Public Health Agency

AGENDA

83rd Meeting of the Public Health Agency board to be held on Wednesday 16 March 2016, at 1:30pm, Fifth Floor Meeting Room, 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 previous meeting held on 18 February 2016		Chair
4.	1.35	Matters Arising		Chair
5.	1.35	Chair's Business		Chair
6.	1.40	Chief Executive's Business		Chief Executive
7.	1.50	Finance Update • PHA Financial Performance Report	**PHA/01/03/16 (for Noting)**	Mr Cummings
8.	2.00	Obesity Campaign		Mr McClean
9.	2.15	Five Year Review of Equality Scheme	**PHA/02/03/16 (for Approval)**	Mr McClean
10.	2.30	Infant Mental Health Framework	**PHA/03/03/16 (for Approval)**	Dr Harper
11.	2.45	PHA Business Plan 2016/17	**PHA/04/03/16 (for Approval)**	Mr McClean
12.	2.55	Board Governance Self-Assessment Tool	**PHA/05/03/16 (for Approval)**	Chair

13.	3.05	Update on Unscheduled Care	Chief Executive
14.	3.25	Any Other Business	

15. **Date, Time and Venue of Next Meeting**
Thursday 19 May 2016
1:30pm
ARC Healthy Living Centre
Irvinestown
116-122 Sallys Wood
Irvinestown
BT94 1HQ

HSC Public Health Agency

MINUTES

Minutes of the 82nd Meeting of the Public Health Agency board held on Thursday 18 February at 1:30pm, in Conference Rooms 3+4, 12/22 Linenhall Street, Belfast, BT2 8BS

PRESENT:

Mr Andrew Dougal	-	Chair
Dr Eddie Rooney	-	Chief Executive
Dr Carolyn Harper	-	Director of Public Health/Medical Director
Mrs Mary Hinds	-	Director of Nursing and Allied Health Professionals
Mr Edmond McClean	-	Director of Operations
Councillor William Ashe	-	Non-Executive Director
Mr Brian Coulter	-	Non-Executive Director
Mr Leslie Drew	-	Non-Executive Director
Mrs Julie Erskine	-	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 Robert Graham	-	Secretariat

APOLOGIES:

Mr Paul Cummings	-	Director of Finance, HSCB
Mrs Fionnuala McAndrew	-	Director of Social Care and Children, HSCB
Mrs Joanne McKissick	-	External Relations Manager, PCC

		Action
15/16	**Item 1 – Welcome and Apologies**	
15/16.1	The Chair welcomed everyone to the meeting and noted apologies from Mr Paul Cummings, Mrs Fionnuala McAndrew and Mrs Joanne McKissick.	
16/16	**Item 2 - Declaration of Interests**	
16/16.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.	

17/16 Item 3 – Minutes of previous meeting held on 21 January 2016

17/16.1 The minutes of the previous meeting, held on 21 January 2016, were approved as an accurate record of the meeting.

18/16 Item 4 – Matters Arising

6/16 Chief Executive's Business

18/16.1 Mr Coulter referred to the recent meeting with Professor Bengoa of the Expert Review Panel and asked whether public health has a place within the "Manchester Model". Dr Harper explained that this model is a multi-agency one which includes social care, education, housing as well as public health. She advised that in England public health budgets have been devolved to local government and that the experience of this has been mixed. Dr Harper added that with the cuts in Council budgets in England public health spending is being reduced with programmes being stood down. She suggested that a factor behind this is that in some Councils the responsibility for public health is held by an officer at second tier level or in some instances it is part of the remit of another officer.

18/16.2 The Chair asked what model Professor Bengoa had referenced. Dr Harper said that PHA had not been given a lot of detail on his model during their discussions with him but that he had asked about the public health delivery model. She added that an integrated model would have services such as GPs, pharmacy and social care all within the same centre.

18/16.3 The Chief Executive said that the Manchester Model is difficult to translate across to Northern Ireland given the different budgetary responsibilities. He said that there is more integration in health and social care but less in education and that local authorities in England have more power. He said that it is not yet known how successful this type of model is.

19/16 Item 5 – Chair's Business

19/16.1 The Chair said that he had attended a conference on anti-microbial resistance at Queen's University. He said that this is an important issue and he would welcome a fuller discussion on

this at a future PHA Board meeting.

19/16.2 The Chair said that he had attended a meeting of the Chairs' Forum at which the Comptroller and Audit General, Kieran Donnelly, had spoken expressing his concern about the volume of paperwork that non-executive Board members receive, and whether this impedes their ability to carry out their fiduciary and scrutiny roles. He said that a working group is being set up by the Northern Ireland Audit Office to look at this.

19/16.3 The Chair advised members of his attendance at the UK Health Forum where there was discussion on obesity and a proposed tax on sugar. He said that the focus of the strategy was on children and young people and sought clarity on Northern Ireland's approach. Dr Harper confirmed that the DHSSPS obesity strategy is for all age groups, but there had been a recent focus on family, children and pregnancy.

19/16.4 The Chair said that he had asked that members receive an update on Zika virus and he welcomed Dr Gerry Waldron to the meeting and asked him to give a brief presentation.

19/16.5 Dr Waldron gave an overview highlighting how the Zika virus is spread and its symptoms. He outlined the possible impact of Zika virus on pregnant women and the advice that is being given to travellers both travelling to and coming home from infected areas. Finally, he outlined how PHA is using its website and social media platforms to give out messages to the public.

19/16.6 The Chair asked how people who do not have access to social media can obtain information. Dr Waldron said that information has been shared with the media and that people can also contact their healthcare professional. He said that the Duty Room also receives queries.

19/16.7 The Chair asked about the Olympics in Rio and possible impact. Dr Waldron said that it is up to individuals to make their own choices as to whether they decide to go.

20/16 Item 6 – Chief Executive's Business

20/16.1 The Chief Executive advised members that he had attended the launch of Ulster Rugby's Wellbeing Strategy and said that he

was impressed with the work that Ulster Rugby does in the community.

20/16.2 The Chief Executive said that he had attended the second meeting of the UK and Ireland Collaborative looking at health inequalities.

20/16.3 The Chief Executive said that he had attended the CAWT management Board meeting yesterday afternoon at which the application to Interreg V was part of the agenda.

21/16 Item 7 – Finance Update – PHA Financial Performance Report (PHA/01/02/16)

21/16.1 Mr Christie advised members that the Financial Performance Report for the period up to 31 December 2015 showed a projected end of year surplus of £684k. He explained that this was due to two main factors; a better than expected position with regard to the management and administration budget; and an underspend in the Lifeline budget. He noted that although the year to date position shows a surplus of £1,988k, he said that this was due to a timing and profiling issue, and would rectify itself before the year end.

21/16.2 Mr Christie went through the Report and drew members' attention to the spike of activity in projected non-Trust programme spend for the months of February and March. He said that PHA was ahead of its spend this year due to quicker and improved processes in terms of raising requisitions and making payments.

21/16.3 Mr Christie said that the prompt payment performance statistics showed that 99.9% of invoices by value were paid within 30 days last month (96% by volume). He said that the 10-day performance figure was 87.6% which he said was excellent.

21/16.4 The Chair commended staff for their prompt payment and budgetary discipline in a straitened environment.

21/16.5 Mr Coulter commented that there are risks in this type of financial profiling, particularly with regard to health improvement and research and development. Mr Christie noted the concern and explained that historically much of PHA's expenditure has been

incurred towards the year end. However, he said that the expenditure profile is based on that of previous years, therefore due diligence has been undertaken.

21/16.6 Mr Mahaffy asked how the programme budget was distributed between Trusts. The Chief Executive explained that the Belfast Trust proportion is higher as many regional programmes are run from Belfast, and then there is an element of capitation. He added that recent procurement exercises have seen a shift away from regional, and into more local, services.

21/16.7 The Chair asked why Service Development and Screening are referenced together. Dr Harper explained that this is because within service development PHA provides advice to HSCB, almost exclusively vis-à-vis screening, and that screening is a core public health function.

21/16.8 Members noted the Finance Report.

22/16 Item 9 – Governance and Audit Committee Update (PHA/03/02/16)

22/16.1 Mr Coulter advised that the minutes of the Governance and Audit Committee meeting of 9 December were available for members and that he would give members a verbal report of the meeting of 4 February. He said that the Committee welcomed Mr Drew to his first meeting.

22/16.2 Mr Coulter said that three of the papers considered by the Committee featured on the agenda for today's Board meeting and that the Committee is happy to recommend these to the Board for approval, namely Standing Orders and Standing Financial Instructions, Scheme of Delegated Authority and Records Management Policy.

22/16.3 Mr Coulter said that the Committee had received a progress report from Internal Audit. He added that a Shared Services audit had shown that there has been an improvement in performance, but still some issues within payroll. He said that the Committee had also considered an update on the Report to those Charged with Governance, the timetable for the preparation of the Annual Report and Accounts for 2015/16, the External Audit Strategy and the Assurance Framework for AHPs.

22/16.4	Mr Coulter updated members on the Corporate Risk Register. He reminded members that the Register currently has six risks, four of which are rated "high", and the other two as "medium". He advised that the risk relating to the reduction in PHA's management and administration budget had been amended to make reference to "essential screening programmes".
22/16.5	The Chair asked which screening programmes were essential. Dr Harper explained that screening programmes are mandated by DHSSPS from the UK Screening Committee; however, due to VES and staff shortages PHA has flagged up issues to DHSSPS with regard to being able to complete these. She said that PHA is attempting to restructure within that area as an inability to complete these programmes could create reputational damage for PHA.
22/16.6	Dr Harper explained that PHA staff carry out an assessment of what screening is needed, undertake quality assurance visits and complete reports on these visits. However, she said that one area of work which has had to be deferred is the work to reach out to those groups of the population who do not take up invitations to attend screening. The Chair asked if this would be flagged up with DHSSPS. The Chief Executive said that this would form part of the discussions as PHA has to ensure that it manages these types of situation and maintains critical functions.
22/16.7	Members noted the update from the Chair of the Governance and Audit Committee.
23/16	**Item 10 – Review of Standing Orders and Standing Financial Instructions (PHA/04/02/16)** **Item 8 – Review of PHA Scheme of Delegated Authority (PHA/02/02/16)**
23/16.1	Mr McClean explained that PHA is required to carry out an annual review of its Standing Orders and Standing Financial Instructions to ensure that they are line with guidance and DHSSPS circulars.
23/16.2	Mr Christie said that the only updates in the SFIs related to DHSSPS circulars. He drew members' attention to the Scheme of Delegated Authority and explained that the key changes in it were an alteration to the EU threshold for procurement and a

reduction in the approval limits for SBNI officers.

23/16.3 Mrs Erskine highlighted that the reference to "Chair" in paragraph 1.4.1 of the Governance and Audit Committee's terms of reference and clarified that this refers to the Committee Chair, and not the Chair of the Board.

23/16.4 Members **approved** the updated Standing Orders, Standing Financial Instructions and Scheme of Delegated Authority.

24/16 Item 11 – Records Management Policy (PHA/05/02/16)

24/16.1 Mr McClean said that Records Management is one of the core Controls Assurance Standards and that since the previous policy was approved in 2012, there has been a new Information Governance Strategy, and that this updated policy reflects that.

24/16.2 Members **approved** the Records Management Policy.

25/16 Item 12 – Performance Management Report – Corporate Business Plan and Commissioning Plan Directions Targets for period Ended 31 December 2015 (PHA/06/02/16)

25/16.1 Mr McClean presented the Performance Management Report which details PHA's progress against its corporate objectives and Commissioning Plan Directions. He said that many of the targets were rated "green" in terms of achievability, but that 18 are rated as "amber" and 3 as "red". He added that an analysis of the targets rated "red" show that the rating is due to factors beyond PHA's control.

25/16.2 Mr McClean said that the three targets rated "red" were number 2.7 (telemonitoring and telecare), number 3.7 (relating to a regional learning system) and number 3.20 (relating to long term conditions regional implementation group). He said that the issue with two of these related to a lack of funding.

25/16.3 With regard to the long term conditions groups, Dr Harper confirmed that PHA has asked HSCB to consider investment in this, but due to other competing priorities this has not been possible. She added that there are currently a number of small piecemeal projects in this area creating a large administrative cost when it would be more efficient to have this programme

centrally procured and managed.

25/16.4 Mr Mahaffy asked about the development of the 2016/17 Commissioning Plan. It was noted that there is no indication as yet as to when the draft Plan will be brought to the PHA Board.

25/16.5 Mr Coulter said that overall the report was a positive one but he expressed concern regarding the lack of progress within telehealth, particularly within the current eHealth agenda. The Chief Executive advised that there are two elements, telemonitoring and telecare. He said that telecare is lower threshold, and supports people in isolation and has a high level of demand, but that telemonitoring has seen different patterns of usage across the HSC Trusts. The Chief Executive went on to say there is an evaluation of telemonitoring being conducted by R&D.

25/16.6 Alderman Porter said that the targets set are very high and although progress is being made, it is perceived that each year the objective has failed. The Chief Executive said that the experience of Trusts has been mixed. He said that patients have seen the benefits of telemonitoring, but clinicians have not. He said he would await the outcome of the evaluation, which should be complete by the end of March. He added that the current contract is due for renewal in March 2017 so there could be a different model put in place depending on the outcome of the evaluation.

25/16.7 Members noted the Performance Management Report.

26/16 Item 13 – Register of Interests

26/16.1 Mr McClean said that the Register of Interests is brought to the Board annually and reminded members that if there are any changes that members should advise the Chief Executive's office.

26/16.2 Members noted the updated Register of Interests.

27/16 Item 14 – Any Other Business

27/16.1 There was no other business.

28/16 **Item 15 – Date and Time of Next Meeting**

Date: Wednesday 16 March 2016
Time: 1:30pm
Venue: Fifth Floor Meeting Room
5th Floor
12/22 Linenhall Street
Belfast
BT2 8BS

Signed by Chair: ________________

Date: ________________

HSC Public Health Agency

Public Health Agency

Finance Report

2015-16

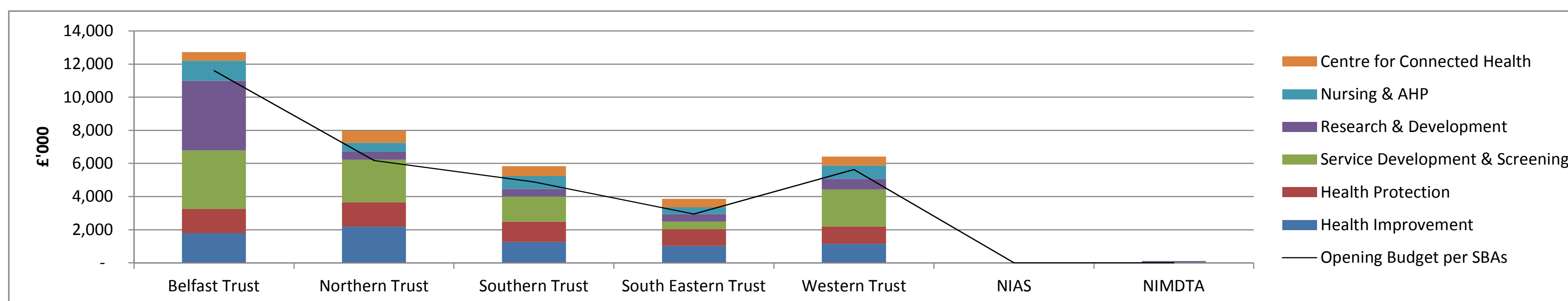
Month 10 - January 2016

Public Health Agency
2015-16 Summary Position - January 2016

	Annual Budget				Year to Date			
	Programme		Mgt & Admin	Total	Programme		Mgt & Admin	Total
	Trust	Non-Trust			Trust	Non-Trust		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources								
Adjusted Departmental Allocation	36,941	47,837	21,784	**106,563**	31,552	31,730	16,272	**79,553**
Income from Other Sources	-	788	556	**1,344**	-	716	441	**1,157**
Total Available Resources	36,941	48,625	22,341	**107,908**	31,552	32,446	16,713	**80,710**
Expenditure								
Trusts	36,941	-	-	**36,941**	31,552	-	-	**31,552**
Non-Trust Programme	-	48,628	-	**48,628**	-	34,226	-	**34,226**
PHA Administration	-	-	21,738	**21,738**	-	-	16,228	**16,228**
Total Proposed Budgets	36,941	48,628	21,738	**107,308**	31,552	34,226	16,228	**82,006**
Surplus/(Deficit)	-	(3)	603	**600**	-	(1,780)	485	**(1,295)**

The year to date financial position for the PHA shows an overspend against profiled budget of £1.3m. This is caused by an underspend on Management & Administration budgets, combined with a year-to-date overspend on Non-Trust Progamme activity, as explained on pages 3 and 4 of this report. It is currently anticipated that the PHA will generate a full year surplus of £600k, primarily as a result of overachieving on the 15% Administration retraction.

Programme Expenditure with Trusts

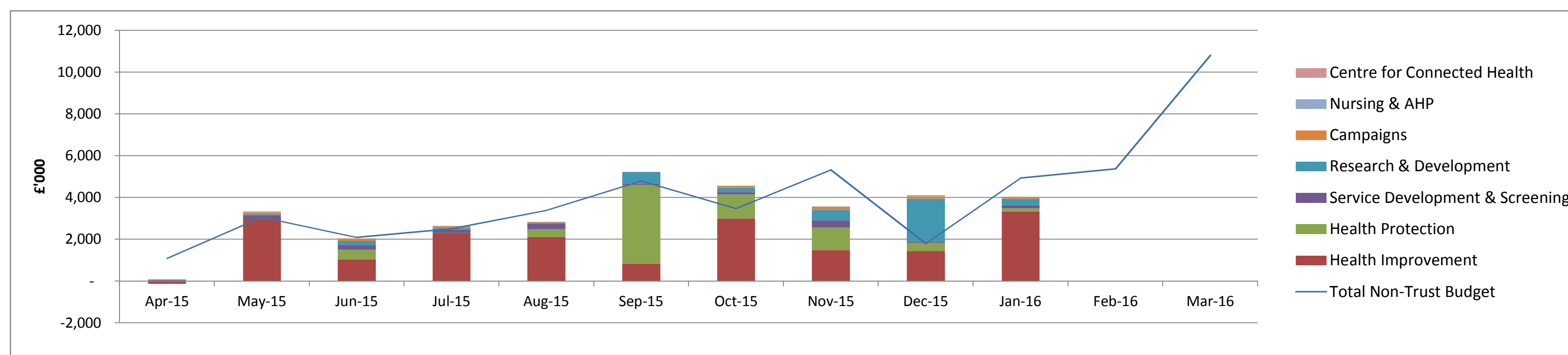


Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	Southern Trust £'000	South Eastern Trust £'000	Western Trust £'000	NIAS £'000	NIMDTA £'000	Total Current Budget £'000
Health Improvement	1,788	2,188	1,263	1,022	1,136	-	-	**7,398**
Health Protection	1,469	1,474	1,218	999	1,058	-	-	**6,217**
Service Development & Screening	3,535	2,562	1,520	460	2,227	-	-	**10,304**
Research & Development	4,204	482	454	465	657	-	107	**6,369**
Nursing & AHP	1,196	542	787	403	789	5	-	**3,721**
Centre for Connected Health	536	732	590	525	549	-	-	**2,932**
Total current RRLs	**12,728**	**7,981**	**5,832**	**3,873**	**6,415**	**5**	**107**	**36,941**
Opening Budget per SBAs	**11,604**	**6,183**	**4,887**	**2,950**	**5,626**	**-**	**-**	**31,250**

As part of a service improvement project the Finance Directorate has coded the Trust Revenue Resource Limits to their budget area, as shown by the summary above. During January an additional allocation of £560k was made to HSC Trusts which primarily related to EITP funding, Strengthening Families, and Integrated Treatment.

January 2016

Non-Trust Programme Expenditure



	Apr-15 £'000	May-15 £'000	Jun-15 £'000	Jul-15 £'000	Aug-15 £'000	Sep-15 £'000	Oct-15 £'000	Nov-15 £'000	Dec-15 £'000	Jan-16 £'000	Feb-16 £'000	Mar-16 £'000	Total £'000	Budget (YTD) £'000	Expenditure (YTD) £'000	Variance (YTD) £'000	Projected Full Year Expenditure £'000
Budget																	
Health Improvement	719	2,378	919	2,006	2,190	649	1,190	3,146	898	2,917	3,616	2,589	**23,217**	17,012	18,385	(1,373)	**24,587**
Lifeline	292	292	292	292	292	292	292	292	292	292	292	292	**3,500**	2,917	1,974	943	**2,370**
Health Protection	-	15	418	12	460	3,026	1,494	375	264	384	169	2,167	**8,785**	6,449	7,389	(940)	**8,669**
Service Development & Screening	83	368	85	83	368	93	127	290	124	(5)	337	215	**2,167**	1,615	1,709	(94)	**2,046**
Research & Development	-	-	237	60	45	501	185	1,120	113	1,013	772	4,635	**8,681**	3,274	3,903	(629)	**8,681**
Campaigns	-	1	131	58	32	230	180	95	85	290	230	414	**1,746**	1,102	796	306	**1,746**
Nursing & AHP	-	3	3	-	3	-	-	8	23	36	(53)	411	**436**	77	154	(76)	**436**
Centre for Connected Health	-	-	-	-	-	-	-	-	-	-	-	-	**-**	-	-	-	**-**
Other	-	-	-	-	-	-	-	-	-	-	-	92	**92**	-	(84)	84	**92**
Total Non-Trust Budget	**1,094**	**3,056**	**2,085**	**2,511**	**3,390**	**4,790**	**3,468**	**5,327**	**1,799**	**4,927**	**5,364**	**10,814**	**48,625**	**32,447**	**34,226**	**(1,780)**	**48,628**
Actual Expenditure	**233**	**3,506**	**2,306**	**2,681**	**3,109**	**5,292**	**4,815**	**3,841**	**4,113**	**4,328**	**-**	**-**	**34,226**				

The Non-Trust Programme budget decreased by approximately £0.475m since the last report, mainly due to a reduction in the EITP funding anticipated for Nursing and an element which went to Trusts.

The financial position to date shows expenditure is £1.8m ahead of profile. This is due to the combined effect of some Health Protection payments for vaccination costs being made earlier than anticipated, earlier than anticipated payments on Health Improvement and R&D contracts, and the continuing underspend on the Lifeline contract. The Programme position is being closely managed and a plan has been developed to manage the variances and ensure a breakeven position for the financial year.

A significant portion of the budget is currently profiled in the last two months of the year, and Budget managers have confirmed this will be utilised in 2015-16. Budget managers have been asked to review these figures closely and liaise with the Financial Management team if amendments to profiles are required.

January 2016

PHA Administration

2015-16 Directorate Budgets

	Nursing & AHP £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Annual Budget							
Salaries	2,840	3,360	10,172	295	318	423	**17,408**
Goods & Services	229	1,575	549	(42)	82	409	**2,802**
VER Scheme	34	119		1,900		77	**2,131**
Total Budget	**3,103**	**5,055**	**10,720**	**2,154**	**400**	**909**	**22,341**
Budget profiled to date							
Salaries	2,361	2,899	8,431	223	264	408	**14,586**
Goods & Services	197	1,282	426	(23)	69	176	**2,127**
Total	**2,558**	**4,181**	**8,857**	**200**	**333**	**584**	**16,713**
Actual expenditure to date							
Salaries	2,402	2,878	8,302	202	269	408	**14,461**
Goods & Services	127	1,141	257	52	13	176	**1,766**
Total	**2,529**	**4,019**	**8,558**	**254**	**282**	**584**	**16,228**
Surplus/(Deficit) to date							
Salaries	(42)	21	129	21	(5)	(0)	**124**
Goods & Services	70	141	169	(75)	56	0	**361**
Surplus/(Deficit)	**29**	**162**	**298**	**(54)**	**51**	**(0)**	**485**

The Management & Administration (M&A) budget for the PHA was reduced by the DHSSPS in 2015-16 by 15%, or £2.8m. However, after discussion and liaison with the DHSSPS, it was agreed that, for the current year only, a total of £1.3m will be generated from within M&A budgets and the balance of £1.5m will be managed across the total PHA budget. This process will allow a more strategic review to be completed in order to deliver a recurrent 15% reduction in future years.

Total recurrent budgets allocated to Directorates have been reduced by the actual 2014-15 surplus and a 20% travel saving, totalling £1.1m. This leaves a balance of £0.151m against the £1.3m savings target, and this is currently held in the PHA Board cost centre being managed centrally through Scrutiny and other measures. While cumulatively to date a surplus of £0.485m is shown, this has largely been generated from Goods & Services budgets, which may be required later in the year. PHA must therefore continue to manage discretionary expenditure and savings plans to ensure a breakeven position at the end of the financial year.

The PHA has received a ringfenced allocation of £1.840m to fund a Voluntary Exit Scheme in 2015-16. It is currently anticipated that VES costs will amount to £2.131m in 2015-16, and it has been assumed in this report that the Department will fund the balance of £0.291m. These funds are currently held in the Chief Executive cost centre, profiled at the end of the year so as not to impact year to date figures, and are being released to budget areas as staff leave under the scheme.

PHA Prompt Payment

Prompt Payment Statistics

	January 2016 Value	January 2016 Volume	Cumulative position as at 31 January 2016 Value	Cumulative position as at 31 January 2016 Volume
Total bills paid (relating to Prompt Payment target)	£3,817,703	427	£43,292,271	4,641
Total bills paid on time (within 30 days or under other agreed terms)	£3,774,341	405	£41,991,760	4,263
Percentage of bills paid on time	**98.9%**	**94.8%**	**97.0%**	**91.9%**

BSO Shared Services have now produced a comprehensive prompt payment report for PHA. A regional review of the accuracy of the BSO calculation, supported by legal advice, has resulted in a cumulative positive adjustment to the PHA figures for 2015/16. This has been reflected in the figures in the table above and the BSO report has been used to calculate the published figures from September 2015 onwards.

Prompt Payment performance to the period ending January 2015-16 shows that on value paid (97%) the PHA is meeting the 30 day target of 95%, while the volume of invoices is below the target at 91.9%. Generally PHA is making excellent progress on ensuring that high value invoices are processed promptly, supported by the January value performance of 98.9%.

In addition, 10 day prompt payment performance was 88.2% by value for the year to date, which significantly exceeds the 10 day DHSSPS target for 2015-16 of 60%.

Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	16 March 2016
Title of Paper	Five Year Review of Equality Scheme
Agenda Item	9
Reference	PHA/02/03/16

Summary

The PHA has committed to reviewing its Equality Scheme within five years of submission. This paper presents the draft report on the review. It is proposed that the final report is brought to PHA board at the March meeting, with a view to submission to the Commission by 31st March 2016.

The Five Year Review

Purpose of the review is to assess the effectiveness of the Equality Scheme in meeting the statutory duties. More specifically, the review considered:

- What has worked well and what hasn't worked that well
- What has been achieved and what remains to be done
- How the PHA could progress further.

The Equality Commission has emphasised that it will not use the outcome of the review to assess compliance and has encouraged public authorities to take an honest and open look. The review was a process of self-assessment.

The Draft Report

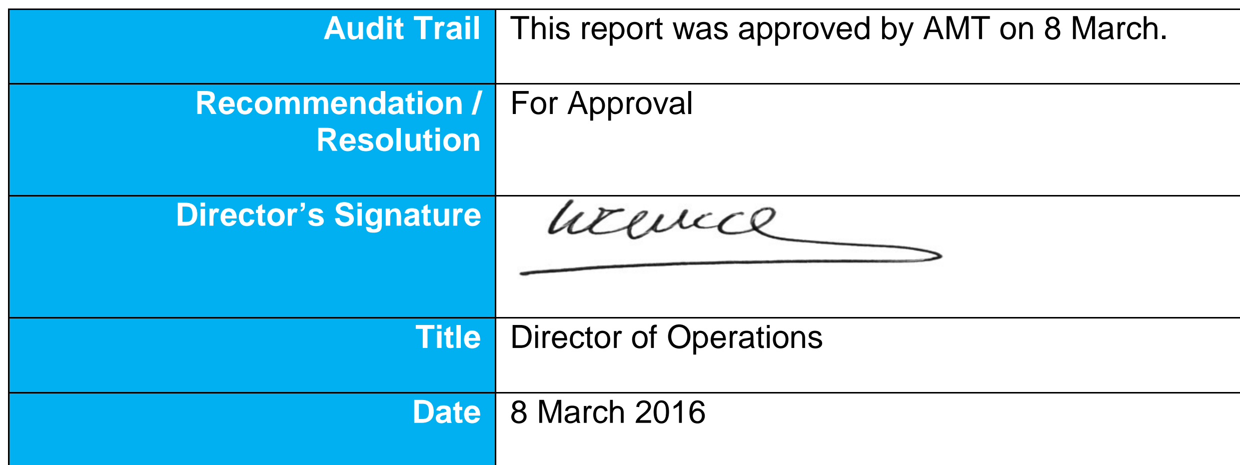
The draft report follows an elaborate reporting template from the Equality Commission. It is informed by information reported on in the Annual Progress Reports to the Commission over the last five years (such as on training and equality screenings) as well as a focus group with OWG members. Quarter 1 2015/16 was agreed with the Commission as a cut-off point. Work on the review commenced last summer.

The report shows that substantial outcomes for Section 75 groups have been achieved. Close engagement and consultation with those affected by PHA work has been part and parcel of the process. Moreover, important progress has been made in relation to conducting equality screenings and equality impact assessments.

Building on the significant achievements to date, the draft report contains a number of proposals that look ahead to the next five years of Equality Scheme implementation. These comprise:

p.10 Platform for sharing good practice

Consider the merits of establishing an internal forum with representation from all divisions or, alternatively, integrating equality more explicitly into the Terms of Reference of existing fora at senior level (such as the Organisational Workforce Development Group). The purpose would be to provide a platform for sharing good practice and encouraging learning to address a concern specifically raised by OWG members. p.15 policy consultations Ensure that all policy consultations include the respective equality screening template alongside the consultation document – by integrating this requirement into internal publication protocols for public consultations. p.16 engagement Integrate equality matters into mainstream engagement structures and exercises. p.21 screening With HSC partners, revisit the scope for introducing a shortened template for evidencing the screening of policies that do not impact on people to reduce the administrative burden. Ensure that all screening templates are published. For policies and decisions which require screening at different stages (for example at design and implementation stage or at tender strategy and specification stage), review and update previous screening rather than undertake multiple screenings to address the potential for duplication. p.22 data collection Address perceived tensions between data protection provisions and Section 75 data collection requirement in any Information Governance training. p.25 contracts Consider including requirements for providers to collect and report on equality monitoring data as part of contract management and monitoring processes. p.31 awareness raising Consider raising staff awareness of needs of equality groupings through awareness days, building on the blueprint developed for disability. p.31 accessible information Engage closely with individuals and representative groups to agree priorities in providing accessible information, for instance in relation to formats accessible for sign language users.	
Equality Screening / Equality Impact Assessment	N/A



Audit Trail	This report was approved by AMT on 8 March.
Recommendation / Resolution	For Approval
Director's Signature	
Title	Director of Operations
Date	8 March 2016

HSC Public Health Agency

Five Year Review of Equality Scheme

Report

March 2016

Name of public authority

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Edmond McClean Telephone: 03005550114 Email: 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 028 9536 3814

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Chair Chief Executive

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Executive Summary

a) To what extent has your public authority's approved scheme provided a workable basis for mainstreaming the need to promote equality of opportunity and good relations into policy-making over the past five years?

The scheme has proved a reasonably workable basis for mainstreaming equality and good relations in decision-making from the point of view that it covers essential elements of mainstreaming.

The mainstreaming of screening has been progressed across the organisation with, for the most part, service and policy outcomes as a result. However at times, mainly in relation to policies with no or only very minor impacts, the screening process can seem overly procedural and not contribute to better outcomes. In turn, this can impact on staff buying into the process and its ability to advance equality of opportunity generally, as a result.

Successful elements include, for example, the training commitments. They underline the importance of delivering sessions to aid the development of specialist knowledge and skills of staff in actively promoting equality in particular. In practice, the refinement of skills in undertaking equality screenings and equality impact assessments largely takes place on the job.

The rationale for inclusion of certain elements of the scheme is not entirely clear. Thus, for instance, the reason for placing particular emphasis on ensuring and assessing access to services (Section 8 of the scheme), as opposed to all aspects of service provision (that is the quality, experience and outcome of services alongside access issues), is unclear. At times, this has tended to lead staff to exclusively focus on access issues in screening and equality impact assessments.

Likewise, the rationale for placing the requirement on public authorities to develop a programme of awareness raising on the Section 75 statutory duties generally (Section 3 of the scheme) remains unclear.

It seems reasonable to conclude that the good relations part of Section 75 has played a less prominent role than the promotion of equality of opportunity. The organisation would argue that progress in this respect has been contingent less so on the equality scheme itself than on a fundamental caution to move away from the concept of a neutral work environment, given conflicting statutory requirements and the resulting risk of being in breach of these. The organisation would welcome clearer guidance as to the implications for organisations which actively promote the expression and discussion of religious and political identities in light of statutory requirements under fair employment legislation.

Ultimately, the question arises whether the scheme itself adds value to the aim of mainstreaming, given that schemes across many public authorities are largely uniform, driven by the existence of the Commission's model scheme.

In other words, it may be argued that if the legislation itself was to bind public authorities directly into the key elements of mainstreaming, rather than requiring them to develop a scheme that does so, further resources could be freed up to focus on implementation. From a corporate point of view, a diversity strategy and action plan specific to the functions of the organisation could become a more meaningful manifestation and driver for implementation. It could also serve to bring together the range of equality related action plans currently in existence (including under Section 75, the Disability Discrimination Order, The Fair Employment and Treatment Order and others). Experience has shown that the existence of separate plans causes confusion to staff and external stakeholders alike.

b) What key lessons have been learnt over the past five years in terms of effectively implementing the approved equality scheme?

The organisation's experience has shown that a partnership approach together with other HSC organisations supported by a specialist unit allows the pooling of resources, creates economies of scale, enables the delivery of a rolling programme of training and the development of relationships with voluntary sector organisations. Most importantly, it facilitates consistency, joint actions and shared learning.

This partnership approach has also been beneficial to our organisation through easier and more efficient facilitation of regional work across Health and Social Care (HSC) in Northern Ireland, including the 11 partnership organisations and the 6 Health and Social Care Trusts. For example, areas of work that have been progressed across HSC NI include a Trans Employment Policy, an Accessible Formats Policy and the development of a suite of eLearning modules for staff on Diversity, Disability and Cultural Awareness.

The partnership organisations have also facilitated engagement with targeted Section 75 groups as and when required. This approach not only maximises our own resources but has proven beneficial to community and voluntary groups, who have limited resources. In turn, this has enhanced their capacity and willingness to participate.

With regards to training, it transpires that those types of training are most effective which have a practical focus. One-to-one follow on support, in particular as regards equality screenings and equality impact assessments (EQIA), is indispensable. Moreover, sessions should be supported by written information materials (practical, jargon-free guidance) to provide a resource that staff can draw on for their reference.

c) What more needs to be done to achieve outcomes for individuals from the nine equality categories?

The PHA focus on tackling inequalities in health and wellbeing and their close alignment with Section 75 categories means that the Agency's core work produces outcomes for individuals from the nine equality categories on an ongoing basis. Arguably, the ongoing challenge which Section 75 poses to the organisation is the consideration of multiple identities – the diversity within some of the defined target groups. This may include, for instance, the consideration of the particular needs of bisexual people under the category of sexual orientation and the needs of people in the workplace who have a dependant with a disability. Likewise, the work of the Agency will need to continue to be refined on an ongoing basis as the way individuals identify themselves evolves, such as in relation to gender identity.

With regards to particular areas of equality scheme implementation, the review has shown that it may be most effective for the organisation to concentrate further efforts on:

(1) screening and Equality Impact Assessments

(2) monitoring

(3) engagement – using existing structure and processes to engage on equality issues rather than creating additional processes.

1. A general introductory statement specifying the purpose of the scheme and the public authority's commitment to the statutory duties.

1a) To what extent were senior management involved in ensuring scheme compliance over the 5 year period and what further steps could be undertaken to ensure effective internal arrangements?

Prompts – Identify any changes to arrangements for managing scheme implementation, and what were the lessons learnt in terms of enablers and impediments to monitoring scheme implementation?

The equality agenda is led and endorsed by the Agency Management Team (AMT) and the PHA board. The board has played a key role in scrutinising and setting strategic direction. AMT and the responsible director for equality, the Director of Operations, have encouraged and taken forward Section 75 implementation in the organisation throughout the five-year period.

Members of the Agency Management Team (AMT) were involved in a number of ways:

- Annual progress reporting: scrutiny of progress and direction setting for the coming year.
  Over time, arrangements were changed in that the timing was brought forward to Quarter 1 every year, to allow greater impact on direction setting for the coming year.
- Considering and taking action on Equality Scheme issues brought to the team by the responsible Director;
- Chief Executive and Director level engagement with Section 75 representative groups;
- Scrutiny of equality screenings and EQIAs on decisions brought before AMT.

Senior managers played an important role by

- Engaging with Section 75 individuals and representative groups on equality matters;

- Contributing to annual progress reporting by identifying relevant initiatives in their area of responsibility;
- Undertaking quality assurance of quarterly equality screening reports
  Over time, arrangements were changed in that a process was established to ensure regular review of equality screenings by each division.
- Ensuring training attendance of relevant staff;
- Scrutinising and signing off equality screenings;
- Assistant Director level engagement with the Equality Commission at key points.

The Assistant Director of Planning and Operations is a member of the client equality forum convened by the Business Services Organisation's Equality Unit.

Throughout the five-year period the group met formally on a quarterly basis to share good practice in the implementation of Section 75 and to plan joint work. At a strategic level, the Equality Unit has represented clients on regional groups, such as the Equality and Human Rights Steering Group convened by the Department of Health, Social Services and Public Safety (DHSSPS).

Some practicalities of the processes have caused difficulties. Some staff struggle with an annual reporting cycle which takes a number of months to prepare in a large organisation such as the PHA, meaning that effectively, considerable time is spent reporting rather than delivering. Moreover, the new Annual Reporting Template questions do not fully allow the PHA to reflect its work, which causes concern for staff involved in filling out the template.

Looking ahead, the organisation will consider the merits of establishing an internal forum with representation from all divisions or, alternatively, integrating equality more explicitly into the Terms of Reference of existing fora at senior level (such as the Organisational Workforce Development Group). The purpose would be to provide a platform for sharing good practice and encouraging learning.

1b) Outline annual **direct** expenditure of resources to ensure that the statutory duties were complied with, in terms of staff and money over

the past 5 years, and comment on the extent that all necessary resources were allocated.

> *Prompts – Identify costs related to equality unit staff, use of consultants, allocation of budgets to training/publications/ research, extent of in-year bids and/or reallocation of resources. What were the lessons learnt in terms of enablers and impediments to monitoring resourcing? What could the public authority do in future to ensure effective allocation and monitoring of necessary resources?*

In addition to staff time in carrying out screening and EQIAs as well as expenditure on alternative formats, the development of eLearning packages and training, the PHA has in place a Service Level Agreement with the Business Services Organisation (BSO) for the provision of equality and human rights support services, along with 10 other regional Health and Social Care organisations. The Unit employs four members of staff, three at senior level and one administrator. The following table specifies the amount of the annual equality SLA over the past five years:

Year	Expenditure
2011/12	80,457
2012/13	61,070
2013/14	62,591
2014/15	63,500
2015/16	63,840
total	**£331,458**

Overall, the partnership arrangements between the 11 regional HSC organisations have produced significant economies of scale. Examples include the design and delivery of training and good practice initiatives, jointly for the organisations, and holding two equality best practice conferences during the five-year period.

Monitoring the allocation of resources on equality scheme implementation becomes more difficult the more successful mainstreaming is. This applies in particular to the monitoring of staff time, for instance the time spent on equality screening as this becomes an integral part of the policy development process.

2. An outline of how the public authority intends to assess its compliance with the Section 75 duties and for consulting on matters to which a duty under that section is likely to be relevant.

2a) Outline impacts and outcomes (for the public authority and/or individuals from the nine equality categories) over the past five years and what further steps could be undertaken to build on these or address underreporting?

> *Prompt – Were outcomes delivered for all of the nine equality categories? Were annual progress reports critically reviewed before or after submission to the Commission? What examples of good practice from other public authorities could be adopted?*

Outcomes for individuals from the nine equality categories

The purpose of the PHA is to protect and improve the health and wellbeing of the people of Northern Ireland and to reduce health inequalities through strong partnerships with individuals, communities and key public, private and voluntary organisations.

In much of the Agency's work, groupings under the Section 75 categories constitute a key target group. Thus, for instance, within the remit of the PHA Health Protection team, it is evident that childhood immunisation programmes produce direct outcomes under the age category. In a similar way, much of the work by the PHA Health and Wellbeing Improvement team directly targets equality groupings, such as trans people, older people or black and minority ethnic people, to name but a few. It is therefore neither possible to provide a comprehensive list of outcomes achieved for individuals from the nine equality categories over the past five years nor to specify which of these are a direct result of Section 75 implementation.

Evidence of work being taken forward using Section 75 mechanisms that has led to improved services includes the health screening programmes, such as the inclusion of people with learning disabilities in breast screening or improvements in cancer screening in prisons.

Appendix 1 provides a selection of key impacts and outcomes as reported on in the Annual Progress Reviews since 2011-12. It

illustrates the wide range of equality groupings benefitting from the work of the Agency. The information also evidences that the work of the Agency has over time increasingly recognised the importance of meeting needs arising from multiple identities. Thus, for instance, in recent years the needs of older lesbian, gay and bisexual people as distinct from those of younger age cohorts have been identified. Targeted initiatives, such as the 'See Me Hear Me Know Me' guidelines for social care settings, have been designed accordingly. In a similar way, the significance of early years in relation to mental health has led to the development of an Infant Mental Health Framework.

The information in the appendix appears to suggest that overall fewer outcomes have been achieved in relation to the categories of political opinion and marital status. This may in part be due to underreporting as staff do not necessarily conceive of measures targeting health inequalities in deprived Protestant/Unionist/Loyalist communities, for instance, as work which promotes equality under political opinion. The same may arguably apply to marital status in the case of interventions relating to bereavement, for example.

At the same time, scope remains for further progressing the consideration of needs of particular groupings within existing categories, such as the particular needs of bisexual people under the category of sexual orientation, for example, or the needs of people in the workplace who have a dependant with a disability.

The PHA focus on tackling inequalities in health and wellbeing and their close alignment with Section 75 categories means that the Agency's core work produces outcomes for individuals from the nine equality categories on an ongoing basis. Arguably, the ongoing challenge which Section 75 poses to the organisation is the consideration of multiple identities – the diversity within some of the defined target groups. This may include, for instance, the consideration of the particular needs of bisexual people under the category of sexual orientation and the needs of people in the workplace who have a dependant with a disability. Likewise, the work of the Agency will need to continue to be refined on an ongoing basis as the way individuals identify themselves evolves, such as in relation to gender identity.

Sharing learning and good practice across the organisation could play an important role in achieving further outcomes for people under Section 75.

Outcomes for the Public Authority

The PHA's activities to deliver on the Section 75 commitments have also produced benefits for the organisation itself:

- Relationships with the voluntary sector have been developed beyond existing contacts. This has served to gain greater insights into the needs and experiences of diverse service users. Likewise, it has provided the organisation with an opportunity to impart further information on its role and activities with regards to health and social care in Northern Ireland.
- Decision-making has become more robust and transparent through the publication of equality screening templates and EQIA reports, in particular in relation to its equality evidence base and the rationale for actions taken.
- Services and decisions have improved as inclusive development processes have led to needs of service users being addressed better at the planning stage rather than through adaptations later on.

2b) Outline the number of equality scheme related consultation exercises undertaken by your authority over the past five years. Set out the number and percentage related to screening exercises and to EQIAs and indicate the extent that your scheme helped you to engage with external stakeholders?

> *Prompt – Identify your authority's most and least successful means of consultation in relation to s75 categories. Why were some means of consultation more or less successful in relation to particular equality categories?*

Over the past five years, the PHA carried out seven consultation exercises that were directly related to the Equality Scheme. One related to EQIAs and five to equality screenings.

- Equality Scheme and Action Plan
- Future of the Lifeline Crisis Intervention Service – EQIA

- Infant Mental Health Framework – equality screening
- Alcohol and Drug Commissioning Framework – equality screening
- Personal and Public Involvement Strategy – equality screening
- Lifeline Crisis Response Service – equality screening
- Volunteering in Health and Social Care – equality screening.

All screenings that the PHA published in this period were included in quarterly equality and human rights screening reports, collated on our behalf by the BSO Equality Unit. These were issued to consultees with the invitation to comment.

Scope remains, however, for ensuring that all stand-alone policy consultations include the respective equality screening template alongside the consultation document. Accordingly, the Agency will integrate this requirement into internal publication protocols for public consultations.

The Equality Scheme contributed to both widening and strengthening our efforts to engage and consult: the maintenance of a Section 75 master consultation list helped us to include further groups in any mainstream policy consultations. Likewise, equality screenings and EQIAs contributed to identifying particular groupings for engagement.

Face-to-face engagement continues to be particularly effective both in eliciting views and in building relationships with those impacted by what we do. For instance, staff engaging with older people on the City Health Plan in Derry/Londonderry found that it is very important to explain what you are doing and why – then have face-to-face discussions as to how this may impact on older people in their own lives.

Some consultations also showed that an informal setting at an existing event or meeting may be the best approach including reaching minorities whose voices are often not heard.

More recently, the PHA has drawn on social media to offer young people in particular new ways of engaging with the organisation. This has allowed the Agency to reach a wider range of consultees.

2c) Indicate if your list of consultees was amended during the 5 year period and what further steps could be taken to develop your level of engagement and consultation?

> *Prompt - Outline the extent your authority did or did not move away from formal consultation and on what criteria was any such consultation targeted? To what extent were requests to be included and/or objections from those not included in the consultation process received and how were these addressed?*

Over the five-year period, the consultation list was updated on a quarterly basis following the issuing of screening reports. Moreover, any requests by consultees to be added to or taken off the list were acted upon. In addition, new emerging groups were added to the list on a regular basis.

As indicated in the previous section, overall, the organisation moved towards focused engagement to add to inclusive formal consultation.

Looking ahead, both the organisation and consultees would benefit from the tighter integration of equality matters into mainstream engagement structures and exercises rather than being undertaken as stand-alone exercises.

2d) To what extent did your authority consult directly with directly affected individuals as well as with representative groups, particularly in relation to young people and those with learning disabilities, and was this sufficient?

> *Prompt – How effective was your authority at providing feedback to consultees as a result of consultation exercises? What were the lessons learnt in terms of enablers and impediments to consulting directly with affected individuals? What could your authority do in future to provide effective consultee feedback?*

With regards to decisions and policies impacting on staff, the organisation undertook

- direct one-to-one or focus group engagement and consultation with affected staff
  This included examples of staff transfers and restructuring in the context of the Lifeline EQIA.

- consultation with selected staff (representatives of divisions) This included examples of Human Resources policies considered by the Agency's Organisational Workforce Development Group.

- direct engagement and consultation with staff in the development of staff fora, including the LGB&T staff forum and the disability staff forum.

In relation to policies and decisions impacting on service users, in the main the organisation consulted with representative groups. However, direct engagement and consultation with individuals facilitated by representative groups increased, in particular in the context of equality screenings and EQIAs, such as for the Lifeline Crisis Intervention Service.

Furthermore the organisation, facilitated by BSO Equality Unit, undertook direct engagement with a range of representative groups and individuals to inform the development of a Regional HSC Trans Employment Policy as well as the Accessible Formats Policy.

Examples of instances where we directly engaged with children and young people to inform our work include health and wellbeing improvement initiatives for Looked After Children, where we engaged through VOYPIC with care leavers. Likewise, through the NCB we were able to engage with young parents in relation to the Infant Mental Health Framework and the Incredible Years programme.

In relation to engagement with people with a learning disability, the AAA health screening programme serves as an example.

The organisation followed a robust process for providing feedback to consultees after the completion of consultation exercises. Consultation reports are published. For any suggestions that the organisation did not take forward, a rationale was provided.

3. The authority's arrangements for assessing and consulting on the impact of policies adopted or proposed to be adopted on the promotion of equality of opportunity.

3a) Outline and discuss the number of policies your authority subjected to screening over the past five years, setting out the number and percentage of 'policies screened in' on the basis of equality considerations and the percentage 'screened in' on the basis of the good relations duty.

> *Prompt - What were the lessons learnt in terms of enablers and impediments to screening in terms of, screening criteria and priority factors? Are there any other criteria which could usefully be included? What lessons are there regarding responsibility for screening at regional level and subsequent screening of local policy? What could your authority do in future to ensure effective screening arrangements? Set out in an appendix a list of all policies screened out during scheme implementation.*

Over the five year period, the organisation screened a total of 40 policies. The table below provides further details. All these policies can be viewed on the joint screening website, facilitated by the BSO Equality Unit: http://www.hscbusiness.hscni.net/services/2166.htm and will be provided as hard copy on request.

	2011-2012	**2012-2013**	**2013-2014**	**2014-2015**	**2015 (Q1)**	**Total**
Total no of policies	15	8	9	2	6	**40**
Screening Decision 1 (screened in)	0	0	0	0	0	**0**
Screening Decision 2 (screened out with	9 (60%)	7 (88%)	7 (78%)	2 (100%)	4 (67%)	**29 (73%)**

mitigation)						
Screening Decision 3 (screened out without mitigation)	6 (40%)	1 (12%)	2 (22%)	0	2 (33%)	**11 (27%)**

Two Equality Impact Assessments were commenced during the five-year period. As these policies went straight to EQIA, it has been recognised that screening reports have to date underreported policies screened in. This will be addressed in future reports.

The organisation did not screen in any policies on the basis of the good relations duty.

Key factors contributing to mainstreaming equality screenings include:

- designing and implementing assurance processes, such as
  - integration of requirement to provide information on screening as part of submission of AMT and Board papers
  - quality assurance by Directors/Assistant Directors of quarterly screening reports
  - integration of the requirement for all procurement tenders to have been screened before tender publication
- conducting equality screening of the Annual Business Plan with identification of key pieces of work to be screened in-year
- staff training
- availability of a number of specialised resources on screening developed by the Equality Unit
- one-to-one in-depth support and advice by equality professionals.

The experience suggests that at times, blockages persist with regards to finalising screening templates for publication. Thus, considerable screening activities are not always reflected in the number of screenings published.

The full-length screening template has proved burdensome for policies that clearly do not impact on people. In the same way as EQIA reports are only completed for policies likely to have a major impact, full-length screening templates should be reserved for policies likely to have at least a minor impact. The introduction of a shortened template for policies that do not impact on people would address the risk of screenings being perceived as a paper exercise by policy leads. It would also serve to focus resources on areas where screening can make a difference.

It is clear that for policies and decisions which require screening at different stages (for example at design and implementation stage or at tender strategy and specification stage) potential for duplication exists. Revisiting and reviewing previous screening rather than undertaking multiple separate screenings may address this concern.

The organisation has experienced difficulties when evidence of equality screening and EQIA of key policies that are owned by other organisations but which impact on the work of the PHA is not available. This relates in particular to the regional level, such as strategies or policies emanating from the DHSSPS. In many cases this means that, firstly, essential equality data to inform screenings at local or organisational level is missing. Secondly, the lack of screening when the strategy or policy is developed at regional level means that individual organisations do not have the authority to introduce mitigating measures if their assessments show that Section 75 groups are adversely affected by the implementation of the policy.

These difficulties are exacerbated by the fact that key stakeholders impacting on the work of the organisation are not designated under Section 75, including independent contractors.

Looking ahead

Notwithstanding these general constraints posed by the regional level, the organisation recognises the scope for strengthening its own

screening activities. To this end, the Agency will take the following measures:

- Continue to reinforce with staff that equality is one of the first considerations they must give (alongside others) when planning work; that screening is a first step, not an after thought, considered after something has been developed or agreed.

- Close the loop by policy leads ensuring that screening templates are published.

- Revisit the scope for introducing a shortened template for evidencing the screening of policies that do not impact on people to reduce the administrative burden.

In relation to the regional level, the Agency will

- Seek to engage with DHSSPS policy leads on equality issues at consultation stage of strategies and policies directly and through the regional equality and human rights steering group

- Seek to influence others by raising the need for the coordination of screening activities between the DHSSPS and HSC organisations as well as between individual HSC organisations, through the regional equality and human rights steering group.

3b) To what extent did your authority's consideration of the screening criteria **not** identify equal opportunity implications on any of Section 75 categories, but for which consultees then highlighted problems?

> *Prompt –Identify the extent the collection of quantitative and qualitative data informed screening processes. Outline the extent consultations with representative groups produced data to inform the screening process which was not otherwise available to your authority. Outline any difficulties in identifying policies and equality implications using the definition of policy set out in the Guide to the Statutory Duties.*

In relation to screenings that are published as part of quarterly screening reports, the organisation has to date received few comments from consultees. In the main, these were requests for

further information and clarification rather than concerns as to a lack of consideration of particular issues.

The evidence base of screenings of policies that impact on staff has become significantly more robust with the introduction of a new Human Resources IT system, the Human Resources Pay and Travel System (HRPTS). Since then, data on all nine Section 75 groups has been captured and drawn upon.

Summary equality data of our staff is made available to staff undertaking screenings on a quarterly basis.

At the same time, the PHA recognises that the quality of staff data lags behind on some of the groupings. HRPTS relies on staff providing diversity data by means of a self-service. Staff completion rates are particularly low in relation to the categories of dependants, ethnicity, sexual orientation, political opinion, and disability. For this reason, a dedicated campaign encouraging staff to complete the data was scheduled for Quarter 4 of 2015-16.

With regards to data collected to identify impacts on service users, progress has been made for policies that impact on the wider NI population as Census 2011 data became available.

Many equality screenings draw on data identified and collated by the Health Intelligence team such as on prisoners, Lesbian, Gay and Bisexual service users, Trans people, people with mental health conditions, and Travellers.

Efforts to harmonise the collection of ethnic monitoring data across HSC IT systems, driven by the Health and Social Care Board in recent years, should begin to bear fruit in the coming years. It will be essential to roll out region-wide data collection to IT systems beyond those prioritised initially.

Fundamental gaps remain, moreover, as to the collection and collation of equality data at regional level in relation to other equality groups, including on carers and trans people.

Some difficulties appear to arise from a perceived tension on what data organisations can hold on people and what information it would be desirable to hold for Section 75 purposes, due to Data Protection

provisions. Looking ahead, the organisation will consider addressing these concerns in any Information Governance training with a particular emphasis on provisions for personally sensitive data.

As regards data becoming available as a result of consultations, this mainly relates to qualitative data on the needs and experiences of service users.

The organisation would hold that the all-inclusive definition of a 'policy' as set out in the Commission's Guide to the Statutory Duties has over time caused less of a difficulty than initially. This is largely due to awareness raising and training measures.

3c) Outline over the past five years how many EQIAs your authority commenced as a result of i) initial screening and ii) as a result of screening new/revised policies subsequently, and discuss the extent that your authority has become more effective at identifying equality of opportunity dimensions in its policies.

> *Prompt – Were changes made to the screening process? Outline any examples of any changes made to policies to better promote equality of opportunity and/or good relations, rather than to address any perceived differential impact, as a result of screening policies that were 'screened out'?*

The EQIA commenced as a result of the screening of a new decision.

3d) Outline over the past five year period the percentage of your authority's initial EQIA timetable that reached i) stage 6 of the EQIA process i.e. decision making, and ii) stage 7 of the EQIA process i.e. annual monitoring & publication of results, and indicate the extent that your authority has become more effective at progressing EQIAs.

> *Prompt – Explain any slippage that occurred and what was done to rectify it. To what extent did you notify representative groups of this slippage and what was their reaction? What were the lessons learnt in terms of enablers and impediments to monitoring EQIAs?*

At the end of June 2015 no EQIAs had reached either stage 6 or 7 yet.

4. The authority's arrangements for monitoring any adverse impact of policies adopted by the authority on the promotion of equality of opportunity.

4a) To what extent were sufficient arrangements put in place to collect data relating to the nine equality categories to monitor the impact of policies and what could your authority do in future to develop monitoring arrangements?

> *Prompt - What were the lessons learnt in terms of enablers and impediments to monitoring and developing new/additional quantitative data over the past five years. Did your authority consult its own employees or collaborate with other authorities to collect data? Did your authority engage with representative groups to develop monitoring arrangements?*

Appropriate arrangements for monitoring staff impacts of policies were put in place with the introduction of HRPTS (see section 3b).

Likewise, in some divisions robust equality monitoring arrangements have been established in relation to service users. Examples of monitoring undertaken include the range of health screening programmes, such as breast cancer screening and AAA screening, as well as smoking cessation services.

At the same time, the most recent Annual Progress Report evidenced that overall equality monitoring is undertaken in practice only to a limited extent. This may be due to staff not necessarily making the link between monitoring and service improvement, equality and quality.

Looking ahead, the consideration of including requirements for providers to collect and report on equality monitoring data as part of contract management and monitoring processes may lead to a significant improvement of the equality evidence base over time.

The mainstreaming at DHSSPS-level of the requirement for HSC organisations to include equality data in relation to service reporting (including on performance) and the aggregation of such data for Northern Ireland as a whole could serve as a strong driver to progress on equality monitoring.

5. The authority's arrangements for publishing the results of equality impact assessments and of monitoring any adverse impact of policies adopted by the authority on the promotion of equality of opportunity.

5a) Indicate the number of reports published outlining the results of EQIAs and monitoring over the past five years, and outline what your authority could do in future in relation to improving the publication of EQIA results and monitoring.

> *Prompt – Identify the number of reports that were provided in alternative formats. What were the lessons learnt in terms of enablers and impediments to publishing the results of EQIAs and monitoring?*

Over the five-year period, the organisation published one draft EQIA report, outlining the results of the respective EQIA. The report closely followed Equality Commission guidance. The publication of the report was announced by a range of means including:

- an email was sent to all groups and individuals on the organisation's consultation list with details on how to access the reports
- the report was placed on the organisation's website
- the launch of the consultation was announced via social media.

The report was drawn up in accordance with accessibility guidance including Arial Font Size 14, left alignment etc.

The organisation has not published any monitoring reports to date (see Section 4 for further comments).

6. A commitment that in making any decision with respect to a policy adopted or proposed to be adopted by it, that the public authority shall take into account any equality impact assessment and consultation carried out in relation to the policy.

6a) In terms of the number of EQIAs that reached stage 6 (i.e. decision making) to what extent were mitigation measures and alternative policies adopted?

> *Prompt - Outline the extent to which your authority produced EQIAs that did **not** identify adverse impact on any of s75 categories, but which consultees then gave an indication of adverse impact of s75 category and/or proposed mitigation measures or alternative policies.*

Not applicable.

6b) To what extent did consideration of EQIAs and consultations contribute to a change in policy, as opposed to policy decisions which would probably have been made in any event by your authority?

> *Prompt - Set out any key examples. What were the lessons learnt in terms of enablers and impediments to making a decision and taking into account an EQIA and consultation? What could your authority do in future to ensure decision making effectively takes these issues into account?*

Not applicable.

7. The authority's arrangements for training staff on issues relevant to the duties.

a) To what extent were sufficient arrangements put in place to develop and deliver a training programme in accordance with scheme commitments?

> *Prompt - Was the training programme focused on the initial period of scheme implementation or did it effectively cover all five years? To what extent were outside trainers from representative groups used in designing or delivering training?*

Was focused training for staff in management and roles associated with aspects of scheme implementation provided on an ongoing basis?

The PHA and its partners implemented a comprehensive training programme over the five-year period. A training plan was developed on an annual basis jointly by the Equality Unit and all partner organisations, thus ensuring the continuing learning and development of staff in relation to equality, good relations and human rights throughout the period.

The following table gives an overview of the type of training and awareness raising delivered and its timing over the five year period.

Number of staff attending face-to-face training during the five year period by type of session.

	2011-2012	2012-2013	2013-2014	2014-2015	2015 (Q1)
Equality Screening	42	20	11	23	
Equality Impact Assessments				6	
Introduction to Equality Screening			1		
Service Commissioning	45				
Audit of Information Systems Briefing Sessions		8			

Number of staff completing eLearning training during the five year period by module.

	2011-12	2012-13	2013-2014	2014-2015	2015 (Q1)
Module 1 to 4 – Diversity	0	5	4	13	2
Module 5 – Disability	0	4	1	8	2
Module 6 – Cultural Competencies	n/a	0	1	7	3

All training sessions were evaluated on a routine basis. It showed that staff found the sessions effective in meeting the set aims and objectives.

A rolling programme of specialised training was provided on particular aspects of equality scheme implementation including equality screening and EQIAs.

The economies of scale achieved by the partnership arrangements were particularly pronounced in the area of training, allowing the organisation to meet the training needs of staff in a highly cost-effective manner. It also allowed shared learning across partner organisations. This has enabled more staff to avail of face-to-face classroom based training than may have otherwise been the case.

Alongside face-to-face training, considerable efforts were spent on developing eLearning programmes. The Agency produced a dedicated package focusing on sexual orientation and gender identity. Moreover, a series of modules were developed within the Discovering Diversity framework in partnership with HSC organisations. The table above provides details on the number of staff who completed a range of modules within the framework.

In addition, a range of equality topics were featured via CONNECT, the PHA intranet for staff.

7b) Have all staff received awareness training and what could your authority do in future to deliver an effective training programme?

> *Prompt – Does the authority have evidence that over the past five years staff understood their role in implementing the scheme? What were the lessons learnt in terms of enablers and impediments to communication and training?*

Following initial focus on raising staff awareness on the Equality Scheme commitments (including through information materials in easy to understand format) efforts shifted in the later part of the five-year period to raising awareness on needs and experiences of one particular group under Section 75, namely people with disabilities. This was undertaken by a series of awareness days, in the main linking in with international awareness days and weeks.

A core element of this work was to bring in speakers and service users via representative groups.

Given the effectiveness of this format the organisation will seek to build on this in relation to other Section 75 groups.

Moreover, it is envisaged to complement the existing eLearning portfolio by development of a new module on general equality awareness.

8. The authority's arrangements for ensuring and assessing public access to information and to services provided by the authority.

8a) To what extent were sufficient arrangements put in place to ensure and assess public access to information and to services provided by the authority?

> *Prompt - Was an audit of information provision undertaken? To what extent did you provide accessible formats without specific requests? What were the lessons learnt in terms of enablers and impediments to ensuring and assessing public access to information and to services? What could your authority do in future to ensure equality of opportunity in public access to information and to services?*

All Section 75 related documents (including consultation documents, screening reports, correspondence with staff and service users) follow RNIB guidance. This involves, for instance, the use of Arial font size 14 and left alignment.

With regards to other documents, the PHA adopted an Accessible Formats Policy for written information. The policy seeks to ensure that the approach to the provision of information either in written or alternative format is accessible, clear, balanced, fair, transparent and accurate.

It spells out criteria for making documentation available in accessible formats. Within the priority areas as identified in the policy where it is more effective, cost efficient or timely to do so it commits to ensuring that a reasonable alternative is provided.

Staff Guidance provides practical advice. The template policy and guidance was developed and publicly consulted on regionally, with adaptation to organisational circumstances.

Alongside the policy, summary information for staff was developed, as well as a toolkit including a range of support products, such as practical guidance, flowcharts and monitoring databases.

Examples where alternative formats were produced up front included translations of leaflets on immunisations, cervical screening, healthy breaks for pre-school children and newborn blood spot screening.

Looking ahead, it will be vital that staff engage closely with individuals and representative groups to agree priorities in providing accessible information, for instance in relation to formats accessible for sign language users.

Issues relating to access to services were examined in the context of individual equality screenings.

9. The authority's timetable for measures proposed in the scheme.

9a) Outline the extent to which measures set out in the original timetable have been implemented. Any detailed information should be included in as an appendix to the report.

> *Prompt –Update any progress previously reported as underway or delayed. Has a mechanism been developed to report by exception i.e. on specific issues that have not been progressed?*

The PHA implemented the measures that were set out in the original timetable (as per the relevant Appendix in the Equality Scheme) as planned with one exception. This relates to monitoring.

While the audit of information system was completed within Year 1 of scheme implementation, the annual review and publication of monitoring information remains behind schedule.

9b) If your authority was to be reconstituted in the next five years what would be the main scheme actions/equality considerations that

an incoming authority should address? Any detailed information should be included as an appendix to the report.

> *Prompt –Outline what arrangements could be put in place to transfer equality scheme knowledge.*

The PHA would recommend that any incoming authority should pay particular attention to further embedding and mainstreaming work in the following areas of scheme implementation:

- screening and EQIAs
- monitoring.

Particular efforts should be placed on regional cooperation on equality screenings and EQIAs (top down and horizontally) as well as on monitoring.

10. Details of how the scheme will be published.

10a) Were scheme commitments in this section delivered and what evidence supports this view?

The PHA closely followed its commitments for publishing the scheme:

- Systems were put in place for making the scheme available on request in alternative formats. Providers of translation services and services to produce the scheme in further alternative formats (including Braille and formats for Young People) were identified.
- An Easy Read version and an easy to understand summary of the scheme were produced.
- The scheme and its alternative versions were published on the organisation's website.
- Communication on the availability of the scheme was disseminated widely including to consultees.

11. The authority's arrangements for dealing with complaints arising from a failure to comply with the scheme.

11a) Outline the number and nature of complaints received by your authority, and what your authority could do in future to develop its complaints handling process and learn from complaints.

> *Prompt – Outline the nature of complaints and scheme element e.g. screening, consultation. What effect did complaints have on the operation of your scheme?*

A complaints procedure for dealing with Section 75 complaints is set out in the organisation's Equality Scheme. The organisation did not receive any complaints under the terms of Section 75 throughout the five-year period. If any complaints are received under Section 75, they are directed to the organisation's Complaints Manager, who will report and monitor the level of complaints on an annual basis.

12. A commitment to conducting a review of the scheme within five years of its submission to the Equality Commission and to forwarding a report of this review to the Equality Commission.

12a) What has been your authority's experience of conducting this review? To what extent has the Commission's guidance been useful in undertaking the review?

The review has proved a time and resource intensive undertaking. The template contains some 25 main questions plus a further 50 questions as prompts, which overall seems somewhat excessive and unwieldy. A theme-based approach (focusing, for instance, on ownership, equality proofing, monitoring and consultation) rather than following the intricate structure of the guidance on the form and content of Equality Schemes, may be preferable.

At the same time, the review served as an opportunity to hold discussions with senior staff and to jointly reflect on progress on equality matters. This in turn helped to raise the profile of the equality mainstreaming agenda.

Appendix 1: A selection of key impacts and outcomes on Section 75 groups since 2011-12

2011-12

Section 75 Category	Outline change in policy or practice which have resulted in outcomes
Persons of different religious belief	• **Personal and Public Involvement:** Development of PPI Strategy; Regional Service User and Carer Re-imbursement Policy • **HSC Research & Development:** PPI representation on all funding panels with continued support and training for PPI representatives • **Communications – Public and Professional Information:** In addition to campaign demographics religious belief taken into consideration when planning and booking press ads for campaign advertising
Persons of different political opinion	• **Personal and Public Involvement:** Development of PPI Strategy; Regional Service User and Carer Re-imbursement Policy • **HSC Research & Development:** PPI on all funding panels with continued support and training for PPI representatives.
Persons of different racial groups	• **Personal and Public Involvement:** Development of PPI Strategy; Regional Service User and Carer Re-imbursement Policy • **Cancer Screening:** Promotion of screening targeted at BME groups. There may be changes to policy or

	practice with outcomes in 2012/13, depending on the content of the action plan from the Strategy Group workshop. • **Service Improvement: Palliative Care and End of Life Care:** Research among varied BME groups in the UK generally identified different cultural practices relating to death and preparation for burial which required to be sensitively handled by service providers. Bereavement co-ordinators in each Trust are taking forward these issues and developing training for staff and information for those who are bereaved. • **Communications – Public and Professional Information:** Translation of publications into minority ethnic languages Programme for Conference on Minority Ethnic Health and Wellbeing Issues Good practice guide for BME groups
Persons of different age	• **Personal and Public Involvement:** Development of PPI Strategy; Regional Service User and Carer Re-imbursement Policy • **Cancer Screening:** Each cancer screening programme has a stipulated age range who are eligible to access screening. • **HSC Research & Development:** PPI representation on all funding panels with continued support and training for PPI representatives. • **Health and Social Wellbeing Improvement**: Work with HSC Board, Local Commissioning Groups, Trusts, Community, Statutory, Voluntary and Independent partners to ensure the needs of older people are recognised and addressed within the development and delivery of all health promotion/ improvement plans, programmes and services • **Communications – Public and Professional Information:**

	Age specific campaign / publications outputs such as flu, bowel, AAA, mental health
Persons with different marital status	• **Personal and Public Involvement:** Development of PPI Strategy; Regional Service User and Carer Re-imbursement Policy • **HSC Research & Development:** PPI representation on all funding panels with continued support and training for PPI representatives.
Persons of different sexual orientation	• **Personal and Public Involvement:** Development of PPI Strategy; Regional Service User and Carer Re-imbursement Policy • **Cancer Screening:** Promotion of screening targeted at LGB&T groups. There may be changes to policy or practice with outcomes in 2012/13, depending on the content of the action plan from the Strategy Group workshop. • **HSC Research & Development:** Support given to colleagues in PHA re LGBT study • **Health and Social Wellbeing Improvement:** LGB&T workshops, engagement with other sector organisations and establishment of staff Forum • **Communications – Public and Professional Information:** Rainbow banner for Gay Pride Cervical cancer leaflet Mental health TV ad obscured the identity of partner in bed scene so sexual orientation was open to interpretation
Men and women	• **Personal and Public Involvement:** Regional Service User and Carer Re-imbursement Policy

generally	• **HSC Research & Development:** PPI representation on all funding panels with continued support and training for PPI representatives • **Communications – Public and Professional Information:** Gender specific campaign / publications outputs such as bowel/cervical/breast screening
Persons with and without a disability	• **Personal and Public Involvement:** Development of PPI Strategy; Regional Service User and Carer Re-imbursement Policy Development of the Neurological Conditions Network Service User and Carer Research project conducted Establishment of a User and Carer Reference Group • **Cancer Screening:** Promotion of screening targeted at people with a physical or sensory disability groups. There may be changes to policy or practice with outcomes in 2012/13, depending on the content of the action plan from the Strategy Group workshop. • **Service Improvement: Palliative Care and End of Life Care:** Many studies have shown that carer needs are key in many cancer and long term conditions as well as those with palliative and end of life care needs. Again we have asked that carer needs are identified and that specific processes are put in place to give key information and support to families and carers, for example through the implementation of key worker function. • **Service Improvement - Long Term Conditions, Stroke, Diabetes and Infertility Services:** FAST campaign to raise awareness of the signs of stroke to promote early treatment and reduce the impact of a stroke. • **HSC Research & Development:**

	Continued to engage with Bamford Monitoring Group to ensure adequate representation of service users with a learning disability and mental health needs involved in our work • **Communications – Public and Professional Information:** Graphics of disabled children on physical activity record book
Persons with and without dependants	• **Personal and Public Involvement:** Development of PPI Strategy; Regional Service User and Carer Re-imbursement Policy • **HSC Research & Development:** Ensure PPI training sessions held at times convenient to people who are full time carers • **Communications – Public and Professional Information:** Poster encouraging carers of elderly or disabled people to get the flu vaccine Information leaflet for parents and carers on screening patients for pseudomonas Information targeted at parents, eg immunisation

2012-13

	Outline change in policy or practice which have resulted in outcomes
Persons of different religious belief	
Persons of different political	

opinion	
Persons of different racial groups	**Cancer screening:** The Action Plan on Promoting Informed Choice in Cancer Screening notes continued engagement with internal and external groups who represent BME groups - to promote screening and discuss accessibility. The One Stop Shop service for newly arrived migrants is to be utilised to promote cancer screening.
Persons of different age	**Health and Wellbeing Improvement:** Work with HSCB, LCG's Trusts, Community, Statutory, Voluntary and Independent partners to ensure the needs of older people are recognised and addressed within the development and delivery of all health promotion/ improvement plans, programmes and services. **Cancer screening:** Screening targets specific age ranges. Planning has commenced to increase the age range of the bowel screening programme to 74 from the current upper limit of 71.
Persons with different marital status	

Persons of different sexual orientation	**Health and Wellbeing Improvement:** LGB&T workshops, engagement with other sector organisations and establishment of staff Forum. **Cancer screening:** The Action Plan notes continued engagement with internal and external groups who represent LGBT groups - to promote screening and discuss accessibility.
Men and women generally	**Nursing, Allied Health Professions and Personal and Public Involvement:** 'Nurse Prescribing review'
Persons with and without a disability	**Cancer screening:** 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. Review options for simplifying the bowel screening home test. Promote cancer screening through Sound Vision Ulster, radio programme for blind and partially sighted people. Cancer screening information to be available in alternative formats as required.
Persons with and	

without dependants	

2013-14

	Outline change in policy or practice which have resulted in outcomes
Persons of different religious belief	**Health and Wellbeing Improvement** • FLOURISH! A guidance resource to promote mental health and wellbeing and prevent suicide in faith communities. • Work is underway with specified neighbourhoods to improve health and wellbeing through interagency action and community development.
Persons of different political opinion	**Health and Wellbeing Improvement** • 'Shoulder to Shoulder' qualitative research into the health and wellbeing of ex paramilitary organisation members in order to inform programme development.
Persons of different racial groups	**Health and Wellbeing Improvement** • 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 statutory service providers. **Service Development and Screening** • The Action Plan notes continued engagement with internal and external groups who represent BME groups, to promote screening and discuss accessibility.

	• The One Stop Shop service for newly arrived migrants is to be utilised to promote cancer screening.
Persons of different age	**Health and Wellbeing Improvement** • Contribution to the development of OFMDFM's Active Ageing Strategy. • Inclusion of home accident prevention focus in Integrated Care Partnership pathways for frail elderly. **Service Development and Screening** • 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.
Persons with different marital status	
Persons of different sexual orientation	**Health and Wellbeing Improvement** • E learning programme developed and rolled out to HSC Trusts and other regional health organisations. • LGB&T website development underway. • LGB&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.

	• 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. • Healthcare People Management Award submitted for work in partnership with Human Resources and Trades Union organisations. **Health Protection** • Data from the enhanced surveillance of gonorrhoea arrangements were used to inform an information campaign targeted at men who have sex with men. **Service Development and Screening** • The Action Plan notes continued engagement with internal and external groups who represent LGB&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.
Men and women generally	**Nursing and Allied Health Professions** • IMROC • mental health core care pathway **Research and Development Office** • 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. • Training sessions are provided to PPI representatives involved with us on our panels and committees.
Persons with and without a disability	**Nursing and Allied Health Professions** • 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 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. • Implementation of a Direct Enhanced Service in Primary Care to facilitate physical health screening for people with a learning disability **Research and Development (R&D) Office** • 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. **Service Development and Screening** • 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. • 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. • 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.
Persons with and without dependants	**Nursing and Allied Health Professions** • IMROC • mental health core care pathway • 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 brought onto units which may be used to injure visitors. **Research and Development Office** • 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.

2014/15

	Outline new developments or changes in policies, practices, service planning or delivery and the difference they have made.
Persons of different religious	**Operations** • Supporting tables on diversity for Directorate of Public Health conference – published on PHA website for use by the PHA and partner organisations.

belief	http://www.publichealth.hscni.net/sites/default/files/PHA%20Annual%20Report%202013%20-%20Diversity%20data.pdf
Persons of different political opinion	**Operations** • Supporting tables on diversity for Directorate of Public Health conference – published on PHA website for use by the PHA and partner organisations. http://www.publichealth.hscni.net/sites/default/files/PHA%20Annual%20Report%202013%20-%20Diversity%20data.pdf
Persons of different racial groups	**Service Development and Screening** • **Newborn Hearing Screening Programme** Translation of pre-screening information leaflets for parents and a corresponding checklist relating to hearing and speech and language development (in 10 languages). These provide information about the screening programme and help parents, whose first language is not English, make informed choices in response to the offer of screening, as well as provide parents with information about relevant developmental milestones and what to do if they have any concerns that their child is not achieving those milestones. • **Cervical Screening Programme** New translations of the cervical screening programme leaflets were undertaken and are now available for use. It is anticipated that these will support women for whom English is not their first language to make an informed decision on attending for cervical screening. • **Regional Infectious Diseases in Pregnancy Screening Programme** Translation of infection information leaflets into 11 languages to support women who do not have English as a first language. Liaison between Trust antenatal screening coordinators,

	the appointments manager in the Royal Victoria Hospital and interpreters to encourage and support pregnant women to attend hepatology appointments. • **Regional antenatal screening** coordinator inputting into the training for new interpreters through presentations and lectures. • A scoping report into the **maternity needs of black and minority ethnic women in Northern Ireland** was produced by Dr Jillian Johnston, PHA. It was disseminated widely following approval by the Chief Medical Officer. This will inform the development of more tailored maternity care for these women. **Health and Wellbeing Improvement** **(1)Minority Ethnic** • Further development of the Northern Ireland New Entrant Service (NINES) which is working toward providing an holistic service for migrants in the southern area. This service will include health checks, screening, health promotion information and advice on how to access mainstream health and social care services. • A three year regional pilot project to improve the mental health and emotional wellbeing of BME communities has been commissioned. • A regional BME Carers Sub- group, which operates under the auspices of the regional BME Health and Social Wellbeing Steering group, has, in collaboration with the 5 Trusts, produced a regional leaflet (in 11 languages) aimed at BME carers, which is available on the PHA website.

	• In addition, the BME Carers Sub- group in collaboration with Trusts, has delivered networking events during March/April 2015 to help identify BME carers and raise awareness of particular health and social wellbeing issues which impact on BME carers. **(2)Travellers** • PHA has commissioned 6 development posts to provide coordination, capacity and support within the Belfast, southern and western localities to improve the health and social wellbeing improvement of Travellers. The proposed model for the service relates to a key recommendation of the All Ireland Travellers Health Study and a key priority outlined in the PHA/HSCB Traveller Health and Social Wellbeing Forum action plan. The work reflects a commitment toward empowering Travellers and supporting their active engagement in all matters which relate to health and wellbeing. The evidence suggests that one of the most successful interventions with Travellers relates to Traveller Health Workers, connecting families to primary care and other targeted services. The context for focus on the health and wellbeing needs of Travellers is based on the Departmental supported All Ireland Travellers Health Study (2009). This, together with other research, highlights that there are huge disparities in life expectancy and other health and wellbeing outcomes for Travellers compared to settled people. Consequently, addressing improvements in the circumstances in which Travellers live and work, as well as progressing a health improvement agenda with Travellers, is of critical importance. In addition, the HSCB/PHA Commissioning Plan requires that "all Trusts should ensure that existing provision is tailored to meet the needs of vulnerable groups including Looked after Children, LGBT and Travellers." • PHA has also commissioned Belfast Trust/Bryson House Roma Health Project to employ two part time officer posts, one community development officer and one Roma lay health worker. The Project ensured the establishment of relationships within the Belfast based

	Roma and addresses their particular needs through health improvement and promoting access to health and healthcare. **Nursing and Allied Health Professions** • The eHealth and Care Strategy (jointly led by HSCB and the PHA) sets objectives to use technology to support person centred health and social care in Northern Ireland. eHealth technology is a key enabler to support the vital changes in how health and social care is delivered to those groups where language could be a potential barrier to accessing services • The 10,000 Voices Initiative is targeted at men and women generally who have availed of HSC Services. The purpose of the Initiative is to ask patients and clients their experience of the HSC Service they have received in order to shape and inform the design and delivery of future services. Through this survey we ask a range of demographic details (i.e.) gender, age group, ethnicity and sexual orientation. This information is used to ensure that the responses are statistically representative. **Operations** • The Health Intelligence team produced a new Health Intelligence brief on BME census data for PHA staff • Supporting tables on diversity for Directorate of Public Health conference – published on PHA website for use by the PHA and partner organisations. http://www.publichealth.hscni.net/sites/default/files/PHA%20Annual%20Report%202013%20-%20Diversity%20data.pdf

Persons of different age	**Service Development and Screening** • The bowel cancer screening programme was extended to include people up to the age of 74 (previously 71) from April 2014. This has increased access to screening for older people and is expected to increase the rate of earlier detection and successful treatment of colorectal cancers in this group. **Research and Development Office** • Research call on dementia -2nd stage - the aim is to improve the evidence base for service planning and delivery for dementia patients (amongst whom older people are highly represented) and their carers and families – ultimately to address key health and wellbeing needs of these groups across the illness trajectory and in different care settings that currently remain unmet. **Health and Wellbeing Improvement** **(1) Older People** • A range of coordinated interventions and services have been developed to reduce the risk of social isolation among older people in all localities. This attention has included the development of 'Age Friendly' environments with the aim of promoting Northern Ireland as an age friendly region. The Belfast Strategic Partnership has prioritised active ageing and an Action Plan is currently being implemented, based on the active engagement of older people. Age Friendly continues to be supported and progressed in the council areas of Derry/Strabane, Omagh/Fermanagh and Limavady. • The Southern Strategic Health Improvement Partnership (SSHIP) continues to support the

	work carried out in all areas to engage older people through 'community conversation' events. Engagement continues with older people in all areas with the development of Local Implementation Groups (LIG) and development of local action plans to address identified needs. The Newry and Mourne Age Friendly Initiative aims to make Newry and Mourne a welcoming and supportive place to grow older. The priorities and concerns of older people have been the driving force behind an intense year of discussions, consultations, and meetings to shape direction of the initiative. • A broader alliance includes representatives in the southern area from a range of organisations, including Council, the Senior Citizens Consortium, U3A, PHA, SHSCT policing, education, housing, churches, transport, and the voluntary sectors. In the northern area engagement with councils continues through the Northern Area Partnership Framework and Local Government Joint Working Arrangements to influence the development of Age Friendly Communities. • PHA continues to work closely with Alzheimer's Association to plan the roll out of Dementia Friendly communities. • PHA continues to work with Artscare NI to engage older people in arts based activities to promote health and wellbeing. Over 250 workshops and 5 Arts and Health festivals have taken place, with over 3,000 older people participating. • The RIPE exhibition at Crescent Arts Centre Belfast showcased the work of emerging artists over the age of 60 who had come to their artwork later in life. • 'In Full Bloom' showcased over 100 Artworks produced by participants from all trust areas which were displayed in the Ulster Hall in Belfast.

	• 'Aloud, Allowed, Aloud' was the showcase event for all the performance work of the project, music, dance and drama and was staged at the Strule Arts centre in Omagh. • PHA continues to work in partnership with Arts Council NI to deliver the Arts and Older People programme. The strategic themes of the programme are loneliness, social inclusion, poverty, health/dementia and advocacy. As part of this programme some 31 grant awards were made to a variety of projects with 3,178 participants taking part. • The Arts and Older People Programme is also developing a portal and website which can be accessed by carers, artists, people living with dementia and decision makers. The portal will encourage engagement regarding the best way to deliver art and creativity programmes for those who have dementia and will also cite emerging research and evidence in the importance of using of art [as a medium for treatment]. • Funding has been awarded to provide training for community artists to develop skills to work with those who have a dementia diagnosis. This is being delivered in eight different care home settings. • Creative Local Action Response & Engagement (C.L.A.R.E.) programme – the PHA has supported the development of an innovative programme in North Belfast which is a new community-led initiative that aims to build the capacity of local people to support vulnerable adults and older people to live independently in caring and responsive communities, achieving better outcomes for clients, volunteers, the community and HSC. **(2) Young People** • Eight One Stop Shops have been commissioned across Northern Ireland, in Ballymena,

	Carrickfergus, Belfast, Newry, Banbridge, Bangor, Enniskillen and Derry/Londonderry with peripatetic services reaching into the rural hinterlands of these towns. These universal services are based on engagement with young people and services are made more accessible by the use of 'youth friendly' environments. The One Stop Shops target young people aged 11- 25yrs and provide a range of services, support and training to address their needs. • The PHA has been working with the SHSCT and Further Education Colleges to develop sexual health services for young people in college settings. Clinics ran in 3 colleges and in Drumglas 16+ centre and continues to expand and develop with clinics planned for 6 colleges in 2015/16. The services offered include a comprehensive contraceptive, STI testing, information / support and treatment service. • The Strengthening Families Programme continues to be delivered in all five HSC Trust areas and is a parenting programme for 12-16 year olds and their families where alcohol and drug misuse is a particular concern. The 14 week programme uses separate structured sessions for parents and children to allow both to work on parenting and life skills. • Barnardos has been commissioned to provide support for young people experiencing the effect of parental alcohol abuse, as well as family support services in 2014/15. This entailed one to one therapeutic support for young people and parents, group work and residentials for the young people experiencing 'hidden harm'. • In 2014/15 the PHA, in partnership with the Southern Education and Library Board (SELB), provided funding for GCSE support for pupils who were expected to achieve Grade D to help them attain grades A*-C in English or Mathematics. 13 schools availed of the funding. The success of the programme will be determined following release of GCSE grades in

	August 2015. **Nursing and Allied Health Professions** • The eHealth and Care Strategy (jointly led by HSCB and the PHA) sets objectives to use technology to support person centred health and social care in Northern Ireland. eHealth technology is a key enabler to support the vital changes in how health and social care is delivered. For older people the use of technology may support them to live independently. For younger people technology enabled access to HSC resources may be seen as advantageous. • Dementia Strategy – investment into memory services including the recruitment of Dementia Navigators which 1. Enhance the number of memory clinics sessions available. 2. Improve the experience of this group as they navigate through the various statutory community and voluntary services. This should direct people to the correct service in a more timely manner. • The 10,000 Voices Initiative is targeted at men and women generally who have availed of HSC Services. The purpose of the Initiative is to ask patients and clients their experience of the HSC Service they have received in order to shape and inform the design and delivery of future services. Through this survey we ask a range of demographic details (i.e.) gender, age group, ethnicity and sexual orientation. This information is used to ensure that the responses are statistically representative. **Operations** • Supporting tables on diversity for Directorate of Public Health conference – published on PHA website for use by the PHA and partner organisations.

	http://www.publichealth.hscni.net/sites/default/files/PHA%20Annual%20Report%202013%20-%20Diversity%20data.pdf
Persons with different marital status	**Operations** • Supporting tables on diversity for Directorate of Public Health conference – published on PHA website for use by the PHA and partner organisations. http://www.publichealth.hscni.net/sites/default/files/PHA%20Annual%20Report%202013%20-%20Diversity%20data.pdf
Persons of different sexual orientation	**Health and Wellbeing Improvement** • On-going support for the LGB&T HSC Staff Forum continues. A dedicated website www.lgbtstaff.hscni.net has been launched and provides a source of information for LGB&T staff working across all HSC Organisations. In June 2014 the LGB&T HSC Staff Forum won Healthcare People Management Award (HPMA) for work in partnership with Human Resources and Trade Union organisations. The current Chair of the HSC Staff Forum facilitated a workshop at the BSO Annual Equality Conference in February 2015. • The PHA Director of Public Health Report 2013 focused on the theme of Diversity and included key health intelligence relating to Sexual Orientation. • The Public Health Scientific Conference in June 2014 focused on the theme of Diversity and included members of the LGB&T community in the conference planning group and on the conference programme. Three of the parallel sessions focused on specific programmes focused on addressing the needs of the LGB&T community. “Don’t Leave it to chance” – a sexual heath campaign targeting Men who have Sex with Men (MSM) and “See me, hear me, know me”, guidelines to support the needs of older LGB&T people; and the lgbt

	elearning programme http://www.lgbtelearning.hscni.net – “Creating inclusive workplaces”. • The MSc in Public Health included a session on LGB&T Health under the theme of Vulnerable Groups. A presentation on the LGB&T Regional Thematic Action Plan was delivered as well as input from The Rainbow Project relating to Sexual Health programmes. • The PHA has been working with the Rainbow Project and colleagues in BSO to take forward the Diversity Champions Northern Ireland programme. The programme enables organisations to be recognised as having equality and diversity policies and practices on LGB&T issues as well as promoting inclusive workplace cultures. As part of the process a review of all HR Policies, which have been benchmarked against best practice, has taken place as well as training for key personnel from HR and Equality Units within the PHA, BSO and others from across the wider HSC family which was really well received. • An LGB&T subgroup of the Children and Young People Strategic Partnership was established and includes representation from LGB&T sector organisations such as The Rainbow Project, HSC Trusts, HSCB, Department of Education and the Northern Ireland Anti-Bullying Forum. The group, which is chaired by PHA, has developed an Action Plan which includes a range of actions to help address the issues impacting on the lives of young people who identify as Lesbian, Gay, Bisexual and Transgender. • PHA has also worked with professional groups to address the needs of the LGB&T community. In March 2015, the Royal College of General Practitioners NI launched guidelines, one of which was to support the care of Lesbian, Gay and Bisexual Patients in Primary Care. • These guidelines, which were supported by the PHA, involved a number of key

	stakeholders including members of the LGB&T communities such as The Rainbow Project, HERe NI and Support Acceptance, Information, Learning (SAIL). • PHA has commissioned The Rainbow Project to provide a range of services in each PHA locality across Northern Ireland for LGB+T clients, including counselling, information workshops, personal development courses, training courses for service providers, production and distribution of safer sex packs and outreach in clubs and bars frequented by LGB&T people. Furthermore, the Rainbow Project, in the southern area specifically, has: • Provided counselling, group work sessions and personal development courses to individuals who are LGB&T • Distributed safer sex packs to MSM at sites and venues • Provided training for counsellors from within the southern area on Gay Affirmative Therapy and co-cultural counselling • Provided workshops for health professionals on LGB&T Health and Social Wellbeing issues • Provided ‘rapid testing’ for HIV and syphilis for MSM The PHA in the southern area commissioned Positive Life to: • Provide a free confidential helpline and telephone support service for individuals with living with HIV • Provide one to one support and counselling to those affected by HIV on a wide range of issues whether via telephone or in person • Provide a range of complimentary therapy sessions to those affected by HIV

	• Facilitate peer support groups for men and women living with HIV • Provide support programmes for newly diagnosed clients (N.B. HIV is experienced by both heterosexual and homosexual individuals) **Nursing and Allied Health Professions** • The 10,000 Voices Initiative is targeted at men and women generally who have availed of HSC Services. The purpose of the Initiative is to ask patients and clients their experience of the HSC Service they have received in order to shape and inform the design and delivery of future services. Through this survey we ask a range of demographic details (i.e.) gender, age group, ethnicity and sexual orientation. This information is used to ensure that the responses are statistically representative. **Operations** • Supporting tables on diversity for Directorate of Public Health conference – published on PHA website for use by the PHA and partner organisations. http://www.publichealth.hscni.net/sites/default/files/PHA%20Annual%20Report%202013%20-%20Diversity%20data.pdf • The Health Intelligence team updated the Health Intelligence brief on Lesbian, Gay and Bisexual people for PHA staff.
Men and women generally	**Service Development and Screening** • A scoping report into the **maternity needs of black and minority ethnic women** in Northern Ireland was produced by Dr Jillian Johnston, PHA. It was disseminated widely

	following approval by the Chief Medical Officer. This will inform the development of more tailored maternity care for these women. **Health and Wellbeing Improvement** • In March 2015 the Royal College of General Practitioners NI launched guidelines to support the care of Trans* Patients in Primary Care. These guidelines which were supported by the PHA involved a number of key stakeholders including members of the Transgender community and the Gender Identity Clinic. • The MSc in Public Health included a session on LGB&T Health under the theme of Vulnerable Groups. A presentation on the LGB&T Regional Thematic Action Plan was delivered as well as input from the Gender Identity Clinic which included developments rerating to services to support Gender Variant Children and Young People and Transgender adults in Northern Ireland. • On-going support for the LGB&T HSC Staff Forum continues. A dedicated website www.lgbtstaff.hscni.net has been launched and provides a source of information for LGB&T staff working across all HSC Organisations. In June 2014 the LGB&T HSC Staff Forum won Healthcare People Management Award (HPMA) for work in partnership with Human Resources and Trades Union organisations. The current Chair of the HSC Staff Forum facilitated a workshop at the BSO Annual Equality Conference in February 2015. • The PHA Director of Public Health Report 2013 focused on the theme of Diversity and included key health intelligence relating to Gender Identity. • The Public Health Scientific Conference in June 2014 focused on the theme of Diversity and included members of the LGB&T community in the conference planning group and on

	the conference programme. Two of the parallel sessions focused on specific programmes focused on addressing the needs of the T community alongside the LGB community: "See me, hear me, know me", guidelines to support the needs of older LGB&T people; and the lgbt elearning programme – "Creating inclusive workplaces". • The PHA has been working with the Rainbow Project and colleagues in BSO to take forward the Diversity Champions Northern Ireland programme. The programme enables organisations to be recognised as having equality and diversity policies and practices on LGB&T issues as well as promoting inclusive workplace cultures. As part of the process a review of all HR Policies which have been benchmarked against best practice has taken place as well as Training for key personnel from HR and Equality units within the PHA and BSO and others from across the wider HSC family which was really well received. • An LGB&T subgroup of the Children and Young People Strategic Partnership was established and includes representation from LGB&T sector organisations SAIL, HSC Trusts, HSCB, Department of Education and the Northern Ireland Anti-Bullying Forum. The group, which is chaired by PHA, has developed an Action Plan which includes a range of actions to help address the issues impacting on the lives of young people who identify as Lesbian, Gay, Bisexual and Transgender. • Furthermore, the Rainbow Project in the southern area specifically, has provided counselling, group work sessions and personal development courses to individuals who are Trans (alongside those who are lesbian, gay or bisexual). Likewise, workshops have been provided for health professionals on Health and Social Wellbeing issues for Trans people, alongside those who are lesbian, gay or bisexual.

	Nursing and Allied Health Professions • The 10,000 Voices Initiative is targeted at men and women generally who have availed of HSC Services. The purpose of the Initiative is to ask patients and clients their experience of the HSC Service they have received in order to shape and inform the design and delivery of future services. Through this survey we ask a range of demographic details (i.e.) gender, age group, ethnicity and sexual orientation. This information is used to ensure that the responses are statistically representative. **Operations** • The Health Intelligence team updated the Health Intelligence brief on Trans people for PHA staff. • Supporting tables on diversity for Directorate of Public Health conference – published on PHA website for use by the PHA and partner organisations. http://www.publichealth.hscni.net/sites/default/files/PHA%20Annual%20Report%202013%20-%20Diversity%20data.pdf
Persons with and without a disability	**Service Development and Screening** • Ongoing progression of an initiative to ensure learning disabled men who are eligible for screening are able to make an informed decision about whether or not to attend for screening. Too early to report on final outcomes at present. • Production of Audio CDs and braille versions of initial screening invitation leaflet and the three screening results leaflets on NI Abdominal Aortic Aneurysm Screening Programme website for men with a visual impairment. In process of identifying a mechanism for

establishing impact of initiative.

- A new alternative pathway was introduced into the bowel cancer screening programme for people with a visual or physical disability. The alternative pathway seeks to simplify as far as possible the sample collection method required with the home test kit for those who may have reduced visual acuity or dexterity. The pathway involves the use of two kits and fewer samples. A new leaflet has been developed to support the pathway.

- New patient information videos were developed for the cervical and bowel cancer screening programmes to promote informed choice. The videos explain the screening pathways and are available in subtitled and sign-language versions to improve access to information for those with a hearing impairment.

Research and Development Office

- Research call on dementia – 2nd stage-the aim is to improve the evidence base for service planning and delivery for dementia patients (who fall under the definition of disability) and their carers and families – ultimately to address key health and wellbeing needs of these groups across the illness trajectory and in different care settings that currently remain unmet

Health and Wellbeing Improvement

- The Regional Health and Social Wellbeing Improvement Forum (one of three work-streams of the Regional Learning Disability Health Care and Improvement Steering Group) has developed a 2 year work-plan to deliver / implement on the Health & Social Wellbeing

	Improvement recommendations and actions contained in the regional Learning Disability Health Care & Improvement Steering Group's Action Plan. The Regional Health & Social Wellbeing Improvement Forum's Action Plan was approved by the Regional Learning Disability Health Care and Improvement Steering Group in July 2014. Examples of Impacts, Outcomes and Good Practice include: • 80% of Health Facilitators across the five Trusts received Smoking Cessation Brief Intervention Training by 31 March 2015. The training of the remaining 20% in this area is planned for the April – June 2015. • The Step by step for health, fitness and fun walking booklet for people with a learning disability was published by the PHA in March 2015. 1000 copies of the booklet have been sent to each of the Physical Activity co-ordinators in the Health & Social Care Trusts. • The 'Cook It' programme was adapted and a resource guide developed for those with learning disabilities by the PHA in 2014/15. The practical tool kit provides training for tutors and includes recipe cards in user friendly formats. These will be available from April 2015. • 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. • 'On Yer Bike' programme funded to allow Cedar Foundation to support people with differing disabilities and needs aged between 16-65 years, to get involved in accessible cycling. • 'Learn to Cycle' programme funded to enable Autism Initiatives to create an opportunity for children aged 5 - 15 years old with a diagnosis of ASC to participate in an innovative Autism specific "Learn to Cycle" programme. As part of Active Schools programme, Autism

	Initiatives NI provided training to Sustrans staff who deliver the programme currently in 120 primary schools. The PHA is represented on the Health and Social Care Board led Physical and Sensory Disability Strategy Group, to progress initiatives which relate to the objective 'Examine how disabled people can be targeted in future health promotion initiatives'. Action has included: • The PHA has a contract with Action on Hearing Loss in partnership with HSCB. Campaigns that have been taken forward during 2014/15: o 'Damage' campaign. This is designed to raise awareness among young people of the dangers of overexposure to loud music and the consequences for their hearing. This includes a social media campaign and engagement with relevant digital platforms – due to complete in May 2015. o 'Isolation Campaign'. This outdoor poster campaign was delivered through billboards and adshels throughout N.I. and encouraged people with unaddressed hearing loss and their families to take action to address their hearing loss. A local radio advertising campaign also accompanied this through local stations throughout Northern Ireland. The disability checklist continues to be a work in progress. It is intended that the development of a checklist/screening document which will act as a prompt for anyone planning a health resource/campaign etc – to ensure that the needs of people with physical and sensory disabilities have been taken into consideration. A wide range of HSC documents pertaining to accessible communication accessible formats and portrayal of people with disabilities are in existence and are located in a range of

	different departments and organisations. Early discussions are underway to develop a portal so that these documents (which include publications such as 'Making Communication Accessible' and 'Guidance on the positive portrayal of Disabled People') can be put into the one accessible place. **Nursing and Allied Health Professions** • The 'implementing recovery through organisation change' programme in mental health has resulted in changing day to day interactions and quality of service user experience through:- 1. the development of mental health service team recovery implementation plans 2. redefining service user involvement 3. the establishment of recovery colleges in every Trust area using a hub and spoke model 4. delivering comprehensive user-led education and co-produced training programmes 5. transforming the workforce, by the establishment of 18 posts for people with lived experience as peer support workers in acute in patient and community mental health teams. • The eHealth and Care Strategy (jointly led by HSCB and the PHA) sets objectives to use technology to support person centred health and social care in Northern Ireland. The aim is to enhance the care and support given to those people with disabilities and their carers and families care through the use of enabling technology. • Direct Access Physiotherapy. The aim is to enable patients to self-refer for musculoskeletal conditions. This has Positive impacts for people with a disability who will be able to access

	physiotherapy. **Operations** • Supporting tables on diversity for Directorate of Public Health conference – published on PHA website for use by the PHA and partner organisations. http://www.publichealth.hscni.net/sites/default/files/PHA%20Annual%20Report%202013%20-%20Diversity%20data.pdf • Website development reflects best practice in relation to accessibility, eg sub-titles for online videos **Health Protection** • Production of a suite of patient and visitor information leaflets in alternative formats. There were nine leaflets in total: Hand Hygiene, Healthcare Associated Infections, Extended spectrum beta lactamase (ESBL) bacteria, Multi-drug resistant bacteria, Scabies, Laundry advice, Norovirus, Clostridium difficile and MRSA. These are all available in accessible formats. Accessible formats are alternatives to printed information, used by people who are blind or visually impaired. These accessible formats include HTML, audio and braille.
Persons with and without dependants	**Research and Development Office** • Research call on dementia –2nd stage- the aim is to improve the evidence base for service planning and delivery for dementia patients and their carers and families – ultimately to address key health and wellbeing needs of these groups across the illness trajectory and in different care settings that currently remain unmet

	Nursing and Allied Health Professions • The eHealth and Care Strategy sets objectives to use technology to support person centred health and social care in Northern Ireland. The aim is to enhance the support for those people with dependents using technology and improving information with HSC. **Operations** • Supporting tables on diversity for Directorate of Public Health conference – published on PHA website for use by the PHA and partner organisations. http://www.publichealth.hscni.net/sites/default/files/PHA%20Annual%20Report%202013%20-%20Diversity%20data.pdf

Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	16 March 2016
Title of Paper	Infant Mental Health Framework
Agenda Item	10
Reference	PHA/03/03/16

Summary

The Infant Mental Health Framework represents a commitment by the Public Health Agency, Health and Social Care Board and Trusts, as well as academic, research, voluntary and community organisations across Northern Ireland, to improve interventions from the ante-natal period through to children aged 3 years old. The Framework aims to ensure that commissioners and policy makers are fully informed of the latest evidence and interventions and are supported to make the most appropriate decisions based on this knowledge. This Framework aims to provide practitioners across a wide range of health, social care and education disciplines with the skills to support parents and children aged 0-3 in the development of positive infant mental health. The Framework has been the subject of an extensive engagement and public consultation process; engagement has involved parents, practitioners, policy makers, young people and a wide range of stakeholders across the statutory, voluntary and community sectors. Over 30 formal submissions were received from a wide range of organisations through the formal consultation response. (see separate consultation summary document).

The following key themes were noted throughout the responses:

- General support for the framework and agreement that a focus on IMH is timely and much needed.
- Agreement that the priority areas are in general appropriate, with additional suggestions (impact measurement and special/additional needs proposed as separate priority areas).
- Increased involvement of community & voluntary sector and programmes and services already in existence, and acknowledgement of the experience and skills currently in the sector.
- Need for clear monitoring and evaluation protocol with measurable, SMART outcomes
- Need to strengthen the overarching focus needed on ‘whole child’ ecological theory
- Confirmation needed on financial resources for supporting key actions – Sustainability
- Capacity building of core services needed to deliver core HCHF programme before looking wider

- Ongoing need for joined up, multi-disciplinary approach with connectivity across departments. Integrated planning, service delivery and funding is key.
- Need for inclusivity and equality for all (including geographical location, special needs etc)
- Call for a much wider involvement of range of practitioners including allied health professionals (for example Occupational Therapists, Speech & Language Therapists), GPs, psychologists, psychiatrists, voluntary & community sector practitioners.
- Clear links needed between CAMHS and adult mental health services, including perinatal pathway
- Good recognition of support for practitioners and services at steps 1 & 2 however development of specialist services is as important, as is workforce development for those with need for a higher level of IMH skill/knowledge
- Services must be informed by service users and practitioners experience, rather than just 'global evidence'
- Framework now needs a clear implementation plan
- Education must reach wider than parents and practitioners. Widespread public awareness campaign is central to dissemination of IMH messages, with a focus on developing a common language for parents, practitioners and policy makers around IMH
- Support for evaluation of local programmes and services in local context, rather than emphasis on manualised global programmes with no local evidence base
- Lack of data available to understand the problem
- Must push for a focus on support for fathers.

Revised Plan

The Revised Document/Framework has incorporated and acknowledged and incorporated many of these themes and issues in the revised Plan and highlighted an Implementation process, including the production and review of an annual Action. The prioritisation of actions and progress will be informed by the available resources particularly on expansion of maternity mental service and full implementation of the perinatal mental health pathway and Healthy Child, Healthy Future.

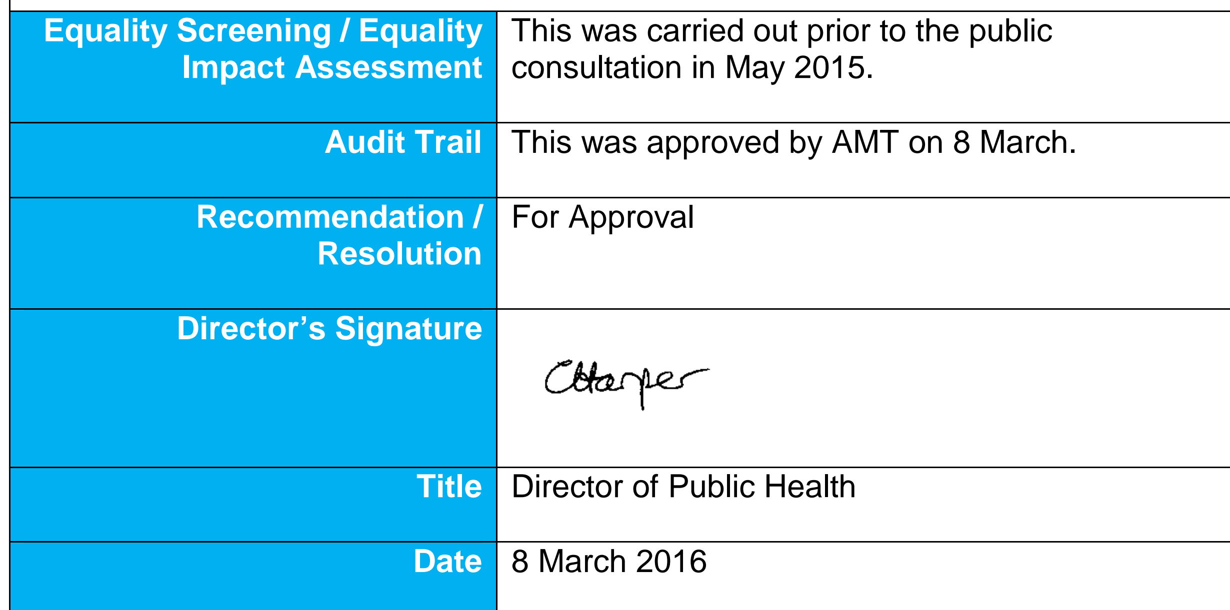
The proposal is consistent with and supported by the Making Life Better Themes 1 and 2: 'Giving Every Child the Best Start in Life' and 'Equipped throughout Life'

Key long term outcomes:

- Good quality parenting and family support-**One of the specific Actions and Commitments listed relates to the implementation of this Infant Mental Health Plan**
- Healthy and confident children and young people
- Children and young people skilled for life.

Improving long-term outcomes for the whole population begins with ensuring that every child has the best possible start in life, with a focus on ensuring that children who are the most vulnerable and at risk are especially supported. There is now a wide body of evidence which demonstrates that disadvantage for some children

starts before birth and accumulates throughout life. Consequently this Framework considers actions required during pregnancy and up to three years, maximising potential for early intervention. The promotion of positive infant mental health and wellbeing is a cornerstone of this Framework as protecting and nurturing mental health in childhood contributes to productive social relationships, effective learning, and good physical health throughout life.



Equality Screening / Equality Impact Assessment	This was carried out prior to the public consultation in May 2015.
Audit Trail	This was approved by AMT on 8 March.
Recommendation / Resolution	For Approval
Director's Signature	CHarper
Title	Director of Public Health
Date	8 March 2016

Supporting the best start in life:
Infant Mental Health Framework and Action Plan 2015-2018

Promoting positive social and emotional development from pre-birth to 3 years

Summary of consultation responses
NCB NI
September 2015

Working with children, for children

The process so far:

To date the following activities have been undertaken to inform this regional Infant Mental Health Framework and Action Plan:

- Audit Phase 1 (June 2012) & Gaps analysis (Sept 2012)
- Audit Phase 2 (September 2013)
- Stakeholder engagement (June 2010 – September 2014)
- Case study visit to Finland (September 2013)
- Regional Infant Mental Health Planning Group (ongoing)
- Regional Infant Mental Health Reference Group (ongoing)

Formal consultation period (March 2015 - May 2015)

The draft framework and action plan was released for public consultation via the Public Health Agency website. The following dissemination activities took place throughout the consultation period:

- Promotion via PHA and NCB NI websites
- Promotion via social media (PHA & NCB Twitter, facebook)
- Email circulation to internal PHA, HSCB and Trust groups
- Email circulation to wide range of interested voluntary/community/statutory contacts via NCB circulation list
- Inclusion on NICVA, Youthnet, Community NI websites and e-newsletters
- Inclusion on Chambré Public Affairs consultation alert email
- Shared via Parenting NI with Parent Forum members (and via Parenting NI facebook page)
- Email circulation to all Sure Starts across NI
- Focus groups held with 6 parent groups in various Sure Starts across NI, at least one per Trust area, and including 56 parents.
- Focus group held with Young NCB ‘Young Parents Matter’ group (5 participants)
- Presentation to Children in NI

Update on consultation responses

33 formal consultation responses have been received from:

- A wide range of voluntary/community sector organisations
- Health and Social Care Trusts
- Health and Social Care Board
- Royal Colleges
- British Psychological Society
- British Association for Counselling and Psychotherapy
- Individual responses

See appendix 1 for a full list of respondents

The way ahead

The following timeline provides details of the analysis and redrafting process:

- Thematic analysis of responses by NCB NI using NVivo (a qualitative software package used to support analysis of large volume of text-based information) and initial redrafting of Framework **(by end August 2015) – full report complete and summary report produced**

- Presentation to the IMH Planning and Reference groups highlighting key themes arising from the consultation for discussion **(August 2015) – opportunity to sense check and feedback**

- Presentation of key themes and implementation plans to Child Development Project Board **(September 2015)**

- Redrafting of IMH Framework and presentation to PHA AMT for approval **(September - November 2015)**

- Launch of final IMH Framework **(January 2016)**

- Identification of implementation group and development of implementation framework for roll out of key actions (**Early 2016)**

Summary of parent group consultations: key themes

Parent focus groups were held in Sure Start venues across each Health and Social Care Trust area. Parents were attending a range of groups, including a Portuguese support group, Cook It class, Incredible Years Programme, Nurture Programme, Breastfeeding Support groups and baby drop in centre. In addition, a focus group was held with Young NCB Young Parents group.

Parents were asked their thoughts on the following:

- What does Infant Mental Health mean to you and where have you received any information on IMH from?
- What services did you find particularly useful in the antenatal period and in particular supporting good infant mental health?
- What do you think would be the most useful methods of communication if we wanted to disseminate messages on infant mental health?

The following provides a summary of key themes raised.

Infant Mental Health definition	Most and least useful services in supporting IMH	Dissemination strategies for IMH messages
Mostly respondents had never heard of IMH however felt that it had a negative meaning and would be a barrier to getting parents interested. WHSCT were noted as having a particular focus on IMH and some had attended an information day in Altnagelvin, while others had attended a Sure Start talk from a student. On discussion, most understood the definition and had heard of attachment/bonding. Most were able to talk about positive behaviours such as skin to skin contact (particularly emphasized straight after birth in most	There was a notable difference in available services across NI; even though focus groups were held in Sure Starts, each had a very different range of options. Sure Start services in general were thought to be extremely helpful. Since all but one focus group took place in a Sure Start, this is to be expected, however several of the groups (mostly breastfeeding support groups) had attendees who were not actually living in Sure Start areas and therefore were only eligible to attend a few groups. They expressed disappointment that they weren’t able to attend other Sure Start services and noted a lack of support outside of	Mixed experiences of using apps, social media, YouTube etc. Mostly more competent parents who had time to use these and not considered useful primary source of information. Messages received from a wide range of practitioners and messages often differed from person to person. Written materials confusing, in particular for those where English isn’t the first language. Green folder in particular found to be very medical in terminology and no translations available for it or other key sources of

hospitals), eye contact, talking to and singing to baby, however weren't necessarily aware of the link between these actions and positive IMH. Different sources mentioned re learning about these behaviours, including family (mostly mother) and friends or television. Most didn't recall getting information on IMH/attachment from healthcare professionals, aside from a few who mentioned that they had had a particularly helpful and knowledgeable midwife or health visitor. Several also said they got information at various Sure Start groups and activities. A few people mentioned the purple pregnancy book and other bits and pieces of literature, while others said that these behaviours are instinctive and they didn't need to be 'taught'.	Sure Start (other than paid places in private activities) Several parents reported finding out by accident what SS services were available and in only a few cases had these been actively promoted by midwife, health visitor or other health professionals. Differing experiences of universal services noted (health visitors, midwives) • Some found midwife & health visitors caring, helpful and knowledgeable while others found them less so • Some had no consistency, seeing several different practitioners therefore were unable to build relationships • Midwives and health visitors sometimes reported as patronising or dismissive (particularly a concern for those mothers where English was not their first language). • Lack of consistency noted in messaging from different practitioners. Support for breastfeeding varied widely across NI • Some received peer support and encouragement, including access to a text helpline • Sure start breastfeeding groups thought to be particularly good	information. (Individual Sure Starts provide selected translated info) Green and purple books felt to be most useful for disseminating information, too many other flyers and they mostly were put in the bin. Green book however given out too late and no time to read it when baby here. Most would rather have professional, one to one practical support rather than written info or advice from chatrooms, forums, newsletters etc. Mixed thoughts re Baby centre newsletters and similar – milestones made some feel guilty that their baby wasn't reaching 'expected' targets; others found the information contradictory to advice from health professionals. Parents mostly reported negative experiences of Parentcraft classes – they said the focus was on birth and labour and dads felt quite uncomfortable. Others said they were too late in pregnancy and weren't able to attend. Classes also only available for first time mums – 2nd time mums weren't able to attend even if their first baby had been quite some time ago.

	• Others were discouraged if they weren't able to feed straight away • Hospital practitioners in particular thought to be too busy and dismissive Lack of support noted for dads, who for many reasons can be left in charge of baby in early days (eg mother experienced particularly traumatic birth or had a caesarean) Lack of support noted for postnatal depression (and in particular for dads when partner is suffering)	Agreement that healthcare professionals, in particular GPs, midwives and health visitors, were in best position to provide support and information, however extra capacity needed to allow continuity, and agreement on a common message from all. Opportunities for peer support also much needed as many parents reported feeling isolated.

Belfast Health and Social Care Trust parent survey: summary of findings

In a separate but very relevant piece of work, the Belfast Infant Mental Health and Wellbeing Project working group widely distributed a questionnaire and carried out 15 focus groups with parents at Sure Start and some other groups across Belfast, aiming to give parents a say in what they thought helped them to attach securely to their babies. The following provides a summary of key findings:

Most important/positive supports during pregnancy:	• Partner • Parents • Other family, friends • Sure Starts, crèche, Home Start, • GPs, midwives, health visitors, family centre Some parents had no support, particularly BME who use phone or Facetime to get advice from parents/family in other country
Sources of information	24/34 respondents felt the information they received prepared them for parenthood (however it was more practical preparation rather than emotional preparation) Useful sources of information include: • Breastfeeding DVD and booklet • Bounty packs • Pregnancy book Concerns include: • Differences in Parentcraft noted across hospitals (interestingly even just across BHSCT) • Information from different sources conflicting • Focus on severe PND rather than 'baby blues' • No translated versions of key written information • Need to balance practical preparation with emotional preparation
Most rewarding aspects of being a new parent	• Joy of witnessing their child reach developmental milestones • Praise from 3rd parties • Seeing a first smile • Others said they loved everything
Most challenging aspects of being a new parent	• Lack of sleep • Worries about 'getting it right' • Breastfeeding • Juggling routine with other commitments • Financial implications • Physical or learning difficulties
Help with bonding	• Sharing experiences with other parents • Most felt more help could have come from medical professionals

	• Peer support groups would help • Family support is often enough • Earlier dissemination of information re groups available would have helped • Breastfeeding support often lacking • Practical support needed • Isolation a particular issue for BME mothers
Thoughts on services	• Mixed feelings on key practitioners • Some individual good experiences re midwife or health visitor (particularly where same practitioner had been there throughout) • Lack of capacity of health visitor and lack of continuity an issue • Some midwives treating mums with lack of empathy, roughly or dismissively • Sure Start breastfeeding groups particularly good • Conflicting advice from different professionals • Positive comments re skin to skin contact and actively promoted • Reassurance needed for those who aren't able to breastfeed • Health visitors in Sure Starts provided more positive experiences, while others stated they didn't actually see a health visitor • Assessments not happening or happening late • BME mothers reported not having interpreter so couldn't see a health visitor • GP generally good but no information or support given re bonding
Other services used include:	• Speech & language therapists, Royal Children's hospital, disability social workers • Sure Start services including baby massage, crèche etc good & supported bonding • Those not in a Sure Start area noted price of such activities • Half of parents attended antenatal courses and generally agreed they helped with bonding, but they are different in each hospital • Mellow Bumps provided in some Sure Start groups and found them useful • Groups also helped alleviate isolation and therefore fear
Additional support required	• Affordable childcare • Wider Sure Start access • More organised parent-toddler groups • Wider support for breastfeeding • Too much information at antenatal classes and should be targeted • Financial support • Higher capacity for core professionals eg health visitor

Summary of consultation responses: Key themes

Responses have been analysed by theme using the NVivo qualitative analysis package and recorded in a comprehensive consultation report. The following summary document provides an overview of key themes and comments emerging under each section of the report. In addition, a summary of recurring themes right across the document has been included at the end of the table.

<table>
<tr><th></th><th>Key themes arising from comments</th></tr>
<tr><td>Vision and outcomes</td><td>
100 % of respondents welcomed the IMH vision and framework document as a concept .
"….warmly welcomes the development of the IMH framework and commitment to multi agency working to ensure its success" VOL sector
"….agree with the vision that all children have the best start in life and the objectives listed" Vol sector
"this is a very positive step, the focus should be from the antenatal period through to age three and IMH is considered everybody's responsibility" Education rep
"We commend the cohesive approach within the plan of joint working through an education and practice model " Health Trust
"We welcome and broadly endorse the PHA IMH framework" Vol sector
"We welcome the increased focus on ensuring the best start possible for children and families is further developed in the early years sector" Health Trust
" the definition of IMH correctly recognises that IMH is inextricably linked with parents and carers"
"The vision is excellent and indeed the whole document is to be welcomed and applauded. It is a credit to those that have contributed to the process" individual response
"..we very much welcomes the Framework and its ethos. Understanding the impact of early childhood experiences is essential and we look forward to supporting this vital work as it progresses." Vol sector
Summary of additional feedback:
Need to incorporate a regular monitoring and evaluation process – impact measurement process should be explicitly stated and linked to measurable objectives
</td></tr>
</table>

	• Must strengthen the need for joined up approach and commitment right across departments including CYPSP • Must continue to acknowledge the experience within the sector, stat and vol and utilise this in the implementation of the framework • Vision must be inclusive of ALL children and young people including those with a disability or special needs, members of minority groups • Must also recognise particular needs and difficulties of parents who have special needs • Clearer statement needed of Ecological approach with the child at the centre- important to recognise the social/cultural context specific to NI and the impact this may have on parenting and/or child outcomes • Objective missing around involvement of parents in service development • Need a clearer statement on definition of framework and intended purpose • Consideration should be given to accessible versions of final framework, including one for parents • Ideally a much wider range of practitioners should be included in the framework eg speech & language therapists, occupational therapists, GPs, early years education practitioners • Parents and practitioners need practical support alongside skills development– they must have the capacity to implement the skills they are taught • Need to acknowledge that parents and practitioners need very different skills. Practitioners at different levels and in different roles also have differing needs in terms of skills and this should be clarified. • Good focus on universal services however needs to clarify 'universal' services and the core staff targeted • Physical and cognitive development too as is inextricably linked eg role of speech and language in attachment (evidence examples given)
Priority areas	**Three priority areas were highlighted in the framework and action plan:** **1. Evidence and policy** **2. Workforce development** **3. Service development** The majority of consultees agreed with these broad priority areas

	"..we broadly agree with the priority areas.." *Vol sector* ***" the three priority areas in the action plan and framework are imperative in ensuring key objectives are made "****Statutory org* ***"..welcomes the consideration of all of these areas and believes that it is essential to ensure strong work foundations by embedding the work in evidence and policy before going towards the development of the workforce and services "*** *Statutory Health Organisation* ***" these are clearly crucial areas for ensuring a more joined up approach to addressing IMH and essential components for delivering the vision for IMH"*** **Summary of additional feedback** • Although included in the evidence and policy section, may want to consider a separate priority for increasing public awareness of the importance of and factors affecting IMH – this was a common theme across many responses • Children and young people with additional needs should be addressed as a standalone priority • Joined up approach is central so perhaps an explicit statement of how a collaborative approach will be taken across departments should be a sole priority area • Should add an objective around better understanding need (gap in availability of data) • Impact measurement should be included as a separate priority area • Safeguarding and risk management as a separate priority?
Evidence and policy: key challenges	**The framework commits to ensuring that policy, practice and service development are informed by the most up to date evidence on child development and infant mental health.** **Q. What do you consider the main challenges to be in addressing this priority area?** **Summary of feedback:** • Need to agree a common language that is accessible to policy makers, practitioners and parents. Currently doubt as to how relevant 'IMH' is. Consistency needed right across NI and across departments and services. • Good acknowledgement that IMH is everyone's business. • Mismatch between parents' needs and what the evidence tells us they need. Framework must include close collaboration

	with parents and mechanism for their feedback to shape services. • Comments highlight a need to move away from manualised American programmes to consider our own 'home grown' services, or to ensure that local delivery can be evaluated. Important to consider unique local context and legacy of troubles. Bias noted in terms of favouring RCTs and Allen report which is now considered 'out of date'. • Lack of disaggregated data available on local context, and in particular for children or parents with a disability. • How will this work be funded? How will PHA ensure sustainability, in particular keeping up to date with emerging evidence across a range of fields and disseminating this appropriately? • More details needed on dissemination strategies – particularly for those with additional needs (other languages, deaf/blind-accessible, and literacy barriers) and how to ensure consistency. No mention of use of new technologies • Learning the theory is not in itself useful without also having the support and capacity to put this into practice. • The current gaps in policy will provide a barrier, particularly around child poverty and the positive mental health strategy not yet out. • Integrated planning and service delivery key right from the beginning to ensure equality of access, lack of duplication and best use of resources.
Evidence and policy: thoughts on key actions	**Q. What are your thoughts on the key actions regarding evidence and policy as set out in the draft framework?** **Summary of feedback:** • Further detail to be added re dissemination process, format of networking events etc. Also more explicit reference to public awareness campaign. • Good acknowledgement of importance of partnership working however clearer articulation of working processes and structures needed, with CYPSP, other depts., vol & comm sector, parents, practitioners and how each will have an opportunity to influence service development and assist in implementation. Also clearer link to a range of strategy docs, not just protect life • Highlights the need for stronger collaboration with adult mental health services. • Concern around the large focus on quant evidence and need for RCT, rather than qual evidence of local programme delivery.

	- Actions themselves not SMART & therefore difficult to measure. Should be linked to outcomes and marked as 'already completed' and 'to do..'. Need to consider resource implications of actions - Clear action needed within Trusts in outworking of local plans - Explicit reference to children or parents with a disability and the particular needs this may raise.
Evidence and policy: additional actions	**Q. What additional key actions, if any, do you think the framework should include regarding evidence and policy?** **Summary of feedback:** - Universal element of parenting support to be strengthened, not just targeted at those thought to need it most. - Production of primary research/accessible local research as important as using international evidence. Views of parents also critical. Promoting our own research and evaluating our own programmes. - Greater antenatal/postnatal period support needed. - Cross-sectoral media campaign, in particular links with adult mental health services, will support getting the message across. - Leadership buy-in is vital for Trust plans - Wider training of frontline practitioners (health, social care and education) and need for awareness of adult mental health issues and the impact on IMH . School nursing, AHP (eg Speech & language therapists) - Funding and sustainability are critical - Role of parental leave in good IMH and need to address this at policy level. - Framework for assessing best practice and evaluating the quality of evidence - Collation of disaggregated data, particularly around disability - Locally developed resources are good but still need to maintain regional consistency - Use of new technologies eg baby apps should be considered - Public awareness campaign re breastfeeding and wider benefits (beyond health to IMH)
Workforce development: key challenges	**The framework prioritises the need for practitioners to be fully equipped to promote positive social and emotional development, to identify any issues at an early stage, and to seek timely help for families at risk.** **Q. What do you consider to be the main challenges in addressing this priority area?**

<table>
<tr><td></td><td>Summary of feedback:

Support for focus on upskilling and supporting practitioners.
Central issue is getting buy-in from managers to allow staff to attend courses, to receive appropriate after-support via supervision etc and to have the time needed to embed training in practice. Training must be given appropriate value & priority
Financial implications, sustainability and lack of resources a big issue
Consistency of training is essential, with the same message being given to parents and families from all practitioners, health, education, stat, vol etc. Also plan needed for consistency over time, with staff moving/leaving etc.
BUT not all practitioners will need the same skills, consideration needed as to how training needs will be identified.
If practitioners become better at identifying those who need support, services must be in place to provide this support. Workforce development and service development should therefore be hand in hand.
It is also critical that training extends IMH knowledge to key practitioners working with adults
Better use of funds to embed baseline knowledge of IMH in primary training
Continuity of care: practitioners need to have built a relationship with family/child before they can best use knowledge to identify issues and support family
Must embed commitment already made in first 2 years of plan and expand on this base.
Solihull expansion supported widely however need acknowledgement of resources and commitment needed to do this properly. Need to aim for a culture change rather than individual one-off training
Allied Health Professionals not referenced and are key part of workforce
Particular consideration needed for training of practitioners working with children with a disability and their families (or indeed parents with a disability)
</td></tr>
<tr><td>Workforce development: thoughts on key actions</td><td>Q. What are your thoughts on the key actions regarding workforce development as set out in the draft framework?

Summary of feedback:

General welcome for the key actions highlighted, however a need to be more specific on some, move the focus from what has already happened, and link to measurable targets.
</td></tr>
</table>

	- Further opportunities for vol & comm sector training would be welcome. - Detail on what happens after the training (how will it be used, what supervision support will practitioners get, practitioner networks and peer support), how this will be resourced, supported and funded. - Particular support for Solihull as an approach that can be rolled out to everyone as a 'baseline' level of IMH knowledge and relevant to all disciplines - Good focus on steps 1&2 but none on 3&4 - There is a notable lack of continuation for funding of specified training programmes – VIG, M7/9, Solihull – we need to build on the investment already made and develop a sustainability plan - Basic level of knowledge may increase identification however where is the help/support to deal with issues once identified. M9 is definitely not clinical child psychotherapy training - More detail needed on role of the IMH postholders in supporting the plan and in the roll out of wider IMH work - Need for a separate developmental training plan for practitioners - Positive move re introduction of IMH content in undergraduate study however important not to neglect Further Education/vocational courses as this is the route that many early years practitioners come through - Workforce training vs workforce development – not necessarily about courses but about general upskilling and education. Practitioners also need the space to develop their own innovative practices and to implement their learning (Continued Professional Development)
Workforce development: additional actions	**Q. What additional key actions, if any, do you think the framework should include regarding workforce development?** **Summary of feedback:** - Focus on specialist support and higher level training, particularly around child psychotherapy. Sensory attachment training suggested. - Widen training opportunities to all relevant sectors, both voluntary and statutory (and particular mention to GPs and AHPs) - Make better use of existing resources, services and training opportunities (including vol sector skills). Example of Brazelton courses. - Coordinated plan for rolling out of training opportunities, including identification of geographical gaps. Less focus on Sure Starts as many people don't live in SS area

	• Support for implementation of training in practice as important as actual training • Training should provide background on the social and economic impact on IMH - ecological approach • Preventative approach – targeting young people before pregnancy (via school nurse, PSHE etc) • No tool to measure IMH, attachment or social and emotional development. How do we know where need is or if we are making a difference? Baseline information should include attachment and impact of relationships/bonding • Consider mainstreaming Solihull in undergraduate courses • Wider roll out of training should include practitioner support forum • Gap around psychological trauma • Document must first define who the workforce are, and shift focus from core statutory infant services
Service development: key challenges	**The framework highlights the importance of appropriate services, both universal and targeted, to support parents and hence promote healthy social and emotional development of infants.** **Q. What do you consider to be the main challenges in addressing this priority area?** **Summary of feedback:** • Equality of access across the region top priority, ensuring not just those in deprived areas have access. • Targeting 'hard to reach' families and those with additional needs (parents or child) • Link with adult mental health services • Joined up approach using existing resources, particularly in the vol & comm sector, to avoid duplication. • How will actions be funded? Cuts in early years budgets and no detail on resources. This includes additional manpower that will be needed to fully deliver. • Services need to better target fathers, and recognise the role of wider family members • Clear referral pathway needed to ensure families and practitioners know how to access services when need identified • Earlier identification will mean more demand for services, services need to be able to meet this need, as well as increased capacity of practitioners across all steps • Buy-in at leadership level to implement the framework actions • Links to the perinatal mental health pathway and key services should be strengthened

	• Proper mapping of need and existing services needed in order to fill gaps. This mapping must incorporate the voices of parents and practitioners. Integrated planning, policy and practice. • Call for more focus on evaluating local services and local context
Service development: thoughts on key actions	**Q. What re your thoughts on the key actions regarding service development as set out in the draft framework?** **Summary of feedback:** • General welcome for focus on universal and targeted services, and in particular the antenatal period and multi-disciplinary approach. • Good identification of services already in place which can be expanded upon • Again, emphasis needed on multi-disciplinary, joined up approach, making best use of what is already available, and disseminating details of what is available. • Naming of particular programmes (IY, FNP) may narrow the options and discounts locally developed services • Agreement that focus is still needed on access to universal services for all. Concern around focus on Sure Start (which not everyone can access) and concern re FNP (again, very targeted). • Detail needed on role of early intervention workers and of health and wellbeing hubs and how vol & comm sector, as well as wider stat sector (eg psychologists, AHPs) can support the work • Evidence suggests that parents don't need more information, they need one to one time to work through with a practitioner who they have got to know. • Wider recognition of links to CAMHS needed – in particular the role of CAMHS practitioners in providing the medium – long term one to one support needed to promote IMH • Not enough detail on development of targeted/specialist services, in particular specialist maternal mental health services • CAMHS stepped care model only specifies IMH at step 1 • More focus needed on potential sex education role for IMH awareness and potential role of school nurses
Service development:	**Q. What additional key actions, if any, do you think the framework should include regarding service development?** **Summary of feedback:**

additional actions	• Very similar comments to those already raised throughout…
	• Balance between prevention and intervention – crisis prevention rather than reaction
	• Equity of access for all, including those with a disability, those in rural areas, outside of Sure start areas etc
	• Acknowledgement and use of ongoing work in vol & comm sector
	• Providing support for locally developed programmes to gather evidence and capture outcomes data
	• Overarching focus on joined up, multi-disciplinary, collaborative working
	• Suggestions for other programmes/services:
	  ◦ Bookstart
	  ◦ Minding the Baby (NSPCC)
	  ◦ Coping with crying (NSPCC)
	  ◦ Baby Steps (NSPCC)
	  ◦ Replay arts practice and IMH (Babble shows etc)
	  ◦ PEEP
	  ◦ Nurture Programme
	  ◦ Lifestart
	  ◦ Mellow Bumps/Babies/Dads
	  ◦ Mood Matters in Pregnancy (Aware)
	  ◦ Parent-Child Interaction Therapy
	  ◦ Pre-school Parent Psychotherapy
	  ◦ Think Family project
	  ◦ New Parent Programme (SE Trust)
	  ◦ From bump to three
	  ◦ Baby Babble and Bounce
	  ◦ Baby Buddy app and other similar technology
	• Need to gather views from service users and practitioners in order to inform service development
	• Invest in capacity building for practitioners so they have the time to build relationships with families and to deliver core component of HCHF before additional services considered. HV/MW services in particular
	• Particular support for EAL families (both written and face to face)
	• No specific mention of postnatal depression and link between IMH and adult mental health, both low level and severe. Link to parents' past experiences and support needed to deal with this. Perinatal pathway also needs highlighted and linked in.
	• Increased risk of teenage pregnancy for LAC – specific preventative services to be targeted here?
	• Scandinavian 'family focus' rather than individual services. Need to look at the family as a whole and the range of needs

	each member has, rather than each attending different services. • Wider focus on premature babies and particular IMH concerns • Should also consider the challenges faced by parents in advances in prenatal diagnostics and the strain this can have on parent-infant relations • Further focus on the IMH benefits of breastfeeding • Mention of high level support needed by some eg post-traumatic birth, addictions etc • Lack of mother and baby unit in NI and impact of separation that this will cause • Acknowledgement of the wide range of practitioners who can and do play a part, in particular occupational therapists • Education for parenthood included in sex education, and role of school nurses in such education should be acknowledged • Kramzorg model in Netherlands and practical support for the new mother in the early weeks • Proposal to expand the Sure Start model of provision right across NI – particular concern with isolation and impact on mental health and SS services can help to address this
Any further comments	**Q. Please provide any additional comments you may wish to make in relation to the IMH framework and action plan** **Summary of feedback:** • The development of a specific Infant Mental Health Framework is warmly welcomed • Should strengthen reference to the UNCRC and UNCRPD and promotion of equality, child centred services, voice of service users and recognition of special needs • Concerns re user friendly-ness. Who is audience? Do we need a parents' version? Young person's version? • Implementation, monitoring and evaluation systems needed. Impact measurement process. However do we have the appropriate data re IMH?? • No details re funding for the actions • More details on integration of this framework with other key strategies and policies • Need for a review of evidence informed programmes from a NI perspective to justify focus on some and not others • Link between emotional health and wellbeing hubs and family support hubs and how they could work together/differ from one another? • Capacity building and supervision support for practitioners central

	• IMH position in 'support path' diagram is confusing – IMH should be central! • Need for a shared language and promotion of IMH across all services • Specific mention of speech and language and central role in communication and therefore IMH development
Summary: recurring themes	**The following key themes were noted throughout the responses:** • General support for the framework and agreement that a focus on IMH is timely and much needed. • Agreement that the priority areas are in general appropriate, with additional suggestions (impact measurement and special/additional needs proposed as separate priority areas). • Increased involvement of community & voluntary sector and programmes and services already in existence, and acknowledgement of the experience and skills currently in the sector. • Need for clear monitoring and evaluation protocol with measurable, SMART outcomes • Need to strengthen the overarching focus needed on 'whole child' ecological theory • Confirmation needed on financial resources for supporting key actions – Sustainability!! • Capacity building of core services needed to deliver core HCHF programme before looking wider • Ongoing need for joined up, multi-disciplinary approach with connectivity across departments. Integrated planning, service delivery and funding is key. • Need for inclusivity and equality for all (including geographical location, special needs etc) • Call for a much wider involvement of range of practitioners including allied health professionals (for example Occupational Therapists, Speech & Language Therapists), GPs, psychologists, psychiatrists, voluntary & community sector practitioners. • Clear links needed between CAMHS and adult mental health services, including perinatal pathway • Good recognition of support for practitioners and services at steps 1 & 2 however development of specialist services is as important, as is workforce development for those with need for a higher level of IMH skill/knowledge • Services must be informed by service users and practitioners experience, rather than just 'global evidence' • Framework now needs a clear implementation plan • Education must reach wider than parents and practitioners. Widespread public awareness campaign is central to

	dissemination of IMH messages, with a focus on developing a common language for parents, practitioners and policy makers around IMH • Support for evaluation of local programmes and services in local context, rather than emphasis on manualised global programmes with no local evidence base • Lack of data available to understand the problem • Must push for a focus on support for fathers

Appendix 1: List of consultation respondents

Association for Infant Mental Health (NI)	Northern Health and Social Care Trust
Aware	Northern Health and Social Care Trust (Midwifery Dept)
Barnardo's NI	NSPCC
Belfast Health & Social Care Trust	Replay Theatre Company
Big Lottery Fund	Royal College of Psychiatrists in Northern Ireland
Book Trust	South Belfast Sure Start
British Psychological Society	South Eastern Health & Social Care Trust
CAPPNI Information & Resource Group	Southern Health and Social Care Trust
Children's Law Centre	The British Association for Counselling & Psychotherapy
Children in Northern Ireland	Royal College of Occupational Therapists
Early Years: The organisation	Royal College of Speech and Language Therapists
HSC Clinical Education Centre	Tinylife
Health and Social Care Board	Western Health & Social Care Trust Health Promotion Department
Institute of Public Health in Ireland	Maria Herron
Lifestart Foundation	Dr J Lynch
Mencap	Eamon McMahon
National Deaf Children's Society	

Public Health Agency

‘Supporting the best start in life’

Infant Mental Health Framework for Northern Ireland

March 2016

Promoting positive social and emotional development from pre-birth to 3 years.

Foreword:

This Infant Mental Health Framework represents a commitment by the Public Health Agency, Health and Social Care Board and Trusts, as well as academic, research, voluntary and community organisations across Northern Ireland, to improve interventions from the ante-natal period through to children aged 3 years old. The Framework aims to ensure that commissioners and policy makers are fully informed of the latest evidence and interventions and are supported to make the most appropriate decisions based on this knowledge. This Framework aims to provide practitioners across a wide range of health, social care and education disciplines with the skills to support parents and children aged 0-3 in the development of positive infant mental health. Finally the Framework encourages and highlights the need for service development to ensure the optimum evidence based interventions with families with 0-3's where there are significant developmental risks.

The Framework has been the subject of an extensive engagement and consultation process; engagement has involved parents, practitioners, policy makers, young people and a wide range of stakeholders across the statutory, voluntary and community sectors. The development of Mental Health Framework has been widely welcomed and we want to thank everyone who has provided constructive and valuable feedback, all of which has helped to shape this final version. .

Why is this important?

Improving long-term outcomes for the whole population begins with ensuring that every child has the best possible start in life, with a focus on ensuring that children who are the most vulnerable and at risk are especially supported. There is now a wide body of evidence which demonstrates that disadvantage for some children starts before birth and accumulates throughout life. Consequently this Framework considers actions required during pregnancy and up to three years, maximising potential for early intervention. The promotion of positive infant mental health and wellbeing is a cornerstone of this Framework as protecting and nurturing mental health in childhood contributes to productive social relationships, effective learning, and good physical health throughout life.

Becoming a parent and having a newborn is both fulfilling and challenging as new roles and responsibilities emerge within the family. For those facing adversities such as very premature births, domestic violence, mental health problems or drugs and alcohol misuse and for those who themselves have had very difficult starts to their own lives and/or are also living in difficult social and economic circumstances, these challenges can be even more considerable. It is therefore important to take an ecological approach to child development, considering the child in relation to their wider family and community circumstances and the impact that these factors may have.

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When secure attachments are not established early in life children can be at greater risk of a number of detrimental outcomes, including poor physical and mental health, relationship problems, low educational attainment, emotional difficulties and conduct disorders.

A large body of evidence demonstrates that many children may face pronounced adverse experiences in infancy, including repeated exposure to neglect, chronic stress, and abuse. Such experiences may disrupt brain development and lead to emotional problems and potential life-long difficulties with self-control, engagement in high-risk health behaviours, aggressive behaviour, lack of empathy, physical and mental ill-health and increased risk of later self-harm or suicide. As well as the human cost there are increased economic costs to society in terms of healthcare, child welfare, education, unemployment, policing, juvenile justice and prisons. It should however also be recognised that for some people their mental health conditions are not in any way related to early childhood experiences; in addition, it is not always inevitable that early childhood trauma leads to mental ill-health in later life.

We know that warm, consistent, positive, and engaged parenting in a safe and secure environment enables the infant to grow into a child and adult who is more likely to have high self-esteem; strong psychological resilience, empathy and trust; the ability to learn; and reduced risk of adopting unhealthy lifestyle choices.

The Framework development has been significantly influenced by ongoing work across the UK. Notable examples of good practice include the work of the Wave Trust who developed the '1001 critical days' and 'Building Great Britons' reports; and the World Health Organisation's 'Investing in Children' report. The publication of the Marmot Review (2010) made a significant contribution to prioritising early years interventions as part of public health policy and practice, particularly the objective of 'giving every child the best start in life'. Of the six policy objectives identified, this was the 'highest policy recommendation' emphasising the Review's life course perspective. The Review also called for an increase in the proportion of overall expenditure allocated to the early years, and emphasised the need to reduce inequalities in the early development of physical and emotional health and in improving cognitive, linguistic and social skills - hence building resilience and wellbeing among young children. The new Public Health Strategic Framework for NI: Making Life Better (2014) makes a clear commitment to ensuring that the theme of 'giving every child the best start in life' will remain a key priority.

This Infant Mental Health Framework for Northern Ireland has 3 key priorities and outlines recommendations for action to:

- **Promote and disseminate evidence and research** on infant mental health to policy makers, practitioners and importantly, the wider population. Infant mental health should be everyone's business; consequently organisations across all

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sectors, including all NI government departments, should be in a position to consider and act on the compelling evidence and implications.

- **Inform workforce development** to ensure frontline staff have the necessary knowledge and skills to assess risks to the mental health of infants by early identification of factors associated with parent-infant interaction, and indeed are adequately supported to put this knowledge into practice.

- **Inform service development** to ensure that universal and targeted services can respond as effectively as possible to maximise the optimal development of newborns and infants**,** particularly taking account of newborns facing the highest levels of risk and adversity**.** Given that infant mental health is fundamentally connected to the physical and mental health and wellbeing of the primary caregiver, as well as their ability to parent, service development is as relevant for those providing adult services as it is for children's services. Ideally there should be an increase in interventions that focus on supporting the parent –infant relationship where the parent faces challenges to their own emotional well-being. Services must also be informed by parent and practitioner feedback.

The Public Health Agency wish to acknowledge the role and considerable contribution undertaken by NCB NI, who have supported wider stakeholder engagement and Framework development informed by the public consultation and Advisory Groups.

This Infant Mental Health Framework indicates the need to intervene at as early a stage as possible to support parents, build capacity, prevent problems arising and maximise outcomes for all children and families. Going forward, we will establish an Implementation Group to oversee the progress of this Framework through subsequent annual action plans. We are confident that considerable learning as well as measurable actions can be undertaken to collectively improve outcomes in later life as we seek to '**support the best start in life**' for all babies.

Dr Eddie Rooney, Public Health Agency. March 2016

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Infant Mental Health Framework Vision

The aim of this framework is to ensure that all children have the best start in life by prioritising and supporting the development of positive social and emotional wellbeing

This framework has the following objectives:

- Parents and practitioners, and the wider population, better understand the importance of attachment and the essential elements of positive social and emotional health in infants.

- Parents and practitioners have improved skills to engage positively with infants to maximise their social and emotional development.

- Practitioners and parents are better able to respond to predictors of vulnerability in infants and families and identify early signs of delayed social and emotional development in infants and /or emotional distress.

- Appropriate services are in place with clear referral pathways and are available to respond to identified infant mental health and wellbeing needs across the region, on an equal basis for all.

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Introduction

Infant Mental Health: a definition.
Infant mental health is defined by the Association for Infant Mental Health UK as ***'the study of mental health as it applies to infants and their families'.***   Infant mental health focuses on social and emotional development during the first three years of life for an infant and their family. This includes a child's ability to form relationships with other children and adults; to recognise and express emotions; and to explore and learn about their environment in a safe and happy way

Why is it important to consider infant mental health?

A growing body of evidence from the clinical and social science fields shows that the areas of the brain that control social and emotional development are most active during the first 3 years of a child's life (and particularly active in the early months). Careful nurturing of a child's social and emotional health during their early years is vital to provide them with the skills necessary to form relationships and interact with society later in life. The quality of relationship between a child and their primary caregiver is central to this process.

The following theories form the basis of current discussions around infant mental health:

- **Attachment:** A strong bond between an infant and a primary caregiver is developed though positive and responsive behaviours from the care-giver, including mirrored behaviours, physical contact and proximity. A securely attached infant will have the social and emotional confidence to build relationships and explore the world around them (Barlow and Svanberg, 2009).

- **Self- regulation:** Neuropsychologists have expanded the link between social development theories and neuroscience, including the central importance of self-regulation (Schore, 2004); that is an infant's ability to regulate its own internal emotional states, soothing itself rather than requiring parental soothing. This then forms the building blocks of healthy external relationships.

- **Building resilience:** Self-regulation is also central to building resilience, which is an infant's ability to 'bounce-back' from difficult or traumatic experiences, and to learn from them. Development of resilience in the first three years of life is essential to dealing with adversities later in life (Newman, 2004)

The key timeframe for healthy attachment and hence healthy social and emotional development is considered to be between **0 and 3 years**, when brain development is in its optimal phase, however it should be noted that these considerations begin long before birth. Development starts during pregnancy and the choices and experiences of the mother during this period can have a significant impact on maternal and infant social and emotional health. Promotion of antenatal bonding with the bump, preparation for parenthood and early detection of antenatal depression are all crucial, and the midwife can play a key role in this. After birth, key factors such as breastfeeding, skin to skin contact, mirroring behaviours, responsive parenting, and a stimulating play environment can also contribute positively to overall healthy development and relationship building between infant and caregiver. All parents/carers play a critical role in ensuring good mental health development for their

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children and in preventing poor developmental outcomes. However if parents are living in adverse circumstances, there are other critical roles and responsibilities required beyond just parents that necessitate provision of additional support and help to them.

The Ecological or 'whole child' approach
Bronfenbrenner (1979) developed the ecological approach to child development, theorising that the child sits at the centre of a series of structures and systems which collectively impact on his/her development. These structures include the family, school, friends, health and social care services and systems, and indeed the wider community, and continually interact with one another as they shape a child's life.

In this regard, it is particularly important to recognise the unique social and cultural context in Northern Ireland, and the very real impact that this may have on parenting and/or child outcomes. In the report 'Towards a better future: the trans-generational impact of the troubles on mental health' (March 2015), the Commission for Victims and Survivors highlights the particular impact that the legacy of conflict in Northern Ireland may have on the early development of children.

It is clear then that we need to consider the child 'in context'. The 'whole child' approach is referenced across a range of health and social care strategies and policies, and recognises that services must work together in order to provide the most efficient and effective support for children and families. Infant mental health is therefore '**everybody's business'**. A joined up approach to service development and delivery is central. It is critical that practitioners across the full range of services in health, social care and education are equipped to support healthy social and emotional development and that a common message is given out by all.

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The Current Policy Context

All policy relevant to children in Northern Ireland (NI) falls under the Children (Northern Ireland) Order (1995) which lays the foundations for all those who work with or care for children and young people. Underpinning the Order is the principle that parents should be, whenever possible, supported to bring up their children in their own home. The UN Commission on the Rights of the Child (UNCRC) also recognises the primary role of the family, with article 18 stating that both parents share responsibility for their child and should consider what is best for him or her; however the government is responsible for providing support services to help parents to do this. Likewise, the UN Convention on the Rights of Persons with a Disability recognises the family as 'the natural and fundamental group unit of society' and should therefore be given the necessary support and assistance.

Health is a key priority right across the policy arena. The current 'Our children and young people: our pledge- A 10 year strategy for children and young people 2006-2016' identifies 'healthy' as the first of the high level outcomes for all children and young people. In addition, as research advances and policy develops, early intervention and support for the antenatal to three years of age period is increasingly highlighted, both here in Northern Ireland and across the UK, and sets the context for this investment in promoting positive infant mental health. The 10 year strategy is due to end in 2016 and a new 'children's strategy' is in the early stages of development; it is essential that the NI Executive's commitment to prevention and early intervention is prioritised in this new strategy.

The Child Health Promotion Programme (Healthy Child: Healthy Future, DHSSPS 2010) sets out the universal child health services delivered to all parents and children in Northern Ireland. It is recognised as being central to securing improvements in child health across a range of issues. Effective implementation by health care professionals including GPs, midwives and health visitors will promote positive parenting and the importance of strong parent child attachments for a child's healthy social and emotional health and wellbeing.

Making Life Better: a Whole System Strategic Framework for Public Health (DHSSPS, June 2014) takes a life course approach to health and wellbeing, hence one of its key themes is 'Giving every child the best start in life'. This theme identifies the following long term outcomes:

- Good quality parenting and family support
- Healthy and confident children and young people
- Children and young people skilled for life

In particular the framework recognises the central roles that parenting and family support play in the healthy physical, social and emotional development of children. The implementation of an Infant Mental Health plan is a key first action of the 'Making life better' framework. Other key actions which contribute to the promotion of positive infant mental health include the roll out of the Family Nurse Partnership; implementation of the breastfeeding strategy and promotion of universal health and maternity services.

Alongside this Public Health Framework, early intervention is prioritised in a number of key government strategies, for example DHSSPS '**Families Matter: Supporting Families in Northern Ireland (March 2009**); Department of Education **'Learning to Learn: a framework for early year's education and learning (December 2012); and the Maternity Strategy for Northern Ireland (2012-2018).** The DHSSPS NI is also developing a new

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***Protect Life: Positive Mental Health Strategy* (due 2016),** which will have a life course approach with a significant emphasis on infant mental health. Each of these policies recognises that health, social care and education are inter-dependent in enabling the best possible outcomes for our children and families. Indeed, the Department of Education provides core funding for the Sure Start service across Northern Ireland; this service is underpinned by policy and aims to deliver health, education and parenting support for families with children aged 0-3 in a coordinated way across the most disadvantaged areas of NI.

Various structures are already in place to take forward the key theme of prevention and early intervention. The Children and Young People's Strategic Partnership (CYPSP) is a multi-agency partnership that brings together the leadership of key statutory, community and voluntary agencies, working to improve outcomes for children and young people. Early intervention is one of the key themes of this work. Through the CYPSP, there are currently 5 outcomes groups, 25 Family Support Hubs and 26 Locality Planning Groups in place across Northern Ireland.

Building on the universal services already delivered to children and families, a collaborative approach to early intervention funding is being taken forward through the newly established **Early Intervention Transformation Programme (EITP),** with six government departments coming together alongside private philanthropy, as part of the Delivering Social Change initiative. The programme seeks to:

- Build on the Child Health Promotion Programme and the NI Maternity Strategy to equip all parents with the skills needed to give their child the best start in life
- Provide additional support for families when problems first emerge, outside of the statutory system
- Positively address the impact of adversity on children by intervening both earlier & more effectively, if and when required, to reduce the risk of poor outcomes later in life.

Children and families do not all have the same level of need, nor do individual families have the same level of need through the lifecourse. The DHSSPS policy document; '***Child and adolescent mental health services: A service model' (July 2012)*** outlines the stepped care model of service provision (see appendix 1) and provides commissioners and service providers with a framework against which to remodel CAMHS service provision. At the centre of this framework is a stepped-care approach whereby; *'the appropriate level of care is provided at the earliest point that best meets the assessed needs of the infant, child and young person whilst also enabling them to move up or down the steps as their need changes'.* (DHSSPS 2012)

The stepped care model shifts the focus of therapeutic intervention from service description, to the provision of a needs-based service. This model of service delivery is aimed at development of integrated care pathways with a focus on skills-based and evidence-based practice aligned to the needs of children and their families/carers. Care interventions are agreed and delivered at the most appropriate step with movement up or down to other services as clinically required. The model is recommended by the National Institute for Health and Clinical Excellence (NICE) on the basis that it promotes a continuum of care approach.

Some of the key priorities within the continuum of care approach include:

- Support of parents and carers, recommended to continue into the adolescent years, in recognition that it is primarily within the family that the mental health and emotional wellbeing of children is secured.

- Multi-agency interventions across the sectors, with services configured on the principle of ‘recovery’ within the context of provision of wrap around care for the individual child/young person and their families.

- Better collaborative working with parents/carers, community & voluntary sector, education sector and other organisations.

- Development of protocols between CAMHS services, adult services, the criminal justice system, and youth services and other stakeholders.

- Development of an effective referral process enabling defined and simplified points of entry to specialist services which are integrated with other referral pathways including child and family services.

Current Practice

Set against this backdrop, securing a strategic approach to early child development and family support is a key priority for the Public Health Agency (PHA). To that end the PHA established the Child Development Project Board (CDPB) in June 2010. Through the CDPB, chaired by the PHA and including members from the Health and Social Care Board, Health and Social Care Trusts, academia and the community and voluntary sector, the PHA has taken a strategic life course approach to child development and family support. Working from an evidence based perspective, the CDPB has identified needs of children and young people, aged 0-18, who experience inequalities, and initiated and supported a range of programmes and services to address these needs. The development of an Infant Mental Health Framework is one of a number of key workstrands.

This Framework is aimed at supporting parents, early year’s practitioners across a wide range of health, social care and education disciplines and organisations who support parents and children aged 0-3, as well as ensuring that commissioners and policy makers are fully informed and therefore supported to make the most appropriate decisions. Through the annual implementation plans the Infant Mental Health Framework will require an extensive range of organisations and stakeholders to contribute to actions across the three identified themes. The PHA and Health and Social Care Board are committed to working closely with Departments, Trusts, Local Government, voluntary and community sector organisations and others in the outworking of this framework, taking a holistic approach to ensure the best outcomes for children and families. It is important to note that many families have additional needs and it is critical that the framework is relevant and supportive of all children and families.

The Framework acknowledges the considerable successes and good practice being led and undertaken across the statutory, voluntary and community sector on the infant mental health theme, and the many family support programmes and services that are currently available. The Framework does not seek to duplicate this work, rather to make best use of what is already available and in addition, to build on this where possible to provide the most effective and efficient family support possible.

The Infant Mental Health Association in NI, for example, has undertaken, over a number of years, a considerable amount of awareness raising through bringing UK and international

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experts to NI to present research and practice as well as policy advocacy on the need for the development of integrated pathways for families and infants in need.

Health and Social Care Trusts have all recognised the importance of focussing on the promotion of positive Infant Mental Health and have organised themselves through various working groups to develop integrated actions across Trust Directorates.

The Health and Social Care Board through the Childcare Partnerships and those involved in the Children and Young People Strategic Partnerships have also been undertaking considerable training and awareness, for example through inputs and dissemination of DVDs from early year's expert Suzanne Zeedyk as well as events focussing on infant development.

We also acknowledge the long experience and essential and wide reaching support that Sure Start provides to families, many of whom are hard to reach and often facing multiple adversities. In addition, Tinylife provides support for those who have experienced still birth, miscarriage or premature birth and works alongside healthcare practitioners and families in order to identify and address need. The Lifestart foundation provides a home visiting service to families and other voluntary and community organisations, such as Barnardo's NI, Action for Children, NSPCC, NIACRO, Aware and Replay Theatre Company who continue to deliver support and services as well as innovations on the infant mental health theme. Over 8,000 families with babies and toddlers participated, for example, in the highly successful Baby Celebration Day, ran as collaboration last year between Replay Theatre Company, Surestarts and Belfast City Council.

These organisations represent only a small sample of those that are well positioned to progress actions on the infant mental health theme and will be critical to the successful implementation of the Framework and yearly action plans thereafter.

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The Process so far

To date the following activities have been undertaken to inform this regional Infant Mental Health Framework:

- **Audit Phase 1-** In June 2012 an audit of infant mental health training and resources available in Northern Ireland was undertaken with key policy makers, practitioners and researchers from the statutory, community, voluntary and academic sectors. The aim of this activity was to establish the extent and sources of current training, target audiences, funders and the uptake of training amongst the statutory, community and voluntary sectors.

- **Gaps analysis**- Following on from the phase 1 audit, a similar group of policy makers, practitioners and researchers were asked to identify gaps in the current provision of training on infant mental health

- **Audit Phase 2** - A second phase of the audit was completed in September 2013 which tracked the progress of key infant mental health training developmental areas that were identified in the phase 1 audit and the gaps analysis.

- **Stakeholder engagement** - Since June 2010 numerous seminars have been organised in order to share good practice and provide feedback on the progress made towards the development of this Framework for Infant Mental Health. Key speakers at these events included Suzanne Zeedyk, George Hosking, Dr Bruce Perry, Dr Ian Manion and Professor Terence Stephenson. These seminars were attended by over 500 different delegates from across the statutory, community, voluntary and academic sectors. An outline draft was presented to a workshop of over 150 people and their comments have been incorporated in this Framework.

- **Case study visit to Finland** - In September 2013 a delegation of 25 policy makers, commissioners and high-level practitioners participated in a case study visit to Finland. The primary aim of the visit was to increase knowledge on the early education and early year's sector in Finland in order to inform the infant mental health agenda and parenting support in Northern Ireland.

- **Regional Infant Mental Health Planning Group**- This group has been working to inform the production and implementation of this Infant Mental Health Framework as well as providing specialist input on infant mental health for the new 'Protect Life: Suicide Prevention strategy from DHSSPS (in development). Members include the PHA, HSC Trusts, HSCB and DHSSPS.

- **Regional Infant Mental Health Reference Group**- This group supports the work of the Infant Mental Health Planning Group. Members represent the voluntary and community sector, as well as academia.

- **Formal 12 week consultation period (March – May 2015)** – the draft framework and initial action plan was released for public consultation between March and May 2015. 33 written consultation responses were submitted, from a range of voluntary and statutory organisations as well as 3 from individual practitioners. In addition, focus groups were held with 56 parents at six Sure Start groups across Northern Ireland, as well as a focus group with 5 members of NCB NI Young Parents group. A

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thematic analysis of consultation responses was carried out using NVivo, a qualitative software package used to support analysis of a large volume of text-based information.   Following analysis, the framework was revised accordingly.

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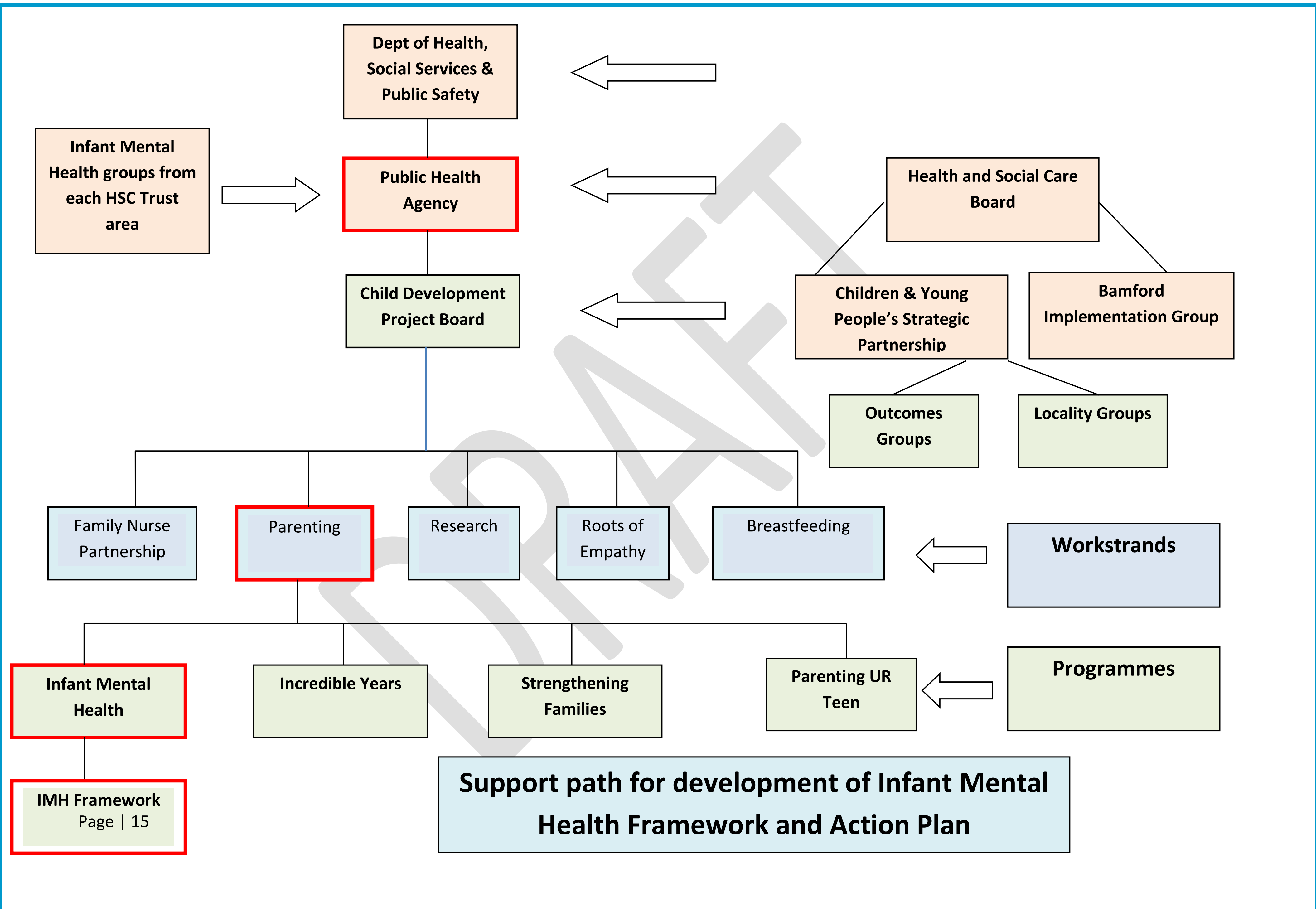
Dept of Health, Social Services & Public Safety
Infant Mental Health groups from each HSC Trust area
Public Health Agency
Health and Social Care Board
Child Development Project Board
Children & Young People's Strategic Partnership
Bamford Implementation Group
Outcomes Groups
Locality Groups
Family Nurse Partnership
Parenting
Research
Roots of Empathy
Breastfeeding
Workstrands
Infant Mental Health
Incredible Years
Strengthening Families
Parenting UR Teen
Programmes
IMH Framework
Support path for development of Infant Mental Health Framework and Action Plan
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Infant Mental Health in Northern Ireland: key statistics

No. of Births in NI (2014)	24,394 (NISRA, 2014)
Population	24,631 under 1 (6%) 102,042 1-4 (24%) (HSCB, 2014)
No. of Births to Teenage mothers (under 20 years) (2013)	Births to mothers aged under 17 reached a new record low in 2014 with 84 births recorded, a rate of 2.4 per 1,000 females aged under 17. (HSCB, 2014) * There is a clear difference in the age profile of mothers by deprivation. In 2012/13, 37% of all mothers aged less than 24 years of age were from the most deprived areas. In comparison, 7% of mothers in this age group were from least deprived areas in 2012/13.
Premature or Low Birth Weight	6.3% of babies were born with low birth weight (i.e. less than 2500 g) (HSCB, 2014) In 2012, more than 1800 babies spent time in a neonatal unit (NICORE Database 2012, QUB)
Postnatal depression	Of 25 273 births in 2011 in Northern Ireland, 2527 women developed antenatal depression, 3790 women developed postnatal depression, 50 mothers developed puerperal psychosis and 50 were admitted as a result of relapsing (DHSSPS, 2013) It should be noted that Postnatal depression often goes unreported and therefore the figure could be much higher than this (Royal College of Psychiatrists, 2011)
Child Protection Register (2014)	1885 children on the child protection register 216 of these are under 1 year of age 512 of these are between 1 & 4 years of age (HSCB, 2014)
Children Looked After in Care (2014)	2,857 children in care, 76.5% - Foster Care, 11.9% - Placed with Family, 6.5% in Residential Care. 103 of these are under 1 year old 579 of these are between 1 and 4 years old (HSCB, 2014)
Smoking during pregnancy	NI total: 15.9%

	Most deprived areas: 28.5% Least deprived areas: 7.4%
Obesity rates during pregnancy	NI total: 49% Most deprived areas: 51% Least deprived areas: 44%
Breastfeeding rate at discharge	NI total: 45% Most deprived areas: 27% Least deprived areas: 59% Mothers under 20: 17%
Breastfeeding exclusively at 6 mths	Less than 1%
Child poverty	22% of children living in poverty, however this varies widely across the region

Sources: HSCB Directorate of Social Care and Children six monthly corporate parenting report September 2014
NISRA (2014) Registrar General annual report http://www.nisra.gov.uk/demography/default.asp8.htm
NICORE Database, QUB (2012)

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Baby's key influences

This Infant Mental Health Framework proposes a whole child approach, where infant mental health is 'everybody's business'. This means that practitioners across a wide range of disciplines including health, social care and education can have an influence over a child's social and emotional development. In addition, parents, siblings and the wider family circle, as well as friends, neighbours and the wider community can all play their part.

- Parents
- Grandparents
- Siblings
- Wider family circle
- GPs
- Health Visitors
- Midwives
- Other maternity professionals
- Nurses
- Social Workers
- Childcare providers
- Early education providers
- Mother and baby groups
- Community & Voluntary sector groups

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Key Priority Areas

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Priority 1: Evidence and Policy

We believe that investment in services must be firmly based on existing and emerging evidence, ensuring best possible outcomes for all children, young people and families. There is an ever growing body of evidence on the impact of adverse pre-birth, baby and infant experiences on later development, and in addition, evidence on 'what works' to address these needs and to prevent further issues developing.

The Framework for infant mental health includes a commitment to utilising the most up-to-date findings when developing services; and to ensuring that emerging local policy development acknowledges this evidence on infant mental health and the critical influence of the early years to later life outcomes. Where possible new and emerging research and evidence will be disseminated to commissioners, policy makers, practitioners and the wider population to inform support for families with children aged 0-3.

Key recommendations: Evidence and policy

- There is a need for agreement on a common language around infant mental health that is accessible to all, including policy makers, practitioners, and importantly parents and the wider community, ensuring consistency of messaging across all departments and services.
- Infant mental health should be regarded as 'everyone's business', and those in a position to do so should use opportunities for dissemination of essential key messages and evidence on infant mental health to practitioners, parents, policy makers and the wider population. It is critical that this information is accessible by all, particularly those with additional needs.
- All concerned with promoting key messages on support for parents in caring for their newborns should consider how new technologies and use of social media can be utilised alongside traditional methods to disseminate key messages.
- In seeking to understand need, we must listen to and engage with those who know best. The diverse voices of children (where possible), parents and practitioners must be heard in gathering evidence, ensuring that they have every opportunity to help shape service development.
- The UNICEF UK Baby Friendly Initiative will be promoted as a model of best practice.
- While acknowledging the importance of international evidence on what works for children and families, a commitment is needed to gathering evidence of local practice, including qualitative evidence of local programme delivery.
- Where appropriate, policies and strategies at Department, Health and Social Care Board/Trust level and NI wide, should utilise the evidence base on infant mental health and the importance of the early years on later child and adult outcomes.
- Individual Trusts should develop an Action Plan to identify relevant actions informed by the Infant Mental Health Framework.

Priority 2: Workforce development

Central to the early identification of infant mental health issues is ensuring that all practitioners working with babies, pregnant or new mothers, fathers (who are often overlooked) and young infants, are fully equipped to promote positive social and emotional learning, as well as to identify the early signs of infant mental health problems and to seek timely help for those families at risk.

This Framework focuses on the need for capacity building of frontline practitioners across all relevant disciplines, ensuring they have the necessary knowledge and skills to support and encourage positive parenting, assess infant mental health and identify any issues and causes in a timely manner so that additional support may be provided.

As already stressed, infant mental health is 'everybody's business', with consistency of messaging a priority, therefore workforce development will be directly relevant to a wide range of health, social care and education practitioners across statutory, community and voluntary sector services. In addition, the link between child and adult services must be recognised, therefore training in infant mental health should be extended to practitioners working in relevant adult mental health settings (in particular those working with expectant parents). We recognise that not every practitioner will require the same level of knowledge in infant mental health so alongside a common baseline of knowledge, we propose a tiered level of training relevant to the CAMHS stepped care model of service delivery (see appendix 2).

In addition to increasing workforce skills, we understand that practitioners need to have the opportunity to consolidate their new skills, attending appropriate follow up networks and practice sharing sessions, and have the opportunity for regular supervision and peer support, hence maximising impact for children and families.

Key recommendations: Workforce development

- Upskilling of practitioners across a wide range of universal and specialist services, including health, education and social care practitioners in both statutory and voluntary/community organisations. This should include a core baseline knowledge of infant mental health for all relevant practitioners, with consistency of message central, and in addition, appropriate specialist training for those delivering specialist services to both infants and families.

- Where possible, training should be provided at as early a stage as possible in a practitioner's career, considering options for inclusion in further/higher education syllabuses for appropriate heath, education and social care courses.

- Commitment has already been made to supporting infant mental health training including the Solihull approach, Video Interaction Guidance and the Tavistock diploma in Infant Mental Health and Child Development and this investment should be embedded and further built upon.

- Alongside training, practitioner support to embed new learning in practice is essential to ensure that investment has an impact on children and families. This Continued Professional Development should include regular supervision, peer networking and support and access to up to date evidence and information to support practice. Buy-in for the process at management level is therefore

essential.

- Continuity of care in provision of universal services is essential in order to allow practitioners to build relationships with families and best meet their needs, and this should be considered when allocating resources.

- In addition, a preventative approach is recommended, with provision of key information on developing positive infant mental health to young people via PSHE.

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Priority 3: Service development

Increased capacity of practitioners to identify additional needs around infant mental health will necessitate not only a clear referral pathway to identify appropriate support, but increased service capacity to meet this need. Workforce development and service development must therefore go hand in hand.

First and foremost we understand that building positive social and emotional wellbeing in a child begins at conception, hence practitioners working within universal services are best placed to disseminate information and identify potential infant mental health issues early. This framework therefore acknowledges all current universal provision as outlined in Healthy Child, Healthy Future and the Maternity Strategy for NI, and seeks to add value. However, sometimes despite best efforts, additional issues for families arise and universal support is not enough. For those families, it is essential that appropriate targeted interventions are also in place to allow timely referrals and treatment interventions, thereby preventing issues from escalating.

Service development therefore reflects both universal and targeted support. For all services, both universal and targeted, we recognise the need for consistency and continuity of care, and a whole family approach to interventions. It is particularly important that fathers are recognised as a key part of the family unit. The level of need should be based on the CAMHS Stepped Care model (see appendix 2).

It is important to acknowledge the numerous services already being provided across Northern Ireland from statutory, community and voluntary sector organisations; the Framework seeks to build on existing work rather than duplicate.

Key recommendations: service development

- Initial priority should be given to maximising opportunities provided for supporting positive infant mental health development through the universal Healthy Child: Healthy Future programme.
- A multi-disciplinary, joined up approach to service development will maximise use of existing resources and support a whole child approach. This should include dissemination of existing opportunities as well as development of new ones.
- Service planning and development must recognise the need for a balance between prevention and intervention, with a range of services to cover all levels of need.
- In line with a joined up approach, links should be made with existing services across CAMHS and perinatal pathways.
- The voice of practitioners and parents as service user must be central to development of services.
- In addition to roll out of globally evidence based programmes and services, it is important to invest in our locally developed programmes, supporting them to evaluate their own services.

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Implementation

Implementation Group

To support actions indicated in this Infant Mental Health Framework being taken forward, an implementation group will be established. The group will consist of representatives from health, social care and education and include the voluntary, community and statutory sectors in order to facilitate a joined up approach to delivery.

Annual implementation plan

The key role of the implementation group will be to develop an annual action plan which will set out key actions relevant to a wide range of organisations and across all sectors. Appendix 1 includes the initial action plan for 2016-2017 and provides details of key first actions already taken. Further yearly action plans will build upon these first actions.

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Appendix 1: Action Plan 2016 - 2017

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The following provides an overview of initial actions taken under the 3 key headings of 'evidence and policy', 'workforce development', and 'service development' during the period 2016/17. Subsequent yearly action plans will be developed in line with implementation plans going forward.

1. Evidence and policy: Key Actions

Key Actions	Timescale	Partners
Support, as appropriate, the strengthening and reinforcement of strategy, legislation, guidance/regulations and policy/programme formulation linked to infant mental health research, evidence and practice through:		
• Informing the development of DHSSPS 'Positive Mental health and suicide prevention' strategy' to ensure that infant mental health is comprehensively included. This includes the identification of any equality issues and ways of addressing these.	Input submitted. Document being released for consultation 2016	DHSSPS
• Development of a local plan in each Health & Social Care Trust to implement the regional infant mental health strategy that embeds infant mental health approaches. This plan should be incorporated within each Trust's Local Implementation Team's Action Plan.	Ongoing	Individual HSC Trust areas
Support dissemination of information on key infant mental health issues by:		
• Implementation of regional networking events for infant mental health lead practitioners to allow sharing of good practice across HSC Trust areas, as well as across programmes of care.	Ongoing	Trusts PHA

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• Provision of user friendly information and up to date evidence for practitioners, parents and the wider population, using a common accessible language (including dissemination of IMH Framework and Action Plan)	Ongoing	PHA
• Supporting development of Trust level information flyers/booklets and individual communication plans as appropriate, & encouraging Trusts to ensure that their plans consider and address the specific information and communication needs of particular equality groupings.	Ongoing	Individual HSC Trusts
• Promotion of best practice standards within universal services such as UNICEF UK Baby Friendly Initiative and provide parent resources such as 'UNICEF: Building a happy baby'.	Ongoing	PHA/Trusts
• Dissemination of emerging evidence regarding what's best for baby and family	Ongoing	PHA
• Establish links with parenting networks to ensure parental engagement on perspectives on Infant Mental Health, and encouraging networks to ensure that a wide range of diverse voices are heard.	Ongoing	PHA/Trusts

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2. Workforce Development: Key Actions

Key Actions	Timescale	Lead partners
Audit of current infant mental health training across NI	Completed	NCB NI/PHA
Universal (Step 1)		
Expansion of Solihull and Solihull Plus training across the region targeting 1500 health and social care practitioners to complete training and attend practice network meetings. Training for Trainers model used. This will be further complemented through Solihull Combined Foundation and Ante Natal training programme supporting Midwives taking part in group based ante natal care and education DE also funding the roll out of Solihull training across all Sure Starts in NI. Development of a regional Solihull Approach Plan	2016/17	Funded by PHA; Training provided by Clinical Education Centre Funded through PHA under Early Intervention Transformation Programme HSCB/Childcare Partnership progressing Solihull training Department of Education PHA/Trusts
Introduce teaching of Solihull Approach to Health Visiting Postgraduate students	2015 – 2016 academic year	PHA/Further and Higher Education Colleges

Expansion of IMH focus within core education curriculum (in particular Undergraduate level) for those providing vocational training for early years (Stranmillis BA (Hons) Early Childhood Studies). Influence development of IMH on curriculum for nursing, social work, midwifery, Health Visiting and psychology.	Ongoing discussions	Stranmillis University College, Queen's University Belfast, University of Ulster
Support the development of Mental Health and Emotional Wellbeing education programme for families with newborns	2016/17	PHA/Aware
Consider the opportunities for roll out of infant mental health training to GPs, Consultants and other key clinicians	Ongoing discussions	PHA In conjunction with NIMDTA
Targeted (Steps 2-5)		
Expansion of child psychotherapy training (Tavistock M7 & M9) for advanced practitioners working across all children's services. On completion, these skilled practitioners will embed learning within their own areas of work and offer advice and support to practitioners working within universal services in order to reduce the need for referral to specialist services.	15 Places to be supported within 2016/17	Funded jointly by PHA and HSCB; Training is delivered locally by the Child and Adolescent Psychoanalytical Psychotherapists in NI (CAPPNI).

Further implementation of Video Interaction Guidance and ongoing support for supervision requirements of practitioners.	2016-2017	

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3. Service Development: Key Actions

Key Actions	Timescale	Lead body
Universal Services (Step 1)		
Increase the emphasis on IMH during the ante-natal and post natal period including revised ante-natal parent education content, giving particular consideration to equality of access for all.	2016/17	PHA via Workstream 1: Early Intervention Transformation Programme and PHA/HSCB through Maternity Strategy
Breastfeeding support and guidance through implementation of the Breastfeeding strategy for NI.	Ongoing	PHA
Expansion and adoption of Baby Friendly Initiative standards including support and advice for breastfeeding and non-breastfeeding mothers	Ongoing	PHA
Expansion of Incredible Years Parents, Babies & Toddlers Programmes (0-3 yrs) and increase of trained leaders and Mentors	Ongoing	PHA
Employ 5 Child Development Intervention Co-ordinator Posts – these postholders will support improved implementation of parenting programmes across Northern Ireland including those related to Infant Mental Health.	Ongoing	PHA/Trusts
Revision of guidance on Relationship and Sex Education currently ongoing by DE	Ongoing	DE

Targeted Services (Step 2 & 3)		
Review of maternal mental health provision	December 2015	HSCB/PHA
Include IMH within the development of eCAT for health visiting service so that interventions relating to IMH can be monitored.	2016/17	PHA
Revise the Perinatal Care Pathway in light of the new Perinatal and Antenatal Mental Health NICE Guidelines 45 (December 2014) and develop proposals to ensure implementation in all Local Commissioning Group areas by addressing gaps in current service.	2016/17	PHA
Identify gaps in our knowledge of data and service delivery and ensuring this information is provided to relevant commissioners, in particular the current antenatal and post-natal data collected from new parents. There will be a follow up with a sample of women who have indicated a need for support in the antenatal period and to assess the extent of support provided.	March 2016	PHA
Implementation of Family Nurse Partnership Services across all Health and Social Care Trusts.	Ongoing	PHA
In line with the DHSSPS CAMHS Guidance framework, and the HSCB 'Working Together Learning Development Framework', develop the capacity of CAMHS practitioners to deliver evidence based interventions/NICE approved therapies.	Ongoing	HSCB/Trusts/LIGs
Embedding infant mental health approaches within Primary Mental Health Teams in each Trust CAMH Service, in line with the DHSSPS Service Model Guidance for CAMHS.	Ongoing	HSCB/Trusts/LIGs

Introduction of 5 Early Intervention Teams across NI focused on supporting families with emerging problems, including families with newborns and infants.	August 2015-March 2018	PHA/Outcomes Groups/Trusts via Workstream 2: Early Intervention Transformation Programme
Introduction of mental health and wellbeing HUBs providing relevant support for target clients including those families and adults with newborns	Ongoing	HSCB/Trusts
Implementation of parenting support programmes including those relevant to parents with newborns and infants	Ongoing	PHA/HSCB/Trusts via Workstream 2: Early Intervention Transformation Programme
Support the development and application of an Adversity Matrix and related assessment for families with 0-3 year olds and development of a programme of support for families identified. The model, if successful, can be potentially implemented across all HSC localities.	2016/17	CAWT. HSCB, PHA, Southern and Western HSCT's

Appendix 2: CAMHS Stepped Care Model

The regional strategy for the development of Psychological Therapy services recommends the adoption of stepped care approaches across CAMHS. This model aims to shift the focus from care interventions based on the service descriptors to a model of care which is needs based.

The model is underpinned by the following:

- Provision of child, young person and family centred care
- Focus on prevention and early intervention
- Provision of recovery and wrap around care
- Embedding coordinated provision
- Active promotion of outreach
- Ensuring services are effective

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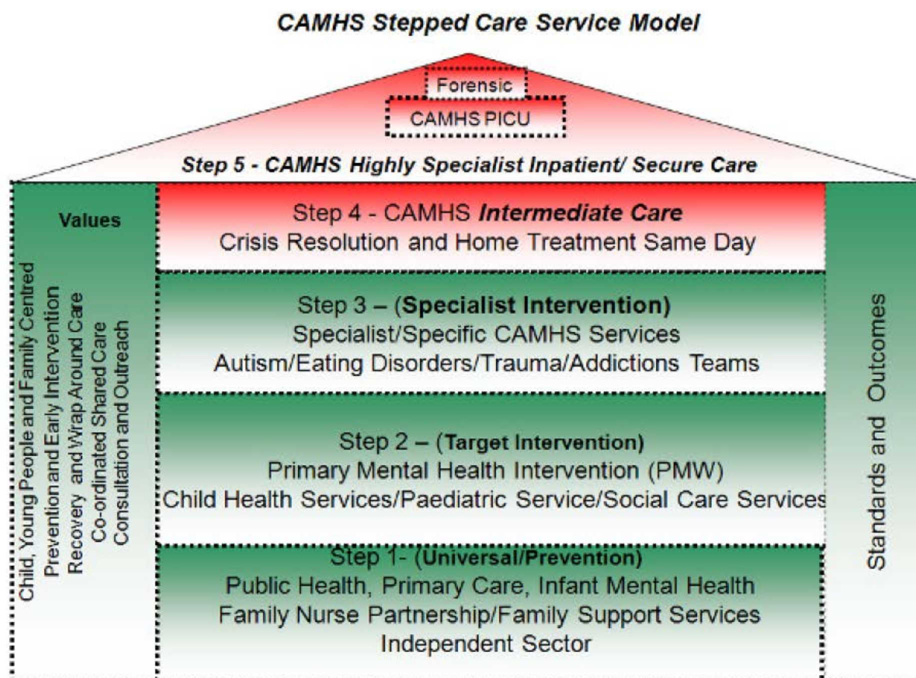

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The foundations for virtually every aspect of human development- physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being

Michael Marmot (2010)

If we intervene early enough, we can give children a vital social and emotional foundation which will help to keep them happy, healthy and achieving throughout their lives and, above all, equip them to raise children of their own, who will also enjoy higher levels of well-being.

Graham Allen MP (Early Intervention: The next steps, 2011)

A young child's experience of an encouraging, supportive, and co-operative mother, and a little later, father, gives him a sense of worth, a belief in the helpfulness of others, and a favourable model on which to build future relationships… by enabling him to explore his environment with confidence and to deal with it effectively, such experiences also promote his sense of competence.

Bowlby, J. (1982). Attachment and loss. Vol. 1: Attachment (2nd Ed.). New York: Basic Books

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Approximately 35-40% of infants are less than securely attached

Barlow, J. & Svanberg, P.O. (2009) Keeping the baby in mind. Infant Mental Health in practice. London: Routledge.

Stress during childhood, , caused by adverse childhood experiences, increases the risk of:

- Alcohol and drug abuse
- Depression and other mental health issues
- Fetal death
- Early initiation of sexual activity
- Suicide attempts
- Chronic ill-health, such as heart, liver or lung disease

(Adverse Childhood Experiences study, Felitti, V. Et al, ongoing)

The infant's first social achievement, then, is his willingness to let the mother out of sight without undue anxiety or rage, because she has become an inner certainty as well as an

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outer predictability. **Erikson, 1963**

In the first three years, babies' brains make 700 new connections every second.

Charles A. Nelson, Neurons to neighbourhoods. J Shonkoff & D. Phillips Eds, Washington DC, National Academy Press, 2000

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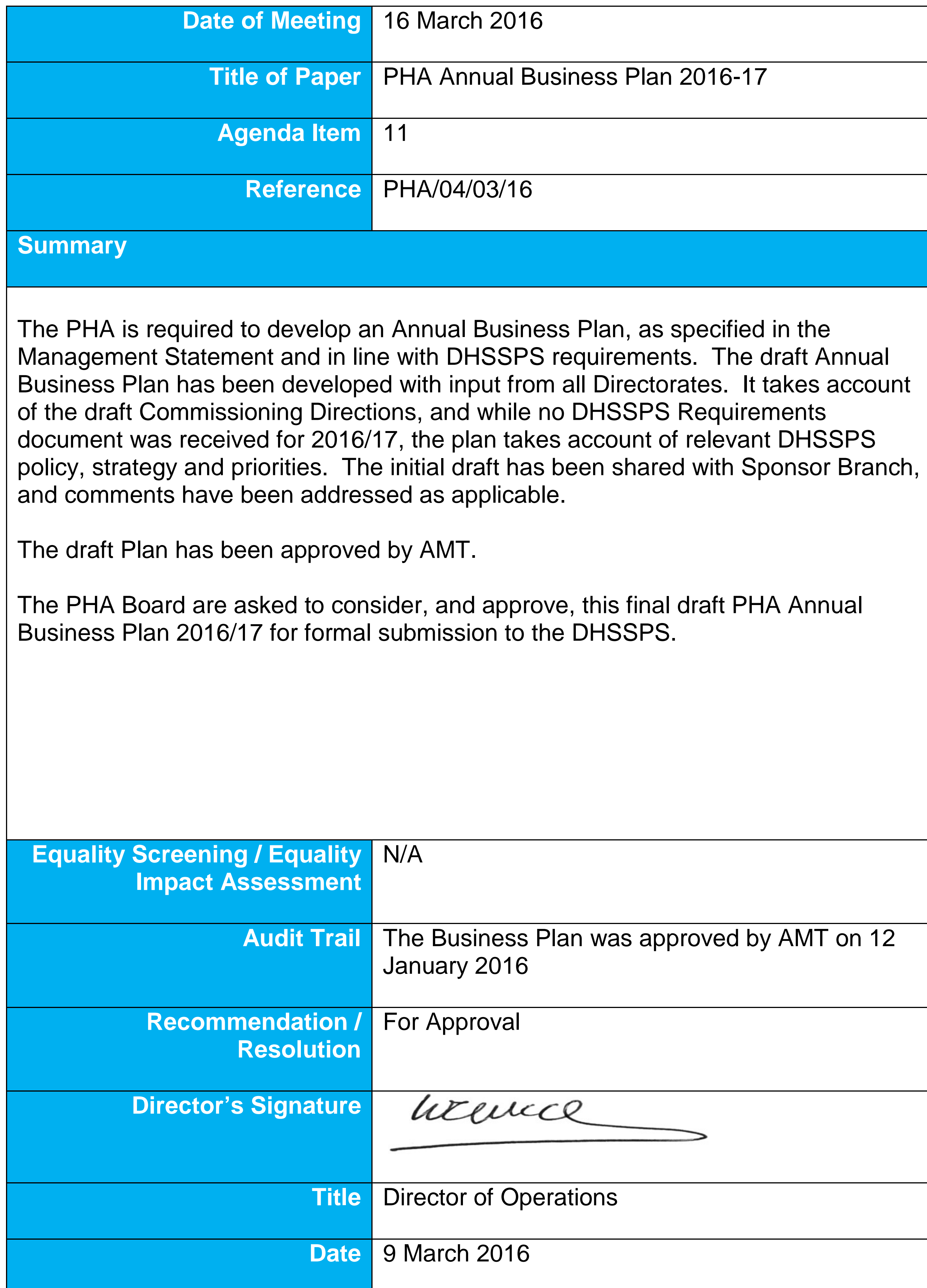
HSC Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER



Date of Meeting	16 March 2016
Title of Paper	PHA Annual Business Plan 2016-17
Agenda Item	11
Reference	PHA/04/03/16
Summary	
The PHA is required to develop an Annual Business Plan, as specified in the Management Statement and in line with DHSSPS requirements. The draft Annual Business Plan has been developed with input from all Directorates. It takes account of the draft Commissioning Directions, and while no DHSSPS Requirements document was received for 2016/17, the plan takes account of relevant DHSSPS policy, strategy and priorities. The initial draft has been shared with Sponsor Branch, and comments have been addressed as applicable. The draft Plan has been approved by AMT. The PHA Board are asked to consider, and approve, this final draft PHA Annual Business Plan 2016/17 for formal submission to the DHSSPS.	
Equality Screening / Equality Impact Assessment	N/A
Audit Trail	The Business Plan was approved by AMT on 12 January 2016
Recommendation / Resolution	For Approval
Director's Signature	
Title	Director of Operations
Date	9 March 2016

ANNUAL BUSINESS PLAN

2016–2017

Approved by the PHA Board 16 March 2016
Approved by DHSSPS 6 April 2016

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Appendix 1: PHA board Framework for Monitoring Performance
Appendix 2: Table of Directors
Appendix 3: Abbreviations
Alternative Formats

Purpose, vision and values

During 2016/17 the PHA will continue to work and be guided by our purpose, vision and values.

Our purpose

To protect and improve the health and social wellbeing of the people of Northern Ireland and to reduce health inequalities through strong partnerships with individuals, communities and key public, private and voluntary organisations.

Our vision

That all people in Northern Ireland can achieve their full health and wellbeing potential.

Our values

- Improving the health and social wellbeing of the community we serve will be at the heart of everything we do.
- In conducting our business, we will act with openness and honesty, treating all with dignity and respect.
- We will work in partnership to improve the quality of life of those we serve.
- We will value and develop our staff and strive for excellence in all we do.

Introduction

The Public Health Agency (PHA) *Annual Business Plan 2016–2017* details how we will make best use of our resources to achieve our core goals, as set out in our *Corporate Strategy 2011–2015 (which has been extended to cover 2016/17, while a new Corporate Strategy is being developed)*. These are:

- Protecting health;
- Improving health and wellbeing and tackling health inequalities;
- Improving the quality of health and social care services;
- Improving early detection of illness.

It also details how we plan to improve how we work by:

- Using evidence, fostering innovation and reform;
- Developing our staff and ensuring effective processes.

This plan focuses on significant new initiatives for 2016/17, incorporating Commissioning Directions and other DHSSPS requirements, and is not intended to cover every aspect of the PHA's planned work.

It will provide a basis for staff objectives and training and is a core accountability tool for the Department of Health, Social Services and Public Safety (DHSSPS).

Strategic context

Since its establishment in 2009, the PHA has continued to take forward work to improve and protect health and wellbeing, reduce health inequalities and to improve the quality and safety of care services within Northern Ireland. Recognising that this is not something that we can do alone, we have also continued to work in partnership with communities, groups, Health and Social Care (HSC) Bodies and other organisations, strengthening our relationships to maximise effectiveness.

Our last Annual Business Plan (2015/16) contained approximately 66 targets, covering every facet of our work. At the time of writing 68% were completed, with 27% on track for completion, albeit slightly delayed. The targets related to actions considered to have a positive impact to improve levels of health and wellbeing, protect the health of the community and ensure patients continue to receive safe and high quality care services.

However, while much progress has been made, we know that there is still much to be done. While the number of deaths from causes considered to be avoidable has reduced over recent years, this still sits at 26% of all registered deaths[1]. One in three deaths in males was as a result of potentially avoidable causes compared to one in five of all deaths in females. While overall life expectancy has continued to increase for both males and females, there is still a significant deprivation gap, with female healthy life expectancy in the most deprived areas of NI 14.2 years lower than in the least deprived areas, and male healthy life expectancy gap 11.8 years[2]. It is also recognised that poor health and wellbeing has a significant negative impact on the local economy.

Health inequalities are impacted by a range of issues, social, economic and educational; no single organisation can bring about the changes required on its own. The PHA is therefore committed to working with partners across all sectors, to improve health and wellbeing, and reduce health inequalities across all areas of our work. Working with communities, groups and organisations is, and will continue to be, at the heart of everything that we do.

In planning our work for 2016/17 the PHA must take account of the strategic, regulatory and legislative environment in which we operate, including:

- Reform;
- Financial context;
- Programme for Government;
- 'Making Life Better';
- DHSSPS policy priorities;
- Partnership working;
- Personal and Public Involvement.

Reform

On 4 November 2015, the Minister announced his intention to remodel the administrative structures of the Health and Social Care system. This was followed by the launch of a consultation

[1] PHA Health Intelligence briefing: Analysis of potentially avoidable premature mortality in Northern Ireland: 2001 to 2013
[2] Health Inequalities in Northern Ireland: Key Facts 2015 – DHSSPS Information Analysis Directorate

on 15 December 2015. The proposals are that the Health and Social Care Board should cease to exist in its current form, with its functions transferring to either the DHSSPS, the PHA or to HSC Trusts. The PHA would be retained, with a focus on early intervention and prevention.

While there is still uncertainty, with the outcome of the consultation as yet unknown, and the details of the reformed structures still to be set out, it is clear that 2016/17 will be a year of change, for the PHA itself and for the HSC organisations we work closely with.

In the midst of this environment, it will be important for the PHA to remain focused, and to effectively manage the changes, in particular ensuring that staff are supported throughout the process.

Financial Context

The PHA, like all other HSC organisations and the wider public sector, faces financial challenges in light of the constrained NI budget. Already in 2015/16 the PHA management and administration budget was reduced by 15%. While actions were taken to reduce goods and services expenditure in 2015/16, the implementation of the Voluntary Exit Scheme (VES) was necessary to achieve the levels of savings required. It will be 2016/17 however when the impact of these staff reductions will be felt. The outworking of VES, along with the potential for further budget reductions in 2016/17 will have implications on how we do our business. The PHA will continue to closely monitor and review its expenditure to ensure that it is used to maximum effect to help improve the health and wellbeing of the people of Northern Ireland and maintain the safety and quality of the services we commission.

Programme for Government

Assembly elections have now been scheduled for May 2016, and while a new PFG is currently being considered, it will not be agreed and issued for consultation until after the new Executive is elected in May.

The PHA will however continue to work closely with the DHSSPS and other partners, to ensure that we are positioned to achieve the relevant PFG targets.

Making Life Better

‘Making Life Better 2013–2023’ is a ten year public health strategic framework for Northern Ireland to improve the health and wellbeing of the public and reduce health inequalities, seeking to create the conditions for individuals and communities to be enabled and supported to lead healthy lives. This is to be achieved through collaborative working across Government Departments and sectors.

The PHA has a lead role in the implementation of ‘Making Life Better’ supporting the DHSSPS and working with partners across all sectors, including chairing the Regional Project Board for Making Life Better.

Making Life Better will continue to be central to the work of the PHA throughout 2016/17, both working with partners through the relevant structures and also influencing the objectives and actions set out in the Annual Business Plan.

Other DHSSPS policy priorities

During 2016/17 the PHA will continue to take forward relevant DHSSPS policy priorities, working with the HSC and other organisations as appropriate, including Quality 2020 and Transforming Your Care.

Partnership Working

The PHA has a statutory responsibility to work closely with partners in the community, the voluntary sector, health and social care, local government and the statutory sector.

We will continue to do this in 2016/17, including through continuing to provide funding and professional leadership to implement specific programmes and initiatives. We will also continue to seek to influence and shape the priorities, processes and budgets of partners to improve longer-term health outcomes.

A key priority in 2016/17 will be to work closely with and further develop and consolidate our relationships with local government, to develop shared approaches and arrangements for improving and protecting the health and wellbeing of our communities.

Personal and Public Involvement

Personal and Public Involvement (PPI), the active and meaningful involvement of service users, carers and the public in the commissioning, design, delivery and evaluation of health and social care services, is a statutory responsibility for all HSC organisations.

PPI is an integral component in improving safety, quality and effectiveness, helping to ensure that services are truly person centred, and also helping to foster a sense of ownership and increase self-responsibility for health and wellbeing. Involvement of patient and carer knowledge and expertise is an integral element of the co-design of services.

In keeping with our PPI strategy and action plan, 'Valuing People, Valuing their Participation', the PHA will continue to work to embed PPI into the culture and practice of the organisation. We will also continue to take forward our regional leadership responsibilities for PPI across the HSC system.

Conclusion

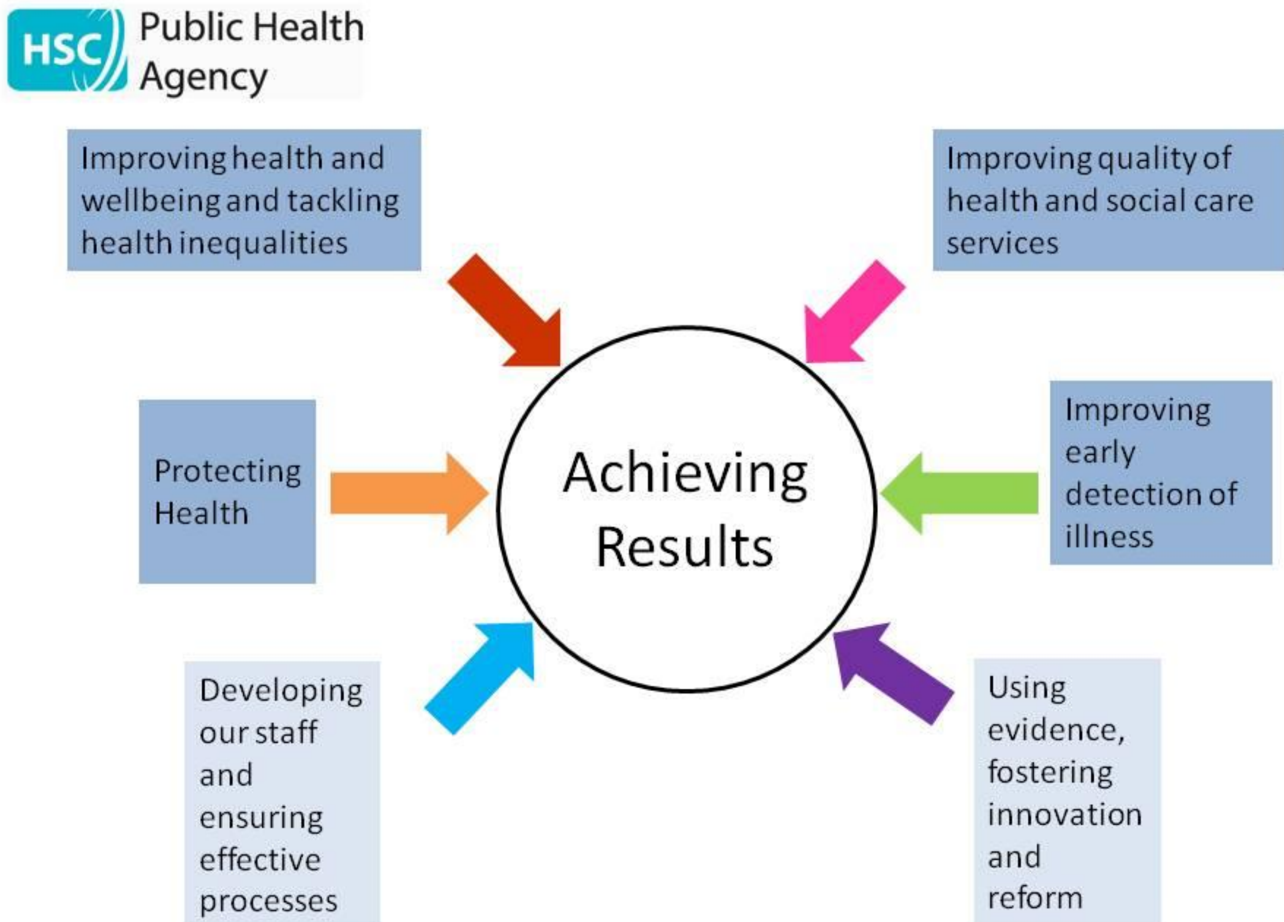
2016/17 will be a challenging year, as we strive to meet our commitments while working in an environment of change and uncertainty and the impact of budget reductions.

It will however also be a year of opportunity, as we seek to develop our new corporate strategy for the period from 1 April 2017, building on the engagement processes and initial development to date, but taking account of the new PFG and the outworking of HSC reform.

Above all we remain committed to working to achieve improvements in the health and wellbeing of the population of Northern Ireland, making best use of our resources to do so in 2016/17 as well as plan for the future.

Our work in 2016/17

In 2016/17 we will continue to focus on our six core areas of work, as illustrated in the diagram below:



The following sections of this business plan break each of these areas down into key actions to be led by specific PHA executive directors, recognizing that many of them will involve input and work across several Directorates.

Reports on the progress against each of these actions will be submitted on a regular basis to the PHA board. This will be supplemented by in-depth reporting on progress on specific issues as summarised in Appendix 1.

More detailed implementation plans for key actions will be presented to and considered by the PHA board. These will form the basis of monitoring and reporting of progress and achievements.

Following the introductory narrative in the following sections of this Plan, a table is presented setting out Key Actions to be taken forward in 2016/17.

Protecting health

The Health Protection Service within the PHA is responsible for the prevention and control of communicable disease and environmental hazards and provides the acute response function to major issues in these areas, such as outbreaks of infectious disease. The PHA Health Protection Duty Room, located in Linenhall Street at PHA headquarters, is the first point of call for all acute issues in relation to infectious disease incidents and for notifications of infectious diseases.

The Health Protection Service has a number of work programmes in key areas with regional consultant leads for each area. These include healthcare associated infections, immunisation, health protection emergency preparedness, gastrointestinal infections, sexually transmitted infections, influenza, and tuberculosis. Immunisation programmes are one of the most successful public health programmes in existence, protecting the population of Northern Ireland against serious diseases.

During 2016/17, the PHA will continue to lead and provide the acute health protection response to incidents, outbreaks and the wide range of issues reported to the Health Protection Duty Room. We will ensure our protocols are fully up to date and further strengthen our service through continuous learning and development.

Priority actions for 2016/17 are:

- Reduce health care associated infections (HCAI);
- In line with DHSSPS priorities work on the development/introduction of a surveillance system for Antimicrobial resistance (AMR);
- Continue to work with HSCNI organisations to vaccinate against Men B and Men ACWY; and
- Continue the flu immunisation programmes.

Protecting health

Key actions for 2016/17

	Action	Lead director	Timescale for completion
1.	**HCAIs:** The Agency will continue to work with Trusts to secure a further reduction of x% (to be determined by DHSSPS) in the total number of in-patient episodes of Clostridium difficile infection in patients aged 2 years and over and in-patient episodes of MRSA bloodstream infection.	Director of Public Health	31st March 2017
2.	**Antimicrobial resistance:** In line with DHSSPS priorities, continue to work on the development/introduction of a surveillance system for anti-microbial resistance (AMR) in Northern Ireland and bring NI in line with the rest of the UK.	Director of Public Health	31st March 2017
3.	**Immunisation:** During 2016/17 achieve uptake targets for seasonal influenza vaccinations set by DHSSPS.	Director of Public Health	31st March 2017
4.	**Immunisation:** Continue to work with HSCNI organisations to vaccinate against Men B and Men ACWY and encourage uptake rates through information/educational campaigns.	Director of Public Health	31st March 2017

Improving health and wellbeing and tackling health inequalities

Our work to improve health and wellbeing and to reduce health inequalities across the population, including with particular communities and groups known to be at increased risk of poorer health, reflects the six key themes of Making Life Better:

1. Giving Every Child the Best Start
2. Equipped Throughout Life
3. Empowering Healthy Living
4. Creating the Conditions
5. Empowering Communities
6. Developing Collaboration

During 2016/17 the PHA will advance these objectives by building strong connections across society to improve health and wellbeing and reduce inequalities. We will also strengthen our joint working with the eleven new councils and ensure close alignment with community planning processes to improve health and wellbeing.

The PHA will continue to progress the early years intervention agenda, in particular through the workstreams of the Early Intervention Transformation Programme, sponsored by a consortium including Government Departments. We will continue to work with communities and organisations to reduce some of the structural barriers to health and we will seek to ensure the active engagement of communities wherever possible.

In addition, we will focus on a number of specific public health issues:

- Breastfeeding;
- Obesity prevention;
- Tobacco control;
- Alcohol and drugs;
- Sexual health;
- Skin cancer prevention;
- Home accident prevention;
- Mental health and wellbeing;
- Suicide prevention;
- Child health promotion.
- Active travel

We will also be taking forward a programme to support the active engagement of older people to improve their health and wellbeing. Four key areas of action will include: promoting active citizenship and positive ageing environments; improving access to and uptake of health and wellbeing programmes; supporting local approaches to include older people in issues that affect their health and wellbeing; and promoting befriending and support for older people and carers.

A significant area of work this year will be the procurement of services including mental health promotion and suicide prevention including the 24/7 Lifeline crisis intervention service. Preparation for this has included extensive engagement with community and voluntary sector partners in developing agreed standards for services. These processes aim to secure the best possible outcomes for the public.

Work will also continue during 2016/17, with the HSCB and others as appropriate, to ensure that the e-Health and care strategy is implemented and reflects the objectives of the PHA and 'Making Life Better'.

Improving health and wellbeing and tackling health inequalities
Key actions for 2016/17

	Action	Lead director	Timescale for completion
1.	Develop and deliver a range of integrated public information campaign solutions to target audiences in line with key PHA priorities.	Director of Operations	On-going throughout 2016/17
	Giving Every Child the Best Start – Theme 1 Making Life Better		
2.	Ensure that implementation of Early Intervention Transformation Programme Work Stream One is in keeping with business goals and implementation plan	Director of Nursing/AHP	31st March 2017
3.	Implement Early Intervention service linking with family support hubs. (Early Intervention Transformation programme Work Stream Two).	Director of Public Health	31st March 2017
4.	Implement the regional Infant Mental Health plan and commission training to HSC and early years workforce.	Director of Public Health	31st March 2017
5.	Implement the Action Plan of the Breastfeeding Strategy for Northern Ireland.	Director of Public Health	31st March 2017
6.	Ensure regional implementation of Family Nurse Partnership in keeping with Family Nurse Partnership specification and licence requirements	Director of Nursing/AHP	On-going throughout 2016/17
7.	Promote the health, wellbeing and safeguarding of children through implementation of Healthy Child Healthy Future and Healthy Futures policy.	Director of Nursing/AHP	On-going throughout 2016/17
	Equipped Throughout Life – Theme 2 Making Life Better		
8.	Procure a range of suicide prevention and mental health promotion services, including a focus on more vulnerable groups. Commission and/or procure the 24/7 Lifeline crisis intervention service.	Director of Public Health	31st March 2017
9.	Provide strategic leadership and co-ordinate the Regional Learning Disability Health Care & Improvement Steering Group on behalf of PHA & HSCB to ensure that good practice is promoted, health inequalities are identified and addressed and that services are responsive and make adequate adaptation to meet the health care needs of people with a learning disability	Director of Nursing/ AHP	31st March 2017

	Empowering Healthy Living – Theme 3 Making Life Better		
10.	Implement the Tobacco Control implementation plan including Brief Intervention Training, smoking cessation services, enforcement control and Public Information.	Director of Public Health	31st March 2017
11.	Support and lead multi-agency partnerships to oversee regional and local delivery of Protect Life and Mental and Emotional Wellbeing strategies including the regional Bamford structures and local Protecting Life Implementation Groups' Action Plans.	Director of Public Health	31st March 2017
12.	Implement the obesity prevention action plan including: weight management programmes for children, adults and pregnant women, development of a common regional Physical Activity Referral programme, implementation of Active Travel programme in schools, implementation of Active Travel Plan Belfast and public information and awareness.	Director of Public Health	31st March 2017
13.	Take forward recommendations of the RQIA 'Review of Specialist Sexual Health services in Northern Ireland' in partnership with DHSSPSNI, HSCB and HSC Trusts.	Director of Public Health	31st March 2017
14.	Ensure Trusts continue to deliver Telehealth and Telecare services including through the Telemonitoring NI contract, to targets set by the PHA.	Programme Director CCHSC	31st March 2017
	Creating the Conditions – Theme 4 Making Life Better		
15.	Develop and implement a consistent approach to workplace health and wellbeing programmes working with local government and other partners.	Director of Public Health	31st March 2017
16.	Lead AHPs in the development of Public Health Strategies for Children & Older People	Director of Nursing/AHP	31st March 2017
	Empowering Communities – Theme 5 Making Life Better		
17.	Further develop the Travellers Health and Wellbeing Forum and delivery of the regional Action Plan.	Director of Public Health	31st March 2017
18.	Work with local communities and community based organisations to develop integrated approaches to improving health.	Director of Public Health	31st March 2017
19.	Encourage, facilitate and support the active involvement and participation of service users, carers and the public in the planning, delivery and evaluation of health to enable people to take more ownership of and self-responsibility for their own health and social well-being	Director of Nursing/AHP	On-going throughout 2016/17

20.	Continue to work with local government on the alignment and development of community planning and PHA planning and to initiate a range of demonstration projects in each council area embedding the key drivers of 'Making Life Better'	Director of Operations/ Director of Public Health	On-going throughout 2016/17
	Developing Collaboration – Theme 6 Making Life Better		
21.	Continue to work with key stakeholders to lead and coordinate implementation of Making Life Better through the Regional Project Board, local partnerships and Health and Social Care Northern Ireland	Chief Executive	On-going throughout 2016/17
22.	As professional Lead in development and implementation of Regional e-Health and Care Strategy, engage with nursing and AHP workforce as part of strategy implementation; agree action plan and monitoring process	Director of Nursing/AHP	On-going throughout 2016/17

Improving the quality of HSC services

The Quality 2020 Strategy defines quality as having three core elements:

- Safety;
- Effectiveness;
- Patient and Client Focus.

The PHA is committed to ensuring safe, effective and high quality care for the population of Northern Ireland and to continually improving services by horizon scanning and developing learning systems to maximise the potential within organisations.

The PHA will continue to lead the Quality 2020 Implementation Team, working with the HSCB, HSC Trusts and the post graduate training bodies for medicine, nursing and social work. We will also continue to support and progress the Quality agenda through a number of work streams.

The PHA will monitor the implementation of the DHSSPS Patient Client Experience Standards and implement the 10,000 Voices initiative to enable patients, carers and their families to affect and inform how services are delivered and commissioned. The Patient & Client Experience (PCE) steering group will provide strategic direction for the implementation of the DHSSPS Patient and Client Experience Standards and agree the annual work plan reflecting the DHSSPS Commissioning Plan Directions, and the annual HSCB/PHA Joint Commissioning Plan. In addition, the PHA as the LSA will ensure adherence to statutory midwifery supervision.

The PHA will lead, or contribute to, workforce reviews as required by the HSC Regional Workforce Planning Group and, when agreeing models of service delivery, will seek to be assured that HSC Trusts and independent practitioners have considered and identified the workforce needs, exercising a challenge function where appropriate in this process and identifying to the Department areas where intervention is required.

During 2016/17 we will progress work to implement service frameworks and improve management of long-term conditions to improve quality of services for patients and clients. We will also continue to engage with the range of clinical networks and other clinical fora.

The PHA will also continue to lead on both the development and implementation of a number of strategies including, but not limited to, the Mental Health Nursing Framework 'Developing Excellence Promoting Recovery', AHP Strategy, Dementia and Maternity Strategies.

The PHA will also review its input to service development and HSCB structures during the coming year in the context of the recent review of commissioning and the Minister's statement.

	Action	Lead director	Timescale for completion
1.	Work with the HSCB to take forward the review of the Cancer Services Framework and implementation of the revised Framework during 2016/17 (staff and financial resource dependant.)	Director of Public Health	On-going throughout 2016/17
2.	Work with the HSCB to take forward the Cardiovascular Services Framework Implementation Plan.	Director of Public Health	On-going throughout 2016/17
3.	Take forward the Implementation Plan for the Respiratory Service Framework, following consultation.	Director of Public Health	On-going throughout 2016/17
4.	Continue to Lead the Long Term Conditions Regional Implementation Group to deliver on its action plan, and commission patient and self – management programmes as outlined in PfG, (subject to funding).	Director of Public Health	31st March 2017
5.	In collaboration with the DHSSPS, DoJ, HSCB and HSC Trusts provide Public Health leadership and professional nursing advice to the Joint Health Care & Criminal Justice Strategy. Work alongside YJA , PSNI and HSCB colleagues to identify health care model for the provision of health care in Police custody and Woodlands Juvenile Justice Centre.	Director of Nursing/AHP	31st March 2017
6.	Produce final report for issue to Department on the mental health nursing framework, 'Developing Excellence, Supporting Recovery' including impact of implementing a Recovery model for service improvement.	Director of Nursing/AHP	31st March 2017
7.	Along with HSCB lead the implementation of the NI Dementia Strategy and lead the OFMDFM/AP funded Dementia Signature Project (due to complete June 2017).	Director of Nursing/AHP	On-going throughout 2016/17
8.	Take forward recommendations on the DHSSPS District Nursing Framework.	Director of Nursing/AHP	On-going throughout 2016/17
9.	Continue to lead on the implementation of PPI policy in HSC, with a focus on promotion of the new PPI Standards, extension of the PPI Monitoring function and roll out of the PHA led PPI Training Programme for staff.	Director of Nursing/AHP	On-going throughout 2016/17

	Action	Lead director	Timescale for completion
10.	Progress existing programs of quality improvement, continue to build capacity and knowledge on patient safety, improvement science and human factors, and explore future options for collaboration in QI and safety with CAWT partners.	Director of Nursing/AHP	31st March 2017
11.	The HSC Safety Forum will work with HSC Trusts to support the further spread of the Sepsis 6 bundle beyond the pilot areas identified in the 2014/15 period.	Director of Nursing/AHP	31st March 2017
12.	The HSC Safety Forum will work with the Regional Learning Disability Healthcare and Improvement Group to identify potential future opportunities to work collaboratively in quality and safety improvement.	Director of Nursing/AHP	31st March 2017
13.	Continue the review of school nursing using a needs led, child focused and evidence based approach to service developments.	Director of Nursing/AHP	31st March 2017
14.	Continue to develop the methodology and models for phases 2–4 of the Delivering Safe and Effective Care Project (ED, DN and HV), and progress monitoring arrangement with HSCB for implementation of Phase 1.	Director of Nursing/AHP	31st March 2017
15.	Ensure adherence to statutory midwifery supervision and provide professional leadership in relation to the development of high quality, safe and effective midwifery services in keeping with the Maternity Strategy.	Director of Nursing/AHP	31st March 2017
16.	Q2020 – Lead the development of the Annual Quality Report in conjunction with the HSCB.	Director of Nursing/AHP	31st March 2017
17.	Lead on the professional issues relating to the transition of HSCB/PHA Medicines Management Model from HSCB to PHA.	Director of Nursing/AHP	31st March 2017
18.	Work with Trusts to integrate the Patient Client Experience work programme and 10,000 Voices Initiative to develop systems to listen to, learn from and act upon patient and client experience.	Director of Nursing/AHP	31st March 2017
19.	Ensure professional readiness of Therapeutic Workforce in WHSCT Radiotherapy Unit.	Director of Nursing/AHP	31st October 2016
20.	Lead a programme of work to drive reform of Allied Health Professionals Services including • Improving data quality; • Development of Care Pathways.	Director of Nursing/AHP	31st March 2017

	Action	Lead director	Timescale for completion
21.	Lead development and implementation of year 4 Allied Health Professionals Strategy Action Plan	Director of Nursing/AHP	31st March 2017
22.	Lead the development of Palliative Care services	Director of Nursing/AHP	31st March 2017
23.	In support of safe and effective person centred care, Commissioners through the Director of Nursing PHA should require of organisations and bodies from which services are commissioned, that appropriate systems are in place to ensure that nurses and midwives are appropriately supported to fulfil regulatory requirements of the NMC, in particular the introduction of revalidation for Nurses and midwives.	Director of Nursing/AHP	On-going throughout 2016/17
24.	Develop framework for primary care nursing.	Director of Nursing/AHP	31st March 2017
25.	Develop and take forward regional service improvement within older peoples environment focusing on initiative regarding workforce recruitment/and education.	Director of Nursing/AHP	31st March 2017
26.	To complete the review of AHP support for children with statements of special educational needs, agreeing a proposed framework and implementation plan for consideration by the Minister of Health, Social Services and Public Safety.	Director of Nursing/AHP	31st March 2017

Improving the early detection of illness

Early detection and treatment can result in better outcomes for some conditions. Screening involves inviting people who have no symptoms of a particular disease, to be tested to see if they have the disease, or are at risk of getting it. As a result they can then be offered appropriate further investigation and treatment. It is recognised that screening programmes can do harm as well as good, so it is important that all those invited for further screening make a fully informed decision as to whether they wish to participate. The PHA is working to promote informed choice for those invited for cancer screening.

During 2016/17 the PHA will continue to commission and quality assure screening programmes for breast, bowel and cervical cancers as well as non-cancer screening programmes including: antenatal infections screening; newborn bloodspot and hearing screening; diabetic retinopathy screening; and screening for abdominal aortic aneurysm (AAA). We will also continue to commission services to support the Bowel Cancer Screening Programme, reflecting the higher uptake rates.

The Diabetic Retinopathy Screening Programme has been under significant pressure to deliver screening at the required intervals and to the agreed standards. A Modernisation Board from Diabetic Retinopathy Screening was established in the latter half of 2014 to oversee a number of elements of service modernisation. During 2014, RQIA undertook a review of the service and the Programme Board will be overseeing the implementations of the recommendations during 2016/17.

Improving the early detection of illness
Key actions for 2016/17

	Action	Lead director	Timescale for completion
1.	Rolling programme of analysis by health intelligence of screening data and evidence reviews of actions elsewhere to better inform targeting of screening in lower uptake populations.	Director of Public Health	On-going throughout 2016/17
2.	Implement actions to address the recommendations in the RQIA review of Diabetic Eye Screening Programme.	Director of Public Health	On-going throughout 2016/17
3.	Maintain all existing screening programmes and the quality assurance function.	Director of Public Health	On-going throughout 2016/17
4.	Develop a TVU service for the early detection of Ovarian Cancer.	Director of Nursing/AHP	31st October 2016
5.	Develop a system to prioritise the X-ray reports of Older people from Nursing Homes.	Director of Nursing/AHP	31st August 2016

Using evidence, fostering innovation and reform

During 2016/17, implementation of the new HSC R&D Strategy ‘Research for Better Health & Social Care (2015–2025)’ will commence. The aim of the strategy is to enhance the health, wellbeing and prosperity of people in Northern Ireland through world renowned research and development.

The strategy aims to build on the success of its predecessor strengthening links between research and policy making, increasing success in competing for additional funding, enhancing our research infrastructure, effectively communicating the findings and developing improved diagnostic, treatment and care pathways for service users.

The strong research base in Northern Ireland has helped the region to attract funding to support participation in national developments such as the 100,000 Genomes Project. This project aims to sequence the full genomes of around 70,000 UK citizens, and focuses on the more effective diagnosis of rare diseases and improved cancer treatments. This aligns with the Northern Ireland Rare Diseases Strategy and will provide a framework towards greater mainstreaming of genetic testing in care pathways for those patient groups who would most benefit.

Northern Ireland has also been selected as a Centre of Excellence in the UK Precision Medicine Catapult. The Precision Medicine Catapult is focused on making the UK the most compelling location in the world for the development and delivery of this new targeted approach. The country has a competitive position in precision medicine, based on its scientific excellence and £1bn of research infrastructure investment from the Government over recent years. By focusing on the main bottlenecks to product delivery, the Precision Medicine Catapult will work with the precision medicine community to build a thriving industry generating economic and healthcare benefits. The Northern Ireland Centre will be based between QUB and Belfast HSC Trust and will focus on Precision Cancer Medicine.

Besides these important developments, the PHA will continue to support high quality research across the entire spectrum of health and social care, and work with HSC professionals, academics, charities and industry to deliver the third HSC R&D Strategy.
In order to do this, we will:

- Maximise opportunities to enrich the HSC R&D Fund by supporting researchers to access funding from external sources; and
- Facilitate the development of evidence-based health and social care, through effective knowledge exchange.

	Actions	Lead director	Timescale for completion
1.	Lead on the implementation of the new HSC R&D Strategy: *Research for Better Health & Social Care (2015-2025.*	Director of Public Health	On-going throughout 2016/17
2.	Support researchers to secure research funding from external sources including NIHR evaluation, trials and studies co-ordinating centre (NETSCC), Horizon 2020 & other EU sources.	Director of Public Health	On-going throughout 2016/17
3.	Support the Northern Ireland Public Health Research Network (NIPHRN) to identify opportunities for research in PHA priority areas.	Director of Public Health	On-going throughout 2016/17
4.	Continue to work with the Social Work community to support and encourage research within Social Work/Care.	Director of Public Health	On-going throughout 2016/17
5.	Working with CCHSC to facilitate service development and service improvement within Telemonitoring NI: • Contribute to the redesign of patient pathways sharing examples of local good practice regionally • Provide professional nursing advice to the specification and implementation process for TMNI replacement •	Director of Nursing/AHP	31st March 2017
6.	Establish new and support existing expert nursing groups, for example Cancer, Neurology and District Nursing, Stroke and Palliative and End of Life Care.	Director of Nursing/AHP	On-going throughout 2016/17
7.	Host a HSC wide Conference on PPI, highlighting best involvement practice, reflecting on the new involvement Standards, sharing findings from the PPI research initiative and examining how to address the report recommendations for the benefit of service users and carers.	Director of Nursing/AHP	30th June 2016
8.	Ensure that the learning from PHA/SBNI/QUB research on infant death is embedded into SCPHN and midwifery practice	Director of Nursing/AHP	31st March 2017
9.	CCHSC will have specified and commenced the implementation of service(s) to replace Telemonitoring NI.	Programme Director CCHSC	31st March 2017

	Actions	Lead director	Timescale for completion
10.	CCHSC will seek opportunities to develop and utilise innovative technologies to improve health and wellbeing including leading the NI input to EIP AHA; EU and other sources of funding and working collaboratively with HSCNI and other key stakeholders	Programme Director CCHSC	31st March 2017
11.	To lead work on the implementation of the eHealth and Care Strategy objectives: • Supporting People; • Using Information and Analytics; • Fostering Innovation. which will contribute to the development of a regional EHCR.	Programme Director CCHSC	31st March 2017
12.	Commence process to benchmark AHP input against National Findings for Unscheduled Care	Director of Nursing/AHP	30th September 2016

Developing our staff and ensuring effective processes

Following the Minister's announcement on 4 November 2015, 2016/17 is likely to be a year of change and transition, with the potential for impact on what we do and how we do it. While the detail of these changes is still to be set out, it is clear that PHA will need to manage the organisation through this period of change, ensuring that core functions and responsibilities are maintained and that staff are supported through the process.

The PHA recognises that its staff are the organisation's greatest resource and the promotion of a safe, productive and fair work environment where all staff are respected and also understand their personal responsibilities and accountability is paramount.

It is also acknowledged that the current financial environment, with budget reductions, puts more pressure on staff and can have negative impact on staff morale.

The PHA will seek to manage all these pressures and communicate with and support staff throughout the year.

During 2016/17 the Organisational Workforce Development Group will continue to take forward its work, including supporting learning and development opportunities to enhance and expand the knowledge base and skillset of individual staff and the organisation as a whole, as well as supporting the work of the Health and Wellbeing and Communication subgroups.

While work on the new Corporate Strategy has been unavoidably delayed due to timescales for the next Programme for Government as well as HSC organisational change, the PHA will seek to build on the work already undertaken, including the initial internal and external engagement events, to review our purpose, vision and values along with our core goals and objectives, reflecting the experience of the early years of the PHA and looking to the future.

The Nursing and Midwifery Council (NMC) has introduced Revalidation for Nurses and Midwives; this will be implemented in April 2016. The Director of Nursing/AHP, who is leading the organisational readiness, has established a professional forum and developed a communication pathway to share information across the PHA and HSCB. Revalidation champions within the PHA have been identified and will provide on-going support to registrants and managers across the PHA and HSCB as well as engaging with GP employed nurses.

During 2016/17 the PHA will build on its existing good governance arrangements, continuing to ensure that these are embedded within the organisation and further developed in line with best practice, and Departmental guidance. This will include meeting key Departmental requirements including preparing a Governance Statement and Mid-Year Assurance Statement, compliance with the NAO Audit Committee Checklist, completing the ALB board self-assessment tool, mid and end year accountability meetings, meeting Controls Assurance Standards and associated self-assessments, preparing our Annual Business Plan within the specified timescales and requirements and complying with procurement and financial regulations.

The PHA will continue to provide the Department with information pertaining to its performance management and reporting requirements in an accurate and timely manner.

The PHA is committed to the objectives of the NI Executive approved Asset Management Strategy and will continue to manage its facilities in line with this.

Developing our staff and ensuring effective processes

Key actions for 2016/17

	Actions	Lead director	Timescale for Completion
1.	Manage the process of organisational change in line with further clarification from the DHSSPS, ensuring appropriate and timely internal and external communication.	Chief Executive with all Directors	On-going throughout 2016/17
2.	Maintain capacity to deliver core duties and deliverables identified for the PHA in 2016/17.	Chief Executive with all Directors	On-going throughout 2016/17
3.	Achieve substantive compliance for all 15 controls assurance standards applicable to the Public Health Agency.	Director of Operations	31st March 2017
4.	Test and review the PHA business continuity management plan to ensure arrangements to maintain services to a pre-defined level through a business disruption.	Director of Operations	31st March 2017
5.	Explore an electronic records management solution in line with Controls Assurance Standards.	Director of Operations	31st March 2017
6.	Continue to take forward implementation of the PHA Procurement Plan.	Director of Operations, with all Directors	On-going throughout 2016/17
7.	Finalise the new PHA Corporate Strategy and the PHA Annual Business Plan for 2017/18 in line with DHSSPS requirements and timescales. (when notified)	Director of Operations (with all Directors)	31st March 2017
8.	Develop and agree a new Internal communications strategy and action plan to ensure PHA business is supported by efficient and effective internal communication systems.	Director of Operations	On-going throughout 2016/17
9.	Review and Revise PHA digital assets including PHA Corporate and Intranet sites.	Director of Operations	On-going throughout 2016/17
10.	Continue to enhance social media activity, extending the agency's reach through its online channels and broadening the types of content used.	Director of Operations	On-going throughout 2016/17
11.	Extend the range of communications tools used by the agency e.g. infographics and audio recordings, to support its work to convey key messages to target audiences.	Director of Operations	On-going throughout 2016/17
12.	Build on the suicide awareness media and engagement work which has been developed by the agency.	Director of Operations	On-going throughout 2016/17

	Actions	Lead director	Timescale for Completion
13.	Ensure that by 30th June 2016 90% of staff will have had an annual appraisal of their performance during 2015/16.	All Directors	30th June 2016
14.	Ensure that by 31 March 2017 we meet the 95% target that doctors working in PHA have been subject to an annual appraisal.	Director of Public Health	31st March 2017
15.	Continue to provide professional leadership, advice and guidance on PPI.	Director of Nursing/AHP	On-going throughout 2016/17
16.	Utilize Safety Forum QI expertise to aid the delivery of training to HSC staff as envisioned by the Attributes Framework and facilitate entry to Scottish Quality and Safety Fellowship programme.	Director of Nursing/AHP Dr	31st March 2017
17.	Ensure that PHA duties and responsibilities in relation to Local Supervising Authority Midwifery Officer are evidenced in annual report presented to AMT & PHA Board.	Director of Nursing/AHP	On-going throughout 2016/17
18.	Revalidation champions will provide on-going support to registrants and managers across the PHA and HSCB, as well as engaging with GP employed nurses.	Director of Nursing/AHP	On-going throughout 2016/17
19.	Provide professional support to Nurses/midwives through the quarterly Professional Forum.	Director of Nursing/AHP	On-going throughout 2016/17
20.	Develop and implement the Nurses and Midwives verification of NMC policy through HRPTS system.	Director of Nursing/AHP	On-going throughout 2016/17
21.	Meet DHSSPS financial, budget and reporting requirements.	Director of Finance	31st March 2017

Appendix 1

PHA board Framework for Monitoring Performance				
	Proposed Timelines for Monitoring			
Area of focus	**Monthly**	**Quarterly**	**Biannual**	**Annual**
General				
Commissioning Development Plan targets				
Corporate Business Plan Targets				
PHA Annual Report				
DPH Annual Report				
Financial Performance Report				
Health Improvement / Inequalities				
Obesity (inc Physical Activity / Food and Nutrition / Breastfeeding				
Smoking Cessation				
Suicide/Mental Health Promotion incl Self harm /OneStopShops/Lifeline				
Marginalised Groups (inc Travellers / Prisoners / ethnic				
Poverty (inc MARA / Fuel Poverty)				
Building Sustainable Communities				
Teenage Pregnancy / Sexual Health				
Drugs and Alcohol				
Early Years Interventions - (including) Roots of Empathy				
Screening and Service Development				
Bowel Cancer Screening				
Abdominal Aortic Aneurysm Screening				
Breast Screening				
Cervical Screening				
New Born Screening				
Diabetic Retinopathy Screening				
Health Protection				
Immunisation and vaccination Programmes				
HCAI				
HIV				
Seasonal Flu				
Nursing and AHP				
Family Nurse Partnerships				
Connected Health				
Quality and Safety - SAIs and Learning lessons				
Quality and Safety - Complaints, PCE Experience standards and updates, and Quality Improvement Plans				
PPI				
Research and Development				
Campaign evaluations				
Connected health				

Appendix 2

Table of directors

	Director title	Name
1.	Chair	Andrew Dougal
2.	Chief Executive	Dr Eddie Rooney, Public Health Agency
3.	Director of Nursing and Allied Health Professions (AHP)	Mary Hinds, Public Health Agency
4.	Director of Operations	Ed McClean, Public Health Agency
5.	Medical Director/ Director of Public Health	Dr Carolyn Harper, Public Health Agency
6.	Non-Executive Director	Billy Ashe
7.	Non-Executive Director	Brian Coulter
8.	Non-Executive Director	Leslie Drew
9.	Non-Executive Director	Julie Erskine
10.	Non-Executive Director	Deepa Mann-Kler
11.	Non-Executive Director	Thomas Mahaffy
12.	Non-Executive Director	Paul Porter
13.	Director of Finance	Paul Cummings, Health and Social Care Board
14.	Director of Human Resources	Hugh McPoland, Business Services Organisation
15.	Director of Social Care and Children's Services	Fionnuala McAndrew, Health and Social Care Board

Appendix 3

Abbreviations

AAA	Abdominal Aortic Aneurysm
ADOG	All Departments Officials Group
AHP	Allied Health Professions
ALB	Arms-Length Body
AMR	Anti-microbial resistance
AMT	Agency Management Team
BSO	Business Services Organisation
CAWT	Cooperation and Working Together
CCHSC	Centre for Connected Health and Social Care
CNS	Clinical Nurse Specialist
DHSSPS	Department of Health, Social Services and Public Safety
DN	District Nurse
DoJ	Department of Justice
ECATS	Electronic Caseload Analysis Tool
ED	Emergency Department
EIP	European Innovation Partnerships
EU	European Union
GP	General Practitioner
HCAI	Health Care Associated Infections
HRPTS	Human Resources, Payroll, Travel and Subsistence
HSC	Health and Social Care
HSCB	Health and Social Care Board
HSC R&D	Health and Social Care Research and Development Division
HSCT	Health and Social Care Trust
HV	Health Visitor
LSA	Local Supervising Authority
MARA	Maximising Access in Rural Areas
Men B	Meningococcal B
Men ACWY	Meningococcal ACWY
MRSA	Methicillin resistant staphylococcus aureus; a bacterium with antibiotic resistance
NAO	National Audit Office
NETS	NIHR, Evaluation, Trials and Studies
NIPHRN	Northern Ireland Public Health Research Network
NMC	Nursing & Midwifery Council
OFMDFM	Office of the First Minister and deputy First Minister
PCE	Patient and Client Experience
PfG	Programme for Government
PH	Public Health
PHA	Public Health Agency
PPI	Personal and Public Involvement
PSNI	Police Service Northern Ireland

QI	Quality Improvement
QSE	Quality & Safety Education
QUB	Queens University Belfast
RoI	Republic of Ireland
RQIA	Regulation and Quality Improvement Authority
SBA	Service Budget Agreement
SBNI	Safeguarding Board Northern Ireland
SCPHN	Specialist Community Public Health Nursing
SQAT	Safety Quality Alerts Team
TMNI	Tele-Monitoring Northern Ireland
TVU	Transvaginal Ultrasound
YJA	Young Justice Agency

Alternative formats

The PHA is committed to making information as accessible as possible and to promoting meaningful engagement with those who use our services.

This document can be made available on request and where reasonably practicable in an alternative format.

Should you wish to request a copy of this document in an alternative format please contact:

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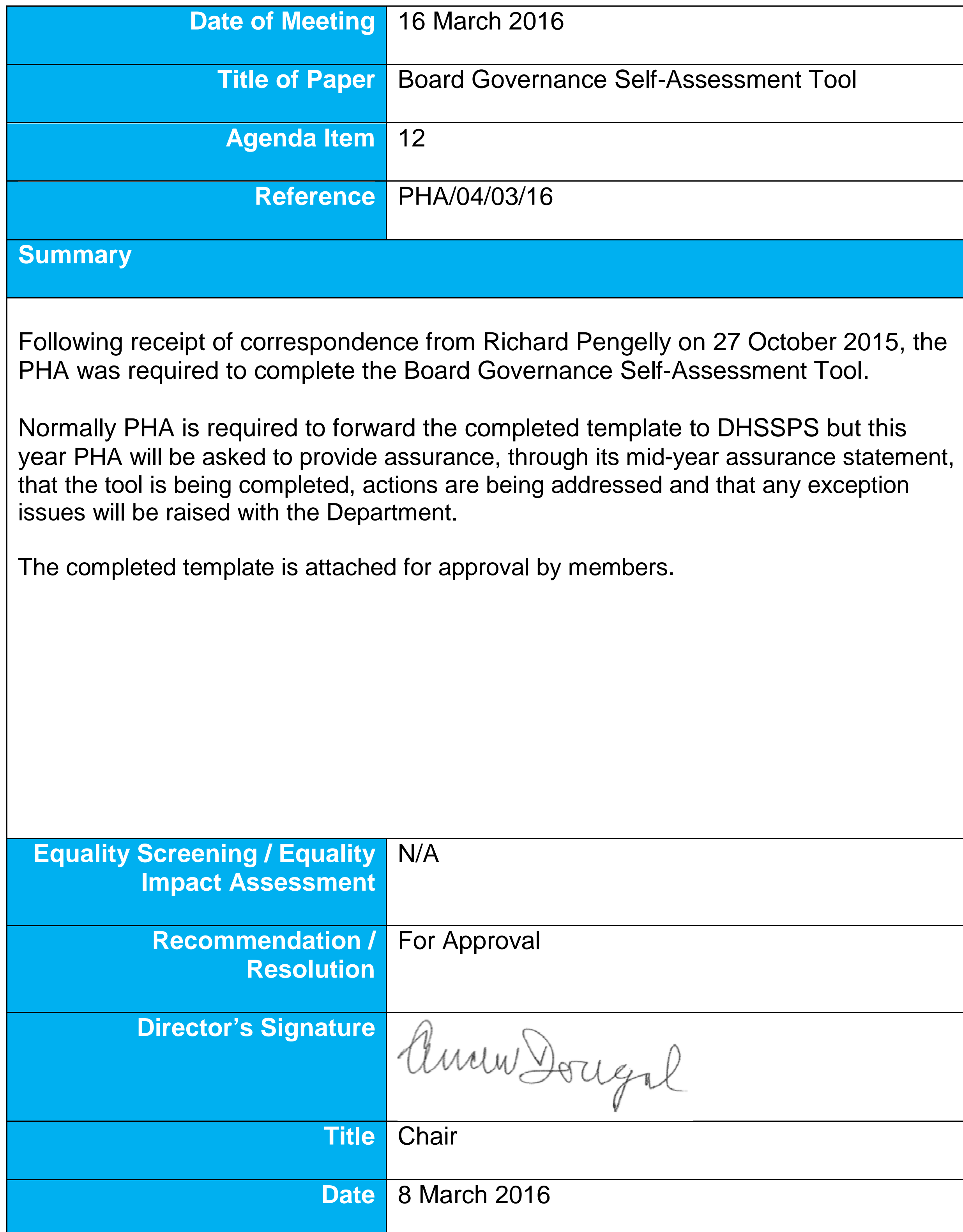
HSC Public Health Agency

PUBLIC HEALTH AGENCY BOARD PAPER



Date of Meeting	16 March 2016
Title of Paper	Board Governance Self-Assessment Tool
Agenda Item	12
Reference	PHA/04/03/16

Summary

Following receipt of correspondence from Richard Pengelly on 27 October 2015, the PHA was required to complete the Board Governance Self-Assessment Tool.

Normally PHA is required to forward the completed template to DHSSPS but this year PHA will be asked to provide assurance, through its mid-year assurance statement, that the tool is being completed, actions are being addressed and that any exception issues will be raised with the Department.

The completed template is attached for approval by members.

Equality Screening / Equality Impact Assessment	N/A
Recommendation / Resolution	For Approval
Director's Signature	[signature]
Title	Chair
Date	8 March 2016

BOARD GOVERNANCE SELF ASSESSMENT TOOL

For use by DHSSPS Sponsored Arms Length Bodies

Updated 19th October 2015

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Introduction

This self-assessment tool is intended to help Arm's Length Bodies (ALBs) improve the effectiveness of their Board and provide the Board members with assurance that it is conducting its business in accordance with best practice.

The public need to be confident that ALBs are efficient and delivering high quality services. The primary responsibility for ensuring that an ALB has an effective system of internal control and delivers on its functions; other statutory responsibilities; and the priorities, commitments, objectives, targets and other requirements communicated to it by the Department rests with the ALB's board. The board is the most senior group in the ALB and provides important oversight of how public money is spent.

It is widely recognised that good governance leads to good management, good performance, good stewardship of public money, good public engagement and, ultimately, good outcomes (Good governance CIPFA). Good governance is not judged by 'nothing going wrong'. Even in the best boards and organisations bad things happen and board effectiveness is demonstrated by the appropriateness of the response when difficulties arise.

Good governance best practice requires Boards to carry out a board effectiveness evaluation annually, and with independent input at least once every three years.

This checklist has been developed by reviewing various governance tools already in use across the UK and the structure and format is based primarily on Department of Health governance tools. The checklist does not impose any new governance requirements on DHSSPS sponsored ALBs.

The document sets out the structure, content and process for completing and independently validating a Board Governance Self-Assessment (the self-assessment) for Arms Length Bodies of the Department of Health, Social Services and Public Safety (DHSSPS).

The Self-Assessment should be completed by all ALB Boards and requires them to self-assess their current Board capacity and capability supported by appropriate evidence which may then be externally validated.

Application of the Board Governance Self-Assessment

It is recommended that all Board members of ALBs familiarise themselves with the structure, content and process for completing the self-assessment.

The self-assessment process is designed to provide assurance in relation to various leading indicators of Board governance and covers 4 key stages:

1. Complete the self-assessment
2. Approval of the self-assessment by the ALB Board and sign-off by the ALB Chair;
3. Report produced; and
4. Independent verification.

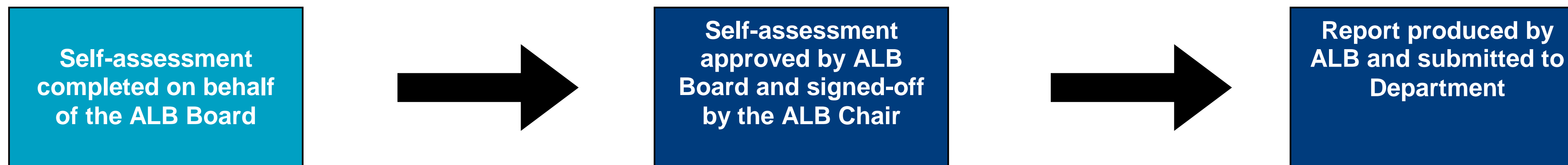
Complete the self-assessment: It is recommended that responsibility for completing the self-assessment sits with the Board and is completed section by section with identification of any key risks and good practice that the Board can evidence. The Board must collectively consider the evidence and reach a consensus on the ratings. The Chair of the Board will act as moderator. A submission document is attached for the Board to record its responses and evidence, and to capture its self-assessment rating.

Refer to the scoring criteria identified on page 7 to apply self assessment ratings.

Approval of the self-assessment by ALB Board and sign off by the Chair: The ALB Board's RAG ratings should be debated and agreed at a formal Board meeting. A note of the discussion should be formally recorded in the Board minutes and ultimately signed off by the ALB Chair on behalf of the Board.

Independent verification: The Board's ratings should be independently verified on average every three years. The views of the verifier should be provided in a report back to the Board. This report will include their independent view on the accuracy of the Board's ratings and where necessary, provide recommendations for improvement.

Overview



The Board Governance self-assessment is designed to provide assurance in relation to various leading indicators of effective Board governance. These indicators are:

1. Board composition and commitment (e.g. Balance of skills, knowledge and experience);
2. Board evaluation, development and learning (e.g. The Board has a development programme in place);
3. Board insight and foresight (e.g. Performance Reporting);
4. Board engagement and involvement (e.g. Communicating priorities and expectations);
5. Board impact case studies (e.g. A case study that describes how the Board has responded to a recent financial issue).

Each indicator is divided into various sections. Each section contains Board governance good practice statements and risks.

There are three steps to the completion of the Board Governance self-assessment tool.

Step 1

The Board is required to complete sections 1 to 4 of the self-assessment using the electronic Submission Document. The Board should RAG rate each section based on the criteria outlined below. In addition, the Board should provide as much evidence and/or explanation as is required to support their rating. Evidence can be in the form of documentation that demonstrates that they comply with the good practice or Action Plans that describe how and when they will comply with the good practice. In a small number of instances, it is possible that a Board either cannot or may have decided not to adopt a particular practice. In cases like these the Board should explain why they have not adopted the

practice or cannot adopt the practice. The Board should also complete the Summary of Results template which includes identifying areas where additional training/guidance and/or assurance is required.

Step 2

In addition to the RAG rating and evidence described above, the Board is required to complete 3 mini case studies on;

- A Performance failure in the area of quality, resources (Finance, HR, Estates) or Service Delivery;
- Organisational culture change; and
- Organisational Strategy

The Board should use the electronic template provided and the case studies should be kept concise and to the point. The case studies are described in further detail in the Board Impact section.

Step 3

Boards should revisit sections 1 to 4 after completing the case studies. This will facilitate Boards in reconsidering if there are any additional reds flags they wish to record and allow the identification of any areas which require additional training/guidance and/or further assurance. Boards should ensure the overall summary table is updated as required.

Scoring Criteria

The scoring criteria for each section is as follows:

Green if the following applies:

- All good practices are in place unless the Board is able to reasonably explain why it is unable or has chosen not to adopt a particular good practice.
- No Red Flags identified.

Amber/ **Green** if the following applies:

- Some elements of good practice in place.
- Where good practice is currently not being achieved, there are either:
  - robust Action Plans in place that are on track to achieve good practice; or
  - the Board is able to reasonably explain why it is unable or has chosen not to adopt a good practice and is controlling the risks created by non-compliance.
- One Red Flag identified but a robust Action Plan is in place and is on track to remove the Red Flag or mitigate it.

Amber/ **Red** if the following applies:

- Some elements of good practice in place.
- Where good practice is currently not being achieved:
  - Action Plans are not in place, not robust or not on track;
  - the Board is not able to explain why it is unable or has chosen not to adopt a good practice; or
  - the Board is not controlling the risks created by non-compliance.
- Two or more Red Flags identified but robust Action Plans are in place to remove the Red Flags or mitigate them.

Red if the following applies:

- Action Plans to remove or mitigate the risk(s) presented by one or more Red Flags are either not in place, not robust or not on track

Please note: The various green flags (best practice) and red flags risks (governance risks/failures) are not exhaustive and organisations may identify other examples of best practice or risk/failure. Where Red Flags are indicated, the Board should describe the actions that are either in place to remove the Red Flags (e.g. a recruitment timetable where an ALB currently has an interim Chair) or mitigate the risk presented by the Red Flags (e.g.

where Board members are new to the organisation there is evidence of robust induction programmes in place).

The ALB Board's RAG ratings on the self assessment should be debated and agreed by the Board at a formal Board meeting. A note of the discussion should be formally recorded in the Board minutes and then signed-off by the Chair on behalf of the Board.

1. Board composition and commitment

1. Board composition and commitment overview

This section focuses on Board composition and commitment, and specifically the following areas:

1. Board positions and size
2. Balance and calibre of Board members
3. Role of the Board
4. Committees of the Board
5. Board member commitment

1. Board composition and commitment

1.1 Board positions and size

Red Flag	Good Practice
1. The Chair and/or CE are currently interim or the position(s) vacant. 2. There has been a high turnover in Board membership in the previous two years (i.e. 50% or more of the Board are new compared to two years ago). 3. The number of people who routinely attend Board meetings hampers effective discussion and decision-making.	1. The size of the Board (including voting and non-voting members of the Board) and Board committees is appropriate for the requirements of the business. All voting positions are substantively filled. 2. The Board ensures that it is provided with appropriate advice, guidance and support to enable it to effectively discharge it responsibilities. 3. It is clear who on the Board is entitled to vote. 4. The composition of the Board and Board committees accords with the requirements of the relevant Establishment Order or other legislation, and/or the ALB's Standing Orders. 5. Where necessary, the appointment term of NEDs is staggered so they are not all due for re-appointment or to leave the Board within a short space of time.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Standing Orders • Board Minutes • Job Descriptions • Biographical information on each member of the Board.

1. Board composition and commitment

1.2 Balance and calibre of Board members

<table>
<tr><th>Red Flag</th><th>Good Practice</th></tr>
<tr><td>1. There are no NEDs with a recent and relevant financial background.
2. There is no NED with current or recent (i.e. within the previous 2 years) experience in the private/ commercial sector.
3. The majority of Board members are in their first Board position.
4. The majority of Board members are new to the organisation (i.e. within their first 18 months).
5. The balance in numbers of Executives and Non Executives is incorrect.
6. There are insufficient numbers of Non Executives to be able to operate committees.</td><td>1. The Board can clearly explain why the current balance of skills, experience and knowledge amongst Board members is appropriate to effectively govern the ALB over the next 3-5 years. In particular, this includes consideration of the value that each NED will provide in helping the Board to effectively oversee the implementation of the ALB's business plan.
2. The Board has an appropriate blend of NEDs e.g. from the public, private and voluntary sectors.
3. The Board has had due regard under Section 75 of the Northern Ireland Act 1998 to the need to promote equality of opportunity: between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; between men and women generally; between persons with a disability and persons without; and between persons with dependants and persons without.
4. There is at least one NED with a background specific to the business of the ALB.
5. Where appropriate, the Board includes people with relevant technical and professional expertise.
6. There is an appropriate balance between Board members (both Executive and NEDs) that are new to the Board (i.e. within their first 18 months) and those that have served on the Board for longer.
7. The majority of the Board are experienced Board members.
8. Where appropriate, the Chair of the Board has a demonstrable and recent track record of successfully leading a large and complex organisation, preferably in a regulated environment.
9. The Chair of the Board has previous non-executive experience.
10. At least one member of the Audit Committee has recent and relevant financial experience.</td></tr>
<tr><td>Examples of evidence that could be submitted to support the Board's RAG rating.</td><td>• Board Skills audit
• Biographical information on each member of the Board</td></tr>
</table>

1. Board composition and commitment

1.3 Role of the Board

Red Flag	Good Practice
1. The Chair looks constantly to the Chief Executive to speak or give a lead on issues. 2. The Board tends to focus on details and not on strategy and performance. 3. The Board become involved in operational areas. 4. The Board is unable to take a decision without the Chief Executive's recommendation. 5. The Board allows the Chief Executive to dictate the Agenda. 6. Regularly, one individual Board member dominates the debates or has an excessive influence on Board decision making.	1. The role and responsibilities of the Board have been clearly defined and communicated to all members. 2. Board members are clear about the Minister's policies and expectations for their ALBs and have a clearly defined set of objectives, strategy and remit. 3. There is a clear understanding of the roles of Executive officers and Non Executive Board members. 4. The Board takes collective responsibility for the performance of the ALB. 5. NEDs are independent of management. 6. The Chair has a positive relationship with the Minister and sponsor Department. 7. The Board holds management to account for its performance through purposeful, challenge and scrutiny. 8. The Board operates as an effective team. 9. The Board shares corporate responsibility for all decisions taken and makes decisions based on clear evidence. 10. Board members respect confidentiality and sensitive information. 11. The Board governs, Executives manage. 12. Individual Board members contribute fully to Board deliberations and exercise a healthy challenge function. 13. The Chair is a useful source of advice and guidance for Board members on any aspect of the Board. 14. The Chair leads meetings well, with a clear focus on the issues facing the ALB, and allows full and open discussions before major decisions are taken. 15. The Board considers the concerns and needs of all stakeholders and actively manages it's relationships with them. 16. The Board is aware of and annually approves a scheme of delegation to its committees.

	17. The Board is provided with timely and robust post-evaluation reviews on all major projects and programmes.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Terms of Reference • Board minutes • Job descriptions • Scheme of Delegation • Induction programme

1. Board composition and commitment

1.4 Committees of the Board

Red Flag	Good Practice
1. The Board notes the minutes of Committee meetings and reports, instead of discussing same. 2. Committee members do not receive performance management appraisals in relation to their Committee role. 3. There are no terms of reference for the Committee. 4. Non Executives are unaware of their differing roles between the Board and Committee. 5. The Agenda for Committee meetings is changed without proper discussion and/or at the behest of the Executive team.	1. Clear terms of reference are drawn up for each Committee including whether it has powers to make decisions or only make recommendations to the Board. 2. Certain tasks or functions are delegated to the Committee but the Board as a whole is aware that it carries the ultimate responsibility for the actions of its Committees. 3. Schemes of delegation from the Board to the Committees are in place. 4. There are clear lines of reporting and accountability in respect of each Committee back to the Board. 5. The Board agrees, with the Committees, what assurances it requires and when, to feed its annual business cycle. 6. The Board receives regular reports from the Committees which summarises the key issues as well as decisions or recommendations made. 7. The Board undertakes a formal and rigorous annual evaluation of the performance of its Committees. 8. It is clearly documented who is responsible for reporting back to the Board.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Scheme of delegation • TOR • Board minutes • Annual Evaluation Reports

1. Board composition and commitment

1.5 Board member commitment

Red Flag	Good Practice
1. There is a record of Board and Committee meetings not being quorate. 2. There is regular non-attendance by one or more Board members at Board or Committee meetings. 3. Attendance at the Board or Committee meetings is inconsistent (i.e. the same Board members do not consistently attend meetings). 4. There is evidence of Board members not behaving consistently with the behaviours expected of them and this remaining unresolved. 5. The Board or Committee has not achieved full attendance at at least one meeting within the last 12 months.	1. Board members have a good attendance record at all formal Board and Committee meetings and at Board events. 2. The Board has discussed the time commitment required for Board (including Committee) business and Board development, and Board members have committed to set aside this time. 3. Board members have received a copy of the Department's Code of Conduct and Code of Accountability for Board Members of Health and Social Care Bodies or the Northern Ireland Fire and Rescue Service. Compliance with the code is routinely monitored by the Chair. 4. Board meetings and Committee meetings are scheduled at least 6 months in advance.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board attendance record • Induction programme • Board member annual appraisals • Board Schedule

2. Board evaluation, development and learning

2. Board evaluation, development and learning overview

This section focuses on Board evaluation, development and learning, and specifically the following areas:

1. Effective Board-level evaluation;
2. Whole Board Development Programme;
3. Board induction, succession and contingency planning;
4. Board member appraisal and personal development.

2. Board evaluation, development and learning

2.1 Effective Board level evaluation

Red Flag	Good Practice
1. No formal Board Governance Self-Assessment has been undertaken within the last 12 months. 2. The Board Governance Self-Assessment has not been independently evaluated within the last 3 years. 3. Where the Board has undertaken a self assessment, only the perspectives of Board members were considered and not those outside the Board (e.g. staff, etc). 4. Where the Board has undertaken a self assessment, only one evaluation method was used (e.g. only a survey of Board members was undertaken).	1. A formal Board Governance Self-Assessment has been conducted within the previous 12 months. 2. The Board can clearly identify a number of changes/ improvements in Board and Committee effectiveness as a result of the formal self assessments that have been undertaken. 3. The Board has had an independent evaluation of its effectiveness and the effectiveness of its committees within the last 2 years by a 3rd party that has a good track record in undertaking Board effectiveness evaluations. 4. In undertaking its self assessment, the Board has used an approach that includes various evaluation methods. In particular, the Board has considered the perspective of a representative sample of staff and key external stakeholders (e.g. commissioners, service users and clients) on whether or not they perceive the Board to be effective. 5. The focus of the self assessment included traditional 'hard' (e.g. Board information, governance structure) and 'soft' dimensions of effectiveness. In the case of the latter, the evaluation considered as a minimum: • The knowledge, experience and skills required to effectively govern the organisation and whether or not the Board's membership currently has this; • How effectively meetings of the Board are chaired; • The effectiveness of challenge provided by Board members; • Role clarity between the Chair and CE, Executive Directors and NEDs, between the Board and management and between the Board and its various committees; • Whether the Board's agenda is appropriately balanced between: strategy and current performance; finance and quality; making decisions and noting/ receiving information; matters internal to the organisation and external considerations; and business conducted at public board meetings and that done in confidential session. • The quality of relationships between Board members, including the Chair and CE. In particular, whether or not any one Board member has a tendency to dominate Board discussions and the level of mutual trust and respect between members.

Examples of evidence that could be submitted to support the Board's RAG rating.	• Report on the outcomes of the most recent Board evaluation and examples of changes/ improvements made in the Board and Committees as a result of an evaluation • The Board Scheme of Delegation/ Reservation of Powers

2. Board evaluation, development and learning

2.2 Whole Board development programme

<table>
<tr><th>Red Flag</th><th>Good Practice</th></tr>
<tr><td>1. The Board does not currently have a Board development programme in place for both Executive and Non-Executive Board Members.
2. The Board Development Programme is not aligned to helping the Board comply with the requirements of the Management Statement and/or fulfil its statutory responsibilities.</td><td>1. The Board has a programme of development in place. The programme seeks to directly address the findings of the Board’s annual self assessment and contains the following elements: understanding the relationship between the Minister, the Department and their organisation, e.g. as documented in the Management Statement; development specific to the business of their organisation; and reflecting on the effectiveness of the Board and its supporting governance arrangements.
2. Understanding the relationship between the Minister, Department and the ALB - Board members have an appreciation of the role of the Board and NEDs, and of the Department’s expectations in relation to those roles and responsibilities.
3. Development specific to the ALB’s governance arrangements – the Board is or has been engaged in the development of action plans to address governance issues arising from previous self-assessments/independent evaluations, Internal Audit reports, serious adverse incident reports and other significant control issues.
4. Reflecting on the effectiveness of the Board and its supporting governance arrangements -The development programme includes time for the Board as a whole to reflect upon, and where necessary improve:
• The focus and balance of Board time;
• The quality and value of the Board’s contribution and added value to the delivery of the business of the ALB;
• How the Board responded to any service, financial or governance failures;
• Whether the Board’s subcommittees are operating effectively and providing sufficient assurances to the Board;
• The robustness of the ALB’s risk management processes;
• The reliability, validity and comprehensiveness of information received by the Board.
5. Time is ‘protected’ for undertaking this programme and it is well attended.
6. The Board has considered, at a high-level, the potential development needs of the Board to meet future challenges.</td></tr>
<tr><td>Examples of evidence that could be submitted to support the Board’s RAG rating.</td><td>• The Board Development Programme
• Attendance record at the Board Development Programme</td></tr>
</table>

2. Board evaluation, development and learning

2.3 Board induction, succession and contingency planning

Red Flag	Good Practice
1. Board members have not attended the CIPFA “On Board” training course within 3 months of appointment. 2. There are no documented arrangements for chairing Board and committee meetings if the Chair is unavailable. 3. There are no documented arrangements for the organisation to be represented at a senior level at Board meetings if the CE is unavailable. 4. NED appointment terms are not sufficiently staggered.	1. All members of the Board, both Executive and Non-Executive, are appropriately inducted into their role as a Board member. Induction is tailored to the individual Director and includes access to external training courses where appropriate. As a minimum, it includes an introduction to the role of the Board, the role expectations of NEDs and Executive Directors, the statutory duties of Board members and the business of the ALB. 2. Induction for Board members is conducted on a timely basis. 3. Where Board members are new to the organisation, they have received a comprehensive corporate induction which includes an overview of the services provided by the ALB, the organisation’s structure, ALB values and meetings with key leaders. 4. Deputising arrangements for the Chair and CE have been formally documented. 5. The Board has considered the skills it requires to govern the organisation effectively in the future and the implications of key Board-level leaders leaving the organisation. Accordingly, there are demonstrable succession plans in place for all key Board positions.
Examples of evidence that could be submitted to support the Board’s RAG rating.	• Succession plans • Induction programmes • Standing Order

2. Board evaluation, development and learning

2.4 Board member appraisal and personal development

Red Flag	Good Practice
1. There is not a robust performance appraisal process in place at Board level that includes consideration of the perspectives of other Board members on the quality of an individual's contribution (i.e. contributions of every member of the Board (including Executive Directors) on an annual basis and documents the process of formal feedback being given and received. 2. Individual Board members have not received any formal training or professional development relating to their Board role. 3. Appraisals are perceived to be a 'tick box' exercise. 4. The Chair does not consider the differing roles of Board members and Committee members.	1. The effectiveness of each Non-Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis by the Chair 2. The effectiveness of each Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis in accordance with the appraisal process prescribed by their organisation. 3. There is a comprehensive appraisal process in place to evaluate the effectiveness of the Chair of the Board that is led by the relevant Deputy Secretary (and countersigned by the Permanent Secretary). 4. Each Board member (including each Executive Director) has objectives specific to their Board role that are reviewed on an annual basis. 5. Each Board member has a Personal Development Plan that is directly relevant to the successful delivery of their Board role. 6. As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level. 7. Where appropriate, Board members comply with the requirements of their respective professional bodies in relation to continuing professional development and/or certification.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Performance appraisal process used by the Board • Personal Development Plans • Board member objectives • Evidence of attendance at training events and conferences • Board minutes that evidence Executive Directors contributing outside their functional role and challenging other Executive Directors.

3. Board insight and foresight

3. Board insight and foresight overview

This section focuses on Board information, and specifically the following areas:

1.Board Performance Reporting

2.Efficiency and productivity

3.Environmental and strategic focus

4.Quality of Board papers and timeliness of information

3. Board insight and foresight

3.1 Board performance reporting

Red Flag	Good Practice
1. Significant unplanned variances in performance have occurred. 2. Performance failures were brought to the Board's attention by an external party and/or not in a timely manner. 3. Finance and Quality reports are considered in isolation from one another. 4. The Board does not have an action log. 5. Key risks are not reported/escalated up to the Board.	1. The Board has debated and agreed a set of quality and financial performance indicators that are relevant to the Board given the context within which it is operating and what it is trying to achieve. Indicators should relate to priorities, objectives, targets and requirements set by the Dept. 2. The Board receives a performance report which is readily understandable for all members and includes: • performance of the ALB against a range of performance measures including quality, performance, activity and finance and enables links to be made; • Variances from plan are clearly highlighted and explained ; • Key trends and findings are outlined and commented on ; • Future performance is projected and associated risks and mitigating measures; • Key quality information is triangulated (e.g. complaints, standards, Dept targets, serious adverse incidents, limited audit assurance) so that Board members can accurately describe where problematic services lines are ;Benchmarking of performance to comparable organisations is included where possible. 3. The Board receives a brief verbal update on key issues arising from each Committee meeting from the relevant Chair. This is supported by a written summary of key items discussed by the Committee and decisions made. 4. The Board regularly discusses the key risks facing the ALB and the plans in place to manage or mitigate them. 5. An action log is taken at Board meetings. Accountable individuals and challenging/demanding timelines are assigned. Progress against actions is actively monitored. Slips in timelines are clearly identifiable through the action log and individuals are held to account.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board Performance Report • Board Action Log • Example Board agendas and minutes highlighting committee discussions by the Board.

3. Board insight and foresight

3.2 Efficiency and Productivity

Red Flag	Good Practice
1. The Board does not receive performance information relating to progress against efficiency and productivity plans. 2. There is no process currently in place to prospectively assess the risk(s) to quality of services presented by efficiency and productivity plans. 3. Efficiency plans are based on a percentage reduction across all services rather than a properly targeted assessment of need. 4. The Board does not have a Board Assurance Framework (BAF).	1. The Board is assured that there is a robust process for prospectively assessing the risk(s) to quality of services and the potential knock-on impact on the wider health and social care community of implementing efficiency and productivity plans. 2. The Board can provide examples of efficiency and productivity plans that have been rejected or significantly modified due to their potential impact on quality of service. 3. The Board receives information on all efficiency and productivity plans on a regular basis. Schemes are allocated to Directors and are RAG rated to highlight where performance is not in line with plan. The risk(s) to non-achievement is clearly stated and contingency measures are articulated. 4. There is a process in place to monitor the ongoing risks to service delivery for each plan, including a programme of formal post implementation reviews.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Efficiency and Productivity plans • Reports to the Board on the plans • Post implementation reviews

3. Board insight and foresight

3.3 Environmental and strategic focus

<table>
<tr><th>Red Flag</th><th>Good Practice</th></tr>
<tr><td>1. The Board does not have a clear understanding of Executive/Departmental priorities and its statutory responsibilities, business plan etc.

2. The Board's annual programme of work does not set aside time for the Board to consider environmental and strategic risks to the ALB.

3. The Board does not formally review progress towards delivering its strategies.</td><td>1. The Chief Executive presents a report to every Board meeting detailing important changes or issues in the external environment (e.g. policy changes, quality and financial risks). The impact on strategic direction is debated and, where relevant, updates are made to the ALB's risk registers and Board Assurance Framework (BAF).

2. The Board has reviewed lessons learned from SAIs, reports on discharge of statutory responsibilities, negative reports from independent regulators etc and has considered the impact upon them. Actions arising from this exercise are captured and progress is followed up.

3. The Board has conducted or updated an analysis of the ALB's performance within the last year to inform the development of the Business Plan.

4. The Board has agreed a set of corporate objectives and associated milestones that enable the Board to monitor progress against implementing its vision and strategy for the ALB. Performance against these corporate objectives and milestones are reported to the board on a quarterly basis.

5. The Board's annual programme of work sets aside time for the Board to consider environmental and strategic risks to the ALB. Strategic risks to the ALB are actively monitored through the Board Assurance Framework (BAF).</td></tr>
<tr><td>Examples of evidence that could be submitted to support the Board's RAG rating.</td><td>• CE report
• Evidence of the Board reviewing lessons learnt in relation to enquiries
• Outcomes of an external stakeholder mapping exercise
• Corporate objectives and associated milestones and how these are monitored
• Board Annual programme of work
• BAF
• Risk register</td></tr>
</table>

3. Board insight and foresight

3.4 Quality of Board papers and timeliness of information

Red Flag	Good Practice
1. Board members do not have the opportunity to read papers e.g. reports are regularly tabled on the day of the Board meeting and members do not have the opportunity to review or read prior to the meeting. The volume of papers is impractical for proper reviewing. 2. Board discussions are focused on understanding the Board papers as opposed to making decisions. 3. The Board does not routinely receive assurances in relation to Data Quality or where reports are received, they have highlighted material concerns in the quality of data reporting. 4. Information presented to the Board lacks clarity, or relevance; is inaccurate or untimely; or is presented without a clear purpose, e.g. is it for noting, discussion or decision. 5. The Board does not discuss or challenge the quality of the information presented or, scrutiny and challenge is only applied to certain types of information of which the Board have knowledge and/or experience, e.g. financial information	1. The Board can demonstrate that it has actively considered the timing of the Board and Committee meetings and presentation of Board and Committee papers in relation to month and year end procedures and key dates to ensure that information presented is as up-to-date as possible and that the Board is reviewing information and making decisions at the right time. 2. A timetable for sending out papers to members is in place and adhered to. 3. Each paper clearly states what the Board is being asked to do (e.g. noting, approving, decision, and discussion). 4. Board members have access to reports to demonstrate performance against key objectives and there is a defined procedure for bringing significant issues to the Board's attention outside of formal meetings. 5. Board papers outline the decisions or proposals that Executive Directors have made or propose. This is supported; where appropriate, by: an appraisal of the relevant alternative options; the rationale for choosing the preferred option; and a clear outline of the process undertaken to arrive at the preferred option, including the degree of scrutiny that the paper has been through. 6. The Board is routinely provided with data quality updates. These updates include external assurance reports that data quality is being upheld in practice and are underpinned by a programme of clinical and/or internal audit to test the controls that are in place. 7. The Board can provide examples of where it has explored the underlying data quality of performance measures. This ensures that the data used to rate performance is of sufficient quality. 8. The Board has defined the information it requires to enable effective oversight and control of the organisation, and the standards to which that information should be collected and quality assured. 9. Board members can demonstrate that they understand the information presented to them,

	including how that information was collected and quality assured, and any limitations that this may impose. 10. Any documentation being presented complies with Departmental guidance, where appropriate e.g. business cases, implementation plans.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Documented information requirements • Data quality assurance process • Evidence of challenge e.g. from Board minutes • Board meeting timetable • Process for submitting and issuing Board papers • In-month reports • Board papers • Data Quality updates

3. Board insight and foresight

3.5 Assurance and risk management

<table>
<tr><th>Red Flag</th><th>Good Practice</th></tr>
<tr><td>1. The Board does not receive assurance on the management of risks facing the ALB.
2. The Board has not identified its assurance requirements, or receives assurance from a limited number of sources.
3. Assurance provided to the Board is not balanced across the portfolio of risk, with a predominant focus on financial risk or areas that have historically been problematic.
4. The Board has not reviewed the ALB's governance arrangements within the last two years.</td><td>1. The Board has developed and implemented a process for identification, assessment and management of the risks facing the ALB. This should include a description of the level of risk that the Board expects to be managed at each level of the ALB and also procedures for escalating risks to the Board.
2. The Board has identified the assurance information they require, including assurance on the management of key risks, and how this information will be quality assured.
3. The Board has identified and makes use of the full range of available sources of assurance, e.g. Internal/External Audit, RQIA, etc
4. The Board has a process for regularly reviewing the governance arrangements and practices against established Departmental or other standards e.g. the Good Governance Standard for Public Services.
5. The Board has developed and implemented a Clinical and Social Care Risk assessment and management policy across the ALB, where appropriate.
6. An executive member of the Board has been delegated responsibility for all actions relating to professional regulation and revalidation of all applicable staff.</td></tr>
<tr><td>Examples of evidence that could be submitted to support the Board's RAG rating.</td><td>• Risk management policy and procedures
• Risk register
• Evidence of review of risks, e.g. Board minutes
• Evidence of review of governance structures, e.g. Board minutes
• Board Assurance Framework (BAF)
• Clinical and Social care governance policy</td></tr>
</table>

4. Board engagement and involvement

4. Board engagement and involvement overview

This section focuses on Board engagement and involvement, and specifically the following areas:

1.External Stakeholders

2.Internal Stakeholders

3.Board profile and visibility

4. Board engagement and involvement

4.1 External stakeholders

The statutory duty of involvement and consultation commits ALBs to developing PPI consultation schemes. These schemes detail how the ALB will consult and involve service users in the planning and delivery of services. The statutory duty of involvement and consultation does not apply to, NISCC, NIPEC, BSO and NIFRS. However, the Department would encourage all ALBs to put appropriate and proportionate measures in place to ensure that their service delivery arrangements are informed by views of those who use their services.

Under Section 75 (NI Act 1998) all ALBs have existing obligations and commitments to consult with the public, service users and carers in the planning, delivery and monitoring of services. Under Section 49a of the Disability Discrimination Act NI (1995) ALBs have a duty to promote the involvement of disabled people in public life.

Red Flag	Good Practice
1. The development of the Business Plan has only involved the Board and a limited number of ALB staff. 2. The ALB has poor relationships with external stakeholders, with examples including clients, client organisations etc. 3. Feedback from clients is negative e.g. complaints, surveys and findings from regulatory and review reports. 4. The ALB has failed to manage adverse negative publicity effectively in relation to the services it provides in the last 12 months. 5. The Board has not overseen a system for receiving, acting on and reporting	1. Where relevant, the Board has an approved PPI consultation scheme which formally outlines and embeds their commitment to the involvement of service users and their carers in the planning and delivery of services. 2. A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of service users, commissioners and the wider public, including 'hard to reach' groups like non-English speakers and service users with a learning disability. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice. 3. The Board can evidence how key external stakeholders (e.g. service users, commissioners and MLAs) have been engaged in the development of their business plans for the ALB and provide examples of where their views have been included and not included in the Business Plan. 4. The Board has ensured that various communication methods have been deployed to ensure that key external stakeholders understand the key messages within the Business Plan.

outcomes of complaints.	5. The Board promotes the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that they provide 6. The ALB has constructive and effective relationships with its key stakeholders.
Examples of evidence that could be submitted to support the Board's RAG rating.	• PPI Consultation Scheme • Complaints • Customer Survey • Regulatory and Review reports

4. Board engagement and involvement

4.2 Internal stakeholders

Red Flag	Good Practice
1. The ALBs latest staff survey results are poor. 2. There are unresolved staff issues that are significant (e.g. the Board or individual Board members have received 'votes of no confidence', the ALB does not have productive relationships with staff side/trade unions etc.). 3. There are significant unresolved quality issues. 4. There is a high turn over of staff. 5. Best practise is not shared within the ALB.	1. A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of staff, including 'hard to reach' groups like night staff and weekend workers. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice. 2. The Board can evidence how staff have been engaged in the development of their Corporate & Business Plans and provide examples of where their views have been included and not included. 3. The Board ensures that staff understand the ALB's key priorities and how they contribute as individual staff members to delivering these priorities. 4. The ALB uses various ways to celebrate services that have an excellent reputation and acknowledge staff that have made an outstanding contribution to service delivery and the running of the ALB. 5. The Board has communicated a clear set of values/behaviours and how staff that do not behave consistent with these valves will be managed. Examples can be provided of how management have responded to staff that have not behaved consistent with the ALB's stated values/behaviours. 6. There are processes in place to ensure that staff are informed about major risks that might impact on customers, staff and the ALB's reputation and understand their personal responsibilities in relation to minimising and managing these key risks.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Staff Survey • Grievance and disciplinary procedures • Whistle blowing procedures • Code of conduct for staff • Internal engagement or communications strategy/ plan.

4. Board engagement and involvement

4.3 Board profile and visibility

Red Flag	Good Practice
1. With the exception of Board meetings held in public, there are no formal processes in place to raise the profile and visibility of the Board. 2. Attendance by Board members is poor at events/meetings that enable the Board to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions).	1. There is a structured programme of events/meetings that enable NEDs to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions) that is well attended by Board members and has led to improvements being made. 2. There is a structured programme of meetings and events that increase the profile of key Board members, in particular, the Chair and the CE, amongst external stakeholders. 3. Board members attend and/or present at high profile events. 4. NEDs routinely meet stakeholders and service users. 5. The Board ensures that its decision-making is transparent. There are processes in place that enable stakeholders to easily find out how and why key decisions have been made by the Board without reverting to freedom of information requests. 6. As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board programme of events/ quality walkabouts with evidence of improvements made • Active participation at high-profile events • Evidence that Board minutes are publicly available and summary reports are provided from private Board meetings

5. Board Governance Self- Assessment Submission

Name of ALB - Public Health Agency

Date of Board Meeting at which Submission was discussed **16th March 2016** (Date)

Approved by **Andrew Dougal** (ALB Chair)

1. Board composition and commitment ALB Name - Public Health Agency Date – 24 Feb 2016

1.1 Board positions and size

	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The size of the Board and the Board Committee structure is sufficient to ensure that there are processes in place to ensure that governance responsibilities are compliant with Standing Orders. There is currently one non-executive post vacant, but this should be filled by 31 March 2016. Over the past 2 years, the Board has rarely been at full capacity and there has been a vacancy since September 2015. This has been difficult to manage but the Board has coped.	Over the past year the Chair has been in contact with PAU and Sponsor Branch to resolve the issues regarding the forthcoming vacancy.		
GP2 Green	The Board is content that it is provided with the appropriate guidance, support and advice to effectively discharge its responsibilities. This is done through its present			

	membership and if required, others have been invited to attend to ensure informed decisions.			
GP3 Green	The process for voting, and who the voting members are is outlined in Standing Order 5.2.17. Members are aware of their responsibilities in this area from induction and through guidance from the chair.			
GP4 Green	The composition of the Board is set out in the Standing Orders and accords with the establishing legislation. The responsibility for appointing non-executive board members lies with the Public Appointments Unit for approval by the Minister, therefore ensuring that the composition is in accordance with legislation is outside the remit of PHA. Executive Board Members are in line with DHSSPS requirements. Membership of Board and committees complies with the terms of reference set out in the PHA Standing orders.			
GP5 Green	The non-executives on the Board have variation in terms of appointment. This can be evidenced in the letters of			

	appointment, updated in relation to their second term. Terms of appointment are determined by the Minister.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		

1. Board composition and commitment ALB Name - Public Health Agency Date - 24 Feb 2016

1.2 Balance and calibre of Board members

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The current balance of skills, knowledge and experience amongst Board members is appropriate to effectively govern the PHA. A member with financial experience was appointed to the Board from 1 July 2015. However, the Board would benefit from a member with a background in marketing/communications.			
GP2 Green	The PHA board members have backgrounds from the public, private and voluntary sectors as well as local councillors. (biographical information on Board members in Annual Report). Members terms of appointment and renewal dates are staggered.			
GP3 Green	Non Executive Board members are appointed through the PAU, who have responsibility for complying with Section 75. Executive Board members are appointed through the HSC recruitment and selection			

	processes which are compliant with Section 75. The Board understands its responsibility in relation to Section 75 and regularly meets with Equality staff to ensure compliance of its statutory obligations and good practice.			
GP4 Green	Several non executive directors have a background related to health care/ health improvement. Non-executive backgrounds also include governace and financial management. (biographical information on Board members in Annual Report)			
GP5 Green	As per legislation, the board is constituted from local government and lay members. The Board includes people with relevant technical and professional expertise.			
GP6 Green	There is a balance between Executive and non-Executive members which ensures an excellent mix of skills and knowledge etc			
GP7 Green	Board members (both executive/non-executive) have served on boards for a number of years, some at the level of			

	Chair. (biographical information on Board members in Annual Report)			
GP8 Green	The Chair has 32 years' experience of working in a large voluntary organisation in the health sector at Chief Executive level.			
GP9 Green	The Chair has 10 years' non-executive experience in the private sector and other voluntary organisations e.g. UK Health Foundation and Ulster Heart Federation.			
GP10 Green	There is now a member appointed to the Board with financial experience and he attended his first Governance and Audit Committee in December 2015.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		

RF6		

1. Board composition and commitment ALB Name – Public Health Agency Date – 24 Feb 2016

1.3 Role of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The role and responsibility of the board is outlined within Standing Orders. Members will have a copy of Standing Orders as part of their induction. Standing Orders are reviewed annually and approved at Board meeting.			
GP2 Green	Ministerial policies and expectations are communicated to members, through Board meetings, workshops and the issue of papers. This is also included in the business planning and strategy processes which include full Board involvement.			
GP3 Green	There is a clear understanding of the role of Executive Officers and non-executive Board members as this is outlined in job descriptions and the scheme of delegation within Standing Orders.			

GP4 Green	The Board recognises fully its collective responsibility in relation to the performance of the PHA. This is outlined in Standing Orders, Management Statement / Financial Memorandum and in the induction process.			
GP5 Green	NEDs are totally independent of management but work with Executive Directors when required.			
GP6 Green	The previous Chairs have had a positive relationship with the Minister and sponsor department. The current Chair has not yet had the opportunity to meet with the Minister.			
GP7 Green	At Board and Committee meetings, NEDs regularly and constructively challenge members on the papers and verbal updates given. This can be seen in the minutes of the meetings.			
GP8 Green	The PHA Board works as an effective team.			
GP9 Green	The PHA board shares corporate responsibility for decisions taken and makes its decisions based on best evidence available.			

GP10 Green	Board members are aware of which papers are brought to public sessions and which are brought to confidential sessions and the need to respect confidentiality and sensitive information.			
GP11 Green	Yes, Executive Directors have responsibility for operational management of the PHA, while the PHA board governs as set out in the PHA Standing Orders.			
GP12 Green	The Board members contribute openly and fully to deliberations and exercise a healthy challenge function.			
GP13 Green	The Chair acts as first port of call for any advice, help or support. If he is not able to provide the help herself, he will refer members on as appropriate.			
GP14 Green	The Chair maintains a clear focus on the important issues facing the Board and facilitates the Board discussions so that all members are heard, engaged and actively involved in debate and constructive challenge prior to making a Board decision.			
GP15	The PHA considers the needs			

Green	of all its stakeholders and fully participates in partnership and public involvement to ensure excellent relationships.			
GP16 Green	The PHA Board clearly understands the scheme of delegation; it is brought to the Governance and Audit Committee and Board for review and approval annually			
GP17 Green	The Board receives timely and robust post-evaluation documentation, when appropriate, in relation to major projects.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		
RF6		

1. Board composition and commitment   ALB Name – Public Health Agency Date – 24 Feb 2016

1.4 Committees of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	Terms of reference for board Committees are clear and specified in Standing Orders. They are systematically reviewed.			
GP2 Green	Tasks, functions and responsibilities are delegated to appropriate committees as per Standing Orders, but the members of Board in totality recognise that they carry the ultimate responsibility for the actions of Committees.			
GP3 Green	The scheme of delegation is outlined in Standing Orders.			
GP4 Green	There are clear lines of reporting and accountability in respect of each Committee with the Board receiving full minutes and a verbal update.			
GP5 Green	There is an Assurance Framework in place that covers the Board, and its Committees, and this is reviewed and			

	approved by the Governance and Audit Committee and also the board.			
GP6 Green	The Committee Chair provides a verbal update to the board at the meeting following the Committee meeting. This can be seen in the board minutes. Minutes of the committee meetings are brought to the next board meeting after their approval.			
GP7 Green	The Governance and Audit Committee has undertaken the Audit Committee Self-Assessment for a number of years taking action to address gaps. An annual GAC Report is included in the Annual Report.			
GP8 Green	The terms of reference for the Governance and Audit Committee and Remuneration Committee highlight who is responsible for reporting to Board. The terms of reference are included within Standing Orders.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		

1. Board composition and commitment ALB Name – Public Health Agency Date – 24 Feb 2016

1.5 Board member commitment

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	An attendance record is maintained by the Secretariat. Attendance is generally very good for board and committee meetings.			
GP2 Green	Members' commitment is 5 days per month which is broken down as 1 day for board meeting, 1 day for committee meetings, 1 day for workshops, 1 day for reading papers and 1 day available for any other ad hoc events and launches			
GP3 Green	Board members have all received a copy of the DHSSPS Code of Conduct and Code of Accountability. Compliance is included in the Chair's annual appraisal of NEDs.			
GP4 Green	An annual schedule of meetings is prepared and agreed with members in relation to Board meetings,			

	workshops and strategic days. Schedules are also in place for Governance and Audit and Remuneration Committees and other specific meetings such as Local Government committee, older people etc.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		

2. Board evaluation, development and learning ALB Name – Public Health Agency Date – 24 Feb 2016

2.1 Effective Board level evaluation

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The Board completed its third self-assessment in 2014/15. This was approved by the Board on 19 March 2015.	The PHA Board will continue to undertake the DHSSPS ALB Board self-assessment annually.		
GP2 Green	The PHA Board continues to review itself to ensure improvement and development.	The PHA Board will continue to use the self-assessment and other tools as a basis for identifying further improvements / changes.		
GP3 Amber	The Internal Audit assists the Board in relation to governance and it carried out an audit of the PHA Board Self-Assessment in 2013/14, providing satisfactory assurance with implementation of the recommendations followed up by Internal Audit. Learning from the audit has been incorporated into subsequent self assessments. An annual meeting takes place between Governance and Audit Committee members with	The Board will consider a further independent evaluation of Board effectiveness in 2016/17.		

	External and Internal Audit.			
GP4 Red	The Board workshop in September 2015 was facilitated by an external facilitator who provided constructive challenge to members. However, there was no staff perspective considered as part of the completion of the self-assessment.	The PHA Board will consider undertaking a survey as part of an assessment of its performance.		
GP5 Amber	The current self-assessment has covered those questions/areas included in the DHSSPS checklist, both 'hard' and 'soft' dimensions of effectiveness.	As part of the the PHA Board workshop in April 2016, it is intended that the Board will carry out an in-depth review of all of the "soft" dimensions.		

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3	The Board will undertake a survey of those outside the part as part of its self-assessment in 2016/17.	
RF4		

2. Board evaluation, development and learning ALB Name – Public Health Agency Date – 24 Feb 2016

2.2 Whole Board development programme

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Amber	In addition to having an annual PHA board planning and review workshop, there have been regular topic specific workshops on key areas of PHA business.This model is continually under review by the Board to ensure it meets their needs. It is recognised that the Board development process could be strengthened.	The Board will consider an overall Board Development Plan as part of the workshop in April 2016.		
GP2 Green	The relationship between the Minister, Department and ALB board members is included in the Management Statement, which is brought to a board meeting annually. The Management Statement and Financial Memorandum was revised by DHSSPS in 2013/14, agreed by the Board and signed by the Chief Executive.			

GP3 Green	Reports on action plans to address governance issues arising from internal audit reports or other significant control issues are reported to the GAC. GAC minutes are brought to the PHA board, and the Chair of the GAC also provides a verbal update to board members. The GAC also prepares an Annual Report.			
GP4 Amber	The 2014/15 PHA workshop included time for members to consider the effectiveness of the Board and arrangements for the coming year. The Board workshop in September 2015 did not include time for reviewing Board effectiveness, this will be undertaken as part of the workshop in April 2016. It may be more appropriate to carry out this audit now as over the past year there has been a new Chair appointed and two new members will have joined the Board.	The Board will review Board effectiveness as part of the workshop in April 2016.		
GP5 Amber	As GP4, this will be undertaken in April 2016.			
GP6 Amber	Members are reminded annually at formal appraisal,	The Board reflects annually on future potential development needs		

	but also throughout the year. They are given the opportunity to avail of relevant development opportunities. It is recognised that the Board development process could be strengthened.	to ensure future needs / challenges as well as reflection on self-assessment.		

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	An overall Board Development Programme needs to be developed followed the Board workshop in April 2016.	
RF2		

2. Board evaluation, development and learning ALB Name – Public Health Agency Date – 24 Feb 2016

2.3 Board induction, succession and contingency planning

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	All Board members have had induction and this includes attendance at the On Board training course. Specific induction is also provided for new members of the Governance and Audit Committee.			
GP2 Green	Induction is undertaken as soon as possible after appointment.			
GP3 Green	At the induction, new members will receive a pack of relevant corporate and strategic documentation. They also have the opportunity to have 1:1 meetings with both the Chair, Chief Executive and Executive Directors. This also includes an overview of services provided by the PHA, the organisational structure. PHA values, objectives and key issues.			
GP4	Deputising arrangements are	Deputising arrangements for the		

Green	specified within Standing Orders and noted in the Board minutes.	Chief Executive have been discussed at Remuneration Committee and should the need arise, appropriate action shall be taken.		
GP5 Green	Appropriate action has been taken by the PHA. The Chair will liaise with PAU to ensure that any future vacancies do not impact on the governance of the PHA.	In the context of changes within the HSC, the Remuneration Committee should look at succession planning.		

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		

2. Board evaluation, development and learning ALB Name – Public Health Agency Date – 24 Feb 2016

2.4 Board member appraisal and personal development

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	Annual appraisals are carried out by the Chair in line with the requirements of the PAU. The new Chair has initiated a series of more regular 1:1 meetings with members.			
GP2 Green	The Chief Executive carries out appraisals with Executive Directors. The performance of the Chief Executive and Executive Directors is discussed at the Remuneration Committee.			
GP3 Green	The Chair receives an appraisal from a Deputy Secretary and this is signed off by the Permanent Secretary			
GP4 Green	As part of the appraisal system, this is clearly discussed and specified to ensure continuous development.			
GP5	Board members appraisals	It is proposed by the Chair that		

Green	allow members to highlight development needs.	annual 1:1 meetings shall be held with members to ensure communication and any issues can be openly discussed.		
GP6 Green	This is covered through the appraisal system and PDPs, as well as through Director/Chief Execuitve away days. Relevant training/awareness is also built in where particular needs arise during the year.			
GP7 Green	Where appropriate, this is the case.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		

3. Board insight and foresight

ALB Name – Public Health Agency Date – 24 Feb 2016

3.1 Board performance reporting

	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The Board receives regular financial and performance monitoring reports the layout of which has been shaped by the business needs of the Board and for ease of use by NEDs. This sets out • performance against a range of performance measures including quality, performance, activity and finance and enables links to be made; • Variances from plan are clearly highlighted, explained and mitigating actions identified • Issues regarding future performance are highlighted The PHA Corporate Strategy, Annual Business Plan including commissioning direction targets (evidence, board papers & internal audit report) set the parameters for performance reporting	The PHA will continue to refine and develop its performance monitoring, in line with the Annual Business Plan for 2015/16. In light of budget issues, the Board will work closely with Executives and Finance to ensure objectives, targets etc. remain achievable.		
GP2	The board receives a quarterly			

Green	performance report outlining progress against objectives in the Business Plan. It also receives monthly financial report and updates on Commissioning Directions.			
GP3 Green	The Committee Chairs provide updates to the Board following each Committee meetings as specified in Standing Orders. The approved minutes of each Committee are brought to the Board for noting.			
GP4 Green	The Corporate Risk Register is openly discussed and challenges on same are made at the Governance and Audit Committee. The Corporate Risk Register is brought to the Board annually, or more frequently at the request of the Governance and Audit Committee.			
GP5 Green	Actions are recorded in the minutes of board meetings against named officers and updates reported on at the following meeting.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		

3. Board insight and foresight

ALB Name – Public Health Agency Date – 24 Feb 2016

3.2 Efficiency and Productivity

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The Board is assured that there are robust processes for assessing risks and the potential knock on or impact these could have on the health and social care family.			
GP2	Not applicable			
GP3	Not applicable			
GP4	Not applicable			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		

3. Board insight and foresight

ALB Name – Public Health Agency Date – 24 Feb 2016

3.3 Environmental and strategic focus

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The Chief Executive presents a report at every Board meeting. This, if required, will cover areas such as the external environment, policy changes and any other areas as required.			
GP2 Green	The board considers the impact of any actions arising from findings as well as the learning outcomes to ensure continuous organisational improvement.			
GP3 Green	The Board actively contributes to the development of the Business Plan through its workshop and strategic days. When all parties / stakeholders etc. have been consulted with, it is brought to the Board for formal approval.			
GP4 Green	As GP3 above, and reports are brought to the board on a quarterly basis as outlined in section 3.1 (GP2). There is also an Assurance Framework			

	which outlines what reports are required to be brought to the board and a corporate calendar outlining when these will be brought to the board			
GP5 Green	The Board's annual programme of work allows for time for the board to consider environmental and strategic risks, (including confidential board meetings, board workshops and board away day). Where relevant the Assurance Framework will be amended to include additional reporting, and or amendments brought back through Executive Directors for the Risk Register.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		

3. Board insight and foresight ALB Name – Public Health Agency Date – 24 Feb 2016

3.4 Quality of Board papers and timeliness of information

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	A plan of Board and Committee meetings is set annually to ensure diary management, for example Board meetings are normally scheduled for the third Thursday of each month. Deadlines such as Annual Reports and Accounts and Governance Statements are also taken account of to ensure completion in a timely manner. The Chair also meets with the Chief Executive and Secretariat two weeks before meetings to discus the agenda and any other current issues.			
GP2 Green	Board and Committee papers are issued at least one week in advance of the meeting to ensure adequate time for reading etc.			
GP3 Green	Board papers have a cover sheet which clearly outlines what decision is required of the			

	Board i.e. noting or approval.			
GP4 Green	Quarterly performance reports are brought to the board. If members wish to raise a specific item at a board meeting, they can do so. The PHA has clearly defined procedures for bringing significant issues to the Board's attention outside the formal monthly meetings.			
GP5 Green	Board papers include the relevant information in respect of proposals or decisions that have been proposed or made. They also state if they have been considered by the Executive Team, or other board committee before they are brought to the board.			
GP6 Green	The Board is presented with quality updates. The PHA has a robust mechanism for ensuring the collection and analysing of data. Board members regularly question and challenge data to ensure quality and understanding of same when both verbal and formal papers are brought to Board meetings. Also, the Governance and Audit Committee have the			

	opportunity to challenge and question data provided. Internal and External Audit report consider data quality in relevant audits.			
GP7 Green	Board minutes clearly demonstrate where members have challenged and questioned information brought in relation to performance management and the grading of same.			
GP8 Green	The Assurance Framework outlines clearly the information being brought to the Board for approval/noting etc. Board members discuss the information status at various workshops.			
GP9 Green	Board members can clearly demonstrate that they understand information presented and openly challenge the collection and presentation of same.			
GP10 Green	The PHA takes all steps to ensure that documentation presented to the Board complies with DHSSPS guidance where appropriate.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		

3. Board insight and foresight

ALB Name – Public Health Agency Date – 24 Feb 2016

3.5 Assurance and risk management

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The PHA has a clear strategy and policy and procedures in relation to risk management and emerging risks which have been approved by the GAC. These are regularly reviewed and are also supported by operational procedures. This clearly includes the level of risk, risk appetite and how risks escalate from directorate risk register to Corporate Risk Register, as well as reporting arrangements to GAC and PHA Board.			
GP2 Green	There is an Assurance Framework in place which outlines the key sources of assurances and how these will be reported to the board. The risk register is brought to the GAC each quarter, where it is scrutinised.			
GP3 Green	The Assurance Framework identifies a range of sources of assurance for the board,			

	including internal and external audit.			
GP4 Green	The Board regularly reviews/updates governance arrangements and practices against DHSSPS standards, good practice and good governance standards for public service.			
GP5 Green	Given the nature of the PHA functions it does not have a separate clinical and social care risk assessment and management. All types of risk are included in the Directorate and Corporate risk registersand are subject to systematic review.			
GP6 Green	The Director of Public Health is responsible for professional issues in respect of medical staff, and the Director of Nursing and AHP for nursing and AHP staff.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		

4. Board engagement and involvement

ALB Name – Public Health Agency Date – 24 Feb 2016

4.1 External stakeholders

	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The PHA has an approved PPI consultation scheme and has had service users present to the Board throughout the year.			
GP2 Green	A variety of methods are used across the PHA to engage with service users and the wider public. Board members attend at a range of activities/events/conferences of voluntary, community organisations as well as other HSC events. Chair and Chief Exeutive report at monthly board meetings in respect of events etc they have attended. Executive Directors will also have direct contact with a range of external stakeholders. The Board has identified two NED disability champions, who will be working with PHA officers and other stakeholders to ensure this agenda is taken			

	forward.			
GP3 Green	Individual programme staff engage with external stakeholders in respect of the various services they are commissioning. This information is used in the development of the PHA business plans.			
GP4 Green	The PHA Business Plan is available in a number of formats to ensure access to a wide range of stakeholders. The Business Plan is in a format that has been tried and tested to ensure a wide range of stakeholders understand the work of the PHA.			
GP5 Green	The PHA ensures that the learning from SAIs is disseminated and where appropriate influences the commissioning of services			
GP6 Green	PHA Board / Agency has very constructive and effective relationships with a range of key stakeholders.			

Red Flags	**Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag**	**Notes/Comments**
RF1		

RF2		
RF3		
RF4		
RF5		

4. Board engagement and involvement **ALB Name – Public Health Agency Date – 24 Feb 2016**

4.2 Internal stakeholders

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	The organisation culture is reviewed by the Remuneration committee bi-annually and discussed at confidential session. Follow up actions in respect of organisational culture are discussed at committee/board. Staff events are regularly held, most recently there was an event organised in November 2015 following the Ministerial announcement regarding the future of the HSC. This gave staff and Board members an opportunity to hear at first hand from the Chief Executive and to raise their concerns. There are other mechanisms for staff to input their views, e.g. through OWD or the Staff Health and Wellbeing Group. The Board receives an Annual Report from the Director of Human Resources and are			

	updated, when appropriate, on emerging issues.			
GP2	Staff are involved in the development of corporate and directorate business plans at directorate/function level. This information is then fed through to the corporate business plan. An event for all staff was held in December 2014 to enable staff to input to the development of the new Corporate Strategy. In addition, an internal social media platform has been set up to continue the conversation			
GP3	This is communicated through Directors to their teams, and is the basis for appraisals.			
GP4	The Board regularly thanks individuals and departments at Board meetings or other group functions, it acknowledges contributions and achievements as and when appropriate.			
GP5	The PHA Board and Agency have clear values and behaviours that have been communicated to staff not only in internal meetings by management, but clearly in policies and procedures.			
GP6	Staff are informed about major			

	risks etc through a range of channels, including emails from the Chief Executive, and through Chief Executive and Directorate briefings.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		

4. Board engagement and involvement

ALB Name – Public Health Agency Date – 24 Feb 2016

4.3 Board profile and visibility

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	Board members attend a range of events and launches across the PHA. Board workshops provide the opportunity for staff to present to board members and discuss programme areas in more depth and with a wider range of staff involved than would be possible at a formal board meeting.			
GP2 Green	Board members, and in particular the Chair and Chief Executive attend a range of meetings and events with external stakeholders.			
GP3 Green	Board members regularly attend events which would include high profile events.			
GP4 Green	NEDs regularly meet stakeholders and service users through events / presentations			

	etc.			
GP5 Green	The Board holds its meetings in public, and only has a small number of confidential sessions, with very specific, sensitive and/or urgent agendas. Board agendas and minutes are published on the PHA website.			
GP6 Green	Yes			

Red Flags	**Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag**	**Notes/Comments**
RF1		
RF2		

Summary Results **ALB Name – Public Health Agency Date – 24 Feb 2016**

1.Board composition and commitment		
Area	Self Assessment Rating	Additional Notes
1.1 Board positions and size	Green	
1.2 Balance and calibre of Board members	Green	
1.3 Role of the Board	Green	
1.4 Committees of the Board	Green	
1.5 Board member commitment	Green	

2.Board evaluation, development and learning		
Area	Self Assessment Rating	Additional Notes
2.1 Effective Board level evaluation	Amber	
2.2 Whole Board development programme	Amber	
2.3 Board induction, succession and contingency planning	Green	
2.4 Board member appraisal and personal development	Green	

3.Board insight and foresight		
Area	Self Assessment Rating	Additional Notes
3.1 Board performance reporting	Green	
3.2 Efficiency and Productivity	Green	
3.3 Environmental and strategic focus	Green	
3.4 Quality of Board papers and timeliness of information	Green	

3.5 Assurance and risk management	Green	

4. Board engagement and involvement		
Area	Self Assessment Rating	Additional Notes
4.1 External stakeholders	Green	
4.2 Internal stakeholders	Green	
4.3 Board profile and visibility	Green	

5. Board impact case studies		
Area	Self Assessment Rating	Additional Notes
5.1		
5.2		
5.3		

Areas where additional training/guidance is required		
Area	Self Assessment Rating	Additional Notes

Areas where additional assurance is required		
Area	Self Assessment Rating	Additional Notes

6. Board impact case studies

6. Board impact case studies

Overview

This section focuses on the impact that the Board is having on the ALB and considers recent case studies in the following areas:

1. Performance failure in the area of quality, resources (Finance, HR, Estates) or Service Delivery;
2. Organisational culture change; and
3. Organisational strategy.

6. Board impact case studies

6.1 Measuring the impact of the Board using a case study approach

This section focuses on the impact that the Board is having on the ALB, it's clients, including other organisations, patients, carers and the public. The Board is required to submit three brief case studies:

1. A recent case study briefly outlining how the Board has responded to a performance failure in the area of quality, resources (Finance, HR, Estates) or service delivery. In putting together the case study, the Board should describe:
    - Whether or not the issue was brought to the Board's attention in a timely manner;
    - The Board's understanding of the issue and how it came to that understanding;
    - The challenge/ scrutiny process around plans to resolve the issue;
    - The learning and improvements made to the Board's governance arrangements as a direct result of the issue, in particular how the Board is assured that the failure will not re-occur.

2. A recent case study on the Board's role in bringing about a change of culture within the ALB. This case study should clearly identify:
    - The area of focus (e.g. increasing the culture of incident reporting; encouraging innovation; raising quality standards);
    - The reasons why the Board wanted to focus on this area;
    - How the Board was assured that the plan(s) to bring about a change of culture in this area were robust and realistic;
    - Assurances received by the Board that the plan(s) were implemented and delivered the desired change in culture.

3. A recent case study that describes how the Board has positively shaped the vision and strategy of the Trust. This should include how the NEDs were involved in particular in shaping the strategy.

Note: Recent refers to any appropriate case study that has occurred within the past 18 months.

6. Board impact case studies

ALB Name – Public Health Agency Date – 24 Feb 2016

6.1 Case Study 1

Performance issues in the area of quality, resources (finance, HR, Estates) or Service Delivery	Management of Lifeline Crisis Response Service Contract
Brief description of issue	In early 2014, the PHA Board was becoming increasingly concerned that the Lifeline Crisis Response Service was operating significantly in excess of its budget.
Outline Board's understanding of the issue and how it arrived at this	Each month the PHA Board receives a monthly Finance Performance Report. This Report contains information regarding budget lines and highlights variances. Board members noted that, although the service is a demand-led one where demand can fluctuate, it seemed that the budget was continuously overspent. The Director of Public Health advised members that PHA had commissioned an independent clinical review on the service to review these issues, and in addition had put in place a series of directives to ensure the provider of the Lifeline service was managing demand within the remit of the contract specification
Outline the challenge/scrutiny process involved	An independent clinical review was undertaken and the findings of this were presented to a confidential session of the PHA Board in August 2014. The Governance and Audit Committee kept a particular interest in this issue. It received a briefing in October 2014. In April 2015 the Committee received a follow-up briefing on the progress made against the recommendations emanating from the review and the response to the directives to the service provider in terms of managing demand. During 2015/16 members have noted in the monthly Financial Performance Reports that the expenditure on the Lifeline contract has greatly reduced. Assurance was also provided that the service was supporting those most in need and was not duplicating other services.
Outline how the issue was resolved	As stated previously, there were two approaches taken in addressing the issue, the first was the issuing of service management directives by the DPH to the Service Provider and the second was the commissioning of an independent clinical review. This review contained recommendations for PHA and an action plan was developed between PHA and the service provider. There continues

	to be regular meetings between PHA and the provider to work through the monitoring reports from the provider. There has helped improved data recording and reporting by the provider. It is important to note that during this time, the helpline has remained free to access 24/7 and that appropriate follow on support is targeted at those most in need and does not duplicate other services. There has also been a significant improvement in the providers performance in terms of KPIs around key issues such as missed calls, dropping from >40% to just 1%
Summarise the key learning points	Overall, more detail on budget variances is included in the monthly financial performance reports and brought to the attention of the Board. The learning from this exercise will be taken account of in the public consultation on the future of the service and the planned re-tendering arrangements for any new contract.
Summarise the key improvements made to the governance arrangements directly as a result of above	From a PHA Board perspective, the Governance and Audit Committee will continue to monitor the progress against the recommendation and will review closely the outcome of any future clinical reviews.

6. Board impact case studies

ALB Name – Public Health Agency Date – 24 Feb 2016

6.2 Case Study 2

Organisational Culture Change	Title:
Brief description of area of focus	
Outline reasons/ rationale for why the Board wanted to focus on this area	
Outline how the Board was assured that the plan/ (s) in place were robust and realistic	
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	

6. Board impact case studies

ALB Name………………………………………………………Date……………

6.3 Case Study 3

Organisational strategy	Title:
Brief description of area of focus	
Outline reasons / rationale for why the Board wanted to focus on this area	
Outline how the Board was assured that the plan/ (s) in place were robust and realistic	
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	
Specifically explain how the NEDs were involved	