.<sup>102</sup>

Minority ethnic and migrant women are more likely to book later in pregnancy, less likely to take up antenatal screening and more likely to have certain medical conditions. They are more likely to have a complicated delivery as a result of complex medical conditions, female genital mutilation and late access to antenatal care. They are more likely to have a longer hospital post-natal stay and more likely to be followed up for longer. Higher rates of post-natal depression and domestic violence have also been described. Rates of breastfeeding are higher in some minority ethnic women, although Irish Traveller mothers have one of the lowest rates.



A variety of initiatives, such as diversity and cultural awareness training, employment of bilingual healthcare workers and the Regional Interpreting Service have enabled HSCTs to largely cater for the needs of migrants in the local population.<sup>103</sup> As a result, the vast majority of women have their needs met within current services. However, there is more than could be done to address the needs that disproportionately affect the most vulnerable groups.

### Next steps

Consideration is being given to the appointment of a regional specialist midwife, who could be a source of advice and training for maternity and community staff. The service could also link with relevant voluntary organisations, which provide vital support and assistance for migrant and minority ethnic individuals.

### Key facts



- In 2012, 2,459 births in Northern Ireland were to non-UK and non-ROI born women (1 in 10 births).<sup>104</sup>
- Half of these births were to women born in one of the A8 countries, compared to less than 1% in 1997. The A8 countries are: Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia.<sup>104</sup>
- According to the 2011 Census, 1.8% (32,414) of the population declare themselves to be from a minority ethnic group and 4% (80,621) were born outside the UK and ROI.<sup>105</sup>

### Further information



**Dr Jillian Johnston**  
Specialty Registrar in Public Health  
Medicine

jillian.johnston@hscni.net



# *Improving health through research*

## **Overview**

Community support models address the transition of adults with intellectual disabilities into old age

Mobility aids for children with physical impairments

Eyecare for children with developmental disability

Mortality patterns among Section 75 equality groups

## Overview

The PHA continues to support HSC research in its widest sense. The research funded may be commissioned in response to specific needs or may be supported in response to a proposal put forward by a research team. The overriding aim is to fund research that can secure lasting improvements in the health and wellbeing of the entire population of Northern Ireland.

By including representatives from service users and the public in the evaluation of research proposals, the HSC Research and Development (R&D) Division aims to ensure that the research involves service users and the public in a meaningful and appropriate way at every stage from design and evaluation through to dissemination of the results.

The Northern Ireland Public Health Research Network (NIPHRN) has continued to flourish during 2013 and has demonstrated success in securing external funding through collaboration with diverse stakeholders. The network draws together research development groups (RDGs), which create research proposals to secure funding for studies that address key public health priorities.

The HSC R&D Division often works in partnership with other funders to help bring additional research funding into Northern Ireland. This year has seen the renewal of funding for a number of major pieces of infrastructure and new partnership funding for others. This includes the continued funding of the Northern Ireland Centre of Excellence in Public Health for a further five years, as well as a Northern Ireland Administrative Data Research Centre (ADRC), one of four in the UK, awarded by the Economic and Social Research Council. Along with the recently-established Honest Broker Service, the ADRC will be part of an emerging system that will facilitate access to and use of routinely collected HSC data for important research studies.

As well as commissioning research in important areas such as dementia care and mental health, the HSC R&D Division is also working to support and facilitate researchers to secure funding from major external sources. 2013 has seen a good success rate, bringing significant funds back to Northern Ireland from UK-wide funding streams and building up a strong profile for Northern Ireland in Europe.

### Further information

**Dr Janice Bailie**  
**Assistant Director Public Health**  
**(Research and Development)**

[janice.bailie@hscni.net](mailto:janice.bailie@hscni.net)

## Community support models address the transition of adults with intellectual disabilities into old age

### Public health challenge

As the general population gets older, so too do people with intellectual disabilities (ID), with many now living into their 70s and 80s.<sup>106</sup>

Within the UK, and especially within Northern Ireland, the majority of people with ID live with their ageing parent(s) or siblings. The *Equal lives* report from the Bamford Review identified ageing as an area that required specific planning within ID services:

“Recommendation 52: The DHSSPS should produce a strategic plan to address current deficiencies in services and future service provision for older people with a learning disability and their families.”<sup>107</sup>

*Transforming your care* says: “The diversity and age appropriate nature of day services remains an issue for people with ID... a one size fits all service will be less attractive in the future.”<sup>108</sup>

Moreover, the *Learning disability service framework* proposed that all people aged 50 years and over with an ID should have the impact of ageing taken into account when having their future needs assessed and proactively managed, and that this population should be enabled to remain in their own home with their family carer for as long as possible, with appropriate care and support to do so.<sup>109</sup>

### Actions

There is considerable evidence available on the improved quality of life outcomes and cost efficiencies associated with models of community accommodation for adults with ID. A review of 118 papers that reported the comparative benefits and cost-effectiveness of residential and community models found ample evidence of quality of life improvements in community settings, but also a need for more research on costs.<sup>106</sup>

However, the current costs of day services for older people with ID in Northern Ireland have not been assessed, and no resource models have been developed to account for possible future costs of day and carer support provision arising from increased dependency.

It has been said that current prevalence rates of older people with ID do not reflect the increased life expectancy of these people.<sup>110</sup> Some researchers have used mortality data from English case registers to revise upwards the prevalence rates of ID in people aged over 50 years.<sup>106</sup>



Using their figures, 35.7% of the Northern Ireland population in 2021 will be aged over 50 years. This means statutory and voluntary services must plan to ensure this growing older population with ID can be accommodated in age-appropriate day activities, respite and domiciliary care. The current study is designed to provide robust evidence that will contribute to the realisation of these goals.

## Impacts

The study commenced in May 2013 and is funded for three years by the HSC R&D Division's Bamford Implementation Programme. It has four stages. Ethical approval and research governance has been obtained. Stage one has begun and comprises a series of focus groups involving older people with ID, their ageing family carers and other stakeholders.

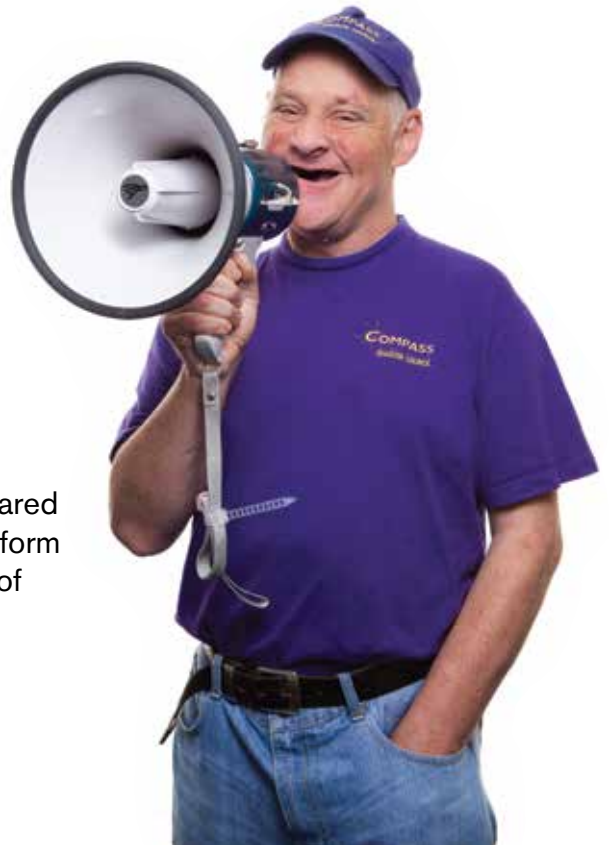
Stage two will involve a series of one-to-one interviews, with managers from both ID and older people's care programmes exploring what constitutes age-appropriate day activities, respite and domiciliary care for this population, and the costs associated with each.

During stage three, data will be gathered on a quota sample of older people with ID and family carers in relation to their current service usage, likely future needs/preferences, and the costs of such services.

Stage four will use a consensus building process to bring together stakeholders who will develop service specifications designed to meet the identified needs of older people with ID and their ageing family carers.

## Next steps

It is envisaged that the findings from this study will be shared and agreed with key stakeholders and policymakers to inform the decision-making process around the future planning of services for the growing older population with ID in Northern Ireland.



### Key facts



It is estimated that across the UK, more than 30,000 older parents (60+ years) are caring for their son/daughter with an ID. Over the next few decades, the average age of this group of people with ID will steadily increase.

### Further information



**Dr Laurence Taggart**  
**Reader in Intellectual Disabilities,**  
**Institute of Nursing and Health Research,**  
**University of Ulster**  
[l.taggart@ulster.ac.uk](mailto:l.taggart@ulster.ac.uk)

## Mobility aids for children with physical impairments

### Public health challenge

Children with physical impairments often find walking difficult and for some it isn't even a possibility, therefore mobility aids or wheelchairs are often required. Having the ability to move and subsequently explore can have a great impact on a young child's development.<sup>111,112</sup> Mobility is important for enabling young children to participate in daily living activities, school and community activities.

### Actions

Currently, children who need a wheelchair for mobility are assessed by occupational therapists. They are then provided with a wheelchair that best meets their physical needs and promotes optimum participation. However, the cost of wheelchairs has been increasing, putting increased demand on both service providers and caregivers. A regional wheelchair training coordinator was appointed in 2013, along with an annual training budget, to ensure therapists are skilled and competent in undertaking these client-centred assessments.

### Impacts

Existing research into the use of wheelchairs by children can be broadly categorised into the areas of:

- prescription of assistive technologies;
- powered wheelchairs;
- development of outcome measurement tools for wheelchair use;
- impact of caregiving for these children.

Parents of children who use wheelchairs can often struggle to accept that their child needs to use the wheelchair and the normality of its appearance, and worry about how others will react to their child in public.<sup>113,114</sup> However, parental attitudes become more positive once they observe the effect the wheelchair has on their child's development and realise the independence their child achieves as a wheelchair user.<sup>115</sup>

There is often a realisation by parents and therapists that providing a child with a wheelchair is not a last resort but a very positive move. The child's use of the wheelchair not only increases their mobility, but can also empower them to explore their environments.<sup>116</sup> This in turn promotes the child's learning ability and independence, and



Wheeled mobility gives young children a great deal more independence and can have a very positive impact on their development.

helps them develop a sense of control and self-esteem, both of which are vital for a child to become an active participant in society or have any quality of life.<sup>117,118</sup>

There still remain a number of barriers to the active participation and inclusion of children who are wheelchair users. These include:

- a lack of wheelchair skills training for children and carers;
- inadequate transportation;
- inaccessible physical environments;
- the attitudes of others.<sup>119,120,121</sup>

Additionally, parents need support to maintain their emotional and physical wellbeing, and to minimise their risk of social isolation.<sup>118,122</sup>

### Next steps

Work is ongoing to ensure greater involvement of service users in the delivery of the regional therapist wheelchair skills training programmes. The University of Ulster is working with both the South Eastern and Belfast HSCTs to develop research proposals on the effectiveness of a children's wheelchair skills community integration programme, as well as the ability of primary school-aged children to use power wheelchairs outdoors.

#### Key facts



- In Northern Ireland, there are approximately 2,562 children who use a wheelchair for their mobility.
- In 2012/13, 54 therapists completed the Regional Foundation level wheelchair training and 61 completed the Regional Intermediate level training, 21 of whom did the children's course.
- In 2013, both of these courses received professional body endorsement.

#### Further information



**Ms Jackie Casey**  
**Lecturer in Occupational Therapy**  
**(University of Ulster)**

[j.casey2@ulster.ac.uk](mailto:j.casey2@ulster.ac.uk)

Jackie is a Cochrane Fellow leading a review in the area of wheelchairs for school-aged children with physical impairment.

## Eyecare for children with developmental disability

### Public health challenge

Research shows that children with developmental disability have more eye and vision problems than typically developing children, and they often go undetected as other health issues take precedence.<sup>123,124</sup>

An audit of adults with disabilities showed high levels of previously unrecognised visual loss, including easily correctable defects present since childhood but compounded by long-term neglect.<sup>125</sup> Undetected and untreated visual problems in childhood have a detrimental impact on visual and educational outcomes, social interactions and ultimately quality of life.<sup>126,127,128,129,130,131</sup> For many, management of visual problems may simply involve wearing glasses or an appreciation by parents, carers and teachers of modifications needed to improve visibility of educational and recreational material.

A key component in successful management of visual problems is appropriate dissemination of information gathered by eyecare professionals, so that families, teachers, therapists and other professionals all understand children's visual strengths and limitations.<sup>132</sup>

### Actions

Funded by the HSC R&D Division, University of Ulster researchers teamed up with clinicians from Belfast HSCT to do the following:

- **Explore the visual status of children with developmental disability.**

This work revealed significant visual deficits and unresolved visual need, particularly in relation to focusing difficulties and need for glasses.<sup>133,134,135,136,137,138</sup>

- **Pilot and audit a multi-disciplinary visual assessment service for children with the most complex neurological problems.**

A novel feature was the issuing of jargon-free reports for parents and other stakeholders. A recipient audit highlighted that the service was valued and reports were appreciated, understood and used in children's care and education.<sup>139</sup>

- **Develop web-based resources that provide open-access information for professionals and parents regarding vision/visual function in the context of developmental disability.**

Downloadable examples of suitable print sizes for visually impaired children, strategies to limit the impact of visual deficits on 'real world' function, and assistance for eyecare professionals writing vision reports are provided at: <http://biomed.science.ulster.ac.uk/vision/-Visual-Acuity-.html> Professional and lay users from the UK and Ireland have acknowledged the value of the resource.<sup>140</sup>



↑ Professor Kathryn Saunders (right) and members of the research team, Dr Julie McClelland (left) and Dr Julie-Anne Little, have developed web-based resources with information about vision for lay and professional stakeholders.

- **Explore, through focus groups with families, support groups, education, eye and health professionals, perceptions of current eyecare services for children with disabilities.**  
A perceived disconnect emerged between what families, therapists and educators understand about vision and the clinicians' appreciation of children's visual status and needs.<sup>141</sup>

## Impacts

The research, clinical and knowledge transfer work undertaken raised the profile of visual needs of children with disabilities. In response, and aligned with the agenda of the DHSSPS *Physical and sensory disability strategy and action plan 2012–2015*, the HSCB approved a new, regional visual assessment service for children with complex neurological impairment and unresolved questions around visual status. Communication of written information on visual status for all stakeholders will be embedded. University and HSCB expertise will be utilised and training incorporated to disseminate skills across HSCTs.

The work has widened attention, beyond those with the most complex conditions, to all children in special education. Clinical and research projects are planned and/or underway to improve and standardise access to high quality eyecare through in-school services. A new orthoptic post in Belfast HSCT, with responsibility for enhancing eyecare for children with disabilities, has been introduced.

## Next steps

Our researchers are participating in a large UK-based service model evaluation led by SeeAbility (a national charity for people with learning disabilities), exploring ways to maximise uptake and success of early eyecare by incorporating services into special schools alongside other therapies.

### Key facts



- Children with developmental disability are at higher risk of visual problems than typically developing children.<sup>123,124,142</sup>
- 12–17% of children in special schools have a visual impairment and 53% have a significant, often unrecognised, need for glasses.<sup>123,124</sup>
- Eyecare services are not routinely funded to provide written communication of children's visual status to parents/educators.
- When written reports of visual status are provided, they impact positively on care – 75% of parents use the information 'daily' to care for their child.<sup>139,140</sup>

### Further information



**Prof Kathryn Saunders**  
**Professor of Optometry and Vision Science**  
**(University of Ulster)**  
 kj.saunders@ulster.ac.uk



## Mortality patterns among Section 75 equality groups

### Public health challenge

Inequalities in health continue to exist between geographic areas, socioeconomic groups and minority groups across Northern Ireland. It is known that people from lower socioeconomic groups tend to experience worse health, die earlier and be more likely to engage in unhealthy behaviours than their peers in higher socioeconomic groups.

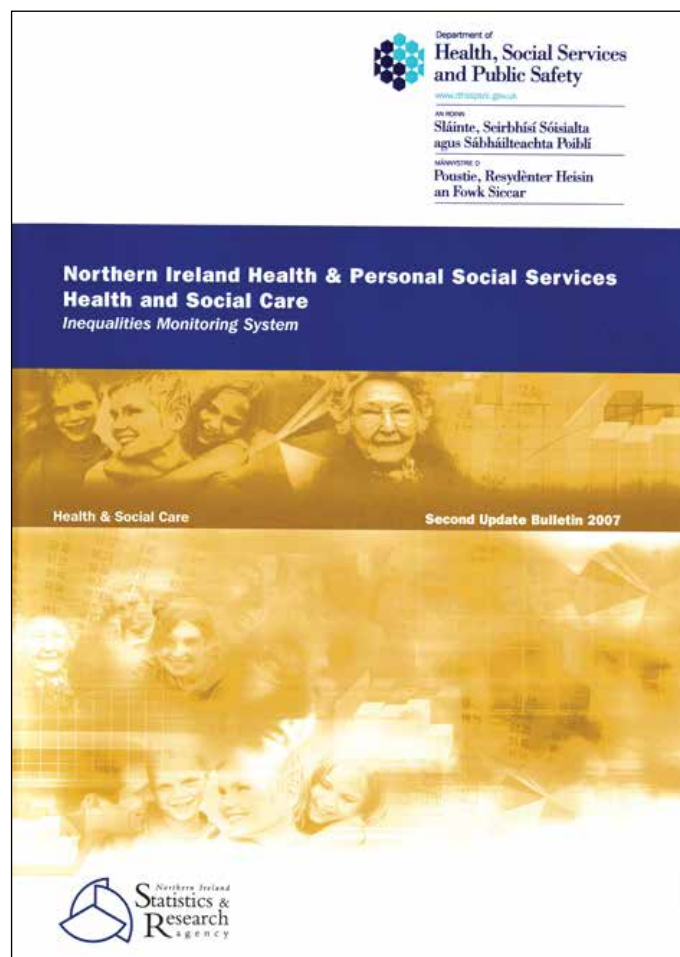
Communities in Northern Ireland are becoming increasingly diverse and, therefore, are experiencing increasingly diverse health needs. The DHSSPS, in aiming to improve the health and wellbeing of the Northern Ireland population, recognises the importance of its role in reducing health inequalities and is fully committed to the discharge of its Section 75 obligations.

### Actions

Within the DHSSPS, cause-specific mortality, particularly for cancers and heart disease, has been routinely used to provide indicators for policy monitoring. However, such analyses have normally been limited to the information provided on death certificates. In terms of availability by Section 75 equality groups, this has amounted to population sub-groups based on gender, age and marital status only.

The Northern Ireland Longitudinal Study (NILS) and its sister project, the Northern Ireland Mortality Study (NIMS) allow exploration of health and socio-demographic characteristics by a wider range of Section 75 individualities.

The DHSSPS monitors the health outcomes of Section 75 groups and disadvantaged populations as part of its Northern Ireland Health and Social Care Inequalities Monitoring System (HSCIMS).<sup>143</sup> This initial research project concentrated on analysing mortality data from NIMS, with the aims of pinpointing differences in mortality between Section 75 groups and examining whether or not they can be explained by social and economic disadvantage factors. This research builds upon previous Office of the First Minister and Deputy First Minister (OFMDFM) work.<sup>144</sup>



## Impacts

This research has enabled the DHSSPS to monitor and review its progress of equality duties within public health strategies as well as in the promotion of equal opportunity among the Section 75 groups. It has also provided valuable data for the screening of DHSSPS policies.

The DHSSPS equality scheme states that it will seek to develop more effective and wide-ranging monitoring and data collection arrangements. It is intended that this research will be repeated to create an ongoing monitoring system using longitudinal data, which will allow observation of changes to mortality rates and life expectancy, and possibly include analyses of various morbidity outcomes.

## Next steps

The findings have been disseminated and presented across a wide number of forums. The DHSSPS intends to continue this research with the establishment of an ongoing monitoring system, and also plans to include linkages to other health-related data in order to extend the research beyond mortality.

### Key facts



- Age and gender were the two main predictors for determining mortality.
- The greatest differences in Section 75 characteristics were seen between those with a limiting long-term illness (higher age-specific mortality rate – higher ASMR) and those without (lower ASMR).
- Social deprivation had a bigger effect on mortality and life expectancy than Section 75 characteristics – excluding age, gender and limiting long-term illness.
- Those from a Catholic background had a slightly higher ASMR and lower life expectancy.
- Those who were married or cohabiting experienced the lowest ASMRs and highest life expectancy.

### Further information



**Dr Janice Bailie**  
**Assistant Director Public Health**  
**(Research and Development)**

janice.bailie@hscni.net

The help provided by the staff of the NILS and NILS Research Support Unit is acknowledged. The NILS is funded by the HSC R&D Division and NISRA. The NILS Research Support Unit (RSU) is funded by the Economic and Social Research Council (ESRC) and the Northern Ireland Government. The authors alone are responsible for the interpretation of the data and any views or opinions presented are solely those of the author and do not necessarily represent those of NISRA/NILS.

# *Protecting health*

## **Overview**

Regional plan ensures coordinated approach to managing incidents and outbreaks across Northern Ireland

Meeting the public health challenges of the G8 Summit

Focusing on the health needs of migrant populations

## Overview

The PHA's health protection department continues to provide a high-quality service to safeguard the population of Northern Ireland from communicable disease and environmental hazards. These include targeted interventions for vulnerable groups within the population.

During 2013, the health protection service delivered responses to a number of challenges. The G8 Summit was held in Fermanagh in 2013 and planning for it was a major undertaking.

Emergency preparedness staff and the health protection service worked closely with the DHSSPS, HSCB and HSCT colleagues to lead preparations, including surveillance and outbreak response, healthcare response to major incidents and casualty preparedness. Notably, a new Enhanced Syndromic Surveillance System (EDSSS) was developed and delivered to support our ability to monitor the impact of the G8 Summit in health terms.

Delivering the response to infectious disease incidents and outbreaks remains a key health protection responsibility. During 2013, the health protection team led the development of an updated Northern Ireland infectious disease incident/outbreak plan to ensure a coordinated approach is taken throughout Northern Ireland to the investigation and control of infectious disease incidents and outbreaks. The plan clarifies roles and responsibilities, and further training will be taken forward during 2014 to ensure clarity across the service in respect of outbreak investigation response.

During 2013, health protection colleagues worked with others in the PHA to ensure the organisation met its responsibilities to prevent the spread of infection in vulnerable migrant populations. This included targeted messages for vulnerable groups and working closely with members of the community health teams who have specific responsibility for migrant communities.

The PHA has also worked closely with the Belfast HSCT to develop NINES aimed at meeting the health and wellbeing needs of new immigrants. These approaches have ensured that communicable disease control services cover the entire population including vulnerable migrant groups.

### Further information

**Dr Lorraine Doherty**  
**Assistant Director Public Health**  
**(Health Protection)**

lorraine.doherty@hscni.net

## Regional plan ensures coordinated approach to managing incidents and outbreaks across Northern Ireland

### Public health challenge

Infectious disease outbreaks and incidents can impact on the health of anyone – young and old, those born within the UK and those born elsewhere. Outbreak and incident management aims to protect public health by:

- promptly identifying the source of infection;
- implementing necessary measures to prevent further spread or recurrence;
- ensuring appropriate medical attention for those infected;
- communicating with patients/clients, the public and professionals.

### Actions

The *Northern Ireland Infectious Disease Incident/Outbreak Plan* has been developed to ensure a coordinated approach is taken throughout Northern Ireland to the investigation and control of infectious disease incidents and outbreaks. It is a generic template that can be used by organisations to identify, risk assess and manage an incident or outbreak of infectious disease.

The plan was developed by the PHA in liaison with HSCT and DHSSPS colleagues as part of the implementation of the RQIA *Review of outbreaks of Pseudomonas aeruginosa in neonatal units in Northern Ireland*.<sup>145</sup> The plan is based on the most up-to-date guidance available on leading and managing an incident or outbreak.

### Impacts

A range of organisations may be involved in the response to an incident/outbreak. These will vary according to the nature of the outbreak, but can include the PHA, environmental health departments in local councils, HSCTs, Food Standards Agency (FSA) and DHSSPS. The plan clearly identifies the roles and responsibilities of organisations in the response.

The plan also clarifies the role of the outbreak control team formed to respond to the incident and identifies the professional groups that should be represented on the team. The role of outbreak team members and their areas of personal responsibility are clearly stated.

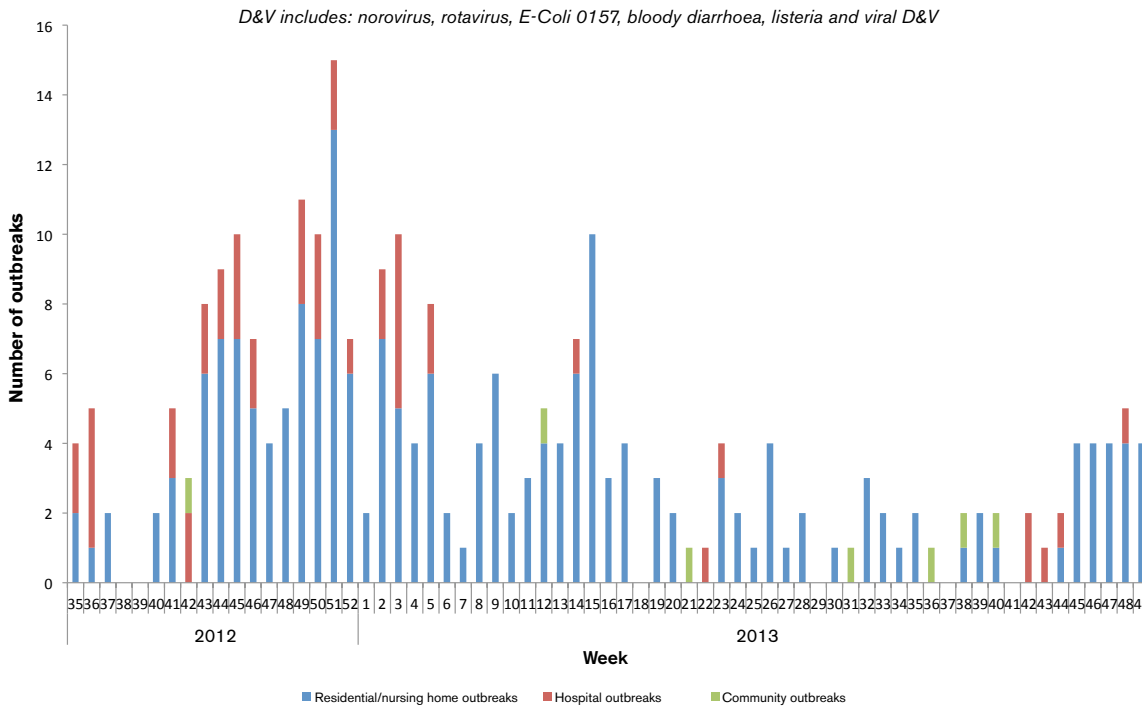
In addition, the plan provides guidance on the management and organisational aspects of outbreak and incident response, communication in these situations, and disease investigation and control procedures. A range of appendices, such as a dynamic risk assessment model, are included for use during incidents and outbreaks.

### Next steps

The plan will be shared with HSCTs and other key stakeholders to enable each organisation to develop or refine their own outbreak plan(s), consistent with this regional plan.

To ensure a consistent approach to outbreaks and incidents across the region, the PHA will arrange training on outbreak planning and response in 2014.

**Figure 13: Number of diarrhoea and vomiting (D&V) outbreaks reported to the PHA per week in 2012–13**



### Key facts

- During 2012, there were 164 outbreaks of infectious gastrointestinal illness in residential institutions, affecting at least 2,693 people, and a further 10 outbreaks linked to other sites (eg nurseries, schools/universities), affecting at least 588 people.
- The most common causative agent of non-foodborne gastrointestinal outbreaks in 2012 was norovirus, which accounted for 117 outbreaks (47% of all outbreaks).
- In the UK, there are up to 17 million cases and 1 million GP consultations due to infectious gastrointestinal illness every year.<sup>146</sup>
- In the United States, it is estimated that foodborne outbreaks result in 76 million illnesses, 325,000 hospitalisations and 5,000 deaths each year.<sup>147</sup>

### Further information

**Dr Philip Veal**  
**Consultant in Health Protection**  
 philip.veal@hscni.net

# Meeting the public health challenges of the G8 Summit

## Public health challenge

On 17 and 18 June 2013, the five star Lough Erne Hotel and Golf Resort hosted the G8 Summit. This major event saw 10 world leaders, along with 3,500 delegates and staff and large numbers of world media, visit Northern Ireland. Based on previous summits and international intelligence, large numbers of protesters were also predicted to attend the event. This brought with it specific security risks and public health challenges for multi-agency emergency planners.

All major events such as the G8, with the temporary increase in local population density, bring with them potential public health risks that have to be assessed and managed.<sup>148</sup> These risks include possible increased illness from the importation, transmission and mixing of infections that are not endemic in Northern Ireland with local endemic infections, and, on occasion, an ensuing strain on local health services.

## Actions

The Chief Medical Officer asked the PHA to project manage and oversee all the operational HSC preparations for the G8. Emergency planners in the PHA's health protection department worked closely with DHSSPS, HSCB and HSCT colleagues to lead HSC preparations for this event.

Figure 14: WHO outline framework for public health planning for mass gatherings

<p><b>Population health</b></p> <ul style="list-style-type: none"> <li>• Disease surveillance and outbreak response</li> <li>• Environmental health, food and water safety</li> <li>• Health promotion opportunities</li> </ul>	<p><b>Health services</b></p> <ul style="list-style-type: none"> <li>• Emergency medical care (pre-hospital, hospital care and diagnostics etc)</li> <li>• From first aid to specialist care</li> <li>• Surge capacity</li> <li>• Impact of event on local services, eg from road closures</li> <li>• Specific arrangements for individual athletes, trainers, spectators, protesters and VIPs.</li> </ul>	<p><b>Disaster planning and response</b></p> <ul style="list-style-type: none"> <li>• Mass casualties</li> <li>• CBRN/HAZMAT incidents (MPC plans)</li> <li>• Severe weather</li> <li>• Command and control arrangements/resilience</li> </ul>
---	--	--

The World Health Organization (WHO) outline framework for public health planning for mass gatherings (Figure 14) was used as the basis of the HSC preparations. Despite the very short timescales, the PHA successfully worked with DHSSPS, HSCB, HSCT and environmental health colleagues to carry out effective risk assessment and public health planning in the areas of:

- disease surveillance and outbreak response;
- environmental health, food and water safety;
- healthcare capacity and mass casualty preparedness;
- chemical and radiation incident response;
- public information and health promotion.

## Impacts

Northern Ireland can be proud that the many weeks of preparation, both within HSC and across all the partner organisations, resulted in what was internationally acclaimed as the most peaceful G8 Summit ever held.

Special command and control arrangements were put in place for the four days leading up to and including the days of the summit. PHA staff worked closely with DHSSPS colleagues and other partner agencies in the central coordination room.

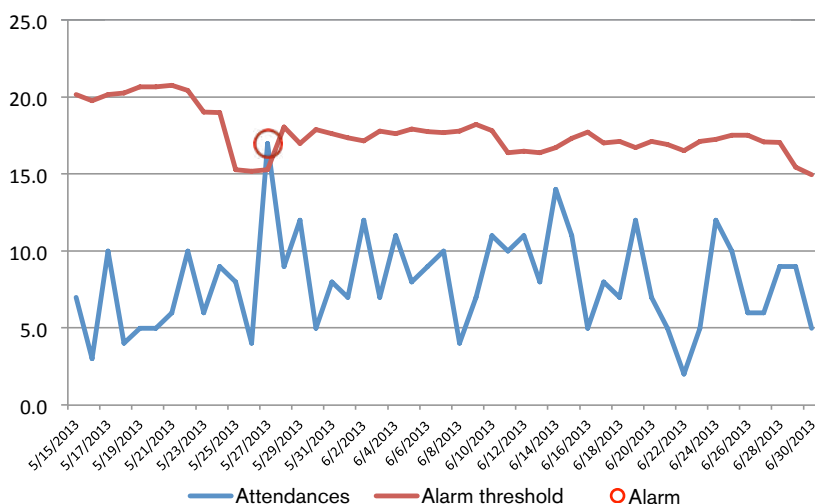
Health protection staff worked with Public Health England (PHE) colleagues to put in place a surveillance system for emergency departments (EDSSS), which was piloted in three Northern Ireland hospitals (Figure 15). A Dedicated Operations Centre (DOC) was set up and run by health protection staff to facilitate the collation and risk assessment of a range of surveillance information including the EDSSS.

## Next steps

Significant learning was gained through the G8 preparations, both within the PHA and across HSC. This learning formed the basis of HSC preparations for the other two major events in 2013, the World Police and Fire Games and the All-Ireland Fleadh Cheoil.

The EDSSS proved very successful and funding is being sought to ensure this system is now embedded as part of the health protection core surveillance function.

**Figure 15: EDSSS alert graph – respiratory attendances at two emergency departments in Northern Ireland, May–June 2013**



Source: Health Protection Surveillance Team, PHA

**Note:** Alarm thresholds are based on an upper prediction level calculated using the Shewhart methodology.

### Further information

**Dr Anne Wilson**  
**Consultant in Health Protection**  
 anne.wilson@hscni.net





## Focusing on the health needs of migrant populations

### Public health challenge

Migrants make up an increasing proportion of the UK population. The 2011 Census estimated the total migrant population to be 81,400 in Northern Ireland (4.5% of the population).<sup>149</sup>

The majority of long-term migrants to the UK are young people with plans to study or work, who have general health needs similar to individuals of equivalent age and sex in the indigenous UK population.<sup>150</sup>

A smaller proportion will experience a range of health needs including (but not limited to):

- access to healthcare;
- racism and racial harassment;
- mental health issues;
- children's health issues;
- health protection issues.

Asylum seekers, refugees and clients who are unable to register for GP services are particularly vulnerable groups.<sup>151</sup>

### Actions

The health protection service within the PHA is responsible for the prevention and control of communicable infectious diseases and provides an acute response function to major issues such as outbreaks of infection.

To ensure the PHA meets its responsibilities to prevent the spread of infection in vulnerable migrant communities, a range of approaches have been taken in response to incidents:

- collaborating with local community workers to explain issues and gain the support of the community for screening and treatment;
- tailoring infection prevention and control messages to meet the communication needs of the community;
- joint working with members of the community health team who have specific responsibility for migrant communities;
- organisation of vaccination clinics to encourage uptake of childhood vaccinations in vulnerable migrant populations.



**Transmission of respiratory infections commonly occurs through droplets from coughs and sneezes. Encouraging the public to use tissues to catch coughs or sneezes, bin the tissues and kill the germs by washing their hands can reduce the spread of infection within the community.**

The PHA has also provided funding for the Belfast HSCT to develop NINES. This offers a holistic service to meet the health and wellbeing needs of new immigrants, including asylum seekers and children aged 0–18 years, through a range of clinics. These are accessed by self-referral and referral by professionals from health, voluntary and other sectors.

## Impacts

Our approaches have ensured communicable disease control services cover all of our population, including vulnerable migrant groups such as those unable to register for GP services.

Through NINES, screening for communicable diseases such as TB, hepatitis B, hepatitis C and HIV is offered to clients from high risk countries. Immunisations against communicable diseases are offered to those who require them. Where appropriate, we also provide assistance with registration for GP and dental services, signposting to other services and onward referral.

## Next steps

The PHA will continue to develop new approaches for reaching migrant populations. NINES will be widened to include more multisectoral elements, such as housing, poverty, community relations and education. Clinic sessions will be further developed to include a GP clinic and a consultant-led paediatric clinic.

### Key facts



- 12,900 people came to live in Northern Ireland from outside the UK between mid-2011 and mid-2012.<sup>149</sup>
- Health risks to the non-UK born population can continue for many years after arrival in the UK. For example, 77% of non-UK born TB cases in 2010 were diagnosed two or more years after arrival in the UK.<sup>150</sup>
- There is little evidence that the wider population is at risk of significant levels of transmission of disease from affected migrants, especially during normal social contact.<sup>152</sup>

### Further information



**Dr Philip Veal**  
**Consultant in Health Protection**  
 philip.veal@hscni.net

# List of core tables 2012 *List of core tables*

<b>Table 1a:</b>	Estimated home population by age/gender, Northern Ireland 2012 .....	2
<b>Table 1b:</b>	Estimated home population by age band, Local Commissioning Groups (LCGs) 2012 .....	3
<b>Table 1c:</b>	Estimated home population by age band, LCGs/Local Government Districts (LGDs) 2012 .....	4
<b>Table 2a:</b>	Population projections, Northern Ireland 2019 and 2024 (thousands) .....	10
<b>Table 2b:</b>	Population projections, LCGs/LGDs 2019 and 2023 (thousands) .....	11
<b>Table 3a:</b>	Live births/stillbirths by maternal residents, Northern Ireland 2003–2012.....	12
<b>Table 3b:</b>	Live births/stillbirths by maternal residents, LCGs/LGDs 2012 .....	13
<b>Table 4:</b>	Total births by maternal residents, LCGs/LGDs 2003–2012.....	14
<b>Table 5a:</b>	Age specific/total period fertility rates, Northern Ireland 2003–2012 .....	15
<b>Table 5b:</b>	Age specific/total period fertility rates, LCGs 2003–2012 .....	15
<b>Table 6a:</b>	Notified live births by maternal residence by birth weight 2003–2012.....	17
<b>Table 6b:</b>	Notified still births by maternal residence by birth weight 2003–2012.....	19
<b>Table 7a:</b>	Infant/perinatal death rates, Northern Ireland 2003–2012.....	21
<b>Table 7b:</b>	Infant/perinatal death rates, LCGs 2003–2012.....	21
<b>Table 8:</b>	Standardised mortality ratios, age 1–14 years, LCGs 2008–2012.....	23
<b>Table 9a:</b>	Directly standardised death rates, selected major causes of death age 15–74 years, Northern Ireland 2003–2012.....	24
<b>Table 9b:</b>	Age standardised death rates (standardised to EU populations), selected major causes of death age 15-74 years, Northern Ireland 2003–2012.....	25
<b>Table 9c:</b>	Directly standardised death rates, selected major causes of death age 15–74 years, LCGs 2003–2012.....	26
<b>Table 10a:</b>	Mortality by cause, Northern Ireland 2012.....	31
<b>Table 10b:</b>	Mortality by cause, LCGs 2012.....	32
<b>Table 10c:</b>	Potential years of life lost (PYLL), selected causes of death age 1–74 years, Northern Ireland 2012... ..	34
<b>Table 10d:</b>	Potential years of life lost (PYLL), selected causes of death age 1–74 years, LCGs, 2012.....	35
<b>Table 11a:</b>	Life expectancy at birth, age 1 and age 65 years, Northern Ireland 1900–2012 .....	36
<b>Table 11b:</b>	Life expectancy at birth, LGDs 1995–1997 to 2008–2010.....	37
<b>Table 11c:</b>	Life expectancy at birth, LCGs 2001–2003 to 2008–2010.....	39
<b>Table 12:</b>	Infectious disease notifications, Northern Ireland 2003–2012.....	40
<b>Table 13a:</b>	Percentage uptake rates immunisation, Northern Ireland 2007–2012.....	41
<b>Table 13b:</b>	Percentage uptake rates immunisation, LCGs and Northern Ireland 2012.....	41
<b>Table 14a:</b>	Number/birth prevalence per 1,000 total registered births, selected congenital abnormalities, Northern Ireland 2003–2012.....	42
<b>Table 14b:</b>	Number/rate Down's Syndrome births, maternal age and LCGs 2008–2012.....	43
<b>Table 15a:</b>	Cervical screening coverage, Health and Social Care Trusts (HSCTs) 2012–2013.....	45
<b>Table 15b:</b>	Breast screening uptake rates (three year screening cycle) by maternal residence, LCGs 2010/11–2012/13.....	46

## Further information

**Ms Adele Graham**  
**Senior Health Intelligence Manager**

adele.graham@hscni.net

These tables are available to download as a PDF from the PHA website at [www.publichealth.hscni.net](http://www.publichealth.hscni.net)

# List of figures and tables *List of figures and tables*

- Figure 1:** Life course approach in public health
- Figure 2:** Proportion of those in each age group with at least one long-term condition
- Figure 3:** Five most common countries of origin for first-time asylum applicants between 1 January 2011 and 31 October 2012
- Figure 4:** Prevalence of different disabilities among adult household population in Northern Ireland
- Figure 5:** Northern Ireland minority ethnic population, by ethnic group, 2011
- Figure 6:** Northern Ireland minority ethnic population, by main language, 2011
- Figure 7:** Estimated net international migration, by Local Government District
- Figure 8:** Relative poverty in Northern Ireland, 2002/03–2011/12
- Figure 9:** Average number of prisoners in Northern Ireland, by prisoner type, 2002–2012
- Figure 10:** Reported religious affiliation of Northern Ireland population, 2001 and 2011 Census
- Figure 11:** Expected life years of the Northern Ireland population, by gender, 1920–2012
- Figure 12:** Breastfeeding rates in the AITHS and Survey of Lifestyle, Attitudes and Nutrition (SLAN) studies, by age at the time of interview
- Figure 13:** Number of diarrhoea and vomiting (D&V) outbreaks reported to the PHA per week in 2012–13.
- Figure 14:** WHO outline framework for public health planning for mass gatherings
- Figure 15:** EDSSS alert graph – respiratory attendances at two emergency departments in Northern Ireland, May–June 2013
- Table 1:** Minority ethnic groups in Northern Ireland, 2001–2011

## References

1. Kuh D, Ben-Shlomo Y. A life-course approach to chronic disease epidemiology. Oxford University Press, 1997.
2. World Health Organization. A life-course perspective of maintaining independence in older age. Geneva: WHO, 1999.
3. World Health Organization. The implications for training of embracing: A life course approach to health. Geneva: WHO, 2000.
4. Institute of Health Equity. Fair society, healthy lives. The Marmot Review England 2010. Available at: [www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review](http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review) Accessed 27 January 2014.
5. Northern Ireland Statistics and Research Agency. Registrar General Northern Ireland Annual Report 2012. Belfast: NISRA, 2013. Available at: [www.nisra.gov.uk/archive/demography/publications/annual\\_reports/2012/RG2012.pdf](http://www.nisra.gov.uk/archive/demography/publications/annual_reports/2012/RG2012.pdf) Accessed 27 January 2014.
6. Department of Health, Social Services and Public Safety. Service framework for older people. Belfast: DHSSPS, 2012.
7. Public Health Agency. Director of Public Health Annual Report 2012. Available at: [www.publichealth.hscni.net/publications/director-public-health-annual-report-2012-and-core-tables-2011](http://www.publichealth.hscni.net/publications/director-public-health-annual-report-2012-and-core-tables-2011) Accessed 27 January 2014.
8. Public Health Agency. Director of Public Health Annual Report 2011. Available at: [www.publichealth.hscni.net/publications/director-public-health-annual-report-2011-and-core-tables-2010](http://www.publichealth.hscni.net/publications/director-public-health-annual-report-2011-and-core-tables-2010)
9. Refugee Action Group. Forced to flee. Belfast: Refugee Action Group, 2007. Available at: [www.mcrc-ni.org/PDFs/ForcedToFlee.pdf](http://www.mcrc-ni.org/PDFs/ForcedToFlee.pdf) Accessed 29 January 2014.
10. Northern Ireland Strategic Migration Partnership. Demographic trends. NISMP. Available at: [www.migrationni.org/demographic-trends#DemNI](http://www.migrationni.org/demographic-trends#DemNI) Accessed 27 January 2014.
11. Belfast Health Development Unit. Barriers to health: Migrant health and wellbeing in Belfast. Available at: [www.belfasttrust.hscni.net/pdf/Migrant-Health-Strategy.pdf](http://www.belfasttrust.hscni.net/pdf/Migrant-Health-Strategy.pdf) Accessed 27 January 2014.
12. Buckner L, Yeandle S. Valuing carers 2011: Calculating the value of carers' support. London: Carers UK, 2011. Available at: <http://circle.leeds.ac.uk/files/2012/08/110512-circle-carers-uk-valuing-carers.pdf> Accessed 3 February 2014
13. Northern Ireland Statistics and Research Agency. Census 2011: Key statistics for Northern Ireland. Belfast: NISRA, 2012. Available at: [www.nisra.gov.uk/Census/key\\_stats\\_bulletin\\_2011.pdf](http://www.nisra.gov.uk/Census/key_stats_bulletin_2011.pdf) Accessed 27 January 2014.
14. Hirst M. Transitions to informal care in Great Britain during the 1990s. *Journal of Epidemiology and Community Health* 2002; 56: 579–587.
15. Hirst M. Carer distress: A prospective, population-based study. *Social Science & Medicine* 2005; 61: 697–708.
16. Yeandle S, Bennett C, Buckner L et al. Stages and transitions in the experience of caring. Leeds: Carers UK, 2007. Available at: [www.carersuk.org/media/k2/attachments/Stages\\_and\\_Transitions\\_in\\_Caring.pdf](http://www.carersuk.org/media/k2/attachments/Stages_and_Transitions_in_Caring.pdf) Accessed 27 January 2014.

17. Carers UK. In poor health: The impact of caring on health. London: Carers UK, 2004. Available at: [www.carersuk.org/media/k2/attachments/In\\_Poor\\_Health\\_\\_The\\_impact\\_of\\_caring\\_on\\_health.pdf](http://www.carersuk.org/media/k2/attachments/In_Poor_Health__The_impact_of_caring_on_health.pdf) Accessed 27 January 2014.
18. Northern Ireland Statistics and Research Agency. The prevalence of disability and activity limitations amongst adults and children living in private households in Northern Ireland. Belfast: NISRA, 2007. Available at: [www.csu.nisra.gov.uk/survey.asp12.htm](http://www.csu.nisra.gov.uk/survey.asp12.htm) Accessed 27 January 2014.
19. Inclusion Project. Fair for all equality and diversity: Handbook for NHS Scotland. Edinburgh: Inclusion Project, 2007. Available at: [www.healthscotland.com/uploads/documents/6380-Health%20Topic%20Briefings%20and%20Personal%20Stories.pdf](http://www.healthscotland.com/uploads/documents/6380-Health%20Topic%20Briefings%20and%20Personal%20Stories.pdf) Accessed 27 January 2014.
20. Disability Rights Commission. Equal treatment: Closing the gap. London: DRC, 2005. Available at: <http://disability-studies.leeds.ac.uk/files/library/DRC-Health-FI-main.pdf> Accessed 27 January 2014.
21. Purdon K, Afkhami R, Olsen W, Thornton P. Disability in the UK: Measuring equality. *Disability & Society* 2008; 23: 53–65.
22. Goffman E. *Stigma: Notes on the management of a spoiled identity*. Englewood Cliffs, NJ: Prentice Hall, 1963.
23. Begum N. General practitioners' role in shaping disabled women's lives. In: Barnes C and Mercer G (Editors). *Exploring the divide: Illness and disability*. Leeds: The Disability Press, 1996.
24. Health Protection Services. Migrant health: Infectious diseases in non-UK born populations in the UK. London: Health Protection Agency, 2011. Available at: [www.hpa.org.uk/webc/HPAwebFile/HPAweb\\_C/1317131998682](http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317131998682) Accessed 27 January 2014.
25. O'Rawe A. Delivering on equality, valuing diversity: A report examining the impact of ethnicity on health needs and relevant statutory service provision in Northern Ireland. Belfast: NICEM, 2004.
26. Russell R. *Census 2011: Key statistics at Northern Ireland and LGD level*. Belfast: Northern Ireland Assembly, 2013. Available at: [www.niassembly.gov.uk/Documents/RaISe/Publications/2013/general/3013.pdf](http://www.niassembly.gov.uk/Documents/RaISe/Publications/2013/general/3013.pdf) Accessed on 27 January 2014.
27. Northern Ireland Statistics and Research Agency. *Census 2011: Key statistics for Northern Ireland*. Belfast: NISRA, 2012. Available at [www.nisra.gov.uk/Census/key\\_report\\_2011.pdf](http://www.nisra.gov.uk/Census/key_report_2011.pdf) Accessed 27 January 2014.
28. Taira DA. Improving the health and health care of non-English-speaking patients. *Journal of General Internal Medicine* 1999; 14: 322–323. Available at: [www.ncbi.nlm.nih.gov/pmc/articles/PMC1496581/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1496581/) Accessed 27 January 2014.
29. Woloshin S, Schwartz LM, Katz SJ, Welch G. Is language a barrier to the use of preventative services? *Journal of General Internal Medicine* 1997; 12: 4472–4477.
30. Ngo-Metzger Q, Sorkin DH, Phillips RS et al. Providing high-quality care for limited English proficient patients: The importance of language concordance and interpreter use. *Journal of General Internal Medicine* 2007; 22(Suppl. 2): 324–330.
31. Northern Ireland Statistics and Research Agency. *Demographic overview of Northern Ireland*. Belfast: NISRA, 2011. Available at: [www.nisra.gov.uk/archive/demography/publications/annual\\_reports/2011/Chapter1.pdf](http://www.nisra.gov.uk/archive/demography/publications/annual_reports/2011/Chapter1.pdf) Accessed 27 January 2014.

32. Office of First Minister and Deputy First Minister. Migration in Northern Ireland: A demographic perspective. Belfast: Northern Ireland Assembly, 2011. Available at: [www.migrationni.org/DataEditorUploads/NI%20ASsembly%20paper%20on%20demographics.pdf](http://www.migrationni.org/DataEditorUploads/NI%20ASsembly%20paper%20on%20demographics.pdf) Accessed 27 January 2014.
33. South and East Belfast Health and Social Care Trust. Exploring mental health needs of the Chinese Community. Belfast: South and East Belfast HSCT, 2005.
34. Kabir Z, Clarke V, Keogan S et al. Smoking characteristics of Polish immigrants in Dublin. *BMC Public Health* 2008; 8: 428.
35. Office of First Minister and Deputy First Minister. Improving children's life chances: The child poverty strategy. Belfast: Northern Ireland Executive, 2011. Available at: [www.northernireland.gov.uk/final\\_child\\_poverty\\_strategy\\_-\\_agreed\\_by\\_executive\\_-\\_22\\_march\\_2011.pdf](http://www.northernireland.gov.uk/final_child_poverty_strategy_-_agreed_by_executive_-_22_march_2011.pdf) Accessed 27 January 2014.
36. Blanden J, Gibbons S. The persistence of poverty across generations: A view from two British cohorts. Bristol: The Policy Press, 2006. Available at: [www.jrf.org.uk/publications/persistence-poverty-across-generations](http://www.jrf.org.uk/publications/persistence-poverty-across-generations) Accessed 27 January 2014.
37. Glaser K, Price D, Willis R, Stuchbury R, Nicholls M. Life course influences and well-being in later life: A review. Manchester: Equality and Human Rights Commission, 2009. Available at: [www.equalityhumanrights.com/uploaded\\_files/research/life\\_course\\_influences\\_on\\_health\\_and\\_well-being\\_in\\_later\\_life-a\\_review.pdf](http://www.equalityhumanrights.com/uploaded_files/research/life_course_influences_on_health_and_well-being_in_later_life-a_review.pdf) Accessed 27 January 2014.
38. Northern Ireland Statistics and Research Agency. Poverty in Northern Ireland: 2011/12. Belfast: NISRA, 2012. Available at: [www.dsdni.gov.uk/ni\\_hbai\\_bulletin\\_2011-12\\_\\_release\\_document\\_.pdf](http://www.dsdni.gov.uk/ni_hbai_bulletin_2011-12__release_document_.pdf) Accessed 27 January 2014.
39. World Health Organization. Systematic review of the link between tobacco and poverty. Geneva: WHO, 2011. Available at: [http://whqlibdoc.who.int/publications/2011/9789241500548\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789241500548_eng.pdf) Accessed 27 January 2014
40. Shepherd R. Income change and food choice. London: Food Standards Agency, 1996. Available at: [http://archive.food.gov.uk/pdf\\_files/summary3.pdf](http://archive.food.gov.uk/pdf_files/summary3.pdf) Accessed 27 January 2014.
41. Department of Health, Social Services and Public Safety. Sexual health promotion strategy and action plan 2008–2013. Belfast: DHSSPS, 2008. Available at: [www.dhsspsni.gov.uk/dhssps\\_sexual\\_health\\_plan\\_front\\_cvr.pdf](http://www.dhsspsni.gov.uk/dhssps_sexual_health_plan_front_cvr.pdf) Accessed 27 January 2014.
42. Department of Health, Social Services and Public Safety. A fitter future for all: Obesity prevention framework for Northern Ireland 2011–2021. Belfast: DHSSPS, 2011. Available at: [www.dhsspsni.gov.uk/obesity-prevention-framework-2011-2021.pdf](http://www.dhsspsni.gov.uk/obesity-prevention-framework-2011-2021.pdf) Accessed 27 January 2014.
43. Department of Justice. The Northern Ireland average prison population in 2012. Belfast: DOJ, 2013. Available at: [www.dojni.gov.uk/index/statistics-research/stats-research-publications/prison-population/the-northern-ireland-average-prison-population-2012.pdf](http://www.dojni.gov.uk/index/statistics-research/stats-research-publications/prison-population/the-northern-ireland-average-prison-population-2012.pdf) Accessed 27 January 2014.
44. Public Health Agency. Prisoners' health care needs assessment. Belfast: PHA, 2011.
45. Northern Ireland Statistics and Research Agency. Census 2011: Detailed characteristics for Northern Ireland on health, religion and national identity. Belfast: NISRA, 2013. Available at: [www.nisra.gov.uk/Census/detailedcharacteristics\\_stats\\_bulletin\\_2011.pdf](http://www.nisra.gov.uk/Census/detailedcharacteristics_stats_bulletin_2011.pdf) Accessed 27 January 2014.

46. Koenig HG, McCullough ME, Larson DB. Handbook of religion and health. Oxford: Oxford University Press, 2001.
47. Koenig HG. Research on religion, spirituality and mental health: A review. Canadian Journal of Psychiatry 2008. Available at: <http://hivdatf.files.wordpress.com/2011/01/research-on-religion-spirituality-and-mental-health-a-review.pdf> Accessed 27 January 2014.
48. Whittle S, Turner L, Al-Alami M. Engendered penalties: Transgender and transsexual people's experiences of inequality and discrimination. Wetherby: Communities and Local Government Publications, 2007.
49. Stewart B, Lyness C, Bell C. NI Health & Social Care Inequalities Monitoring System. Belfast: NISRA, 2011. Available at: [www.dhsspsni.gov.uk/hscims\\_life\\_expectancy\\_decomposition\\_2013.pdf](http://www.dhsspsni.gov.uk/hscims_life_expectancy_decomposition_2013.pdf) Accessed 3 February 2014.
50. Scottish Transgender Alliance. Transgender experiences in Scotland. Edinburgh: Scottish Transgender Alliance, 2008. Available at: [www.scottishtrans.org/page/research.aspx](http://www.scottishtrans.org/page/research.aspx) Accessed 3 February 2014.
51. Fish J. Reducing health inequalities for lesbian, gay, bisexual and trans people – briefings for health and social care staff. London: Department of Health, 2007. Available at: [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh\\_078347](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_078347) Accessed 3 February 2014.
52. Breitenbach E, Galligan Y. Gender equality indicators for Northern Ireland: A discussion document. Belfast: OFMDFM, 2004. Available at: [www.ofmdfmi.gov.uk/gender.pdf](http://www.ofmdfmi.gov.uk/gender.pdf)
53. Department of Trade and Industry. Final regulatory impact assessment: Civil Partnership Act 2004. London: DTI, 2004.
54. Jarman N. Attitudes towards lesbian, gay and bisexual people in Northern Ireland. Research update No.66. Belfast: Institute for Conflict Research, 2010.
55. Jarman N, Tennant A. An acceptable prejudice: Homophobic violence and harassment in Northern Ireland. Belfast: Institute for Conflict Research, 2003.
56. Meads C, Pennant M, McManus J, Bayliss S. A systematic review of lesbian, gay, bisexual and transgender health in the West Midlands region of the UK compared to published UK research. Birmingham: University of Birmingham, 2009.
57. Quiery M. Invisible women. A review of the impact of discrimination and social exclusion on lesbian and bisexual women's health in Northern Ireland. Ballymena: Lesbian Advocacy Services Initiative, 2007.
58. Public Health Agency. HIV and STI surveillance in Northern Ireland 2009: An analysis of data for the calendar year 2008. Belfast: PHA, 2010.
59. Krieger N. Genders, sexes, and health: What are the connections – and why does it matter? International Journal of Epidemiology 2003; 32(4): 652–657.
60. Strategic Review of Health Inequalities in England post-2010. Fair society, healthy lives. The Marmot Review, 2010. Available at: [www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review](http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review) Accessed 31 March 2014.



61. Guasp A, Balfour J. Peak performance: Gay people and productivity. Stonewall, 2008. Available at: [www.stonewall.org.uk/documents/productivity.pdf](http://www.stonewall.org.uk/documents/productivity.pdf) Accessed 3 January 2014.
62. Badgett L, Durso L, Kastanis A, Mallory C. The business impact of LGBT-supportive workplace policies. The Williams Institute, 2013. Available at: [williamsinstitute.law.ucla.edu/wp-content/uploads/Business-Impact-LGBT-Policies-Full-Report-May-2013.pdf](http://williamsinstitute.law.ucla.edu/wp-content/uploads/Business-Impact-LGBT-Policies-Full-Report-May-2013.pdf) Accessed 3 January 2014.
63. McDermott M. Through our eyes: Experiences of lesbian, gay, bisexual and transgender people in the workplace. Belfast: The Rainbow Project, 2011. Available at: [www.rainbow-project.org/aboutus/publications](http://www.rainbow-project.org/aboutus/publications) Accessed 3 January 2014.
64. Equality Commission for Northern Ireland. Do you mean me? Discrimination: attitudes and experiences in Northern Ireland. Belfast: Equality Commission for Northern Ireland, 2012. Available at: [www.equalityni.org/archive/pdf/DYMMSurveyMainReport\(webB\).pdf](http://www.equalityni.org/archive/pdf/DYMMSurveyMainReport(webB).pdf) Accessed 3 January 2014.
65. Equality Commission for Northern Ireland. Promoting sexual orientation equality: Priorities and recommendations. Belfast: Equality Commission for Northern Ireland, 2013. Available at: [www.equalityni.org/archive/pdf/ECNI\\_SexualOrientation\\_PolicyPriorities3\\_v0c\\_301013.pdf](http://www.equalityni.org/archive/pdf/ECNI_SexualOrientation_PolicyPriorities3_v0c_301013.pdf) Accessed 3 January 2014.
66. Belfast Health Development Unit. Barriers to health: Migrant health and wellbeing in Belfast. Belfast: BHDU, 2011. Available at: [www.belfasttrust.hscni.net/pdf/Migrant-Health-Strategy.pdf](http://www.belfasttrust.hscni.net/pdf/Migrant-Health-Strategy.pdf) Accessed 9 January 2014.
67. Burnett T, Mort M. Improving access to healthcare for farming communities: The Farmers' Health Project. In: Shaw T and Sanders K (Editors). Foundation of Nursing Studies Dissemination Series. Vol.1. No.5. Available at: [www.fons.org/resources/documents/DissSeriesVol1No5.pdf](http://www.fons.org/resources/documents/DissSeriesVol1No5.pdf)
68. Fraser CE, Smith KB, Judd F, Humphreys JS, Fragar LJ, Henderson A. Farming and mental health problems and mental illness. *International Journal of Social Psychiatry* 2005; 51(4): 340–49.
69. Department of Health, Social Services and Public Safety. Physical and sensory disability strategy and action plan 2012–2015. Belfast: DHSSPS, 2013. Available at: [www.dhsspsni.gov.uk/disability\\_strategy\\_and\\_action\\_plan\\_-\\_2012-2015.pdf](http://www.dhsspsni.gov.uk/disability_strategy_and_action_plan_-_2012-2015.pdf)
70. Department of Culture, Arts and Leisure. Sport matters: a culture of lifelong enjoyment and success in sport. The Northern Ireland strategy for sport and physical recreation 2009–2019. Belfast: DCAL, 2009.
71. All Ireland Traveller Health Study Team. All Ireland Traveller Health Study: Our Geels. Dublin: University College Dublin, 2010. Available at: [www.dohc.ie/publications/aiths2010/ExecutiveSummary/AITHS2010\\_SUMMARY\\_LR\\_All.pdf?direct=1](http://www.dohc.ie/publications/aiths2010/ExecutiveSummary/AITHS2010_SUMMARY_LR_All.pdf?direct=1) Accessed 20 January 2014.
72. Children & Young People's Strategic Partnership. Outcomes for children – Southern area action with Travellers: Outcome monitoring report 2011/12. CYPSP, 2013. Available at: [www.cypsp.org/publications/monitoring/other/SAATOutcomeMonitoring2012.pdf](http://www.cypsp.org/publications/monitoring/other/SAATOutcomeMonitoring2012.pdf) Accessed 20 January 2014
73. Public Health Agency. Breastfeeding Action Plan 2013–2014. (Unpublished)
74. Department of Health. Departmental Report 2009: The Health and Personal Social Services Programmes. London: The Stationery Office, 2009. Available at: [www.official-documents.gov.uk/document/cm75/7593/7593.pdf](http://www.official-documents.gov.uk/document/cm75/7593/7593.pdf) Accessed 20 January 2014.

75. Northern Ireland Statistics and Research Agency. 2001 Census. NISRA, 2001. Available at: [www.nisra.gov.uk/Census/2001Census.html](http://www.nisra.gov.uk/Census/2001Census.html) Accessed 22 January 2014.
76. Northern Ireland Statistics and Research Agency. 2011 Census. NISRA, 2011. Available at: [www.nisra.gov.uk/Census/2011Census.html](http://www.nisra.gov.uk/Census/2011Census.html) Accessed 22 January 2014.
77. Northern Ireland Statistics and Research Agency. Migration statistics for Northern Ireland (2009). Belfast: NISRA, 2010. Available at: [www.nisra.gov.uk/archive/demography/population/migration/Migration%20Report%202009.pdf](http://www.nisra.gov.uk/archive/demography/population/migration/Migration%20Report%202009.pdf) Accessed 24 February 2014.
78. Belfast Health Development Unit. Barriers to health: Migrant health and wellbeing in Belfast. Belfast: Belfast Health and Social Care Trust, 2011. Available at: [www.belfasttrust.hscni.net/pdf/Migrant-Health-Strategy.pdf](http://www.belfasttrust.hscni.net/pdf/Migrant-Health-Strategy.pdf) Accessed 22 January 2014.
79. Geraghty T, McStravick C, Mitchell S. New to Northern Ireland: A study of the issues faced by migrant, asylum seeking and refugee children in Northern Ireland. London: NCB, 2010. Available at: [www.ncb.org.uk/media/105565/ntni\\_final.pdf](http://www.ncb.org.uk/media/105565/ntni_final.pdf) Accessed 22 January 2014.
80. Centre for Social Justice. Completing the revolution: Transforming mental health and tackling poverty. London: CSJ, 2011. Available at: [www.centreforsocialjustice.org.uk/UserStorage/pdf/Pdf%20reports/CompletingtheRevolution.pdf](http://www.centreforsocialjustice.org.uk/UserStorage/pdf/Pdf%20reports/CompletingtheRevolution.pdf) Accessed 24 February 2014.
81. Sigma Research. Vital statistics 2010: The UK gay men's sex survey – Northern Ireland region of residence data report. 2011. Available at: [www.sigmaresearch.org.uk/files/local/All\\_NorthernIreland\\_2010.pdf](http://www.sigmaresearch.org.uk/files/local/All_NorthernIreland_2010.pdf) Accessed 8 January 2014.
82. Department of Health, Social Services and Public Safety. Sexual health promotion: Strategy & action plan 2008–2013. Belfast: DHSSPS, 2008. Available at: [www.dhsspsni.gov.uk/dhssps\\_sexual\\_health\\_plan\\_front\\_cvr.pdf](http://www.dhsspsni.gov.uk/dhssps_sexual_health_plan_front_cvr.pdf) Accessed 8 January 2014.
83. Public Health Agency. HIV surveillance in Northern Ireland 2013: An analysis of data for the calendar year 2012. Belfast: PHA, 2013. Available at: [www.publichealth.hscni.net/sites/default/files/directorates/files/HIV%20surveillance%20report%202013.pdf](http://www.publichealth.hscni.net/sites/default/files/directorates/files/HIV%20surveillance%20report%202013.pdf) Accessed 8 January 2014.
84. Public Health Agency. Sexually transmitted infection surveillance in Northern Ireland 2013: An analysis of data for the calendar year 2012. Belfast: PHA, 2013. Available at: [www.publichealthagency.org/sites/default/files/directorates/files/STI%20surveillance%20report%202013.pdf](http://www.publichealthagency.org/sites/default/files/directorates/files/STI%20surveillance%20report%202013.pdf) Accessed 8 January 2014.
85. Northern Ireland Statistics and Research Agency. Mid-population estimates and population projections. Belfast: NISRA, 2012.
86. Knocker S. The whole of me: Meeting the needs of older lesbians, gay men and bisexuals living in care homes and extra care housing. London: Age Concern, 2006. Available at: [www.ageconcern.org.uk/openingdoors](http://www.ageconcern.org.uk/openingdoors) Accessed 20 December 2012.
87. Matthews A, Brandenburg D, Johnson T, Hughes T. Correlates of underutilization of gynaecological cancer screening among lesbian and heterosexual women. *Preventive Medicine* 2004; 38(1): 105–113. Available at: [www.ncbi.nlm.nih.gov/pmc/articles/PMC2834453/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2834453/) Accessed 20 December 2013.
88. Dibble S, Roberts S, Nussey B. Comparing breast cancer risk between lesbians and their heterosexual sisters. *Womens Health Issues* 2004; 14(2): 60–68. Available at: [www.whijournal.com/article/S1049-3867\(04\)00018-0/abstract](http://www.whijournal.com/article/S1049-3867(04)00018-0/abstract) Accessed 20 December 2013.

89. Frisch M, Smith E, Grulich A, Johansen C. Cancer in a population based cohort of men and women in registered homosexual partnerships. *American Journal of Epidemiology* 2003; 157: 966–972. Available at: [www.ingentaconnect.com/content/oup/aje/2003/00000157/00000011/art00966](http://www.ingentaconnect.com/content/oup/aje/2003/00000157/00000011/art00966) Accessed 20 December 2013.
90. Rooney E. All partied out: Substance use in Northern Ireland Lesbian, Gay, Bisexual and Transgender community. Belfast: The Rainbow Project, 2012.
91. O'Hara M. Through our minds: Exploring the emotional health and wellbeing of Lesbian, Gay, Bisexual and Transgender people in Northern Ireland. Belfast: The Rainbow Project, 2013.
92. O'Doherty J. The health of ageing LGB&T people in Northern Ireland. Belfast: The Rainbow Project, 2013. (Unpublished)
93. Public Health England. Protocols for the surveillance of women at higher risk of developing breast cancer. Version 4. NHS, 2013. Available at: [www.cancerscreening.nhs.uk/breastscreen/publications/nhsbsp74.pdf](http://www.cancerscreening.nhs.uk/breastscreen/publications/nhsbsp74.pdf) Accessed 7 January 2014.
94. The Lesbian & Gay Foundation. Cervical screening sample taker online toolkit. Available at: [www.lgf.org.uk/screeningtoolkit](http://www.lgf.org.uk/screeningtoolkit) Accessed 2 December 2013.
95. Department of Health, Social Services and Public Safety. A strategy for maternity care in Northern Ireland 2012–2018. Belfast: DHSSPS, 2012.
96. Phillimore J, Thornhill J. Delivering in an age of super-diversity: West Midlands review of maternity services for migrant women. Birmingham: University of Birmingham, 2010.
97. Feldman R. When maternity doesn't matter: Dispersing pregnant women seeking asylum. London, 2013. Available at: [www.refugeecouncil.org.uk/assets/0002/6402/When\\_Maternity\\_Doesn\\_t\\_Matter\\_-\\_Ref\\_Council\\_\\_Maternity\\_Action\\_report\\_Feb2013.pdf](http://www.refugeecouncil.org.uk/assets/0002/6402/When_Maternity_Doesn_t_Matter_-_Ref_Council__Maternity_Action_report_Feb2013.pdf) Accessed 3 January 2014.
98. All-Ireland Traveller Health Study Team. All-Ireland Traveller Health Study: Our Geels. University College Dublin, 2011. Available at: [www.dhsspsni.gov.uk/technicalrep1.pdf](http://www.dhsspsni.gov.uk/technicalrep1.pdf) Accessed 3 January 2014.
99. Centre for Maternal and Child Enquiries. Saving mothers' lives: reviewing maternal deaths to make motherhood safer. London: CMACE, 2000–2008. Available at: [www.hqip.org.uk/cmace-reports](http://www.hqip.org.uk/cmace-reports) Accessed 3 January 2014.
100. Northern Ireland Council of Ethnic Minorities. The experiences of ethnic minority women in Northern Ireland. Belfast: NICEM, 2013.
101. Centre for Maternal and Child Enquiries. Perinatal mortality 2009. London: CMACE, 2011.
102. Belfast Health and Social Care Trust. Barriers to health: Migrant health and wellbeing in Belfast. Belfast: BHSCT, 2010.
103. Public Health Agency. Good Practice Guide 4: Promoting health and wellbeing in black and minority ethnic (BME) groups, including travellers and migrant workers. Belfast: PHA, 2010.
104. Northern Ireland Statistics and Research Agency. Registrar General Northern Ireland Annual Report 2011. Belfast: NISRA, 2012.
105. Northern Ireland Statistics and Research Agency. Census 2011. Available at: [www.nisra.gov.uk/census/2011census.html](http://www.nisra.gov.uk/census/2011census.html) Accessed 3 January 2014.

106. Emerson E, Hatton C. Estimating the current need/demand for supports for people with learning disabilities in England. Lancaster: Lancaster University, 2004. Available at: [www.improvinghealthandlives.org.uk/uploads/doc/vid\\_7008\\_Estimating\\_Current\\_Need\\_Emerson\\_and\\_Hatton\\_2004.pdf](http://www.improvinghealthandlives.org.uk/uploads/doc/vid_7008_Estimating_Current_Need_Emerson_and_Hatton_2004.pdf) Accessed 24 January 2014.
107. Department of Health, Social Services and Public Safety. Equal lives: Review of policy and services for people with a learning disability in Northern Ireland. Belfast: DHSSPS, 2005. Available at: [www.dhsspsni.gov.uk/equallivesreport.pdf](http://www.dhsspsni.gov.uk/equallivesreport.pdf) Accessed 24 January 2014.
108. Health and Social Care Board. Transforming your care: A review of Health and Social Care in Northern Ireland. Belfast: HSCB, 2011. Available at: [www.dhsspsni.gov.uk/transforming-your-care-review-of-hsc-ni-final-report.pdf](http://www.dhsspsni.gov.uk/transforming-your-care-review-of-hsc-ni-final-report.pdf) Accessed 24 January 2014.
109. Department of Health, Social Services and Public Safety. Learning disability service framework. Belfast: DHSSPS, 2011. Available at: [www.dhsspsni.gov.uk/learning\\_disability\\_service\\_framework.pdf](http://www.dhsspsni.gov.uk/learning_disability_service_framework.pdf) Accessed 24 January 2014.
110. McConkey R, Mulvany F, Barron S. Adult persons with an intellectual disability on the island of Ireland. *Journal of Intellectual Disability Research* 2006; 50(3): 227–236.
111. Casey J, Paleg G, Livingstone R. Facilitating child participation through power mobility. *British Journal of Occupational Therapy* 2013; 76(3): 158–160.
112. Campos JJ, Anderson DI, Barbu-Roth MA, Hubbard EM, Hertenstein MJ, Witherington D. Travel broadens the mind. *Infancy* 2000; 1(2): 149–219.
113. Shahid M. Buggy-to-wheelchair progression for children with cerebral palsy: Parents' and therapists' opinions. *International Journal of Therapy and Rehabilitation* 2004; 11(12): 560–566.
114. Huang IC, Sugden D, Beveridge S. Children's perceptions of their use of assistive devices in home and school settings. *Disability and Rehabilitation: Assistive Technology* 2009; 4(2): 95–105.
115. Furumasu J, Guerette P, Tefft D. Relevance of the pediatric powered wheelchair screening test for children with cerebral palsy. *Developmental Medicine & Child Neurology* 2004; 46(7): 468–474.
116. Sawatzky B, Rushton PW, Denison I, McDonald R. Wheelchair skills training programme for children: A pilot study. *Australian Occupational Therapy Journal* 2012; 59: 2–9.
117. Isabelle S, Bessey SF, Dragas KL, Blease P, Shepherd JT, Lane SJ. Assistive technology for children with disabilities. *Occupational Therapy in Health Care* 2002; 16(4): 29–51.
118. Nicolson A, Moir L, Millsteed J. Impact of assistive technology on family caregivers of children with physical disabilities: A systematic review. *Disability and Rehabilitation: Assistive Technology* 2012; 7(5): 345–349.
119. Department for Education and Skills. Aiming high for disabled children: Better support for families. London: HM Treasury, 2007.
120. Meyers AR, Anderson JJ, Miller DR, Shipp K, Hoenig H. Barriers, facilitators and access for wheelchair users: Substantive and methodologic lessons from a pilot study of environmental effects. *Social Science and Medicine* 2002; 55(8): 1435–46.
121. Hutchinson T, Gordon D. Towards nationally useful definitions of disability: Final project report. NHS Research and Development: Maternal and Child Health. London: Department of Health, 2001.

122. Witt WP, Gottlieb CA, Hampton J, Litzelman K. The impact of childhood activity limitations on parental health, mental health and workdays lost in the United States. *Acad Pediatrics* 2009; 9(4): 263–269.
123. Das M, Spowart K, Crossley S et al. Evidence that children with special needs all require visual assessment. *Arch Dis Child*. 2010; 95: 888–92.
124. Woodhouse JM, Davies N, McAvinchey A, Ryan B. Ocular and visual status among children in special schools in Wales: The burden of unrecognised visual impairment. *Arch Dis Child* 2013 Nov 26. doi: 10.1136/archdischild-2013-304866. [Epub ahead of print]
125. Lindsay J, McGlade A, Jackson AJ. Visual impairment and learning disability in adults. *CE Optometry* 2004; 7(2): 63–67.
126. Decarlo DK, McGwin G Jr, Bixler ML, Wallander J, Owsley C. Impact of pediatric vision impairment on daily life: Results of focus groups. *Optom Vis Sci*. 2012; 89(9): 1409–16.
127. Cass HD, Sonsken PM, McConachie HR. Developmental setback in severe visual impairment. *Arch Dis Child*. 1994; 70: 192–196.
128. Cochrane GM, du Toit R, Le Mesurier RT. Management of refractive errors. *BMJ* 2010; 12(34): 855–860.
129. Coleman AL, Yu F, Keeler E, Mangione CM. Treatment of uncorrected refractive error improves vision-specific quality of life. *J Am Geriatrics Soc*. 2006; 54: 883–90.
130. Taylor HR. Eye care for the future: The Weisenfeld Lecture. *Invest Ophthalmol Vis Sci*. 2003; 44(4): 1413–1418.
131. Boulton M, Haines L, Smyth D, Fielder A. Health-related quality of life of children with vision impairment or blindness. *Dev Med Child Neurol*. 2006; 48(8): 656–661.
132. Lennon J, Harper R, Lloyd C, Biswas S. Usefulness of post-assessment reports in a paediatric low vision clinic: A questionnaire survey of parents and education professionals. *Ophthalmic Physiol Opt*. 2008; 28: 247–252.
133. McClelland JF, Parkes J, Hill N, Jackson AJ, Saunders KJ. Accommodative dysfunction in children with cerebral palsy: A population-based study. *Invest Ophthalmol Vis Sci*. 2006; 47(5): 1824–30.
134. Saunders KJ, Little JA, McClelland JF, Jackson AJ. Profile of refractive errors in cerebral palsy: Impact of severity of motor impairment (GMFCS) and CP subtype on refractive outcome. *Invest Ophthalmol Vis Sci*. 2010; 51(6): 2885–90.
135. Little JA, McCullough S, McClelland J, Jackson AJ, Saunders KJ. Low-contrast acuity measurement: Does it add value in the visual assessment of Down syndrome and cerebral palsy populations? *Invest Ophthalmol Vis Sci*. 2013; 54(1): 251–7.
136. Little JA, Woodhouse JM, Saunders KJ. Corneal power and astigmatism in Down syndrome. *Optom Vis Sci*. 2009; 86(6): 748–54.
137. Saunders KJ, McClelland JF, Richardson PM, Stevenson M. Clinical judgement of near pupil responses provides a useful indicator of focusing ability in children with cerebral palsy. *Dev Med Child Neurol*. 2008; 50(1): 33–7.

138. McClelland J, Saunders KJ, Hill N, Magee A, Shannon M, Jackson AJ. The changing visual profile of children attending a regional specialist school for the visually impaired in Northern Ireland. *Ophthalmic Physiol Opt.* 2007; 27(6): 556–60.
139. Lundy C, Hill N, Wolsley C, Shannon M, McClelland J, Saunders K, Jackson J. Multidisciplinary assessment of vision in children with neurological disability. *Ulster Med J.* 2011; 80(1): 21–7.
140. Saunders KJ, Little JA. Information is not communication: Meaningful reporting of visual status. Presented at the XIV meeting of the Child Vision Research Society, Waterloo, Canada, June 2013.
141. Saunders KJ. A clearer vision: Improving stakeholders' understanding of the nature of vision and visual function in the presence of complex neurological problems. Responsive Mode Adding Value – Knowledge Transfer Scheme (RES/4214/09). Final report 2012. Available at: <http://biomed.science.ulster.ac.uk/vision/-Summary-Report-.html> Accessed 13 January 2014.
142. O'Donoghue L, McClelland JF, Logan NS, Rudnicka AR, Owen CG, Saunders KJ. Refractive error and visual impairment in school children in Northern Ireland. *Br J Ophthalmol.* 2010; 94(9): 1155–9.
143. Department of Health, Social Services and Public Safety. Health and Social Care Inequalities Monitoring System. Available at: [www.dhsspsni.gov.uk/index/stats\\_research/stats-equality/stats-equality-publications.htm](http://www.dhsspsni.gov.uk/index/stats_research/stats-equality/stats-equality-publications.htm) Accessed 10 January 2014.
144. McClelland A. Differences in mortality rates in Northern Ireland 2002–2005: A Section 75 and social disadvantage perspective. Belfast: NISRA, 2008. Available at: [www.ofmdfmi.gov.uk/differences-in-mortality-rates-in-ni-2002-2005.%20%20Accessed%2010%20January%202014](http://www.ofmdfmi.gov.uk/differences-in-mortality-rates-in-ni-2002-2005.%20%20Accessed%2010%20January%202014) Accessed 10 January 2014.
145. The Regulation and Quality Improvement Authority. Independent review of incidents of pseudomonas aeruginosa infection in neonatal units in Northern Ireland. Belfast: RQIA, 2012. Available at: [www.rqia.org.uk/cms\\_resources/Pseudomonas%20Review%20Phase%20II%20Final%20Report.pdf](http://www.rqia.org.uk/cms_resources/Pseudomonas%20Review%20Phase%20II%20Final%20Report.pdf) Accessed 12 December 2013.
146. Tam CC et al. Longitudinal study of infectious intestinal disease in the UK (IID2 study): incidence in the community and presenting to general practice. *Gut.* 2012; 61(1): 69–77.
147. Mead PS et al. Food related illness and death in the United States. *Emerg Infect Dis.* 1999; 5(5): 607–25.
148. Abubakar I et al. Global perspectives for the prevention of infectious diseases associated with mass gatherings. *The Lancet Infectious Diseases* 2012; 12(1): 66–74.
149. Northern Ireland Statistics and Research Agency. Long-term international migration estimates for Northern Ireland. Belfast: NISRA, 2013.
150. Health Protection Agency. Migrant health: Infectious diseases in non-UK born populations in the United Kingdom: An update to the baseline report – 2011. London: HPA, 2011.
151. Belfast Health Development Unit. Barriers to health: Migrant health and wellbeing in Belfast. Belfast: Belfast Health Development Unit, 2010.
152. Health Protection Agency. Migrant health: Infectious diseases in non-UK born populations in England, Wales and Northern Ireland. A baseline report – 2006. London: HPA, 2006.

# Abbreviations and acronyms

## A

AAA	Abdominal aortic aneurysm
ADRC	Administrative Data Research Centre
AIDS	Acquired immunodeficiency syndrome
AITHS	All Ireland Traveller Health Study
ASMR	Age-specific mortality rate

## B

BEBE	Belfast Experts By Experience
BME	Black and minority ethnic
BMI	Body mass index

## C

CBRN	Chemical Biological Radiological Nuclear
CHNI	Council for the Homeless NI
CYPSP	Children and Young People's Strategic Partnership

## D

DARD	Department of Agriculture and Rural Development
DCAL	Department of Culture, Arts and Leisure
DH	Department of Health
DHSSPS	Department of Health, Social Services and Public Safety
DOC	Dedicated Operations Centre
DPH	Director of Public Health
D&V	Diarrhoea and vomiting

## E

ED	Emergency department
EDSSS	Enhanced Syndromic Surveillance System
EMIS	European MSM Internet Sex Survey
ESRC	Economic and Social Research Council

## F

FSA	Food Standards Agency
-----	-----------------------

## G

GP	General practitioner
GUM	Genito Urinary Medicine

## H

HAZMAT	Hazardous materials
HIV	Human immunodeficiency virus
HSC	Health and Social Care
HSCB	Health and Social Care Board
HSCIMS	Health and Social Care Inequalities Monitoring System
HSCT	Health and Social Care Trust
HYPE	Health for Youth through Peer Education

## I

ID	Intellectual disabilities
----	---------------------------

## L

LCG	Local Commissioning Group
LGB	Lesbian, gay or bisexual
LGB&T	Lesbian, gay, bisexual and transgender
LGD	Local Government District

## M

MARA	Maximising Access in Rural Areas
MRI	Magnetic resonance imaging
MSM	Men who have sex with men

## N

NASS	National Asylum Support Service
NI	Northern Ireland
NICEM	Northern Ireland Council of Ethnic Minorities
NIHSCIS	Northern Ireland Health and Social Care Interpreting Service
NILS	Northern Ireland Longitudinal Study
NIMS	Northern Ireland Mortality Study
NINES	Northern Ireland New Entrant Service

NIPHRN Northern Ireland Public Health Research Network

NISRA Northern Ireland Statistics and Research Agency

NSC National Screening Committee

## O

OFMDFM Office for the First Minister and Deputy First Minister

## P

PDF Portable document format

PHA Public Health Agency

PHE Public Health England

PYLL Potential years of life lost

## Q

QARC Quality Assurance Reference Centre

## R

R&D Research and Development

RDG Research development group

RJMH Royal Jubilee Maternity Hospital

ROI Republic of Ireland

RQIA Regulation and Quality Improvement Authority

RSU Research Support Unit

## S

SLAN Survey of Lifestyle, Attitudes and Nutrition

STI Sexually transmitted infection

SUN Service user network

## T

TB Tuberculosis

## U

UK United Kingdom

## V

VIP Very important person

## W


WHO World Health Organization

WRDA Women's Resource Development Agency





**PUBLIC HEALTH AGENCY BOARD PAPER**

<b>Date of Meeting</b>	19 June 2014
<b>Title of Paper</b>	Personal and Public Involvement Report
<b>Agenda Item</b>	15
<b>Reference</b>	PHA/09/06/14
<b>Summary</b>	
<p>The PHA, as part of the Governance &amp; Reporting arrangements, receives an update Report on PPI on a twice yearly basis.</p> <p>Attached is the PPI Update report for the period from December 2013 to the end of May 2014.</p> <p>Following the positive feedback received at the last Board Update whereby Service Users were involved in sharing their experiences of PPI in action, it is proposed to follow a similar format for this update whereby a report will be tabled and a presentation delivered in partnership with service users.</p>	
<b>Equality Screening / Equality Impact Assessment</b>	N/A
<b>Audit Trail</b>	This report was brought to AMT on 10 June 2014.
<b>Recommendation / Resolution</b>	For Noting
<b>Director's Signature</b>	
<b>Title</b>	Director of Nursing and AHPs
<b>Date</b>	10 June 2014

**DRAFT**

**Personal and Public Involvement (PPI)**

**Board Update June 2014**

**Personal & Public Involvement:**

PPI is about empowering people and communities to give them more confidence and more opportunities to influence the planning, commissioning and delivery of services in ways that are relevant and meaningful to them. It is a two way process, not solely an approach that we use when we want to hear the views of service users and carers on something which we bring to them for their consideration. People are no longer the passive recipients of health and social care services. People have a right to be and increasingly they expect to be actively involved in decisions that affect them.

**Statutory Duty:**

Under the HSC (Reform) Act (NI) 2009, PPI is a legislative requirement. The PHA and other HSC organisations now have a Statutory Duty to Involve & Consult Service Users, Carers and the Public on:

- 1) The planning and provision of care
- 2) The development and consideration of proposals for change in the way that care is provided
- 3) Decisions that affect the provision of care.

## **Progress / Update Report**

In the last 6 months since the last update report to the Board, the PHA has continued to make progress in a number of important areas, helping to embed PPI into the culture and practice of both our own organisation and the wider HSC system. Noticeable amongst these have been:

- Training -** External Consultancy support has been procured and the team are working with a Steering Group led by the PHA and comprised of HSC staff, Service Users & Carers to Design & Develop an Awareness Raising & Training programme for Involvement.
- Standards -** Under the leadership of the PHA, three further standards, this time with a focus on outcomes, have been co-produced by HSC organisations, Service Users & Carers. These will be sent to the DHSSPS for consideration by the end of June.
- Monitoring -** Pilot arrangements for PPI monitoring internally & externally have been reviewed and revised. Formal monitoring will now commence with Trusts from June 2014 onwards.
- Engage website -** The PHA has approved the business case for the Engage Website & associated PPI Outreach Development Programme. This has been submitted to the DHSSPS for consideration.
- Funding** Of the projects funded through the PHA PPI Promotion & Advancement programme, one has achieved national recognition, being shortlisted in the top 5 from 600 applicants from across GB & NI in the National Patient Safety Care Awards 2014.

The table below provides more detail on these and other key work priorities taken forward by the PHA.

The strategic leadership provided by the PHA through the work detailed below is critical in helping to set the context and direction for developments in this important field. It is worth remembering that apart from the Statutory Duty to Involve, the PHA also has the lead policy implementation role for PPI across HSC. This primacy has been given to the PHA as a result of Policy Guidance, the Legislation and the Department's Health and Social Care Framework Document. In addition, the PHA has a range of Leadership responsibilities which were confirmed with the issuing of a further Departmental Circular on PPI in September 2012. The PHA is now required to:

- Oversee the implementation of PPI policy across the HSC
- Ensure Trusts meet their PPI Statutory and Policy responsibilities.

- Promote consistency of PPI policy implementation including capacity building across the region through professional guidance, commissioning of training, monitoring of performance, sharing of best practice and undertaking research

Subject Area	General Information	Update Since Last report	Next Steps
<b>Regional HSC PPI Forum</b>	<p>The establishment of the Forum emerged from a previous PfA target.</p> <p>Operating through the Forum, the PHA provides leadership and support to the HSC in this critical field.</p>	<p>Through the HSC PPI Regional Forum the PHA has:</p> <p>Continued to pro-actively promote good practice in PPI across HSC. NB The exchange of best practice and the delivery of case study reports is now a standing item on the agenda of the Forum.</p> <p>Completed the PPI Annual Report, published it on our website and distributed to HSC partners.</p>	<p>Update the Forum PPI Action Plan for 2014/15</p> <p>Focus on supporting the PHA to take forward work on the Engage Website &amp; HSC wide PPI training programme.</p>
<b>PPI Strategy and Action Plan</b>	<p>The PHA led the development of a Joint PHA/HSCB PPI Strategy.</p> <p>The PHA also developed a 3 year Action Plan to facilitate the implementation of the Strategy.</p>	<p>Continued with the programme of work emerging from the agreed actions, many of which are reflected in the work areas below.</p> <p>A Business Case for Engage &amp; the associated PPI outreach &amp; development programme has been completed, approved by PHA AMT and submitted to the DHSSPS.</p>	<p>Initiate work to renew the Strategy and Action Plan for 2015/16</p> <p>Take forward Engage &amp; the Outreach programme if approved.</p>

<b>Subject Area</b>	<b>General Information</b>	<b>Update Since Last report</b>	<b>Next Steps</b>
<p><b>Promotion and Advancement of PPI</b></p>	<p>The PHA has operated a programme for the promotion and advancement of PPI across the HSC for the last 3 years, allocating over £300,000 in total to PPI projects.</p> <p>It effectively operates as an Action Research initiative testing out new approaches with the intention that good practice is identified, shared and replicated for the benefit of service users and carers.</p>	<p>The 19 projects funded at the end of 2013 have in the main concluded. These included a number of projects with a Neurological focus.</p> <p>NB one of the funded projects has been shortlisted for the final of the National Patient Safety Care Awards 2014. It is in the 5 finalists from 600 applications from across GB &amp; NI.</p> <p>The PHA has partnered with the NI Rare Diseases Partnership to support the pro-active involvement of Service Users &amp; Carers in the International Rare Diseases Day in Stormont hosted by Simon Hamilton MLA. NIRDP has also been partnered in the design, development and roll out of a major engagement exercise utilising Sensemaker to help inform and shape the HSC Response to &amp; Implementation of, the UK Strategy for Rare Diseases.</p>	<p>Promote the active sharing of best practice emerging from these projects through the PPI section of the PHA website and other communication mediums. In future, the Engage website would be a key vehicle for such information dissemination and knowledge transfer.</p>

Subject Area	General Information	Update Since Last report	Next Steps
<b>PPI Training</b>	The PHA has identified Training as a key area for PPI development on an organisational and regional level.	An external Consultancy team has been commissioned and are working with the PHA, HSC colleagues and Service Users & Carers to design and develop a PPI Awareness raising & training programme for the HSC system. The Regional PPI Lead continues to provide awareness raising training across HSC and reach out into Pre & Post Registration training. Circa <b>200</b> staff & students have been engaged in this process in the last 6 months	Complete the design & development of the PPI Awareness Raising & Training Programme.  Agree a plan with HSC partners for the promotion and roll out of the programme
<b>PPI Standards / Indicators</b>	The development of standards is the responsibility of DHSSPS. It has been agreed that the PHA operating in partnership with the Forum will develop indicative standards for Departmental consideration and key performance indicators to support the monitoring of PPI.  These will be shared with the DHSSPS to be reviewed and considered for endorsement as PPI Standards.	The Process based Standards have been refined further as a result of on-going comment and input from HSC organisations, service users and carers.  Indicative Outcome based Standards for PPI have been developed under the leadership of the PHA. These are currently being finalised.	Share the Indicative Outcome based Standards for PPI and the associated key performance indicators with the DHSSPS for their consideration and hopefully endorsement.  It is anticipated that the Standards, both Process & Outcome based, alongside their associated Key Performance Indicators will form the basis against which the PHA will monitor and then performance manage PPI Implementation across HSC.

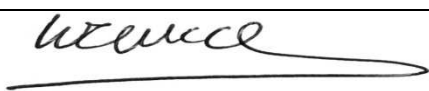
Subject Area	General Information	Update Since Last report	Next Steps
<p><b>PPI Monitoring &amp; Performance Management</b></p>	<p>The PHA was allocated this additional Responsibility emerging from the last DHSSPS Circular on PPI</p>	<p>The pilot PPI monitoring exercise with Trusts has been reviewed and the template revised. Formal monitoring will now commence by the end of June.</p> <p>The PHA have identified good practice examples of PPI such as the BHSCT's Children Travelling for Care Project which worked directly with critically ill children and their parents to tailor this service to need, improve quality and satisfaction with an essential component of this sensitive service.</p> <p>The PHA are working with RQIA and other relevant bodies to ensure there is clarity in respect of monitoring roles and responsibilities.</p> <p>The PHA's internal monitoring pilot for PPI has been reviewed, the template revised and it will be re-issued by the end of June.</p> <p>Again excellent examples of good practice were identified including:</p> <ol style="list-style-type: none"> <li>1. AHP/PPI Divisions work with the Neurological Conditions Service User &amp; Carer Reference Group, which has developed an awareness raising E-Learning programme.</li> </ol>	<p>The responses will be with the PHA PPI team by the end of the summer. The external monitoring will be subject to a verification process and reports will be compiled for PHA and subsequently Departmental consideration</p> <p>The aim is to build robust and effective systems that will enable the PHA to both monitor and then introduce performance management arrangements for PPI into the HSC system.</p>



Subject Area	General Information	Update Since Last report	Next Steps
		<p>2. Health improvement colleagues have endeavoured to embed PPI into work associated with Suicide prevention through their support of the Family Voices Forum. 3. Health Protection colleagues are finalising an innovative engagement project which has seen the involvement of hundreds of school children &amp; their parents in the development of Hand Hygiene posters, a song and DVD.</p>	
<p><b>PPI Leadership, Professional advice and guidance</b></p>	<p>The PHA provides advice and guidance to a range of professional colleagues across the PHA and other HSC organisations.</p>	<p>The PPI team provide a wide range of advice and guidance to HSC colleagues on an on-going basis. Since the last update, there have been some <b>25</b> separate requests for support and advice in this respect. Included were Corporate issues, Commissioning &amp; Service Development projects, Cross Organisational Strategies etc.</p>	<p>PHA PPI staff, continue to provide leadership, advice and guidance across the HSC in respect of embedding PPI into culture and practice.</p> <p>The development of aids and informative guides is also something that is currently underway.</p> <p>Plans are being developed to raise the profile of PPI across the HSC system including a PPI recognition event.</p>

Subject Area	General Information	Update Since Last report	Next Steps
<b>PPI Staffing</b>	There remains a demand / capacity gap in respect of PPI. This is in part due to increased awareness of HSC responsibilities in respect of PPI and increased expectations from service users and carers. The allocation of additional responsibilities from the DHSSPS have further exacerbated this.	A staffing proposal has been submitted for consideration against the recurrent Stakeholder Involvement budget.	PHA is reviewing the situation and giving consideration to the most appropriate way to support the team to deliver against identified objectives.

**PUBLIC HEALTH AGENCY BOARD PAPER**

<b>Date of Meeting</b>	19 June 2014
<b>Title of Paper</b>	Annual Progress Report 2013/14 to the Equality Commission
<b>Agenda Item</b>	16
<b>Reference</b>	PHA/10/06/14
<b>Summary</b>	
<p>This paper presents the draft annual progress report to the Equality Commission on implementation of Section 75 and the duties under the Disability Discrimination Order.</p> <p>The report is due for consideration by the PHA board at its June meeting, for subsequent submission to the Equality Commission.</p>	
<b>Equality Screening / Equality Impact Assessment</b>	N/A
<b>Audit Trail</b>	This report was brought to AMT on 10 June 2014.
<b>Recommendation / Resolution</b>	For Approval
<b>Director's Signature</b>	
<b>Title</b>	Director of Operations
<b>Date</b>	10 June 2014



## **EQUALITY COMMISSION FOR NORTHERN IRELAND**

### **Public Authority 2013 – 2014 Annual Progress Report on:**

- **Section 75 of the NI Act 1998 and**
- **Section 49A of the Disability Discrimination Order (DDO) 2006**

**June 2014**

**Name of public authority** (Enter details below)

**Public Health Agency (PHA)**

12-22 Linenhall Street

Belfast

BT2 8BS

Phone: 03005550114

Textrelay: 18001 03005550114

Website: [www.publichealth.hscni.net](http://www.publichealth.hscni.net)

**Equality Officer** (Enter name and contact details below)

**Ed McClean**

Director of Operations

Public Health Agency

[Edmond.McClean@hscni.net](mailto:Edmond.McClean@hscni.net)

We receive support services on the implementation of our Section 75 duties from the Equality Unit at the Business Services Organisation. For further information you can contact our equality advisor:

**Anne Basten**

Equality, Diversity and Human Rights Manager

Business Services Organisation

[Anne.Basten@hscni.net](mailto:Anne.Basten@hscni.net)

## Table of Contents

<b>Part A: Section 75 Annual Progress Report 2013- 2014</b> .....	4
<b>What we do</b> .....	4
<b>Executive Summary</b> .....	6
<b>Section 1: Strategic Implementation of the Section 75 Duties</b> .....	19
<b>Section 2: Examples of Section 75 Outcomes / Impacts</b> .....	22
<b>Section 3: Screening</b> .....	23
<b>Section 4: Equality Impact Assessment (EQIA)</b> .....	24
<b>Section 5: Training</b> .....	25
<b>Section 6: Communication</b> .....	26
<b>Section 7: Data Collection &amp; Analysis</b> .....	28
<b>Section 8: Information Provision, Access to Information and Services</b> ....	33
<b>Section 9: Complaints</b> .....	40
<b>Section 10: Consultation and Engagement</b> .....	41
<b>Section 11: The Good Relations Duty</b> .....	48
<b>Section 12: Additional Comments</b> .....	49
<b>Part B: ‘Disability Duties’</b> .....	50
Appendix 1: Equality Action Plan – Progress on the progress we made during 2013-14	
Appendix 2: Changes to policies using screening (mitigation)	
Appendix 3: Equality and Human Rights Screening Report 2013-14	
Appendix 4: Disability Action Plan – What we did between April 2013 and March 2014	

## **Part A: Section 75 Annual Progress Report 2013- 2014**

### **What we do**

The Public Health Agency (PHA) is part of health and social care in Northern Ireland. We do things like:

- We find out what things people need to protect them from diseases and other hazards.
- We find out what services people in Northern Ireland need to keep healthy.
- We do not provide the services but work with other organisations that are called Trusts and other voluntary and private organisations that do so.
- We buy services from Trusts including, for example, hospital services.
- We organise and buy screening services. This is about finding out at an early stage whether a person is ill or is at risk of becoming ill.
- We try to make it easier for people to make healthier choices, for example in what they eat.
- We work with other organisations to try and reduce the big differences between different groups of people in Northern Ireland in how healthy and well they are.
- We develop and run campaigns for the general public in Northern Ireland on important health topics, for example on smoking.
- We develop websites on a number of health topics, for example on drugs, alcohol and smoking. Some sites are for specific groups such as young people or health professionals.
- We support research. We also buy and pay for research. We carry out some of the research ourselves.
- We make sure we learn from when something goes wrong in how health care is provided in Northern Ireland.
- We work with other organisations to improve the range and quality of services, for example for people of all ages with learning disabilities.
- We need to make sure services are good quality and check out that they are.

- We work with other health and social care organisations to improve how they engage with those who use their services, with carers and with the public.
- We also employ staff.
- We have to make sure that we obey the laws about employment, services, equality and rights.

Addressing inequalities in health and wellbeing is at the core of our work. As we face a difficult economic climate, inequalities may worsen over the coming period. For this reason, we will redouble our efforts, working with partners in many different sectors, as well as directly with communities, to ensure we make best use of our collective resources.

The PHA has been systematically examining evidence of best practice and effectiveness to ensure that investment and joint working will bring clear benefits. We are setting out four key themes to our work:

### **Give every child and young person the best start in life**

Investment in early years brings significant benefits later in life across areas such as health and wellbeing, education, employment, and reduced violence and crime. We are committed to pursuing strongly evidenced programmes to build resilience and promote health and wellbeing.

### **Ensure a decent standard of living for all**

Lower socioeconomic groups have a greater risk of poor health and reduced life expectancy. We will focus efforts in a number of areas where, working with partners, we can impact on achieving a decent standard of living for all.

### **Build sustainable communities**

The views, strengths, relationships and energies of local communities are essential in building effective approaches to improving health and wellbeing. We are committed to community development, engaging people in decision-making and in shaping their lives and social networks.

### **Make healthy choices easier**

Creating an environment that encourages and supports health is critical. We are committed to working across a range of settings to ensure that healthier choices are made easier for individuals.



## **Executive Summary**

What were the key policy / service developments made by the authority during this reporting period to better promote equality of opportunity and good relations and what outcomes were achieved?

The PHA continues to work with the Business Services Organisation (BSO) in the planning and implementation of equality and good relations activity. The BSO's Equality Unit provides support to 11 regional Health and Social Care organisations in total.

Appendix 1 provides a report on the progress made during 2013-14 in delivering on our Equality Action Plan.

Appendix 2 and 3 relate to changes to policies or practices as a result of screening activity and details on screening reports.

In Appendix 4 we report on progress in implementing our Disability Action Plan during 2013-14.

### **Key developments during 2013-14**

We made key developments to better promote equality and good relations across a wide range of our functions.

#### **Health and Wellbeing Improvement**

The PHA has run a wide range of consultation and engagement processes in order to inform the future procurement of services which aim to meet the needs of the population, and which include section 75 groups. This has included: mental health and suicide prevention, including service standards; services to address alcohol and drugs misuse; and relationships and sexual health services.

##### **Prisons**

Health and Social Wellbeing Improvement programmes to enhance skills and improve mental health and wellbeing have been commissioned for prisoners, for example My Mood Matters (a mental health and wellbeing programme), Listening Sounds project, Yoga and Music Therapy.

A process to support the development of a system to capture the health care needs of prisoners on a rolling basis is also underway, in partnership with South Eastern Health and Social Care (HSC) Trust.

## Travellers

Information on pre-employment support processes and the experience of the Belfast Travellers Health Advocacy Project has been shared with other Trusts in order to promote the employment of Travellers.

Breastfeeding is being promoted in areas where breastfeeding rates are low. Rates are being monitored and expanded incrementally through a series of actions, including the employment of a local coordinator to support the work of volunteers and peer support workers.

A number of public information campaigns have been developed and run during 2013/14 which focused on: reducing levels of smoking; promoting healthier weight and the promotion of mental health and wellbeing and suicide prevention. These campaigns were aimed at the general public and in the case of mental health, young men in particular.

## Older People

A range of coordinated interventions and services have been identified to reduce the risk of social isolation among older people in all localities. The Older People's Service Framework was launched in October 2013. 'Age Friendly' environments have been developed along with promoting Northern Ireland as an 'Age Friendly' region – these have been included in the draft 'Active Ageing Strategy' by the Office of the First Minister and Deputy First Minister (OFMDFM), 'Promoting Good Nutrition Guidelines for Older People' and the 'See me, hear me, know me' – guidelines for Lesbian, Gay, Bisexual & Transgender (LGB&T) people in nursing and residential settings have been produced in collaboration with the Regulation and Quality Improvement Authority (RQIA) and have also been published.

## Communications

For the first time in the UK, ads for a public information campaign on smoking were put on audio description.

## Nursing and Allied Health Professions

Key developments included:

- the National Institute for Clinical Excellence (NICE) 136 guidelines on Service User Experience in Adult Mental Health

- Implementation of Implementing Recovery through Organisational Change (ImROC) programme (following service user experience findings from GAIN Mental health sensemaker Audit).
- Regional Guidelines for the Search of Patients, their Belongings and the Environment of Care within Adult Mental Health and Learning Disability Inpatient Settings were developed and issued across the 5 HSC Trusts. There have been a number of incidents across the 5 HSC Trusts where inpatients in Mental Health and Learning Disability facilities have brought harmful weapons and/or illicit substances into the facility causing harm to themselves or others. The overarching purpose of these guidelines is to ensure the safety of service users, staff and visitors by ensuring that illicit substances, weapons and alcohol are not brought into inpatient settings. They will also protect the safety of service users who may harm themselves, ensuring that where there is a concern for a service user's safety, a clear procedure is in place to support searching them.
- Implementation of a Health Care and Improvement steering group to follow on from the Direct Enhanced Service to improve health screening for those people with a learning disability
- Implementation of a Direct Enhanced Service in Primary Care to facilitate physical health screening for people with a learning disability
- Completion of a thematic review of 100 suicides within mental health services, to consider trends and improve service provision
- Implementation of a steering group to consider peri-natal mental health provision regarding those mothers and babies who may require admission.

## **Disability**

After much of our efforts were focused on the development of our Disability Action Plan in the previous year, this year we were able to turn to delivering on it.

This has involved, for example, working with our 10 regional HSC partner organisations to raise staff awareness about specific disabilities. As the first in a series of awareness days, we decided to focus on the issues faced by people with epilepsy. We did so by promoting Purple Day, the International Epilepsy Awareness Day, in the workplace. It took place on 26th March.

We also worked with the Health and Social Care Board, the BSO's Human Resources Directorate and other regional partners to explore creating meaningful

work placement opportunities for people with disabilities. We intend to offer 6-months placements in our organisation from 2014-15 onwards.

Two of our board members have engaged with staff from across our business units to discuss issues and perceptions as to what the organisation can do to further make a difference for people with a disability, both in its work and as an employer.

## Transgender

Building on the learning from recent local seminars on the needs and experiences of transgender people in the workplace, the Equality Unit commenced work with Human Resources colleagues to explore the scope for the development of a policy on transgender. In a first step, this has involved reviewing good practice materials and recommendations published on the internet.

The main objective is to provide support to current and potential employees who identify as Transgender. We thereby seek to ensure that our workplaces are inclusive.

Examples of how we changed policies or practices which have resulted in outcomes are listed below:

	<b>Outline change in policy or practice which have resulted in outcomes</b>
Persons of different religious belief	<b>Health and Wellbeing Improvement</b> <ul style="list-style-type: none"> <li>• FLOURISH! A guidance resource to promote mental health and wellbeing and prevent suicide in faith communities.</li> <li>• Work is underway with specified neighbourhoods to improve health and wellbeing through interagency action and community development.</li> </ul>
Persons of different political opinion	<b>Health and Wellbeing Improvement</b> <ul style="list-style-type: none"> <li>• ‘Shoulder to Shoulder’ qualitative research into the health and wellbeing of ex paramilitary organisation members in order to inform programme development.</li> </ul>
Persons of different racial groups	<b>Health and Wellbeing Improvement</b> <ul style="list-style-type: none"> <li>• Ongoing work with Black and Minority Ethnic (BME) groups to identify and meet specific needs with the development of health improvement programmes and services in partnership with community, voluntary and</li> </ul>

	<p>statutory service providers.</p> <p><b>Service Development and Screening</b></p> <ul style="list-style-type: none"> <li>• The Action Plan notes continued engagement with internal and external groups who represent BME groups, to promote screening and discuss accessibility.</li> <li>• The One Stop Shop service for newly arrived migrants is to be utilised to promote cancer screening.</li> </ul>
Persons of different age	<p><b>Health and Wellbeing Improvement</b></p> <ul style="list-style-type: none"> <li>• Contribution to the development of OFMDFM's Active Ageing Strategy.</li> <li>• Inclusion of home accident prevention focus in Integrated Care Partnership pathways for frail elderly.</li> </ul> <p><b>Service Development and Screening</b></p> <ul style="list-style-type: none"> <li>• Each screening programme is for a specific age range. Breast 50-70; cervical 25-64; bowel 60-74. The bowel screening programme upper age limit was increased from 71 to 74 from April 2014.</li> </ul>
Persons with different marital status	
Persons of different sexual orientation	<p><b>Health and Wellbeing Improvement</b></p> <ul style="list-style-type: none"> <li>• E learning programme developed and rolled out to HSC Trusts and other regional health organisations.</li> <li>• LGB&amp;T website development underway.</li> <li>• LGB&amp;T Health and Social Care staff Forum has been further developed to engage with HSC Trusts and sector organisations such as Rainbow, HereNI and Transgender NI.</li> <li>• Application for Diversity Champions programme submitted. The programme allows organisations to be recognised as having robust equality and diversity policies and practices in place as well as promoting inclusive workplace cultures.</li> <li>• Healthcare People Management Award submitted for work in partnership with Human</li> </ul>

	<p>Resources and Trades Union organisations.</p> <p><b>Health Protection</b></p> <ul style="list-style-type: none"> <li>• Data from the enhanced surveillance of gonorrhoea arrangements were used to inform an information campaign targeted at men who have sex with men.</li> </ul> <p><b>Service Development and Screening</b></p> <ul style="list-style-type: none"> <li>• The Action Plan notes continued engagement with internal and external groups who represent LGB&amp;T groups. To promote screening and discuss accessibility. A cervical screening toolkit was disseminated to smear takers. This is an online training toolkit which enables cervical screening practitioners to improve patient experience for lesbian and bisexual women.</li> </ul>
Men and women generally	<p><b>Nursing and Allied Health Professions</b></p> <ul style="list-style-type: none"> <li>• IMROC</li> <li>• mental health core care pathway</li> </ul> <p><b>Research and Development Office</b></p> <ul style="list-style-type: none"> <li>• All of our funding panels to evaluate research applications now include Personal and Public Involvement (PPI) representatives who are service users, carers or members of the public. These have included panels to evaluate applications to a commissioned call in dementia care, telemonitoring, Personal and Public Involvement as well as our annual award schemes for doctoral fellowships and Knowledge Exchange and the open Enabling Award Scheme.</li> <li>• Training sessions are provided to PPI representatives involved with us on our panels and committees.</li> </ul>
Persons with and without a disability	<p><b>Nursing and Allied Health Professions</b></p> <ul style="list-style-type: none"> <li>• In patients within Mental Health and Learning Disability settings are often vulnerable and can pose a risk to themselves and others in terms of using dangerous implements or substances to cause harm and injury. These guidelines provide direction for Trusts in terms of preventing</li> </ul>

	<p>harmful implements and substances being brought into facilities and also how to respond in the event they are found in the facilities or on a patient's person. It is anticipated that implementation of these guidelines will enhance the safety of patients, visitors and staff.</p> <ul style="list-style-type: none"> <li>• Implementation of a Direct Enhanced Service in Primary Care to facilitate physical health screening for people with a learning disability</li> </ul> <p><b>Research and Development (R&amp;D) Office</b></p> <ul style="list-style-type: none"> <li>• HSC R&amp;D Division participates in The Northern Ireland Autism Strategic Research Advisory Committee who is tasked with providing advice to the OFMDFM regarding the action plan of the Autism Strategy for Northern Ireland. One of the recent tasks is to identify how inclusion of families affected by Autistic Spectrum Disorder be measured.</li> </ul> <p><b>Service Development and Screening</b></p> <ul style="list-style-type: none"> <li>• The Action Plan notes continued engagement with internal and external groups who represent people who have a physical or sensory disability, to promote screening and discuss accessibility.</li> <li>• Options for simplifying the bowel screening home test have been considered. Upon request, partially sighted people are being sent the FIT test kit which is easier to complete. They will then be "tagged" on the system to issue this kit for future screening rounds.</li> <li>• Cancer screening information leaflets have been transcribed into audio format for the benefit of people who are blind or partially sighted. This task was completed in conjunction with RNIB.</li> </ul>
<p>Persons with and without dependants</p>	<p><b>Nursing and Allied Health Professions</b></p> <ul style="list-style-type: none"> <li>• IMROC</li> <li>• mental health core care pathway</li> <li>• The above guidelines will help enhance the safety of carers visiting the unit in that it advocates a proactive approach to managing the potential for harmful items and substances being</li> </ul>

	<p>brought onto units which may be used to injure visitors.</p> <p><b>Research and Development Office</b></p> <ul style="list-style-type: none"> <li>• The research and development strand of the child development group within the PHA seeks to identify robust evidence which is used to support families who are vulnerable, socially excluded, have developmental delay, or require additional levels of support within the community sector.</li> </ul>
--	---

What are the main initiatives planned in the coming year to ensure the authority improves outcomes in terms of equality of opportunity and good relations for individuals from the nine categories covered by Section 75?

## Main initiatives planned for 2014-2015

### Communications

Campaigns are planned in the following areas aimed at improving outcomes under all/some categories below: Smoking, Obesity, Mental Health, Organ Donation, Cancer Awareness, Sexual Health, Flu, Bowel Cancer Screening. A range of media will be booked for campaigns to ensure reach among people with a disability, such as radio advertising (for visually impaired and blind people), teletext (for hearing impaired and deaf people), as well as audio description.

	<b>Key new initiatives planned in 2014/15</b>
Persons of different religious belief	
Persons of different political opinion	
Persons of different racial groups	<p><b>Health and Wellbeing Improvement</b></p> <ul style="list-style-type: none"> <li>• Increase employment opportunities to promote employability and improve health and wellbeing of Travellers.</li> <li>• Promotion of cultural awareness regarding Traveller culture and create positive welcoming images in HSC sites.</li> <li>• Uptake of cancer screening to be promoted among Travellers.</li> <li>• ROMA – further development of health liaison worker posts.</li> </ul>



	<ul style="list-style-type: none"> <li>• Expansion of the Northern Ireland New Entrant Service.</li> </ul> <p><b>Communications</b></p> <ul style="list-style-type: none"> <li>• Commission photography to initiate stock library of images for use in materials</li> </ul> <p><b>Research and Development Office</b></p> <ul style="list-style-type: none"> <li>• HSC R&amp;D Division is leading the organisation of the PHA Annual conference in the area of ‘Diversity’ to be held in June. Topics covered will include disability, LGB&amp;T and travellers. The planning committee includes representative from all of the section 75 Groups who are cascading information on the conference to their relevant communities.</li> </ul> <p><b>Service Development and Screening</b></p> <ul style="list-style-type: none"> <li>• Further engagement to occur with community groups who represent BME people and also internally with Health Improvement colleagues within the PHA.</li> </ul>
Persons of different age	<p><b>Health and Wellbeing Improvement</b></p> <ul style="list-style-type: none"> <li>• Plans/in discussion with Alzheimers Association to shape roll out of regional project to establish Dementia Friendly communities.</li> <li>• New service model to engage and support older people and their health and wellbeing.</li> <li>• Sexual Health services promoted to young people in partnership with Further Education Colleges.</li> <li>• Age Friendly City focus for older people in Belfast in partnership with Belfast Health Cities and Healthy Ageing Strategic Partnership.</li> <li>• Age Friendly Neighbourhoods work to be progressed in five pilot localities in the Southern area.</li> </ul> <p><b>Communications</b></p> <ul style="list-style-type: none"> <li>• Commission photography to initiate stock library of images for use in materials</li> </ul>
Persons with different marital status	<p><b>Communications</b></p> <ul style="list-style-type: none"> <li>• Commission photography to initiate stock library of images for use in materials</li> </ul>

<p>Persons of different sexual orientation</p>	<p><b>Health and Wellbeing Improvement</b></p> <ul style="list-style-type: none"> <li>• Action plan being developed in 14/15 to include actions to address Homophobic and Transphobic Bullying.</li> <li>• The theme of this year’s Public Health Scientific conference is Diversity. LGB&amp;T support organisations are part of working group to inform the development of the programme. The PHA Annual Report for 2013/14 will echo the diversity theme and include a number of articles relating to programmes of work.</li> <li>• Guidelines are being developed in partnership with the Royal College of GPs to address the needs of LGB&amp;T people whilst engaging with GPs.</li> <li>• Mental health and suicide prevention services will be commissioned to specifically address needs in the LGB&amp;T community.</li> </ul> <p><b>Communications</b></p> <ul style="list-style-type: none"> <li>• Commission photography to initiate stock library of images for use in materials</li> </ul> <p><b>Research and Development Office</b></p> <ul style="list-style-type: none"> <li>• HSC R&amp;D Division is leading the organisation of the PHA Annual conference in the area of ‘Diversity’ to be held in June. Topics covered will include disability, LGB&amp;T and travellers. The planning committee includes representative from all of the section 75 Groups who are cascading information on the conference to their relevant communities.</li> </ul> <p><b>Service Development and Screening</b></p> <ul style="list-style-type: none"> <li>• Further engagement to occur with community groups who represent LGB&amp;T people and also internally with Health Improvement colleagues within the PHA.</li> </ul>
<p>Men and women generally</p>	<p><b>Health and Wellbeing Improvement</b></p> <ul style="list-style-type: none"> <li>• Plans for a staff survey to be conducted in partnership with Human Resources.</li> <li>• Diversity Champions programme to commence from April 2014.</li> </ul>

	<p><b>Communications</b></p> <ul style="list-style-type: none"> <li>• Commission photography to initiate stock library of images for use in materials</li> </ul> <p><b>Nursing and Allied Health Professions</b></p> <ul style="list-style-type: none"> <li>• To complete a thematic review of 100 suicides within mental health services, to consider trends and improve service provision</li> <li>• Implementation of a steering group to consider peri-natal mental health provision regarding those mothers and babies who may require admission</li> </ul> <p><b>Research and Development Office</b></p> <ul style="list-style-type: none"> <li>• On May 20th we will be organising a public awareness event on International Clinical Trials Day to encourage service users and the public to ask their health care professionals about research. This campaign will align with a national campaign called It's ok to ask.</li> <li>• HSC R&amp;D Division is currently developing a new website which will include a dedicated section for service users and the public.</li> </ul>
Persons with and without a disability	<p><b>Health and Wellbeing Improvement</b></p> <ul style="list-style-type: none"> <li>• PHA in early stages of exploring the development of a resource to include prevention messages for hearing loss.</li> <li>• A 'checklist' is in the early stages of development for 14/15; it is anticipated that this resource could be added to the PHA Communication Toolkit and be used by staff when developing public health campaigns and resources.</li> <li>• Disability champion approach within PHA to coincide with the move to new accommodation (to improve accessibility).</li> <li>• The Regional Learning Disability Health Care and Improvement Group will take forward and deliver on recommendations for service improvement identified in the evaluation of the learning disability Direct Enhanced Service (DES). This DES was initially introduced in</li> </ul>

	<p>Primary Care to offer health screening to people with a learning disability. It was agreed that certain actions were necessary for improvement in Health and Wellbeing for adults with a learning disability.</p> <p><b>Communications</b></p> <ul style="list-style-type: none"> <li>• Commission photography to initiate stock library of images for use in materials</li> </ul> <p><b>Nursing and Allied Health Professions</b></p> <ul style="list-style-type: none"> <li>• Implementation of a Health Care and Improvement steering group to follow on from the Direct Enhanced Service to improve health screening for those people with a learning disability</li> </ul> <p><b>Service Development and Screening</b></p> <ul style="list-style-type: none"> <li>• Further engagement to occur with community groups who represent people with a disability and also internally with Health Improvement colleagues within the PHA.</li> </ul>
Persons with and without dependants	

## Disability

During 2014-2015 we plan to progress a number of actions. These include working with disabled people to consider the diversity of images used and the potential for portraying wider range of individuals when developing information materials including websites. It also relates to exploring the scope and interest in the establishment of a forum for staff on disability. We will also seek to prompt staff to keep up to date their personal equality monitoring records (via self-service on new Human Resources IT system), in order to improve our equality evidence base for any equality screenings and impact assessments of policies and decisions relating to the workplace.

## Accessible Formats

During 2014-2015 we will focus on raising awareness amongst our staff on their roles and responsibilities in implementing the accessible formats policy. We will also work with regional HSC partners to put in a place a contract for the provision of accessible formats services (such as the production of documents in Braille or Makaton formats).

## **Transgender**

We intend to engage closely with transgender individuals, representative groups and trade unions to ensure our transgender policy meets the needs of those we seek to support.

## **New / Revised Equality Schemes**

Please indicate whether this reporting period applies to a new or revised scheme and (if appropriate) when the scheme was approved?

Our new Equality Scheme was approved by the Equality Commission in 18 November 2011.

## Section 1: Strategic Implementation of the Section 75 Duties

Please outline evidence of progress made in developing and meeting *equality and good relations objectives*, performance indicators and targets in corporate and annual operating plans during 2013-14.

The PHA continues to be an active partner of the Equality Forum, convened by the BSO Equality Unit. The forum brings together the equality leads from all the 11 HSC organisations that the Equality Unit supports.

In our Business Plan for 2013-14, we included a wider range of objectives directly related to promoting equality and good relations for the Section 75 groups. These included:

### (1) Improving health and wellbeing and tackling health inequalities

- Commission delivery of five new Early Years Intervention Programmes through Government's Delivering Social Change initiative: Incredible Years, Strengthening Families Programme, Parenting ur Teen, Triple P and Infant Mental Health Training.
- Scope existing health improvement programmes for those with physical and sensory disability and develop/adapt public health information to meet the needs of people with physical and sensory disability.
- Improve long-term outcomes for the children of teenage mothers by rolling out the Family Nurse Partnership Programme to commence work on one further site.
- Develop a coordinated approach to the provision of training for HSC staff to increase their understanding of the specific health needs of LGB&T to ensure that services are 'LGB&T friendly'.
- Establish a new model of services to reduce social isolation of older people and increase social engagement opportunities.
- Increase uptake of stop smoking services, in particular with young people, pregnant smokers and disadvantaged adults by 10%.

### (2) Improving the early detection of illness

- Prepare for the extension of the Bowel Cancer Screening Programme to invite people up to the age of 74 years, to invite in 2013/14 50% of all eligible

men and women aged 60-71, with a screening uptake of at least 55% in those invited, and will have in place all the arrangements necessary to extend bowel cancer screening to everyone aged 60-74 from April 2014.

- Improve informed choice in cancer screening (particularly amongst hard to reach groups).

(3) Using evidence, fostering innovation and reform

- Commission a research call in Dementia in Care.
- Commission a call in Public Health Suicide Research.

### **Equality Action Plan and Disability Action Plan**

In addition, we commenced delivery on our Equality Action Plan and Disability Action Plan. Both of these cover the period 2013-18.

These plans focus on specific actions to promote equality and good relations, to promote positive attitudes towards people with a disability and to encourage their participation in public life.

Key Year 1 objectives that we delivered on under our Equality Action Plan are provided in Appendix 1.

Key Year 1 objectives that we delivered on under our Disability Action Plan included:

- Raise awareness of specific barriers faced by people with disabilities including through linking in with National Awareness Days or Weeks.
- Identify, provide and promote opportunities for more engagement for people with a disability in key work areas.
- Nominate a champion at senior level.
- Create and promote meaningful placement opportunities including for people with disabilities.

Further details are provided in Appendix 4.

## **Equality screening**

The new processes put in place during 2012-13 to manage the Agency's Procurement Plan have had a noticeable impact in relation to equality screenings. From a corporate perspective, the management of the Plan allows early identification of screenings to be undertaken and timely monitoring that evidence of screening is in place. At times, the publication of screenings relating to tenders has to be stalled until the tender process is completed, to ensure that the process is not compromised. This explains why the greater activity in this area during 2013-14 is not necessarily reflected in the screening reports.



## Section 2: Examples of Section 75 Outcomes / Impacts

Given the renewed focus of Section 75 aiming to achieve more tangible impacts and outcomes and addressing key inequalities; please report in this section how the authority's work has impacted on individuals across the Section 75 categories. Consider narrative in the following structure:

- *Describe* the action measure /section 75 process undertaken.
- *Who* was affected across the Section 75 categories?
- *What impact* it achieved?

Please see information provided in the Executive Summary on pages 6 to 13. This summarises some of the outcomes achieved by key policy and service developments that we undertook during the year.

Please give examples of changes to policies or practices using **screening or EQIA**, which have resulted in **outcomes or impacts for individuals**. If the change was a result of an EQIA please indicate this and also reference the title of the relevant EQIA.

See Appendix 2 of this report for details on mitigation.

Please give examples of **outcomes or impacts on individuals** as a result of any **action measures** undertaken as part of your Section 75 action plan:

See Appendix 1 of this report for details.

Please give examples of **outcomes or impacts on individuals** as a result of any **other Section 75 processes** e.g. consultation or monitoring:

Please see examples highlighted in Sections 6, 7, 8 and 10 in particular.

## **Section 3: Screening**

Please provide an update of new / proposed / revised policies screened during the year.

See screening report for 2013-2014 attached as Appendix 3. This report provides details on all policy screenings, screening outcomes and mitigation.

## **Section 4: Equality Impact Assessment (EQIA)**

Please provide an update of policies subject to EQIA during 2013-14, stage 7 EQIA monitoring activities and an indicative EQIA timetable for 2014-15.

No EQIAs were undertaken during this reporting period.

- EQIA Timetable: April 2013 - March 2014 – not applicable
- Ongoing EQIA Monitoring Activities: April 2013- March 2014 – not applicable
- 2014-15 EQIA Timetable – not applicable

## **Section 5: Training**

Please outline training provision during the year associated with the Section 75 Duties / Equality Scheme requirements including types of training provision and conclusions from any training evaluations.

During 2013-2014, 12 members of staff participated in training and briefing sessions on equality and human rights matters. 11 individuals completed Equality Screening training, one members of staff attended an introductory session on screening.

All regular training sessions are evaluated. The evaluation figures have remained consistently high over recent years. A recurring feature are the somewhat lower scores for the development of skills in practically carrying out screening. Given the challenging nature of equality screening it is arguably to be expected that the development of practical skills cannot be completed within the timeframe of a 3h session. The definition of learning outcomes will therefore be reviewed accordingly.

## **Section 6: Communication**

Please outline how the authority communicated progress on delivery of the Section 75 Duties during the year and evidence of the impact / success of such activities.

As in previous years, our Annual Report included an update on the progress we made in delivering on our Section 75 duties.

### **Bulletins, newsletter, senior briefings, intranet and email**

We provided our staff with information in the form of emails, features on our intranet or staff newsletters and bulletin. These focused on the following:

- Screening Good Practice Resource and training 2013-14
- Launch of final Disability Action Plan
- Anti-Homophobia Week
- Disability Action Plan implementation - expression of interest from staff
- Carers Week
- Refugee Week 2013
- Belfast Mela
- Census 2011 equality data
- International Epilepsy Day (preannouncement, quiz and feature).

### **Senior briefings**

In addition, a number of senior briefings were provided on the following issues:

- Shared Learning resource
- Census 2011 equality data (detailed briefing)
- Disability Action Plan – raising staff awareness of disabilities
- Disability Action Plan – work placements for people with a disability
- Accessible Formats Policy – adoption and implementation
- Accessible Formats Policy – support products for staff
- Good Relations
- Screening and Equality Impact Assessments
- Enforcement of screening.

Moreover, case law relevant to equality and human rights was reviewed. Senior staff were provided with a summary of the cases and learning points arising for the organisation.

## **International Day of Epilepsy Awareness**

During this year, we worked with our regional HSC partners with the aim to raise staff awareness around the barriers experienced by people with particular disabilities in the workplace. Together with our partners, we featured Purple Day, the International Epilepsy Awareness Day, in the workplace on 26th March.

The aim was to raise staff awareness about the nature of the disability, how it affects people and what staff can do to support a colleague with epilepsy. To this end, the first of a new series 'Disability Insight' was produced and circulated amongst staff on the day. This included further information as well as links to personal stories and video testimonials by people living with epilepsy. Likewise, a quiz was issued one week in advance as a lead in.

Moreover, we have created a new section on our intranet dedicated to 'Disability Insight' to serve as a central location from which staff can access briefings on individual disabilities and the barriers experienced by people.

## **Section 7: Data Collection & Analysis**

Please outline any systems that were established during the year to supplement available statistical and qualitative research or any research undertaken / commissioned to obtain information on the needs and experiences of individuals from the nine categories covered by Section 75, including the needs and experiences of people with multiple identities.

Please outline any use of the Commission's Section 75 Monitoring Guide.

### **Health and Wellbeing Improvement**

Persons of different political opinion

Completion of a qualitative research study with members/ex-members of a Loyalist paramilitary organisation. The 'Shoulder to Shoulder' study highlighted the significant levels of emotional health and wellbeing issues within ex-members of one of the main paramilitary organisations in NI, and high levels of drug and alcohol misuse.

BME

A database for Minority Ethnic groups and programmes has been updated for Northern Ireland. Monitoring of Ethnic groups has been introduced to Health and Social Care Systems.

A research proposal is in development relating to the mental health and emotional wellbeing needs of minority ethnic communities in Northern Ireland and revision of the Public Health Agency Health Intelligence briefing relating to information gathered from the 2011 census is currently underway.

Older People

An online survey, focus groups and one to one interviews have been completed to produce guidelines on the needs of LGB&T older people in nursing and residential settings. The PHA established a working group to write guidelines on nutrition for older people 'Promoting Good Nutrition Guidelines for Older People' that are now published and disseminated in all five Health and Social Care Trust (HSCT) areas.

Women

Contribution has been made to a study regarding women and peace building in Northern Ireland. PHA has worked with organisations such as the Women's

Resource and Development Agency (WRDA) and Women in Sport and Physical Activity (WISPA).

WRDA is a charity which provides support for women's groups and networks across Northern Ireland with a mission to advance women's equality and participation in society by working to bring about social, political and economic change.

WISPA is a cross community women's project which works to identify gaps existing in local communities with regards to women's health. The project is linked with Active Belfast (of which PHA is a lead partner) and has been successful involving large numbers of women in physical activity programmes, many of whom had not been involved in physical activity before. It has worked to empower women and helped understanding of healthy lifestyle messages.

## **Health Intelligence**

Relevant work during the year included:

- Enhancement of routine HSC systems to collect standardised ethnicity data. This has been rolled out to the Child Health System and in early stages of the NI Maternity System (NIMATS) and the Social Services Client Administration and Retrieval Environment (SOSCARE). The main Patient Administration System software is being amended and will be implemented in 2014/15.
- Sexual orientation questions were included along with disability, carers and community background on Public information campaign awareness surveys around cancer and organ donation and will be in such work going forward.
- Health Intelligence brief written on Minority Ethnic groups data from the census and LGB&T.
- Antenatal education focus groups on recent mothers and fathers experience and information needs included two groups of fathers and a specific group on travellers as well as a couple of specific interviews with minority ethnic women.
- Commissioned work from the Rainbow Project will be in health improvement reports.
- Amendments to data collection on Lifeline to include specific collection of sexual identity.



- Cook IT for minority ethnic groups being developed including focus groups to test.
- Review of Sudden Death 1 early notification process for suspected suicide reporting looking at how to include ethnicity consistently going forward.

## **Nursing and Allied Health Professions**

The 10,000 Voices Project facilitates the collection of patient experience using the Sensemaker methodology. Sensemaker uses the 'cognitive edge' system to support the collection of both qualitative and quantitative data. Within the demographic section of the survey it asks the patient to confirm their age range, gender and ethnicity which are included within the categories covered by Section 75. A new survey has been developed for phase 2 of the project and it includes the demographics listed above in addition to a question on sexual orientation.

Regional Mental Health Team (tier 3 &4) recovery implementation plan baseline survey to access how recovery focused services are for patients, relatives and carers.

Within the review of Allied Health Professions (AHP) support for children with statements of special educational needs in special and mainstream schools it is recognised that accurate data collection is vital to ensure the efficacy of the baseline established. Data is being collected from key stakeholders, including Children/Young people, Parents/Carers, Education staff and AHPs in order to seek views and gather information on levels and models of AHP provision. Data collected will include both qualitative and quantitative information. Gathering appropriate data from key stakeholders will assist in the identification of themes and issues within the review of AHP support for children with statements of special educational needs and subsequent recommendations for further action.

Let's Talk about – Survey support was provided by the Public Health Agency and the Health Service Executive in the Republic of Ireland to collect the public experience of living with a progressive illness which will not be cured - ie a palliative care focus.

The Centre for Connected Health and Social Care has been working with Trusts and TF3 (the Telemonitoring NI service provider) to design and implement a general customer satisfaction survey. All patients and carers are surveyed.

The Centre has also worked with Patient & Client Council to enable the undertaking of a patient survey.

## **Research and Development Office**

Relevant work during the year included the following:

- A priority exercise was undertaken in conjunction with the James Lind Alliance and the Alzheimer's Society to identify local gaps in dementia care which could be addressed by a commissioned programme of research. The priority exercise took place with dementia care professionals as well as patients and carers. The results of the exercise formed the basis of a large commissioned call in the area of dementia care. A patient and carer took part in the evaluation of proposals to the first stage of this call with a second currently in process.
- HSC R&D Division is leading the organisation of the PHA Annual conference in the area of 'Diversity' to be held in June. Topics covered will include disability, LGB&T and travellers. The planning committee includes representative from all of the section 75 Groups who are cascading information on the conference to their relevant communities.
- An initial priority setting exercise was undertaken with social care staff in February 2014 in conjunction with the Social Care Lead at HSCB, Anne McGlade. This included academic and Trust staff and members from the community and voluntary sector. The overarching aim is to provide key information for the Social Work/Social Care Research Strategy which is currently being developed.
- HSC R&D Division participates in The Northern Ireland Autism Strategic Research Advisory Committee who is tasked with providing advice to the OFMDFM regarding the action plan of the Autism Strategy for Northern Ireland. One of the recent tasks is to identify how inclusion of families affected by Autistic Spectrum Disorder be measured.
- The research and development strand of the child development group within the PHA seeks to identify robust evidence which is used to support families who are vulnerable, socially excluded, have developmental delay, or require additional levels of support within the community sector.

## **Health Protection**

Enhanced surveillance arrangements were put in place for new diagnoses of gonorrhoea made at Northern Ireland GUM clinics between June and August 2013. These data included detail on sexual orientation.

## **Service Development and Cancer Screening**

A pilot was undertaken in the Breast Screening Programme to capture section 75 information from attendees at clinics in the Northern Trust. The pilot was undertaken in July 2013. Analysis was completed and a further pilot for the Western Trust area is planned in 2014. The PHA will then consider implementing the capture of section 75 information as routine within the Breast Screening Programme.

At present section 75 information is not collected in the bowel or cervical screening programmes. It is more complex as when people are in a screening “unit” they will be receiving treatment or having an appointment to discuss receiving treatment.

## **Section 8: Information Provision, Access to Information and Services**

Please provide details of any initiatives / steps taken during the year, including take up, to improve access to services; including provision of information in accessible formats.

### **Health and Wellbeing Improvement**

#### **BME**

PHA continues to liaise with key stakeholders on the commissioning, development, implementation and review of the Northern Ireland New Entrant Service.

A leaflet specifically targeting BME carers has been developed which will be available in the 11 most popular ethnic minority languages. It will be launched during Carers week in June 2014 and will be distributed as widely as possible to BME Carers through interpreters, HSC staff, carers organisations and ethnic minority organisations and networks.

A range of public health information is available in an alternative format, for example the Healthy Breaks poster, leaflet and letter were produced in Irish translation.

Extensive work has been completed on the BME pilot for Cook it! a community nutrition programme to support people to enhance their cooking skills and interest in healthier eating, particularly where cost is a consideration. Recipes from the following communities have been developed with BME participants; Polish; Chinese; Bulgarian; East Timorese; Muslim; Indian; Irish Traveller; and Lithuanian. Pilot testing is underway in each Trust locality and is due to be completed in Summer 2014.

A new resource, Ethnic Minorities Mental Health Toolkit – A Guide for Practitioners is currently being developed as a training resource to meet identified cultural competence needs of HSC practitioners.

A profile of needs of the ROMA community was developed in partnership with community, voluntary, statutory and independent sectors. A Health liaison worker has been supported to address the needs of the ROMA community in Northern Ireland. This role, in partnership with the Belfast HSC Trust and Bryson House, aims to increase access to health and social care services (such as maternity,

family and childcare services, unscheduled care and GPs) and to promote the health and wellbeing of this marginalised group.

## Travellers

As part of the work of the Travellers Health Forum, preparation has been made for the employment of Travellers and those who work with Travellers to promote health and wellbeing, building on the experience of Belfast HSC Trust. PHA have been working with other stakeholders to re-establish a Travellers support network in the western Trust area. This has included collaboration with partners in the Republic of Ireland through the CAWT initiative.

Travellers have been actively involved in the development of a poster to appear in Health and Social Care sites to portray a more welcoming and friendly environment. This, it is hoped, will encourage Travellers to access HSC services and promote trust within the community.

Work has also begun to improve screening services with Travellers. PHA work with WRDA to raise awareness and improve uptake of screening services with a range of groups including BME, women with a disability and more disadvantaged communities.

## Early Years and Young People

As part of a larger expansion in early years development, a range of programmes and training are being advanced. This has included Infant Mental Health training, Triple P, Parenting Your Teen and Incredible Years.

## Young people

A network of One Stop Shops (services aimed at meeting the needs of a wide range of young people) has been developed across Northern Ireland. The service is based on engagement with young people and services are made more accessible by the use of 'youth friendly' environments. Dissemination of learning and good practice with young people, access to sexual health services and education services is shared across the region and has been promoted in schools and Further Education colleges.

The PHA has been working with Health & Social Care Trusts and Further Education Colleges to look at how sexual health services for young people can be delivered in college settings. The Northern HSC Trust and the North Eastern Regional College have a memorandum of understanding signed by both Chief Executives with sexual health clinics provided at both the Ballymena and

Newtownabbey campus sites. When the service was set up (initially in the Ballymena campus), young people attending the college were fully involved in its development, location and delivery model. The services offered include a comprehensive contraceptive, STI testing, information / support and treatment service. It is called "The Clinic" and the name was chosen by the students.

An LGB&T subgroup has been established to look at issues for young people particularly in relation to their experiences in health and education settings. The work is based on engagement with LGB&T young people. A key focus of the work is on how to be inclusive of LGB&T issues by promoting fair and representative coverage in educational materials and public information.

PHA is working closely with DHSSPS on the development of an Early Intervention Service for children and young people which will link into the Family Support Hubs and the Children and Young People's Strategic Partnership.

Much of this work is aimed at improving outcomes with more disadvantaged/vulnerable groups.

## LGB&T

A new poster to help increase visibility has been developed by Health and Social Care staff, Forum members, equality leads, PHA and Trade Unions. Some 3000 posters have been distributed across all HSC sites and there has been positive feedback from LGB&T staff and service users. A targeted E-learning programme, aimed at increasing awareness and visibility of LGB&T colleagues, has also been developed and promoted among HSC sites and with other regional organisations.

A radio campaign was commissioned to promote services provided to LGB&T people and to increase the visibility of LGB&T people which was aired on a number of local and regional radio stations in 2013.

Efforts to increase the accessibility of Stop Smoking services for LGB&T individuals has been undertaken with training provided in Brief Intervention with the Rainbow Project.

A specific LGB&T programme was supported as part of the UK City of Culture 2013 initiative to raise the profile of the contribution of the community to civic society in Derry/Londonderry. A separate initiative was undertaken with the transgender community to raise awareness of the challenges they face and how those could be addressed.

## Learning Disability

A new Learning Disability Strategy has established an Implementation Group (Regional Learning Disability Health Care and Improvement Group). One of the health improvement workstreams aims to improve the health and wellbeing of people with learning disabilities and their carers. A major conference, 'Health Matters, Everyone's Business', was held on 7 March 2014. Attendees included service users, carers, advocacy groups and service providers.

The 'Cook It' programme has been adapted and a resource guide has been developed for those with learning disabilities. The practical tool kit provides training for tutors and includes recipe cards in user friendly formats.

The PHA, in conjunction with the Northern Health & Social Care Trust, has developed a pictorial information leaflet about Type 2 Diabetes for people with a Learning Disability.

## **Communications**

Communications staff represented the PHA on the Contract Adjudication Group for a new Interpreting and Translations contract. Likewise, the team issued guidance to health leads for the procurement of translations. This guidance was subsequently shared across HSC organisations.

Health leads procured translations for the following topics:

- 10,000 voices survey
- Hepatitis B – factsheets for patients
- Hepatitis B – Could I be at risk?
- Healthy breaks for pre-school children – letter, poster, leaflet
- Healthy breaks for schools – letter, poster, leaflet
- Abdominal aortic aneurysm screening: Things you need to know
- Protecting your child against flu - Vaccination for your 2 or 3 year old child
- Protecting your child against flu - Vaccination for your P6 child
- Letter for Duty room regarding TB in close contact in the workplace
- Immunisation for babies just after their first birthday
- Teenage immunisations for ages 14 to 18
- Immunisation for babies up to a year old
- Immunisation for pre-school children three years and four months old.

The team moreover developed visuals for the LGB&T Staff Forum, and drew up a web development specification for the group.

## **Nursing and Allied Health Professions**

The 10,000 Voices Project has developed 4 surveys during phase one and phase two. This included a survey focused on 'Unscheduled Care', 'Nursing and Midwifery Care', 'Northern Ireland Ambulance Service Care' and 'Care in the Home'. All of these documents have been translated into the 6 main languages within Northern Ireland. All of the surveys are available in larger font upon request and a helpline has been established in order to provide assistance to individual patients. In addition, the surveys can be completed in a variety of ways including voice recording, online and hard copy. Comprehensive engagement plans have been developed for each Trust area in order to ensure the patient experience is collected from a wide range of individuals and is representative of the population of Northern Ireland.

Discussion groups were held with pregnant and postnatal women throughout Northern Ireland to assess their views on community maternity care. These groups have included women from a variety of backgrounds: political, religious and economic. An online survey has also been available for women.

The team likewise produced a pregnancy book for all pregnant women, including a section specifically for same sex couples during pregnancy.

Recovery work via the ImROC programme focused on patient experience of mental health services.

The production on pathway to access mental health services was progressed to its final stage.

Within the Review of Allied Health Professions' (AHP) support for Children with Statements of Special Educational Needs within special schools and mainstream education project documents were published online on the PHA website for access to all stakeholders. These documents are the:

- Project Initiation Document
- Terms of Reference of Project
- Engagement Plan
- Terms of Reference of Project Board.

These documents can be made available in a range of formats on request including audio format, Braille, Easy Read, accessible html. They can be made available on request and where reasonably practicable in further alternative formats, such as large print, DVD or other languages to meet the needs of those for whom English is not a first language.



Let's Talk about Survey support by the Public Health Agency and HSE in Republic of Ireland has been approved by NALA (Plain English approval).

Your Life Your Choice: Plan Ahead booklet aimed to provide information relevant to NI for making a will, organ donation, advanced decision to refuse treatment, advance care planning etc. has been published. This booklet should enable citizens to access information and support in these topic areas.

The Telemonitoring NI contract requires that all equipment should be accessible to all patients including those with disabilities (such as people who are blind) and also to those who do not speak English.

### **Research and Development Office**

The HSC R&D Division is currently developing a new website which will include a dedicated section for service users and the public.

### **Service Development and Screening**

Work is on-going within the action plan, Promoting Informed Choice in Cancer Screening, which was approved by PHA Board and published to stakeholders in 2012. This includes actions that will be undertaken to promote informed choice, remove obstacles to people accessing cancer screening and hopefully to improve uptake. The focus of the plan is on groups of people that we know find cancer screening programmes less accessible for a variety of reasons than the general population. These include travellers, BME groups, LGB&T people, prisoners, people with learning difficulties and people who have a physical or sensory impairment.

A review was completed in 2013 of the public information leaflets of the Breast Screening Programme. A revised information leaflet on breast screening (which was developed by an independent group) has been published by the national screening office. This has prompted a review of all breast screening leaflets used in the Northern Ireland programme. Reference was made to the comments received as part of the engagement to promote informed choice. Updated information has been published and distributed.

An interview to promote bowel screening to blind and partially sighted people was undertaken for the Sound Vision Ulster audio magazine produced by RNIB in 2014. This magazine is issued to all people registered as blind in Northern Ireland.

### **Accessible Formats Policy**

During 2013-2014, the PHA progressed the development of its Accessible Formats Policy. Moreover, much of our efforts were dedicated to developing resources for staff. These aim to support staff in implementing the policy and include:

- flowcharts to assist information authors step by step in their decision-making on accessible formats, both at the planning stage and in response to any requests received for accessible formats
- guidance to assist staff step by step in procuring translations and in undertaking basic checks of completed translations
- monitoring databases to record decision-making on accessible formats.

### **Disability Action Plan**

We commissioned Action on Hearing Loss to develop a version of our Disability Action Plan 2013-2018 that is accessible to people with hearing impairments. A signed and subtitled DVD was produced.

### **Signpost to Support Networks in the Community**

By the end of March, our annual update of the staff resource “*Signpost to Support Networks*” was under way. This resource collates information on a range of Section 75 networks and groups within the community.

## **Section 9: Complaints**

Please identify the number of Section 75 related complaints:

- received and resolved by the authority (including how this was achieved);
- which were not resolved to the satisfaction of the complainant;
- which were referred to the Equality Commission.

The PHA did not receive any Section 75 complaints during 2013-14.

## Section 10: Consultation and Engagement

Please provide details of the measures taken to enhance the level of engagement with *individuals* and representative groups during the year.

Please outline any use of the Commission's guidance on consulting with and involving children and young people.

### Health and Wellbeing Improvement

#### BME

Links have continued with the regional Ethnic Minority Monitoring Group to improve ethnic monitoring by HSC service providers. Information and good practice continues to be shared through the 'Stronger Together' minority ethnic health and social wellbeing network steering group. Information is shared through this alliance with community and voluntary sector and health and social care practitioners.

The Network currently (i.e. March 2014) has 168 members from across the community, voluntary and statutory sectors. A Stronger Together website was launched in November 2013 and in the period Jan to March 2014 has had 2347 visits and 6195 page views. Networking is achieved through online communication, facilitation and signposting to a wide range of events including an annual Stronger Together conference, workshops, seminars and training on key issues relating to the health and social wellbeing of migrants and ethnic minority communities.

PHA has worked with Arts Ekta (Ethnic Arts organisation) to engage Somalian women who have recently been granted refugee status in Northern Ireland. An 8 week programme of arts and crafts was delivered aimed at improving interaction, communication, personal confidence and reducing social isolation.

#### Travellers

A number of events were also held with Travellers and the Travellers Health Forum. In addition, a specific piece of work was undertaken to explore increasing breastfeeding rates among Traveller women, with the 'Uplift' group.

#### Older People

PHA is supporting the Transforming Your Care reform agenda through influencing the commissioning of mainstream health and social care services.

PHA has supported a range of services that engage older people and prevent social isolation (for example Healthy Living Centres, Community Grants, Community gardens and allotments, 'Good morning' services and the provision of a Befriending service to engage with isolated older people).

Work continues with ArtsCare to engage older people in a range of arts based activity to promote health and wellbeing. Over 300 workshops were held with older people across the region and five arts and health festivals have taken place, with over 3000 older people having participated in these festivals.

A series of 'Community Conversations' have been organised by the Southern Strategic Health Improvement Partnership (SSHIP), of which PHA is a member, to engage with older people in five specific localities in the southern area in order to identify their views about how to co-produce neighbourhoods for ageing well.

### Early Years

The Roots of Empathy programme is being delivered in 119 schools in Northern Ireland within 2013/14, notably including schools with a diverse population (for example, 6 current schools have Traveller children in attendance).

### LGB&T

A confidential Forum for HSC staff who identify as LGB&T continues to develop. Members have recently engaged with sector organisations such as Rainbow Project, HereNI and Transgender NI.

PHA has also worked with a range of stakeholders (such as AgeNI, The Rainbow Project, HereNI, Regulation and Quality Improvement Authority) to produce guidelines for LGB&T older people. The guidelines, 'See me, hear me, know me', were launched in March 2014. PHA is also represented on a regional LGB&T Consultative Forum and Transgender Consultative Forum chaired by LGB&T sector organisations.

Members of the Forum hosted information and awareness stalls in 10 HSC sites in order to raise awareness of the Forum through the year and also attended Pride and Outburst festivals. Forum members were actively involved in branding and logo creation for the Forum.

Members of organisations representing the LGB&T community continue to play a key role in steering committees and sub-groups led by the PHA, for example, the Mental Health and Emotional Wellbeing Group of Belfast Strategic Partnership.

PHA engaged with members of the LGB&T community to ensure that these views informed service development and service standards for example, in relation to mental health and wellbeing and suicide prevention.

### Standards for emotional wellbeing and suicide prevention

A package has also been developed to include quality standards relating to complementary therapies, training, core governance arrangements, counselling services and self-harm support services. Consultation and engagement included a wide range of section 75 affected groups.

The process followed is set out below:

#### Complementary Therapies:

A small regional working group was established to develop draft standards for Complementary Therapies in situations of mental health crisis and de-escalation. The group included practitioners, service managers and commissioners across community, voluntary and statutory sector services.

#### Training Standards:

Standards for training were publically consulted on previously in a process which was facilitated by 'Dare to Stretch'. The four Training Standards consultation events were attended by 56 Individuals from a range of Community, voluntary and statutory sector organisations.

#### Core, counselling and self harm services:

In February 2013 the Public Health Agency (PHA) hosted a Stakeholder Engagement Event on the Future Development of Quality Initiatives to Support Emotional Wellbeing and Suicide Prevention (standards). Following feedback from participants at this event the PHA extended their consultation process to seek further views on the Standards for promoting mental & emotion wellbeing and suicide prevention.

The PHA disseminated the consultation document widely with the community of interest, including:

- Persons who expressed an interest in the consultation event;
- Members of the Suicide Strategy Implementation Board (SSIB);
- Members of the Bamford commissioning team;
- Members of the Bamford Mental & Emotional Wellbeing Sub Group;
- Members of the Locality Implementation Groups and Locally Funded services;

- Members of the Family Voices Forum;
- Patient and Client Council / Bamford monitoring group.

Since this consultation closed the PHA has worked to finalise a standards toolkit which PHA will use as part of the requirements in procuring emotional wellbeing/suicide prevention services in the future.

## **Communications**

The team is represented on the Information and Training Workstream of the Physical and Sensory Disability Strategy. This group includes representatives from Section 75 groups.

## **Nursing and Allied Health Professions**

10,000 Voices Project: During the development stage for each Survey, stakeholder workshops, which included service user representation, were held in order to design the survey. In addition, the surveys were presented to a number of service user forums in order to gather wider service user views. Local engagement plans have been developed for each Trust area and include a wide range of engagement through community and voluntary groups, church groups, schools/university as well as acute and community hospital settings.

Work also included the co-the production of mental health core care pathway with service users and carers.

Recovery champions were identified and trained in all Trust areas from service user and carers groups.

The PHA working through the Regional HSC Personal and Public Involvement (PPI) Forum has pro-actively encouraged the direct involvement of service users and carers on local PPI panels and Reference Groups in Trusts and other HSC organisations.

The PHA PPI Team have supported the establishment and development of a User and Carer Reference Group for people with a Neurological Condition and their Carers, to help shape the development of services and to improve the quality of life.

The PHA has also directly supported work with the N.I. Rare Diseases Partnership, including a launch of an engagement exercise during International Rare Diseases Day, which aimed to encourage active involvement of people with Rare Diseases in discussions and plans about the way forward in this area.

Within the Review of Allied Health Professions' (AHP) support for Children with Statements of Special Educational Needs within special schools and mainstream education there has been engagement with parents/carers, Education staff and AHP staff in order to seek views.

It is recognised that meaningful engagement with key stakeholders, including children/young people, parents/carers, Health & Education staff is vital to the success of the review. The scoping exercise in special schools, phase 1 of the review, has involved collaboration and a partnership approach with all key stakeholders

The Project Board considered the best options for engagement so that this is carried out in the most effective way.

Examples of engagement in phase 1 include:

- Survey regarding AHP services available to all parents/carers of children in special schools
- Direct meetings with parents in a sample of special schools selected to represent variety in terms of categorisation of schools and geographical areas
- Direct engagement with children/young people in special schools being carried out by Barnardo's Disabled Children and Young People's Participation Project
- Visits to all appropriate special schools across Northern Ireland
- Meetings with all AHP groups working with children
- Meetings with other key stakeholders, eg Children's Law Centre, the NI Commissioner for Children and Young People, Children in Northern Ireland.

Let's Talk about Survey support by the Public Health Agency and HSE in Republic of Ireland: engagement has been through a variety of media and attendance at stakeholder meetings with particular focus outside health and social care and in rural areas. An engagement matrix can be provided.

During the year TF3 (the Telematics service provider) met with a number of service users to discuss their use of the service with a view to service development.

### **Research and Development Office**

During the year, we promoted engagement and consultation through a number of activities:



- All of our funding panels to evaluate research applications now include PPI representatives who are service users, carers or members of the public. These have included panels to evaluate applications to a commissioned call in dementia care, telemonitoring, Personal and Public Involvement as well as our annual award schemes for doctoral fellowships and Knowledge Exchange and the open Enabling Award Scheme.
- A PPI representative took part in an interview panel for the post of Director: Cochrane Ireland, a new post we are jointly funding with the Health Research Board in Dublin.
- Training sessions are provided to PPI representatives involved with us on our panels and committees.
- PPI representative included in the Research Workstrand of The Breastfeeding Strategy Action Plan.
- We have collaborated with Macmillan Cancer Support and NI Cancer Consumer Forum to develop a course for researchers and service users and the public on implementing PPI in research called Building Research Partnerships. This is now being run twice a year facilitated by a local service user trained who has become the first fully trained service users in the UK to deliver the course
- Through our Workshop and Conference Scheme we have part funded a conference on Huntington's Chorea for local stakeholders including service users
- On May 20<sup>th</sup> we will be organising a public awareness event on International Clinical Trials Day to encourage service users and the public to ask their health care professionals about research. This campaign will align with a national campaign called It's ok to ask.

## **Service Development and Screening**

As indicated in Sections 7 and 8, engagement with these community and voluntary groups will be on-going and is documented in the respective action plan.

## **Disability**

In order to deliver on our commitment to raise awareness amongst staff of the barriers experienced by people with disabilities, we invited our staff to become involved in a working group. This group, convened by the Equality Unit on our

behalf, brought together volunteers from a range of HSC partner organisations. We particularly encouraged staff who have a disability or who care for a person with a disability to join the group.

In the development of our feature on epilepsy, we engaged with Epilepsy Action and the Epilepsy Society and were able to draw on their materials and testimonials.

In the development of a work placement scheme for people with a disability, the HSC Board worked closely with Supported Employment Solutions and the Cedar Foundation as its facilitator on our behalf.

### **Maintaining Section 75 Consultation list**

Various equality consultation exercises conducted during 2013-2014 provided opportunity for regular review and updating of our Section 75 Consultation list. This ensures that the list remains as accurate as possible.

### **Publication of screening reports**

During 2013 – 2014, we continued the process for informing consultees either via email or by post of quarterly screening reports. Following quality assurance, screening documentation, in an easy to understand format, is made available centrally on the BSO website. This is available at:  
<http://www.hscbusiness.hscni.net/services/2166.htm>

## **Section 11: The Good Relations Duty**

Please provide details of additional steps taken to implement or progress the good relations duty during the year. Please indicate any findings or expected outcomes from this work.

Please outline any use of the Commission's Good Relations Guide.

We also took the opportunity to promote good relations by featuring refugee week. To this end, we provided staff with information and encouraged them to access materials published by the Red Cross. These presented real life stories from refugees.

Facilitated by the Equality Unit, we likewise engaged with our HSC partner organisations to begin discussing options for reinvigorating activity in relation to Section 75 (2). These included, for instance, adopting a good relations statement. Further consideration will be given to this in 2014-15.

## Section 12: Additional Comments

Please provide any additional information/comments.

### Transgender

Building on the learning from recent local seminars on the needs and experiences of transgender people in the workplace, the Equality Unit commenced work with Human Resources colleagues to explore the scope for the development of a policy on transgender. The main objective is to provide support to current and potential employees who identify as Transgender. We thereby seek to ensure that our workplaces are inclusive.

The policy is aimed at creating a workplace where:

- transgender people feel comfortable to express their gender identity
- transgender people can fulfil their full potential and fully contribute to the workplace
- all staff (including line managers and managers more generally) are empowered to support transgender staff and thereby to strive to meet their needs
- discrimination against transgender people (whether by staff or third parties we interact with) is not tolerated and any allegations thereof are dealt with in an effective manner.

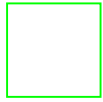
## **Part B: 'Disability Duties'**

### **Annual Report 1 April 2013 / 31 March 2014**

When we produced our Disability Action Plan we decided that it is important to do so in a language and format that is easy to understand. A copy of our Plan for 2013-2018 is available on our website.

In the same way, we want to make sure that people can easily follow what we do from year to year as we carry out our plan. We have therefore produced a report for 2013-14. It is attached as Appendix 4. This report provides all the information requested in the template below in what we hope is a more accessible language and format.

**1. How many action measures** for this **reporting period** have been



Fully  
Achieved?



Partially  
Achieved?



Not  
Achieved?

2. Please outline the following detail on **all actions that have been fully achieved** in the reporting period.

2 (a) Please highlight what **public life measures** have been achieved to encourage disabled people to participate in public life at National, Regional and Local levels:

Level	Public Life Action Measures	Outputs <sup>1</sup>	Outcomes / Impact <sup>2</sup>
National <sup>3</sup>			
Regional <sup>4</sup>			
Local <sup>5</sup>			

<sup>1</sup> **Outputs** – defined as act of producing, amount of something produced over a period, processes undertaken to implement the action measure e.g. Undertook 10 training sessions with 100 people at customer service level.

<sup>2</sup> **Outcome / Impact** – what specifically and tangibly has changed in making progress towards the duties? What impact can directly be attributed to taking this action? Indicate the results of undertaking this action e.g. Evaluation indicating a tangible shift in attitudes before and after training.

<sup>3</sup> **National** : Situations where people can influence policy at a high impact level e.g. Public Appointments

<sup>4</sup> **Regional**: Situations where people can influence policy decision making at a middle impact level

<sup>5</sup> **Local** : Situations where people can influence policy decision making at lower impact level e.g. one off consultations, local fora.

2(b) What **training action measures** were achieved in this reporting period?

	<b>Training Action Measures</b>	<b>Outputs</b>	<b>Outcome / Impact</b>
1			
2			
3			
4			



2(c) What Positive attitudes **action measures** in the area of **Communications** were achieved in this reporting period?

	<b>Communications Action Measures</b>	<b>Outputs</b>	<b>Outcome / Impact</b>

2 (d) What action measures were achieved to 'encourage others' to promote the two duties:

	<b>Encourage others Action Measures</b>	<b>Outputs</b>	<b>Outcome / Impact</b>

2 (e) Please outline **any additional action measures** that were fully achieved other than those listed in the tables above:

	<b>Action Measures fully implemented (other than Training and specific public life measures)</b>	<b>Outputs</b>	<b>Outcomes / Impact</b>

3. Please outline what action measures have been **partly achieved** as follows:

	Action Measures partly achieved	Milestones <sup>6</sup> / Outputs	Outcomes/Impacts	Reasons not fully achieved
1				
2				
3				
4				

<sup>6</sup> **Milestones** – Please outline what part progress has been made towards the particular measures; even if full output or outcomes/ impact have not been achieved.

4. Please outline what **action measures have not been achieved** and the reasons why?

	<b>Action Measures not met</b>	<b>Reasons</b>
1		
2		
3		

5. What **monitoring tools** have been put in place to evaluate the degree to which actions have been effective / develop new opportunities for action?

(a) Qualitative

---

---

---

---

(b) Quantitative

6. As a result of monitoring progress against actions has your organisation either:

- made any **revisions** to your plan during the reporting period or
- taken any **additional steps** to meet the disability duties which were **not outlined in your original** disability action plan / any other changes?

Please delete: Yes / No

If yes please outline below:

	Revised/Additional Action Measures	Performance Indicator	Timescale

7. Do you intend to make any further **revisions to your plan** in light of your organisation's annual review of the plan? If so, please outline proposed changes?



# **Equality Action Plan 2013 – 2018: Report on the progress we made during 2013-14**

June 2014

This document summarises progress made during 2013-14 against the actions we identified in our Equality Action Plan. The plan covers the period 2013-18 and is available on our website: [www.publichealth.hscni.net/sites/default/files/PHA%20EAP.pdf](http://www.publichealth.hscni.net/sites/default/files/PHA%20EAP.pdf)

If you require this document in an alternative format (such as large print, Braille, disk, audio file, audio cassette, Easy Read or in minority languages to meet the needs of those not fluent in English) please contact the Business Services Organisation's Equality Unit:

2 Franklin Street; Belfast; BT2 8DQ; email: Equality.Unit@hscni.net; phone: 028 95363961 (for Text Relay prefix with 18001).

Theme 1: Provision of Accessible Information.....	3
Theme 2: Cancer Screening.....	3
Theme 3: Childhood Immunisation.....	6
Theme 4: Migrants .....	7
Theme 5: Lesbian, Gay, Bisexual and Transgender.....	10
Theme 6: Personal and Public Involvement .....	12
Theme 7: PHA as an employer .....	14
Theme 8: Board composition.....	15

## Theme 1: Provision of Accessible Information

Action Point	Progress to end Mar 2014 and Comments	Outcomes for Section 75 groups
Complete review of existing sites and ensure new sites are compliant with relevant guidelines and standards (such as W3C A4).	All websites are undergoing technical upgrade and, concurrently, are being reviewed for accessibility and usability. For all new sites we endeavour to match expectations set down in W3C and put user experience at the heart of the W3C process.	Through correct design, development and editing, enabling equal access to online information and functionality by people with disabilities.

## Theme 2: Cancer Screening

Action Point	Progress to end Mar 2014 and Comments	Outcomes for Section 75 groups
Implement actions from the action plan on promoting informed choice in cancer screening (Mar 2014 and into 2014-15).	Work is on-going within the action plan. This includes actions that will be undertaken to promote informed choice, remove obstacles to people accessing cancer screening and hopefully to improve uptake. The focus of the plan is on groups of people that we know find cancer screening programmes less accessible for a variety of reasons than the general population. These include travellers, BME groups, LGBT, prisoners, people	This work will have a positive impact on the following section 75 groups because it will raise awareness of cancer screening and make services more accessible: <ul style="list-style-type: none"> <li>• Persons of different racial groups</li> <li>• Persons of different sexual orientation</li> <li>• Persons with a disability</li> </ul>

with learning difficulties and people who have a physical or sensory impairment. Some examples are:

A review was completed in 2013 of the public information leaflets of the Breast Screening Programme. A revised information leaflet on breast screening (which was developed by an independent group) has been published by the national screening office. This has prompted a review of all breast screening leaflets used in the Northern Ireland programme. Reference was made to the comments received as part of the engagement to promote informed choice. Updated information has been published and distributed.

An interview to promote bowel screening to blind and partially sighted people was undertaken for the Sound Vision Ulster audio magazine produced by RNIB in 2014. This magazine is issued to all people registered as blind in Northern Ireland.

Options for simplifying the bowel screening home test have been considered. Upon request, partially

This work will have a positive impact on the following section 75 groups because it will raise awareness of cancer screening and make services more accessible:

- Persons of different racial groups
- Persons of different sexual orientation
- Persons with a disability

This will promote bowel screening to all people in Northern Ireland who are registered as blind. It will promote screening and advise that an alternative process can be undertaken which will be easier for these people to complete.

	<p>sighted people are being sent the FIT test kit which is easier to complete. They will then be “tagged” on the system to issue this kit for future screening rounds.</p> <p>Cancer screening information leaflets have been transcribed into audio format for the benefit of people who are blind or partially sighted. This task was completed in conjunction with RNIB.</p> <p>Cervical Screening toolkit disseminated to smear takers. An online training toolkit which enables cervical screening practitioners to improve patient experience for lesbian and bisexual women.</p>	<p>This should result in a better patient experience for lesbian and bisexual women.</p>
--	---	--

### Theme 3: Childhood Immunisation

Action Point	Progress to end Mar 2014 and Comments	Outcomes for Section 75 groups
Feed back individual uptake rates to health professionals, along with comparative data, so they know how they are performing compared with their peers.	Our capacity to address this issue has been limited during this year due to an unprecedented number of new vaccines coming on line. Overall our uptake rates have been maintained at their very high levels or improved still further for MMR – which now stands at over 96% at 2 years.	n/a
Visiting individual practices with low rates to discuss how these can be improved.		
Develop a one stop shop for new migrants that will include a range of services including bringing children up to date with their immunisations.		
Work with Trusts to develop initiatives to promote childhood immunisations with the Travelling community.		
Continue to monitor uptake closely and work with professionals to achieve ongoing improvement.		

## Theme 4: Migrants

Action Point	Progress to end Mar 2014 and Comments	Outcomes for Section 75 groups
<p>Improve data collection of migrants and their health and social wellbeing needs with a particular focus on community systems (SOSCARE); hospital systems (PAS) and GP systems (Mar 2014).</p>	<p>Progress on ethnic monitoring as follows:</p> <p><u>Child Health System</u>: 5 Trusts have completed ethnic group field for 2013/14 as follows:</p> <p>WHSCCT97%;NHSCT 94.4%;SHSCT 86.8%; BHSCT82%;SEHSCT52.6%</p> <p><u>NIMATS</u>: now recording ethnicity of child, mother's country of birth.</p> <p><u>SOSCARE and PAS</u>: work ongoing - PAS have new software and implementation across all hospitals' inpatients is expected by end of the year.</p> <p>The regional ethnic monitoring group are undertaking a review of the quality of the information across each system. Plans are also being developed for a further roll out of the codes and agreed definitions to all other systems across health and social care.</p> <p>The ethnic monitoring guidance</p>	<p>Effective monitoring will benefit migrants by allowing providers to assess numbers accessing services, highlight possible inequalities, investigate their underlying causes and remove any unfairness or disadvantage.</p>

	document is at sign off point and launch and issue is expected in the near future	
Work with PHA, HSCB, Trust, BSO and community and voluntary sector colleagues to achieve an effective information and good practice sharing Migrant Health and Social Wellbeing Collaborative Network for health and social care professionals, ME groups and others (Mar 2014).	The Stronger Together, minority ethnic health and social wellbeing network was established in December 2012. The Network currently (i.e. March 2014) has 168 members from across the community, voluntary and statutory sectors. The initiative's website was launched in November 2013 and in the period Jan to March 2014 has had 2347 visits and 6195 page views. Networking is achieved through online communication and facilitation and signposting to a wide range of events including an annual Stronger Together conference; workshops, seminars and training on key issues relating to the health and social wellbeing of migrants and ethnic minority communities.	The collaborative network benefits ethnic minority communities and migrants by facilitating regional co-operation and creating a common forum for accessing and sharing information, good practice, knowledge and skills relating to the holistic health and social wellbeing of ethnic minorities. This is contributing to increased awareness of the health and social wellbeing needs of migrants and ethnic minority communities and of opportunities for addressing those needs.
Review the evidence on approaches taken to improving minority ethnic health and social wellbeing, elsewhere across the UK and internationally, to help inform local commissioning and decision making (Dec 2013).	Work is currently underway to develop a research proposal to examine factors affecting the mental and emotional wellbeing of migrants and minority ethnic communities in Northern Ireland and to look at good practice from other places.	Programmes and services which reflect evidence and good practice developed in other areas are more likely to be effective in achieving improved minority ethnic health and social wellbeing.



<p>Continue to work with key agencies and organisations across the sectors to review, develop and implement an annual regional action plan to address minority ethnic health and social wellbeing issues (annually).</p>	<p>A regional 2013/14 action plan with 5 objectives and 10 related actions to address minority ethnic health and social wellbeing issues was developed and is being implemented by key agencies and organisations across the sectors that have come together, under the auspices of the PHA, as the Regional Minority Ethnic Health and Social Wellbeing Steering Group.</p>	<p>The 2013/14 action plan continues to address the fact that ethnic minority communities are at increased risk of health inequalities and has adopted a co-ordinated, cross – sectoral partnership approach to tackle identified issues, reflecting evidence and best practice from the literature.</p>
--	--	--

## Theme 5: Lesbian, Gay, Bisexual and Transgender

Action Point	Progress to end Mar 2014 and Comments	Outcomes for Section 75 groups
Engage with key stakeholders on eLearning programme (Mar 2018).	E-Learning programme informed by LGB&T individuals and their carers.	The experiences of individuals who identify as Lesbian, Gay, Bisexual and Transgender were taken into account in the development of the content of the e-learning programme.
Promote e-learning programme (Mar 2018).	On-going promotion of the e-learning programme as part of Equality and Diversity Training with HSC Trusts and BSO.	<p>To date there has been 349 registered users of these 184 staff working within HSC Settings have registered and 98 have successfully completed the programme.</p> <p>The expected outcomes are that staff are better informed of issues impacting on the lives of LGB&amp;T people including work colleagues within HSC Settings.</p>
Continue to support the HSC LGB&T Staff Forum (Mar 2018).	<p>Quarterly meetings of the forum continue.</p> <p>An annual action plan is developed by the Forum and reviewed annually.</p>	There are currently 115 individuals who identify as LGB&/orT on the confidential email address for the Forum. Feedback from Forum members is that the Forum has helped to raise visibility of LGB&T issues within HSC Settings and has provided a valuable source of information and

		support both individually and collectively.
Develop a dedicated website for the Forum (Mar 2018).	A dedicated website has been developed and can be accessed on <a href="http://www.lgbtstaff.hscni.net">www.lgbtstaff.hscni.net</a>	The website has helped to increase visibility of the Forum and provided a source of information on a range of issues including services and support for LGB&T people.
Conduct survey with staff across HSC settings (Mar 2018).	No progress has been made in relation to the research. Awaiting endorsement by HR.	N/A
Research proposal developed by PHA which will be commissioned in 2013/2014 (Mar 2018).	Research proposal developed but Research has not been commissioned.	Members of the LGB&T Staff Forum were involved in the development and pilot of the online survey questionnaire. Members expressed that they welcomed the development of the research which would help provide baseline data to measure progress in the future.
Work with AgeNI, RQIA, LGB&T Sector, Unison and the Independent Care Sector to develop guidelines to support older LGB&T people in residential and day care facilities. (Mar 2018)	Guidelines developed and launched on March 27.  Copies of the guidelines have been disseminated to all Registered Nursing, Day Care, Residential and providers of domiciliary care.	The guidelines have been informed by the experiences of LGB&T people and their carers.  Member of the writers group included representatives from the LGB&T sector and Age Sector organisations.
Work with The Rainbow Project to	Campaign developed and launched in	The campaign was developed in

develop a Sexual Health Campaign targeting Men who have sex with men (MSM). (November 2013)	November 2014.	partnership with the Rainbow Project. The concepts and draft designs were informed by MSM. Feedback from the Rainbow Project is that there has been an increase in demand for sexual health services including Rapid Testing for HIV from MSM.
Work with the Equality Leads in HSC Trusts and BSO to develop and disseminate posters within all HSC Settings to help create a more inclusive environment for LGB&T people and staff. (August 2013)	Posters developed and disseminated to all HSC Settings.	Feedback from services users and staff has been that they welcomed the posters and feel that they help create a more inclusive environment for service users and staff working within these settings.

### Theme 6: Personal and Public Involvement

Action Point	Progress to end Mar 2014 and Comments	Outcomes for Section 75 groups
Develop a protocol to evidence compliance with personal and public involvement for planning, delivery & evaluation of services (Dec 2013)	A clause on PPI is now embedded into the procurement and monitoring arrangements for PHA contracts.	Encourage staff to think more pro-actively about the involvement of service users and carers, including section 75 groups when commissioning/developing services.
Include Section 75 as scoring criteria in the allocation of funds from the	Section 75 criteria compliance is now incorporated into the application forms	Increased number of projects pro-actively targeting the involvement of

Promotion and Advancement of PPI Programme (Mar 2014).	and scoring criteria for PPI funding.	section 75 groups.
Commission PPI training programme for use across HSC (Mar 2014).	The PPI training programme has been commissioned. Its design and development is underway.	It will raise profile of the importance of section 75 groups. Service users and carers from such groups will be co-producers in the development of the resource.
Develop a PPI communication and promotional strategy (Mar 2014).	This has been delayed. Consideration is being given to the development of a HSC wide communication plan for PPI.	Section 75 groups will be actively involved in shaping the communication strategy if taken forward.
PHA to identify gaps in PPI research, theory & practical application (Dec 2013).	Gaps in PPI Research identified.	Opportunities for section 75 groups to contribute to and help shape the findings of research are actively pursued.
Commission research with a focus on lessons to be extrapolated & shared across the HSC (from June 2014 onwards).	Joint call for research made with the PCC. Awaiting submissions	Opportunities for section 75 groups to contribute to and help shape the findings of research are actively pursued.

## Theme 7: PHA as an employer

Action Point	Progress to end Mar 2014 and Comments	Outcomes for Section 75 groups
Engage with staff to (a) provide information on existing policies and pension arrangements (b) find out about staff preferences for working on beyond previous retirement age and suggestions for additional support (Mar 2016).	Scheduled for 2015-16	n/a
Work with BSO and partner organisations to develop a line manager guide on reasonable adjustments for staff from a range of Section 75 groups (Mar 2015).	Scheduled for 2014-15	n/a
Develop communication strategy for staff on rationale for collecting data. Collect staff data. (from 2014-15 onwards)	Scheduled for 2014-15	n/a

## Theme 8: Board composition

<b>Action Point</b>	<b>Progress to end Mar 2014 and Comments</b>	<b>Outcomes for Section 75 groups</b>
Approach Office for Public Appointments or Public Appointments Unit to welcome thoughts on the matter and seek advice on how greater diversity can be achieved (Mar 2018)	Scheduled for 2017-18 This will take into consideration the report published by the Commissioner for Public Appointments in January 2014 on Lack of Diversity in Public Appointments in Northern Ireland.	n/a



Public Health Agency  
4<sup>th</sup> floor South, 12-22 Linenhall Street, Belfast, BT2 8BS  
Phone: 028 9032 1313  
For text relay please prefix with 18001  
Website: [www.publichealth.hscni.net](http://www.publichealth.hscni.net)

**June 2014**



## **Appendix 2 – Changes to policies or practices using screening (mitigation)**

See also web link

<http://www.hscbusiness.hscni.net/services/2166.htm>

### **Commissioning Plan 2013-14 – April 2013**

**Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to the policy or decision in order to promote equality of opportunity?**

Ensuring successful screening during the commissioning year remains a key objective. The reliance of previously used data collection echoes one of the findings that emerged out of the HSCB's Audit of Inequalities.

Through the newly convened Equality and Human Diversity Working Group arrangements will be made to ensure equality and decisions that affect equality are informed by robust and up to date information.

Specific actions include:

- Ensure each commissioning team and local commissioning office has systems in place to build and update relevant policy and population based information.
- Ensure that all staff receives training on equality and related issues.
- Develop the capacity of staff to use the information to inform policy or decision making and regularly reviewed.
- Regular updates to Commissioning Programme Board on equality reviews and equality issues from the commissioning teams.

These efforts will include mechanisms to engage with ethnic minorities, people with disability, gay lesbian, bisexual and trans-gender people, older people and younger people, who often face barriers in engaging in Commissioning processes.

<b><i>In developing the policy or decision what did you do or change to address the equality issues you identified?</i></b>	<b><i>What do you intend to do in future to address the equality issues you identified?</i></b>
---	---

*Health and Social Wellbeing Improvement*

Work has been undertaken in a number of areas to include: sexual orientation, race and ethnicity, including specific thematic action plans to address areas of particular need such as Travellers, Minority Ethnic groups (ME), Lesbian, Gay, Bisexual and Transgender (LGB&T), older people, poverty; as well as community development.

Consideration of minority groups has influenced the strategic direction of the PHA, and one of the key pillars for achieving our objectives is to 'ensure a decent standard of living for all'.

Specific examples of work undertaken in 2012/13 included:

- development of an E-learning programme on Sexual Orientation training, website development, further development of the LGB&T Staff Forum, linkages with other HSC and wider organisations;
- development of a costed LGB&T Action Plan;
- The NI New Entrant Service (NINES) has started providing screening and health promotion clinics and should be fully operational by April 2013.
- Establishment of a Migrant Health and Social Wellbeing Multisectoral, Collaborative Network.
- Training needs relating to minority ethnic health and social wellbeing issues Identified and addressed.

In order to address these needs the PHA and HSCB intends, through its commissioning activities to monitor, evaluate and respond to the needs of those groups facing health inequalities and deprivation. We will continue to collect data to highlight population deprivation in Northern Ireland and ensure that staff are trained to deliver services to those groups affected by health inequalities.

- analysis conducted of the All Ireland Travellers Health report and a specific briefing prepared on mental health and wellbeing;
- establishment of a Regional Travellers Forum and action plan;
- PHA working in partnership with other health and social care organisations, and sectors including DHSSPSNI;
- Ensured there has been community involvement in each aspect of decision making.
- PHA has established a Homelessness Programme Board to ensure a co-ordinated approach to meeting the needs of homeless people.
- PHA has invested in the regional FareShare Food Poverty initiative and food banks in order to improve access to healthier affordable choices.
- Development of a range of programmes to address poverty including fuel poverty eg Maximising Access in Rural Areas.
- The development of a holistic strategy and implementation plan to promote the health and wellbeing of prisoners.
- development of an Older People's Action Plan
- New opportunities have been developed to address social inclusion eg Arts and Health programmes with Older People.

The health improvement teams will continue to commit to

advocating the importance of the equality agenda by ensuring consideration to those groups named under Section 75 within our action plans. Any evidence or research which has been undertaken and endorsed will form the basis for commissioning plans which address the issues of health inequalities in Northern Ireland.

#### *Specialist Services*

During 2011/12 investment of over £650,000 was made in vulnerable specialist paediatric services to ensure their continued safety and sustainability to maintain access within Northern Ireland. This involved additional staffing and initiation of clinical networks in a number of areas. Support was also given to the services in the RBHSC in order to provide network support across the region into local paediatric services in managing more care locally. Paediatricians with a specialist interest in local centres will also be supported through this investment.

This work will be supported by a specifically funded Network Co-ordinator.

It is proposed to expand Paediatric Intensive Care Capacity (PICU) in the Belfast Trust. This will address the need to increase the current number of PICU beds to meet demand in the 0-14 age group. An increase from 8 to 12 beds will ensure that refusals to PICU due to capacity reasons would be exceptional. Costs for the expansion are in the

The Network Co-ordinator will be funded for 3 years to drive forward implementation.

Investment will continue for Wet AMD in the 2 centres.

Investments in biologic therapies for severe, debilitating psoriasis will be made in all Trusts in 2012/13.

The Specialist Services Commissioning Team will continue to work with the Northern Ireland Rare Disease Partnership in the planning and delivery of services for people with rare diseases.

region of £2.25m and it is expected that the additional 4 beds would be fully established by June 2013.

Investment in Wet AMD services in the West as well as Belfast in 2012/13 will support a higher degree of local access for older people with this condition.

Investment in biologics for Rheumatoid conditions in all Trusts will support better geographic access for this group of patients who will have a degree of disability.

Investments in rare genetic conditions will support improved outcomes for some ethnic groups.

The Specialist Services Commissioning Team will work with the Northern Ireland Rare Disease Partnership to develop and pilot a regionally agreed patient journey for Duchenne Muscular Dystrophy.

The Board has taken a decision that primary percutaneous cardiac intervention services should be delivered from two centres, one in Belfast and one in Altnagelvin. These centres give the greatest geographic coverage for the population of Northern Ireland.

*Elective Services*

During 2011/12 The Board funded additional capacity in the Trusts and in the Independent Sector to ensure equity of access for all patients who required treatment.

The Board also held Trusts to account for delivering agreed maximum waiting times for

The commissioning team will strive towards agreeing detailed data returns for selected specialties from Trusts which identify patient numbers in relation to the categories in 2.2 /2.3

This data will be used to identify any inequalities in service provision.

specialties.

#### *Older People*

The Team has arranged two seminars with Older Peoples and Disability constituencies to share Commissioning intentions and to take feedback from them.

Equality issues were not strongly articulated in the discussions by voluntary sector representatives.

#### *Cancer*

Research suggests that cancer survival could be improved by as much as 40% with improved awareness of the early signs and symptoms and early detection. It is known that awareness of early signs and symptoms is related to deprivation and BME. Work will commence in year to undertake a baseline survey to identify current levels of knowledge and awareness and to identify key messages for a public awareness campaign. This campaign will consider how best to target hard to reach groups, including BME.

#### *Unscheduled Care*

Plans to develop dedicated paediatric assessment units are evidence of the importance of having dedicated unscheduled care pathways for children. Consideration will also be given to the development of unscheduled care pathways for patients with long term conditions, most of whom will be older people with complex needs.

#### *Palliative Care*

The development of a palliative

Ensure effective user/carer input to implementation arrangements.

Ensure regular dialogue with voluntary/user representatives as a feature of Commissioning Team functioning.

care service specification for nursing homes will improve the access to palliative care for older people.

The development of disease specific service specifications for non-cancer conditions such as heart failure, renal failure, cystic fibrosis etc will address age and gender inequalities in relation to palliative care services.

#### *Long Term Conditions*

The development of a programme of enhanced primary care management of cardiovascular risk factors will address health inequalities.

The review of the pilot projects on pre pregnancy care and structured patient education programmes for children and adolescents.

#### *Maternity and Child Health*

Maternity and pregnancy related gynae services are available at point of need for all women who are pregnant.

The gap in infant mortality between the most deprived and least deprived areas in Northern Ireland has narrowed.

The Commissioning priorities have been established based on the evidence above, relevant data and an understanding of the variance between services here and standards set nationally. The regional Maternity Strategy is the basis for commissioning and service priorities for Maternity services in Northern Ireland for the next 6 years. One of the aims of implementing the strategy is to

ensure that services are easily accessible in the community so they are available to vulnerable groups of women.

The maternity information system (NIMATS) is being developed to capture data on mother's ethnicity.

A scoping exercise is being developed (resources permitting) to gain more information on the specific needs of ethnic minority pregnant women and their impact on maternity services.

A pilot regional maternity obesity intervention programme for pregnant women with a BMI over 40 will commence in all Trust's early in 2013.

The Family Nurse Partnership pilot programme targeting 100 teenage mothers who will be recruited up to the 28th week of pregnancy in the Western area is being taken forward by the Public Health Agency to provide enhanced services to pregnant young women during and after their pregnancy. The outcomes for this target group are demonstrably poorer than for other mothers and this pilot will test a proven effective model of service delivery for this group in Northern Ireland for the first time.

#### *Physical Disability*

Address the recommendations of the Physical Disability Strategy, in particular the needs of carers. Introduction of a re-ablement model to promote rehabilitation, self care and independence.

#### *Children and Families*



The priorities which are contained within the Children and Families section of the Commissioning Plan demonstrate that the Section 75 groups being considered explicitly include age and disability. The other groups either have been or will also be taken into account in that if gender is a particular issue for the reconfiguration of residential child care provision this will be stated in any such review. It is also intended that the views of service users will be integrated within the work schedule, either through representatives or with direct engagement of users, which already applies to some of the working groups in place. Reference has been made previously to best practice and learning from other areas and the work to be taken forward on reviewing speech and language therapy support in special schools will be informed by a model of practice which has been successfully introduced in Scotland and will provide a template for local discussion. Equally the review of Intercountry Adoption Practice will take account of models operating in other parts of the UK. The adoption legislation in NI is different than that in other parts of the UK in that unmarried or gay couples cannot jointly adopt. This matter is currently the subject of a judicial review.

*Mental Health and Learning Disability*

It is widely evidenced that people

with a learning disability have increased mortality and live with higher levels of illness both physical and mental than the non learning disabled population. Previously the HSCB/PHA commissioned a Directed Enhanced Service for Learning Disability. This DES ensures that all adults with a learning disability have an annual health screening for both physical and mental health with their GP. It also follows up the health plans put in place and any secondary care referrals made to ensure that better health results can be monitored. The DES relies on dedicated health facilitator in each Trust to contact hard to reach patients.

During 2011/2012 the HSCB/PHA began implementing the Specialist Visual Assessment Clinics for Learning Disability across all Trusts. This service delivers specialist visual assessment clinics in settings where people with a learning disability live and attend for day support. It aims to pick up undiagnosed visual acuity problems and address these through treatments or prescriptions. It also makes referral to secondary services where more serious conditions are found.

Recognising the higher levels of mental ill health allocated to learning disability and to young adults generally the HSCB/PHA invested in Transition Services in 2011/2012 to put in place a greater capacity and range of

post school day opportunities to promote inclusion in training, further education and vocational settings. There is also further investment in specialist services which aim to support people with a learning disability who also have mental health issues, which often manifest themselves in challenging behaviour which in turn can lead to admissions to hospital.

Additional investment has been provided to help assist those people with a mental illness and who have particularly challenging/complex problems. This includes the development of services for people with forensic mental health problems and also services for people with a personality disorder. Individuals within these services tend to have, in general, much higher levels of ill health and morbidity than the general population. These services endeavour to provide person centred care and assistance to the particularly vulnerable cohort of clients/individuals referred to them. Regionally, the HSCB/PHA have brought together service providers within Network arrangements to promote best practice and more standardised care within these services. In turn, the output of these groups aims to improve outcomes for/care provided to people with serious mental illness.

#### *Screening*

Work has been undertaken to promote informed choice in

- Take relevant action to remove any identified obstacles to

cancer screening programmes to optimise uptake amongst eligible populations. There is particular focus on groups known to experience difficulties in attending for cancer screening: LGBT, BME groups, travellers, prisoners, people with physical or sensory disabilities, and people with learning disabilities.

### *Prison Health*

The commissioning priorities for prison health services are based in the principal of providing an equivalent health service to prisoners as that provided to the general population. The provision of health care is, however, subject to a number of restrictions due to the nature of the prison environment. Priorities include:

- Improve the committal process for people with complex needs; including substance misuse, diabetes and epilepsy.
- Work with the South Eastern Trust to ensure the introduction of the stepped care model within prisons to address mental health problems.
- Encourage the development of appropriate care pathways for prisoners with a learning disability.

attending for cancer screening.

- Continue to engage as appropriate with community and voluntary organisations who represent Section 75 groups
- Keep abreast of research and developments throughout the UK to improve access to cancer screening programmes.

**Proposal to reallocate part of the Screening Programmes  
Budget – March 2013**

Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to the policy or decision in order to promote equality of opportunity?

<b><i>In developing the policy or decision what did you do or change to address the equality issues you identified?</i></b>	<b><i>What do you intend to do in future to address the equality issues you identified?</i></b>
<p>AAA screening is fully resourced and the service meets the needs of eligible men. The breast screening service is currently understaffed and will not fully meet the needs of the eligible population in accordance with screening programme standards. Part of the funding is targeted at improving screening up take in harder to reach groups including those with disability, and LGBT groups.</p>	<p>No further action will be required in relation to the equality issues described. The PHA will continue to ensure funding is adequate to deliver screening programmes to standards.</p>

## PHA Annual Business Plan 2013-14 – September 2013

Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to the policy or decision in order to promote equality of opportunity?

<b><i>In developing the policy or decision what did you do or change to address the equality issues you identified?</i></b>	<b><i>What do you intend to do in future to address the equality issues you identified?</i></b>
<p>The Annual Business Plan development included ensuring that it fully reflected the PHA role in reducing health inequalities. Some of these explicitly aim to address key equality issues. Using our Communication department's expertise in public information the Business Plan was written in a style to make it accessible and understandable for a wide range of external stakeholders as well as PHA staff.</p>	<p>The key actions and focus on reducing health inequalities contained within the plan will guide the work of the PHA throughout the year and will be closely monitored through a variety of established performance monitoring systems.</p> <p>When preparing the plan we took the opportunity to review the direction set out in the Corporate Strategy to ensure its continued relevance to our work.</p> <p>The Annual Business Plan will be widely accessible and will be available in alternative formats.</p> <p>As each of the actions are taken forward equality issues will be reviewed and addressed as appropriate. Service leads have been reminded to keep under constant review the need for screening at an early stage when planning.</p> <p>We will also implement the actions detailed in our action plan which accompanies our Equality Scheme 2013-18.</p> <p>Ultimately, however, we remain committed to equality screening,</p>

	and if necessary equality impact assessing, the policies we develop and decisions we take.
--	--

**PHA/HSCB Regional Day Opportunities – September 2013**

Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to the policy or decision in order to promote equality of opportunity?

<b><i>In developing the policy or decision what did you do or change to address the equality issues you identified?</i></b>	<b><i>What do you intend to do in future to address the equality issues you identified?</i></b>
People with learning disabilities have been involved throughout this development of the model.	People with learning disabilities will continue to be involved. User consultation will be arranged independently of the HSC to ensure independent feedback

**Regional Guidelines for the Search of Patients, their Belongings and the Environment of Care within Adult Mental Health/ Learning Disability Inpatient Settings – May 2013**

Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to the policy or decision in order to promote equality of opportunity?

<b><i>In developing the policy or decision what did you do or change to address the equality issues you identified?</i></b>	<b><i>What do you intend to do in future to address the equality issues you identified?</i></b>
<p>Communication issues will be addressed as per policy. Capacity issues will be dealt with as per guidelines in relation to Capacity. Provisions include:</p> <p>1.4 The inclusion of equality matters in the principles serves to alert staff to the importance of taking equality issues into consideration before any search.</p> <p>3.2 Staff are alerted to the need to consider appropriate communication pathways.</p> <p>4.1 Staff are reminded of the need to consider religion, belief and personal preference of the service user as to who conducts the search and in the items of clothing to be removed.</p> <p>5.2 Assessment of service users over 16 and under 18 as to their capacity to consent. Contact with appropriate adult/person with parental responsibility if they do not have capacity to consent and for those under the age of 16.</p>	<p>Trusts will provide training for staff in relation to the Search Policy and Procedures used.</p> <p>Trusts will monitor the frequency of the policy being put into action and compliance with section 75 monitoring data.</p> <p>The Policy will be reviewed and updated as part of the Trusts Policy Review Programme.</p>



## Accommodation Business Case – January 2014

Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to the policy or decision in order to promote equality of opportunity?

<b><i>In developing the policy or decision what did you do or change to address the equality issues you identified?</i></b>	<b><i>What do you intend to do in future to address the equality issues you identified?</i></b>
<p>Ensured that all potential accommodation options were capable of being made DDA compliant and that they were located in a neutral venue, close to transport hubs, accessible to people with different disabilities, ethnicity and community backgrounds.</p> <p>The non-monetary benefit criteria included:</p> <ul style="list-style-type: none"> <li>• Quality of accommodation</li> <li>• Staffing issues</li> <li>• Flexibility</li> <li>• Accessibility</li> <li>• Community outreach</li> <li>• Ensuring that equality issues were addressed while identifying the preferred option.</li> </ul>	<p>Once the business case has been approved and implementation commences, the design will take account of the needs of staff and visitors.</p> <p>Steps will be taken to ensure DDA compliance.</p> <p>Care will be taken that all reasonable adjustments for people with a disability that have been implemented in previous offices will be put in place in the new premises, as appropriate. The need for these will be determined in consultation with those affected.</p> <p>PHA will liaise with Belfast City Council to explore the designation of one or more (onstreet) parking spaces outside 21 Linenhall Street as 'Disabled Access'.</p>

**Lifeline Crisis Response Service- Consultation with regular stakeholders.**

Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to the policy or decision in order to promote equality of opportunity?

<b><i>In developing the policy or decision what did you do or change to address the equality issues you identified?</i></b>	<b><i>What do you intend to do in future to address the equality issues you identified?</i></b>
<p>A series of meetings are planned across the region.</p> <p>The consultation process will be promoted particularly with groups identified in 2.2 and 2.3. Relevant providers / service users / carers will be encouraged to engage in the consultation process.</p> <p>Young men, prison population, travellers, LGB&amp;T and black &amp; ethnic minorities communities have specifically been identified as groups who may be marginalised from taking part in public consultation. To meet their needs the PHA intend to contact; The Helpline Network, Stronger Together Network, NICEM - Migrant Service, Youth Action, Rainbow, Cara-friend project, Traveller support organisations known to PHA, SE Trust-Mental health service provider in prisons, NI prison &amp; probation services to inform them of the consultation process and encourage engagement.</p>	<p>The consultation will provide all stakeholders with an opportunity to shape future service design. Findings from consultation process will help shape the specification of the Lifeline service.</p> <p>Broader learning will be disseminated to other relevant PHA &amp; HSCB funded initiatives.</p> <p>A culture of openness and transparency is in place.</p> <p>The consultation process will be an opportunity to actively tackle discrimination and support people and communities to do so.</p>

# Equality and Human Rights Screening Report 2013-2014



<b>*1</b>	<b>'screened in' for equality impact assessment-<u>including date of (EQIA)</u></b>			
<b>2</b>	<b>'screened out' with mitigation</b>			
<b>3</b>	<b>'screened out' without mitigation</b>			
<b>Org.</b>	<b>Policy/ Procedures &amp; Screening Documentation</b>	<b>Policy Aims</b>	<b>Date*</b>	<b>*Screening Decision</b>
<b>PHA</b>	Commissioning Plan 2013-2014	Sets the direction for the development of health and social care services for the population of Northern Ireland. It is consistent with the direction set out in Transforming your Care.	Apr-13	2
<b>PHA</b>	Environmental Policy	This Policy is designed to bring to the attention of all employees, suppliers and contractors, the PHA's position in regard to environmental issues and demonstrates a desire to continually improve its performance in environmental sustainability.	Jan-13	3
<b>PHA</b>	Waste Management Strategy and Policy	This Strategy and Policy is designed to bring to the attention of all employees, suppliers and contractors, the PHA's position in regard to waste reduction (prevent/reuse/dispose) and demonstrates a desire to continually improve its performance in Waste Management.	Jan-13	3

PHA	Proposal to reallocate part of the Screening Programmes Budget	The purpose of the decision to reallocate screening programme money is to ensure all screening programmes are adequately funded to meet service requirements for the eligible population across Northern Ireland.	Mar-13	2
PHA	PHA Annual Business Plan 2013-14	The Annual Business Plan 2013-2014 details how we will make best use of our resources to achieve our core goals, as set out in our Corporate Strategy 2011-2015. This plan focuses on significant new initiatives for 2013-14, and does not detail all the PHA's planned work.	Sept-13	2
PHA	PHA/HSCB Regional Day Opportunities	Sets out the Commissioning Intentions by Health and Social Care Board and Public Health Agency for Day Opportunities for Adults with a learning disability.	Sept-13	2
PHA	Regional Guidelines for the Search of Patients, their Belongings and the Environment of Care within Adult Mental Health/ Learning Disability Inpatient	The purpose of the guidelines is to ensure the safety and promote the protection of patients, staff and visitors by ensuring that dangerous items or hazardous substances are not brought into the in-patient setting.	May-13	2

	Settings			
PHA	Accommodation Business Case	The Business Case aims to provide the Public Health Agency, Patient and Client Council and Safeguarding Board for NI with an assessment of their accommodation pressures in Belfast, over the next 10 years together with recommendations on how they could best meet this need within the minimum resources possible that deliver value for money in the expenditure of public funds.	Jan-14	2
PHA	Lifeline Crisis Response Service- Consultation with relevant stakeholders	The Public Health Agency (PHA) is currently reviewing the 'Lifeline Crisis Response Service' model. The current Lifeline contract is due to end 31 March 2015 and the Public Health Agency is keen to engage with relevant stakeholders to ensure that the future service specification is appropriately informed and that future services are fit for purpose. The consultation process seeks to obtain feedback from key stakeholders to inform the decision making process on the future of	Mar-14	2

		the Lifeline Crisis Response Service.		
--	--	--	--	--

# **Disability Action Plan 2013-2018**

Public Health Agency (PHA)

**What we did between April  
2013 and March 2014**

If you need this document in another format please get in touch with us.



**(1) Communication**

<b>Action Measure</b>	<b>Intended Outcome</b>	<b>Performance Indicator and Target</b>	<b>Timescale and Ownership</b>
1. Work with disabled people to consider the diversity of images used and potential for portraying wider range of individuals when developing information materials including websites.	Disabled people are portrayed in a positive manner.	Checklist for authors developed and in use.	Business Services Organisation's (BSO) Equality Unit Year 2
<b>Relevant Duty: Promote positive attitudes towards disabled people.</b>			
<p><b>What we did over the last year</b></p> <ul style="list-style-type: none"> <li>• We have produced a first draft of guidance on how to portray people who have a disability in a positive way.</li> <li>• We looked for images that portray people who have a disability in a positive way. We found a very useful library of images. It is promoted by the Office for Disability Issues. We contacted the people who look after it. They have allowed us to use these images.</li> </ul>			

2. Adopt Accessible Information policy and guidance.	Improved accessibility of information.	Common wording relating to alternative formats for inclusion in documents. Protocol on how to deal with requests for alternative formats. For electronic communication, staff are supported to ensure that settings meet needs regarding accessible font size.	Agency Management Team (AMT) Year 2  BSO Information Technology Services (ITS) Year 2
--	--	--	---

**Relevant Duty: Promote positive attitudes towards disabled people AND Encourage participation by disabled people in public life.**

**What we did over the last year**

- We have developed a policy and guidance.
- We have developed tools for our staff. With these tools, we want to help our staff when they develop documents. They guide staff through what they need to think about. For example, if the document is for people who have a learning disability, staff may need to produce it in Easy Read format. The tools also tell staff what to do when somebody asks them for a document in a different format.

## (2) Awareness Raising and Training

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
3. Raise awareness of specific barriers faced by people with disabilities including through linking in with National Awareness Days or Weeks (such as Mind your Health Day).	Increased staff awareness of the range of disabilities and needs.	Awareness Days profiled in collaboration with voluntary sector groups. Stalls set up and road shows organised. Equality event hosted. Features run on Connect (PHA intranet). Staff awareness survey undertaken demonstrates increased awareness.	BSO Equality Unit Year 1 onwards  BSO Human Resources Year 3

**Relevant Duty: Promote positive attitudes towards disabled people.**

### **What we did over the last year**

- We brought people together to discuss how we can help our staff better understand what it is like for a person with a disability when they work with us. We want staff to be more aware of what barriers they face. We decided to look at one disability at a time.
- We invited all our staff to be part of this group. We especially encouraged staff who have a disability themselves to join the group. We also asked staff who care for somebody who has a disability. We thought that they would know best.
- The group decided to look at epilepsy this year. The 26th March 2014 was International Day of Epilepsy

Awareness. A week before this day, we sent round a quiz about epilepsy to get staff interested. On the day, we brought out a newsletter for all our staff. The newsletter told them more about epilepsy. It also talked about how it can affect a person. It then explained how best they can support a person who has epilepsy at work. We thought it would be best to let people speak about their own experiences. So we included links to videos and to stories by people who have epilepsy in the newsletter.

- We talked to groups who know a lot about epilepsy. Epilepsy Action, the Epilepsy Society and Disability Action all helped us with our work.

### (3) Getting people involved in our work, Participation and Engagement

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
4. Identify, provide and promote opportunities for more engagement for people with a disability in key work areas.	Better engagement of people with a disability (adults and children where relevant) in key areas.	Opportunities provided in key areas. Welcoming statement included and announcement issued to local disability organisations.	Directors and Assistant Directors Year 1 onwards

**Relevant Duty: Encourage participation by disabled people in public life.**

#### What we did over the last year

- We started with trying to get our own staff who have a disability involved in our work on making all our staff more aware of disability issues. This group of staff met 3 times to plan and prepare for Epilepsy Awareness Day.

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
5. Nominate a champion at senior level.	Evidence of leadership at senior level.	Champion identified.	Agency Management Team Year 1

**Relevant Duty: Promote positive attitudes towards disabled people AND Encourage participation by**

**disabled people in public life.**

**What we did over the last year**

- Two members of our Board came forward and said that they would like to be involved. Since then, they have spoken to staff who are Assistant Directors in our organisation. They asked them what they thought the organisation should do to make a difference for people who have a disability.

#### (4) Recruitment and Retention

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
<p>6. Create and promote meaningful placement opportunities including for people with disabilities in line with good practice and making use of voluntary expertise in this area.</p> <p>7. Produce practical guidance on process and external support available.</p>	<p>People with a disability gain meaningful work experience.</p>	<p>Guidance in place. Provide increased number of placements.</p>	<p>BSO Equality Unit BSO Human Resources Year 1 onwards</p>
<p><b>Relevant Duty: Encourage participation by disabled people in public life.</b></p>			
<p><b>What we did over the last year</b></p> <ul style="list-style-type: none"> <li>• We worked with the Health and Social Care Board to plan work placements for people who have a disability. Staff from the Health and Social Care Board talked to organisations who have done this before. This was to learn about their experiences. It was also to find out how we can best organise our placements.</li> <li>• We have decided that placements are for six months.</li> <li>• Staff from the Health and Social Care Board also spoke with the Cedar Foundation. They have agreed to help us find people with a disability who want to work with us on a placement. The Cedar Foundation have a lot of experience in organising placements. They work together with seven other disability organisations. This is to make sure that as many people with disabilities as possible get the chance to work with us on a</li> </ul>			

placement.

### **(5) Additional Measures**

- Three members of staff completed e-learning training on Disability.
- We always include Disability on our list of things to talk about at our quarterly Equality Forum.
- We report on progress against our Disability Action Plan to our Board and Agency Management Team (the people at the top of our organisation).

### **(6) Encourage Others**

- We include the duties in Screening Training. Our senior managers and those who take decisions attend this training. We also include the duties in Discovering Diversity e-learning training. All staff have to do this training.
- We include questions relating to the two duties in our screening form. The screening form is completed for all policies and decisions.

### **(7) Monitoring**

- We will develop a plan for checking how well our placement scheme works.
- We will have a think about how we can best check how well our Awareness Days are working.
- We will keep a note of how many requests we get for accessible formats. We will also keep a note of how many of those requests are met. Our Accessible Formats Policy will promise that we will do this.



## **(8) Conclusions**

We have still some work to do to complete actions 4 and 7. We will do this next year.

All of the actions in our action plan are at regional and at local level.

Our action plan is a live document. If we make any changes to our plan we will involve people with disabilities. We will tell the Equality Commission about any changes.



4th floor (South), 12-22 Linenhall Street, Belfast, BT2 8BS

Telephone: 03005550114

Textrelay: 18001 03005550114

You can also email us through our website on:

<http://www.publichealth.hscni.net/contact-us>