AGENDA

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

No	Time	Item	Paper	Sponsor
1.	1:30	Welcome and Apologies		Chair
2.	1:30	Declaration of Interests		Chair
3.	1:30	Minutes of the PHA board Meeting held on 17 April 2014		Chair
4.	1:35	Matters Arising		Chair
5.	1:40	Chair's Business		Chair
6.	1:45	Chief Executive's Business		Chief Executive
7.	1:50	Finance Update • PHA Financial Performance Report	**PHA/01/05/14 (for Noting)**	Mr Harkin
8.	2:00	HCAI Target Monitoring Report	**PHA/02/05/14 (for Noting)**	Dr Harper
9.	2:10	HALT Report 2013: Healthcare Associated Infections and Antimicrobial Use in Long-Term Care Facilities in Northern Ireland	**PHA/03/05/14 (for Noting)**	Dr Harper
10.	2:30	Performance Management Report – Corporate Business Plan and Commissioning Plan Directions Targets for Period Ending 31 March 2014	**PHA/04/05/14 (for Noting)**	Mr McClean

11.	2:45	Health and Social Wellbeing Improvement Update	**PHA/05/05/14 (for Noting)**	Dr Harper
12.	3:05	Child Development Programme Board Update	**PHA/06/05/14 (for Noting)**	Dr Harper
13.	3:25	Development of PHA Corporate Strategy 2015-2019		Chief Executive
14.	3:40	ALB Self-Assessment Action Plan	**PHA/07/05/14 (for Noting)**	Chair
15.	3:50	Draft Investment Plan 2014/15	**PHA/08/05/14 (for Noting)**	Mr McClean
16.	4:05	Any Other Business		

17. **Date, Time and Venue of Next Meeting**
Thursday 19 June 2014
1:30pm
Conference Rooms 3/4
Public Health Agency
12-22 Linenhall Street
Belfast
BT2 8BS

MINUTES

Minutes of the 64th Meeting of the Public Health Agency board held on Thursday 17 April 2014 at 1:30pm, in Public Health Agency, Conference Rooms, 12/22 Linenhall Street, Belfast, BT2 8BS

PRESENT:

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

IN ATTENDANCE:

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

APOLOGIES:

Alderman Paul Porter	-	Non-Executive Director
Mr Owen Harkin	-	Director of Finance, HSCB
Mrs Fionnuala McAndrew	-	Director of Social Services, HSCB
Mrs Joanne McKissick	-	External Relations Manager, Patient Client Council

		Action
49/14	**Item 1 – Apologies**	
49/14.1	The Chair noted apologies from Alderman Paul Porter, Mr Owen Harkin, Mrs Joanne McKissick and Mrs Fionnuala McAndrew. The Chair welcomed Mr Tony Rodgers, who will be attending meetings while Fionnuala McAndrew is acting Chief Executive of the HSC Board.	

50/14	**Item 2 - Declaration of Interests**
50/14.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. None were declared.
51/14	**Item 3 – Minutes of the PHA Board Meeting held on 20 March 2014**
51/14.1	The minutes of the previous meeting, held on 20 March 2014, were approved as an accurate record of the meeting. The minutes were duly signed by the Chair.
52/14	**Item 4 – Matters Arising**
	46/14 Update on Inter-sectoral Programme Boards
52/14.1	The Chair asked members to confirm which of the three programme boards they wished to join. It was agreed that confirmed dates would be distributed and members could advise which group(s) they wished to join.
53/14	**Item 5 – Chair's Business**
53/14.1	The Chair advised that the PHA Business Plan for 2014/15 had been approved by DHSSPS and would be published on the PHA website shortly.
53/14.2	The Chair said that she had visited the Arc Health Living centre in Irvinestown to see the range of community projects and said that it was an excellent example of integrated working and collaboration.
53/14.3	The Chair had attended the launch of the recent LGBT guidelines for older people and had heard a range of both good and bad individual stories. She added that this was an important piece of work for PHA.
53/14.4	The Chair reminded members that anyone wishing to attend the NHS Confederation annual conference in Liverpool from 4 to 6 June 2014 should advise the Secretariat as soon as possible.
53/14.5	The Chair shared correspondence with members from Patient

Client Council regarding the HSC Online User Feedback System. The correspondence was noted by members.

54/14 Item 6 – Chief Executive's Business

54/14.1 The Chief Executive advised that he had attended some very positive projects over recent weeks including the Eden Village project run by FASA in Ballywalter and the Incredible Edible project in Cloughmills.

54/14.2 The Chief Executive said that he had met with representatives from the Waterside area who wished to establish a health hub in the area.

54/14.3 The Chief Executive said that he had met with representatives from families who were expressing concern about the impact of having wind turbines near their homes. He said that this was a complex issues and that he had agreed to follow up with some of the families that he had met.

55/14 Item 7 – Local Government: Development of Community Planning

55/14.1 Mr McClean welcomed Ian Maye from DOE and Nigel McMahon from DHSSPS to the meeting. Mr Maye introduced his colleagues, Keith Ruffles, Nicola Gregg and Catherine McKinney and delivered a presentation on the local government reform programme.

55/14.2 Mr Maye outlined the new model of 11 Councils and the new powers they will have. He gave an overview of the new governance arrangements with particular focus on the new general power of competence.

55/14.3 Mr Maye talked about community planning and the role of PHA in community planning. He said that the new Councils had to be clear about the priorities in their areas and work with partner organisations. He added that it was important that this work commenced as soon as possible and that it linked with Transforming Your Care, Delivering Social Change and the new Public Health Framework. He acknowledged that there would not be a "one size fits all" approach. Ms McKinney said that she was aware that the PHA had been working proactively with local

	councils and hoped that this work would continue.
55/14.4	Alderman Ashe said the joint working would be critical to the success of the new Councils taking forward the public health agenda.
55/14.5	The Chief Executive stated that the Health and Social Care legislation places a duty of health and wellbeing on PHA which has allowed it to work flexibly with all bodies across all of Northern Ireland. He said that the local government reform programme provides a significant opportunity and he added that it was critical that all government departments involved worked together to achieve success, and to make it work, particularly in the areas of health and wellbeing.
55/14.6	Mr McClean cited section 41 of the Community Planning Foundation Programme and the reference to equipping communities with the skills to enable them to engage effectively in community planning. Mr Maye said the responsibility for engagement with the community and voluntary sector will fall to the new Councils. Ms Gregg said that some community planning work had taken place and Ms McKinney added that there had been examples of community organisations amalgamating as part of the community planning agenda. Mr Maye cited Mid and East Antrim as an area where this had worked well.
55/14.7	Mr Coulter suggested that PPI represented an excellent opportunity area for joint working. He added that he was particularly interested in seeing how health inequalities could be tackled with collaborative working. Mr Maye said that he hoped that the new arrangements would make a difference.
55/14.8	Mr McClean said that his biggest concern was the transition period for areas where health improvement and health protection worked closely with existing environmental health functions, and dealing with uncertainty until new arrangements were clear. Mr Maye said that he hoped to work with all of the Chief Executive Designates to ensure that there would be a smooth transition.
55/14.9	Mr Rodgers said that the next year will present particular challenges but added that within HSC, work had been undertaken in community planning and developing performance indicators and he hoped that the existing processes would be

	used instead of creating new ones. Mr Maye said that there may be some minor changes with regard to health, but this may not be case with regard to education.
55/14.10	The Chair thanked Mr Maye and his colleagues for their presentation. Members noted the update on community planning.
56/14	**Item 8 – Finance Update** **PHA Financial Performance Report (PHA/01/04/14)**
56/14.1	Mr Christie presented the Finance Report and said that the report indicated that at the end of February, there was a year to date surplus of £1.3m. He added that since the report was produced, a significant amount of investigative work had been undertaken by HSCB finance staff and he was now satisfied that the projected expenditure for the months of February and March would be spent before the year end. He said that the current projected end of year position is a surplus of £169k.
56/14.2	Mr Christie said that the prompt payment statistics had improved and he added that almost two-thirds of invoices had been paid within 10 days.
56/14.3	Mrs Karp asked whether there was any greater assurance that could be provided regarding the year end position. Mr Christie said that a significant amount of work had been undertaken during March to complete the accounts and to quality assure them, and that this work was half complete. However, he was optimistic that PHA would achieve a break even outcome. He added that there is always a concern around the year end with the amount of projected expenditure during February and March.
56/14.4	The Chair asked whether it was possible to avoid having this year-end bulge. Mr Christie said that there is room for improvement, but noted that until PHA receives confirmation of its financial allocation, it is difficult to fully plan the annual expenditure. Furthermore, PHA has been receiving additional funding in recent years to spend in new areas.
56/14.5	The Chief Executive said that each year PHA is seeking to improve its planning processes and for 2014/15, members had seen the draft Investment Plan. He acknowledged that there

remain some systems issues and room for improvement.

56/14.6 Members noted the Finance Report.

57/14 Item 9 – Governance and Audit Committee Update (PHA/02/04/14)

57/14.1 Mrs Erskine said that the minutes of the Governance and Audit Committee meeting of 6 February were available for noting by members.

57/14.2 Mrs Erskine advised that, at the meeting of the Committee on 10 April, the Committee had reviewed the Assurance Framework. She added that following consideration of the Internal Audit end of year follow up reports, 90% of outstanding audit recommendations had been completed. She added that the Internal Audit work plan for 2014/15 had also been considered.

57/14.3 Mrs Erskine said that the Committee had received an update on finance, fraud and BSTP. With regard to BSTP, she said that there were some outstanding issues regarding customer service and communication and to this end, the Committee had invited Paddy Anderson and Hugh McPoland to attend a future meeting.

57/14.4 Mrs Erskine said that the Governance Committee Annual Report had been considered, as well as the Declaration of Assurance from SBNI.

57/14.5 Members noted the update from the Committee Chair.

58/14 Item 10 – HSC Research and Development Division Update (PHA/03/04/14)

58/14.1 Dr Janice Bailie joined the meeting and gave members an overview of the work of the Research and Development (R&D) Division. She outlined the role of the division and highlighted some of the key achievements during 2013/14 and finished with a look forward to 2014/15.

58/14.2 Dr Harbison thanked Dr Bailie for her presentation and acknowledged the amount of activity undertaken. He commended the ability for Northern Ireland researchers to access UK funding and how £4.5m worth of funding had already been

	leveraged. He asked about Horizon 2020 and the ability of Northern Ireland researchers to access EU funding.
58/14.3	Dr Bailie said that she was aware of some of the proposals, but she noted that there was an issue for HSC staff having the skills and wherewithal to access EU funding. She added that to receive £350k of funding during 2013/14 was a positive step and she hoped this would increase in 2014/15.
58/14.4	Mr Coulter commented that there is a good spread of work in the areas where grants had been awarded and asked whether this is monitored. He also asked about research in social care. Dr Bailie said that R&D would be responsive to policy requests for research funding, and would also look at Programme for Government targets. She said that research projects have evaluations carried out by independent panels to ensure they are of good quality and that there is a good spread of research topics.
58/14.5	With regard to social care research, Dr Bailie said that there is work ongoing in this area as the PHA has appointed a Programme Manager and HSCB a Project Lead, who will both work in this area. She said she would encourage them to link in with the Northern Ireland Public Health Network. She said that there is a challenge to get discussions with Trusts and universities in this area.
58/14.6	Members noted the update on the R&D Division.
59/14	**Item 11 – Management Statement / Financial Memorandum (PHA/04/04/14)**
59/14.1	Mr McClean presented the Management Statement and Financial Memorandum and explained that this is required to be brought to the Board annually for noting and that there had not been any revisions made.
59/14.2	Members noted the Management Statement and Financial Memorandum.
60/14	**Item 12 – PHA Procurement Plan**
60/14.1	Mr McClean presented the current PHA procurement plan and

	explained that the plan has been developed in line with EU social care procurement requirements. He said that procurement is not new to PHA as for many years PHA has been awarding programme funding using tenders. He added that both Internal Audit and the Northern Ireland Audit Office will be closely monitoring this area of PHA's work to ensure it complies with EU requirements as appropriate.
60/14.2	Mr McClean advised that procurement is a complex area and that PHA is grateful for the input it receives from Orla Donachy (PALS) and Catherine Thompson (Legal), who he introduced to members. He said that PHA would also be looking at how to maximise the impact of social clauses and was mindful of the recent Central Procurement Directorate (CPD) guidance on developing key performance indicators.
60/14.3	Mr McClean advised that the PHA organised a series of roadshows, which had been attended by over 200 organisations, and developed a series of Frequently Asked Questions (FAQs) to assist these organisations understand the approach it was taking.
60/14.4	Mr Mahaffy suggested that across the UK, different organisations were interpreting the laws differently and he asked about how the health system in Northern Ireland was looking at the issue of the living wage. Ms Donachy advised that the CPD had issued guidance which covered a range of performance indicators in areas such as health and safety, fair payment terms, apprenticeships and work placements for students. She said that PHA would consider these, where appropriate, but she added that PHA was being innovative in terms of promoting PPI and engagement activity. With regard to the living wage, Ms Thompson advised that this was a policy issue, rather than a legal issue, and probably beyond the scope of the PHA to apply unilaterally. Ms Donachy added that it was within the capacity of the Northern Ireland Assembly to approve a policy on the living wage.
60/14.5	Mr Mahaffy enquired about social clauses being within the award criteria. Ms Donachy said that PHA can look at this, but cannot be seen to be discriminating against other providers. Mr McClean agreed that this was the crux of the issue. He said that to maximise community benefits, it is important to address not only award criteria, but also ensuring as much detail as possible

	in the service specification, in advance of the procurement stage in order to ensure social benefits could be maximised.
60/14.6	Dr Harbison expressed a concern that although PHA is attempting to restructure the large number of contracts that it has and to strengthen links with the local community, there is a concern that smaller community organisations might face difficulties in meeting the requirements and that instead of encouraging these organisations, it would discourage them. Mrs Erskine also expressed concern that the new arrangements could provide difficulties for the capacity of both PHA staff and the organisations involved.
60/14.7	Mr McClean said that the need to find balance made it important that "bundling" of contracts needed to be at the right scale as there are benefits for local communities by having localised contracts instead of situations where there is one contract for a service across all of Northern Ireland.
60/14.8	Mr Coulter asked if PHA obtains feedback from organisations which have had experience of PHA's procurement processes in order to help build capacity for other groups. Ms Donachy said that feedback can be provided if required, but she acknowledged that there is room for improvement in this process as it would be a reactive approach, rather than a proactive one.
60/14.9	Mr Christie said that, with regard to the living wage, PHA would not have the authority to create policy in this area, and that the DHSSPS would not have this authority, this would have to be directed by the Northern Ireland Assembly.
60/14.10	The Chief Executive said that many groups had approached PHA to seek funding to help with capacity building, and explained that there was an onus on organisations to think collaboratively if they wish to survive in this new environment. Mr McClean said that Belfast City Council had organised capacity building workshops and the PHA would be encouraging other Councils to do likewise.
60/14.11	Mr Mahaffy asked about taking forward the recommendations in the Marmot Review, and he expressed concern about the terms and conditions for staff in domiciliary care agencies. Mr McClean said that as part of the PHA's new Corporate Strategy, it would be looking at areas emanating from the Marmot Review.

60/14.12	Members noted the procurement plan.
61/14	**Item 13 – Any Other Business**
61/14.1	The Chief Executive advised members that a paper outlining the proposed development of the next PHA Corporate Strategy would be brought to the May Board meeting.
61/14.2	Mr Coulter asked if there had been any comments received from DHSSPS regarding the draft Commissioning Plan. Members were advised that there was no update.
61/14.3	There was no other business and the Chair drew the meeting to a close.
62/14	**Item 14 – Date and Time of Next Meeting**

Date: Thursday 15 May 2014
Time: 1:30pm
Venue: Public Health Agency
Conference Rooms
2nd Floor
12-22 Linenhall Street
Belfast
BT2 8BS

Signed by Chair: ____________

Date: 15/05/14

PHA Financial Performance Report

May 2014

PHA Board Report

March 2014

HSC Public Health Agency

Summary Position

March 2014

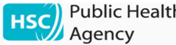
Income

	Page Reference	Year End Position £000s
Department Allocation		94,341
Income from Other Sources		975
Total Income		95,316
Expenditure		
Non-Trust Programme	2	43,022
Trusts & BSO	3	32,476
PHA Administration	4	19,658
Total Expenditure		95,156
Surplus/(Deficit)		160

Position Synopsis:

The final position for PHA is a surplus of £160k, which is within the limits of the PHA's 0.25% breakeven target.

Within Management and Administration budgets there was a total of £549k of slippage generated during 2013/14. Also, a number of baseline programme areas both over and under spent against budgets, details of which can be found within this report. This resulted in the net position reflected above.



Non-Trust Programme

March 2014

Non-Trust Programme Spend

Non-Trust Programme Expenditure 2013/14

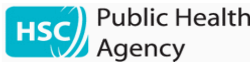
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Total
Budget	409	4,100	564	945	2,533	4,926	4,598	4,379	3,767	3,669	6,442	6,301	42,633
Expenditure	332	3,211	1,979	1,109	2,470	4,523	4,250	4,702	3,337	4,082	5,665	7,362	43,022
Surplus/(Deficit)	77	889	(1,415)	(164)	63	403	348	(323)	430	(413)	778	(1,061)	(389)
Surplus/(Deficit) made up as follows:													
Health Improvement - Belfast LCG	(79)	202	(413)	48	114	3	77	67	(24)	3	46	(21)	22
Health Improvement - South East LCG	145	142	(223)	247	(305)	45	23	(59)	(56)	75	352	(285)	101
Health Improvement - North LCG	0	(13)	(6)	(144)	231	43	(49)	(77)	(20)	(5)	170	(71)	59
Health Improvement - South LCG	(54)	748	(659)	(65)	(142)	145	121	(195)	120	(23)	(44)	104	57
Health Improvement - West LCG	12	120	(202)	46	377	(21)	(171)	(82)	(7)	(30)	53	(78)	16
Health Improvement - Lifeline Contract	0	(3)	(64)	(30)	(34)	(28)	(102)	128	(100)	(320)	(86)	(129)	(767)
Health Improvement - Smoking Cessation	16	0	(21)	(76)	58	(15)	(5)	0	26	16	80	(77)	2
Health Protection	0	(68)	20	(31)	(30)	24	11	80	41	(31)	174	(167)	25
Service Development & Screening	(2)	(21)	(22)	(37)	(76)	86	90	(9)	89	(22)	(63)	(34)	(22)
Research & Development	39	2	(22)	8	(64)	(5)	262	(184)	12	5	(53)	(13)	(12)
Campaigns	0	(217)	232	(110)	(45)	66	74	6	(60)	(95)	181	(208)	(176)
Nursing	0	(3)	(35)	(20)	(21)	60	16	2	20	14	(33)	(42)	(43)
Additional Internally generated slippage towards programme pressures									389	0	0	(40)	349

Position Synopsis:

The current position shows an overspend of £389k at the end of March which is after the introduction of £349k from previous internally generated slippage.

The budgets for Lifeline and Campaigns were permitted to overspend by approximately £800k and £210k respectively due to the cost pressures on the Lifeline Contract and the delivery of the Organ Donation Campaign. For other areas, while there were over and under spends against budget, the most significant was in South Eastern Health Improvement which underspent by £101k, or 3% of budget, which had not been anticipated.

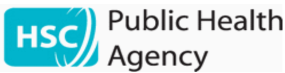
As previously reported the majority of PHA programme budgets are skewed to expend in the last quarter of the year, this caused a significant amount of work in the last 2 months to ensure budgets were fully utilised as expected. This profile brings with it an inherent risk of an unexpected event causing slippage when there is little opportunity to redirect it. Efforts should be made in 2014/15 to minimise the risk which this places on the PHA.



Revenue Resource Limits (RRLs) to Trusts

March 2014

	Annual Budget (per revised SBAs) £'000s	Budget to Date £'000s	Variance from Annual Budget £'000s	Main Reasons for Increase in Funding
Western Trust	5,065	5,793	728	
Northern Trust	5,663	6,490	827	
Belfast Trust	10,672	11,375	703	Over the course of the year the PHA have issued £3.2m over and above that identified in the original Service Budget Agreements to Trusts.
South Eastern Trust	2,808	3,247	439	
Southern Trust	4,403	4,950	547	
BSO	621	621	0	
Total	**29,232**	**32,476**	**3,244**	



PHA Administration

March 2014

	Total		Current Month			Year to Date	
	Budget	**Budget**	**Expenditure**	**Variance**	**Budget**	**Expenditure**	**Variance**
	£'000's	£'000's	£'000's	£'000's	£'000's	£'000's	£'000's
Salaries & Wages	17,497	1,537	1,499	38	17,497	17,018	479
Goods & Services	2,710	334	416	(82)	2,710	2,641	69
Total Administration	20,207	1,871	1,915	(44)	20,207	19,658	549

Position Synopsis:

The final position for Management and Administration is relatively unchanged from last month with the underspends due to vacant posts and a small element of un-utilised Goods & Services budget.

Prompt Payment Statistics

	March 2014 Value £'000	March 2014 Volume of Invoices	Cumulative position as at 31/3/14 £'000	Cumulative position as at 31/3/14 Volume of Invoices
Total bills paid (relating to Prompt Payment target)	4,146	771	31,724	8,289
Total bills paid on time (within 30 days or under other agreed terms)	3,466	675	27,735	7,392
Percentage of bills paid on time	**83.6%**	**87.5%**	**87.4%**	**89.2%**

At 31 March 2014, the Business Services Organisation had reported 30 day prompt pay figures of 4,822 invoices paid, with 4,171 (86.5%), of these paid within the 30 day requirement. The prompt pay report provided by BSO included and excluded payments which required a recalculation.

HSCB finance staff on behalf of PHA, reviewed and reconciled all payments made by PHA in 2013/14, classified all payments in accordance with the method ratified by external audit for the 2012/13 accounts and produced the figures shown in the table above. This method will continue into 2014/15 to ensure robust and consistent monthly reporting, while work continues with BSO to produce a suitable report for PHA.

PHA had been making good progress in utilising the new systems to clear invoices promptly up to January 2014 with approximately 90% of invoices being paid within 30 days (by volume of invoices) each month. This payment efficiency has reduced slightly following the move to Shared Service payments in February but this is expected to be a short term reduction while the new processes become embedded.

In addition it should be noted that for the period to March 2014, PHA have paid 73.4% of all invoices within 10 days of receipt by BSO, despite delays in scanning invoices by the Shared Service Centre.

PHA/02/05/14

HCAI Target Monitoring Report

May 2014

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	15 May 2014
Title of Paper	HCAI Target Monitoring Report
Agenda Item	8
Reference	PHA/02/05/14
Summary	
To note the HCAI Monthly Target Monitoring Report up to and including 31st March 2014.	
Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This report was brought to AMT on 6 May 2014.
Recommendation / Resolution	For Noting
Director's Signature	CHarper
Title	Director of Public Health
Date	2 May 2014

Target Monitoring Report

S.aureus and *C.difficile*

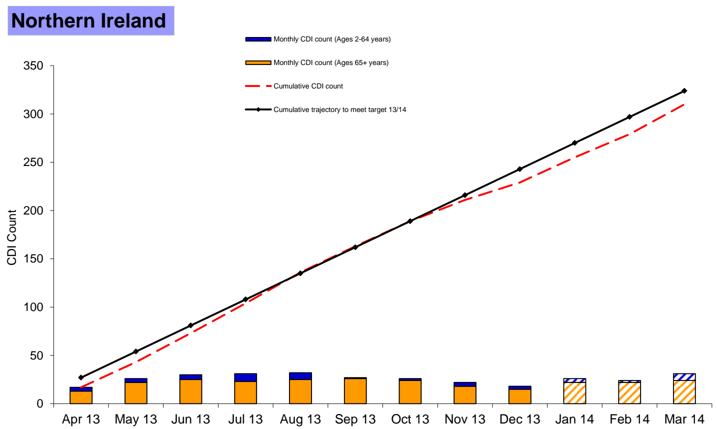
March 2014

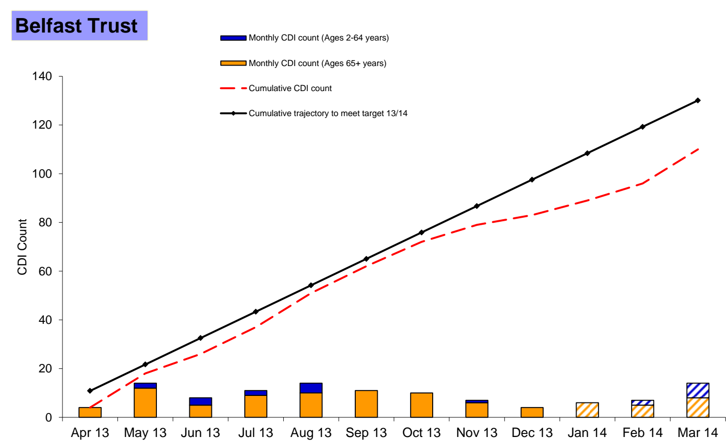
(Information up to 31/03/2014)

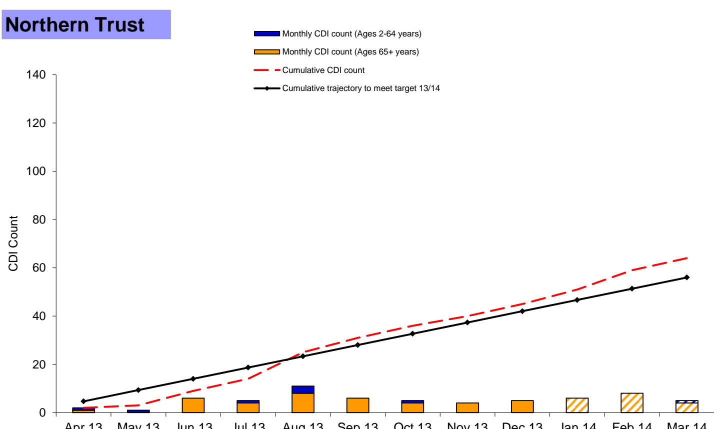
Please note:

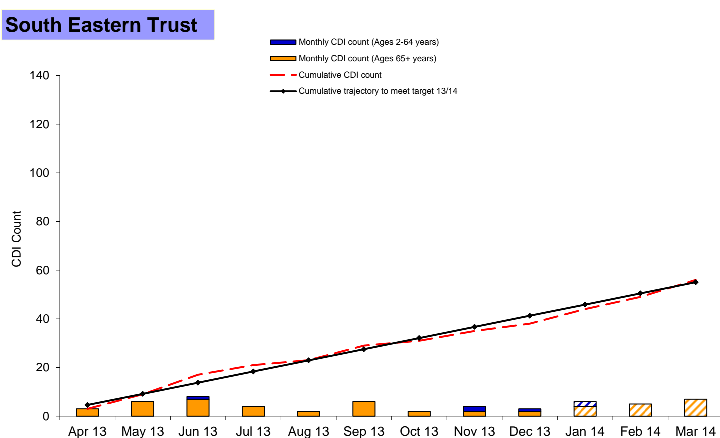
- HCAI monthly monitoring reports issued to Trusts include cases reported through the HCAI web surveillance system per calendar month.
- HCAI monthly monitoring reports will be issued by PHA during the 3rd week of the following month. This is to ensure that HCAI data included in monitoring reports has been verified during Chief Executive sign-off (which occurs on the 15th of each month).
- *C. difficile* performance target for 2013/14 includes hospital in-patients aged 2 years and over – note this is a change from 2009/10 when *C. difficile* performance target included hospital in-patients aged 65 years and over.
- *S. aureus* performance target for 2013/14 includes patients whose specimens were taken in an Acute Trust Hospital setting only e.g. Hospice records will not be counted towards targets.
- Surveillance of MSSA bacteraemias remains mandatory – however there is no performance target associated with MSSA during 2013/14. To facilitate ongoing surveillance of MSSA bacteraemias during 2013/14 MSSA data for 2012/13 has been used as a comparison.
- Presentation of the monitoring report is based on updated 2013/14 performance targets for MRSA bacteraemias and *C. difficile* as advised by HSCB on 07/06/2013.
- There has been a change in the monitoring and reporting arrangement of *C.difficile* from 1st April 2013. All *C.difficile* isolates now reported are both GDH and toxin positive (previous reporting was based on toxin positivity only).

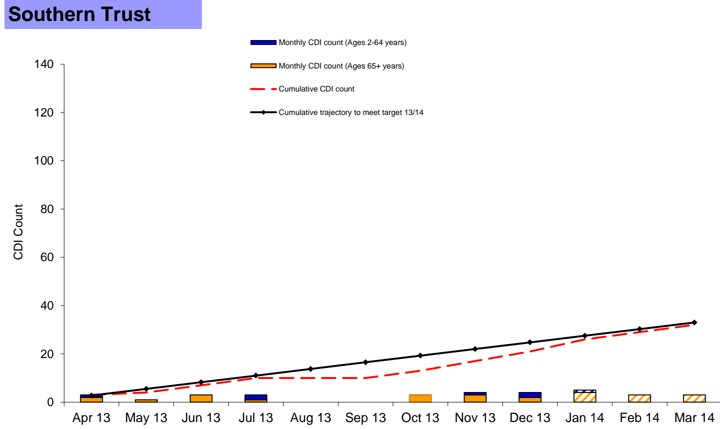
Figure 1: CDI (inpatients 2 years and over) trajectory figures based on cumulative counts (see Appendix 1 for derivation).

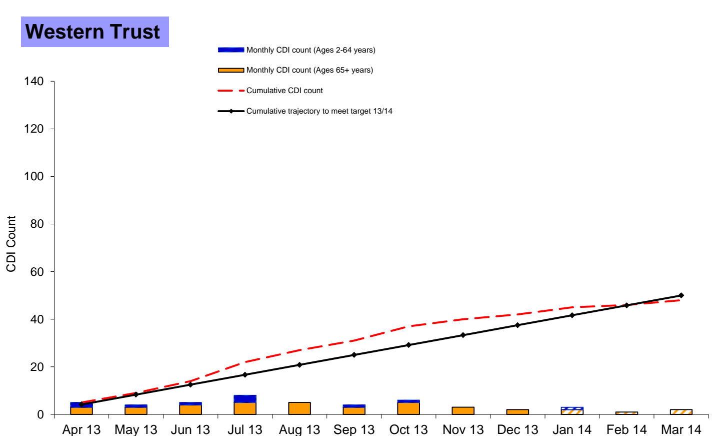












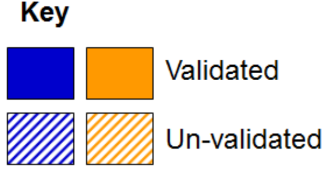


Figure 2: CDI (inpatients 2 years and over) performance figures based on monthly data and 3 monthly rolling totals (see Appendix 1 for derivation and key).

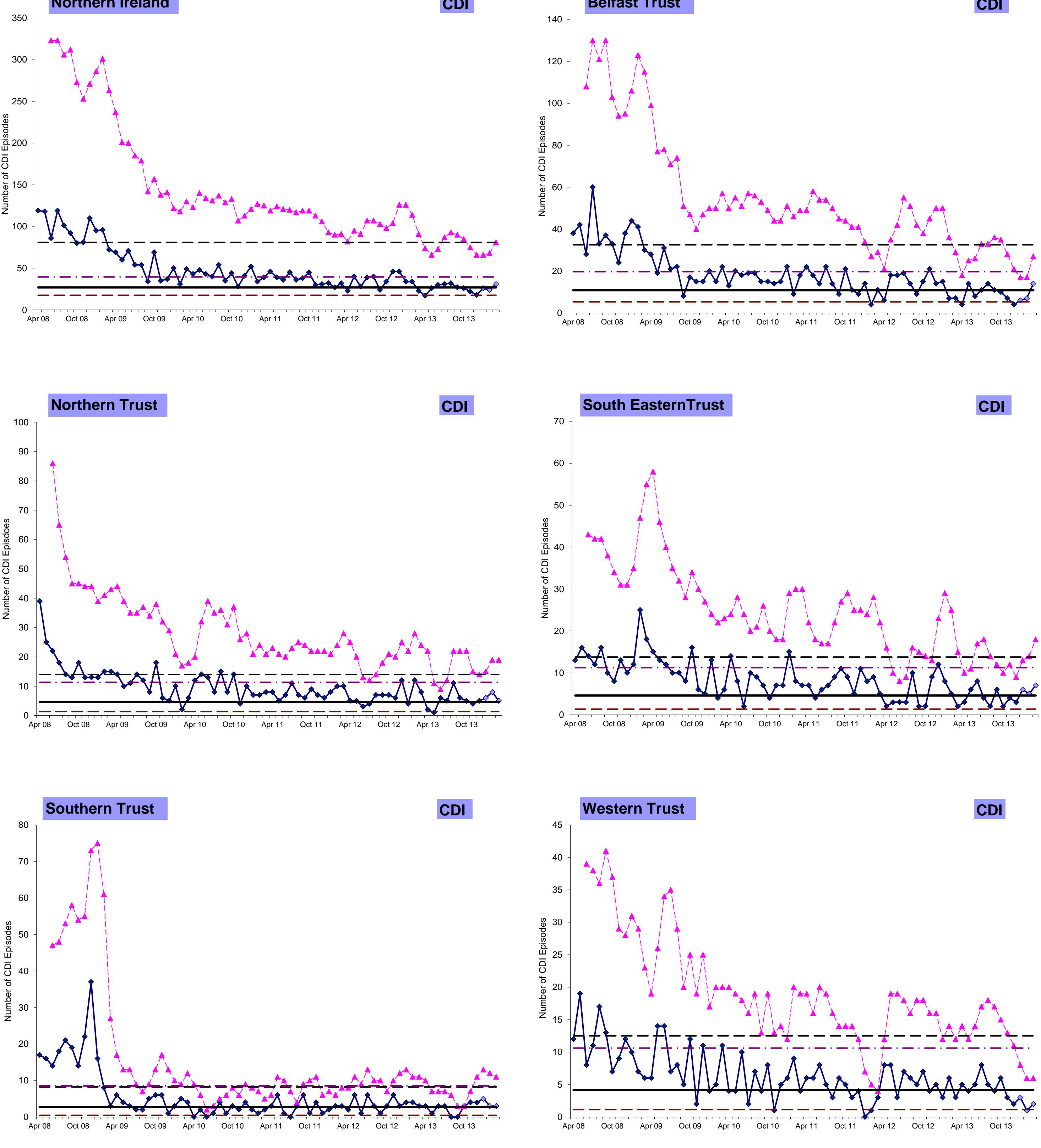
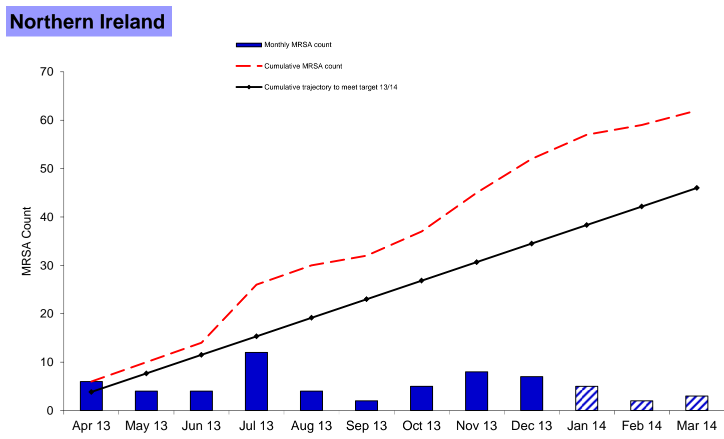
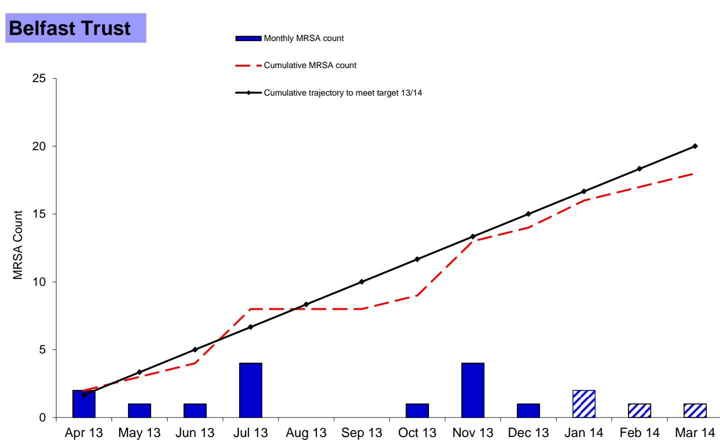
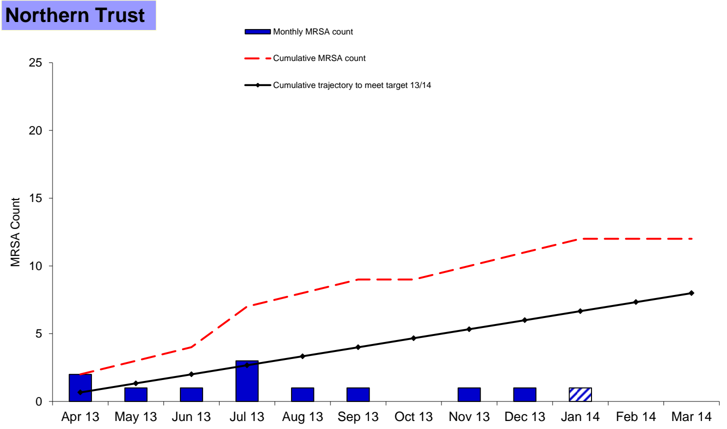
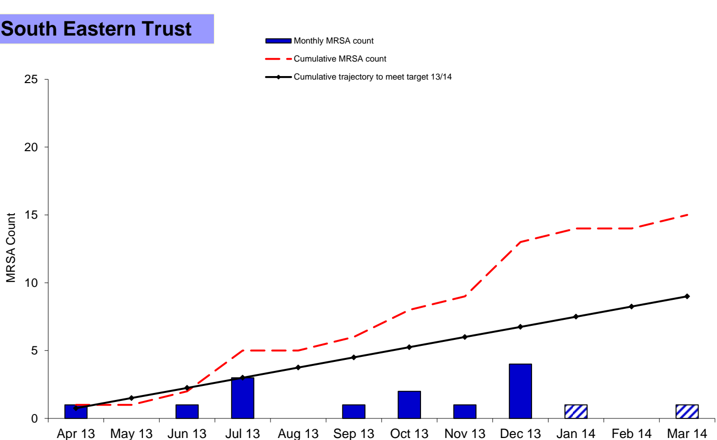


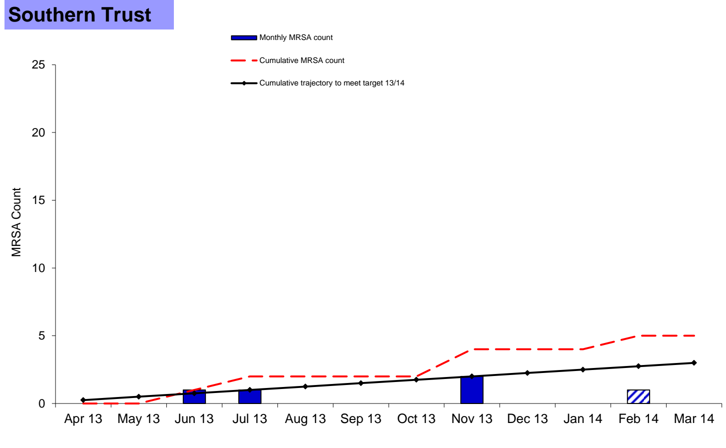
Figure 3: MRSA trajectory figures based on cumulative counts (see Appendix 1 for derivation).

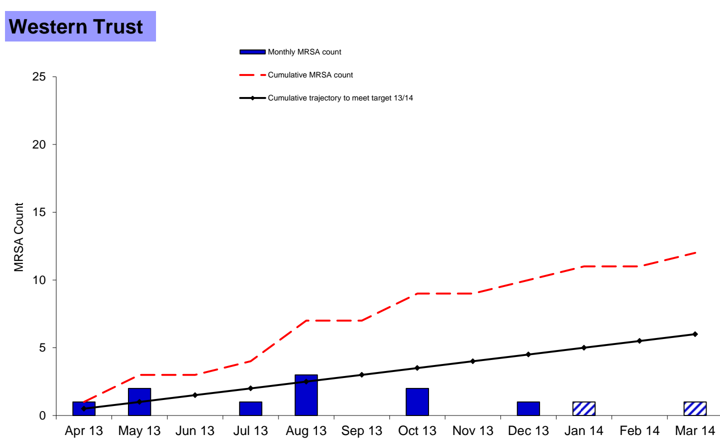












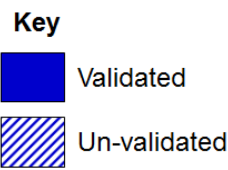


Figure 4: MRSA performance figures based on monthly data and 3 monthly rolling totals (see Appendix 1 for derivation and key).

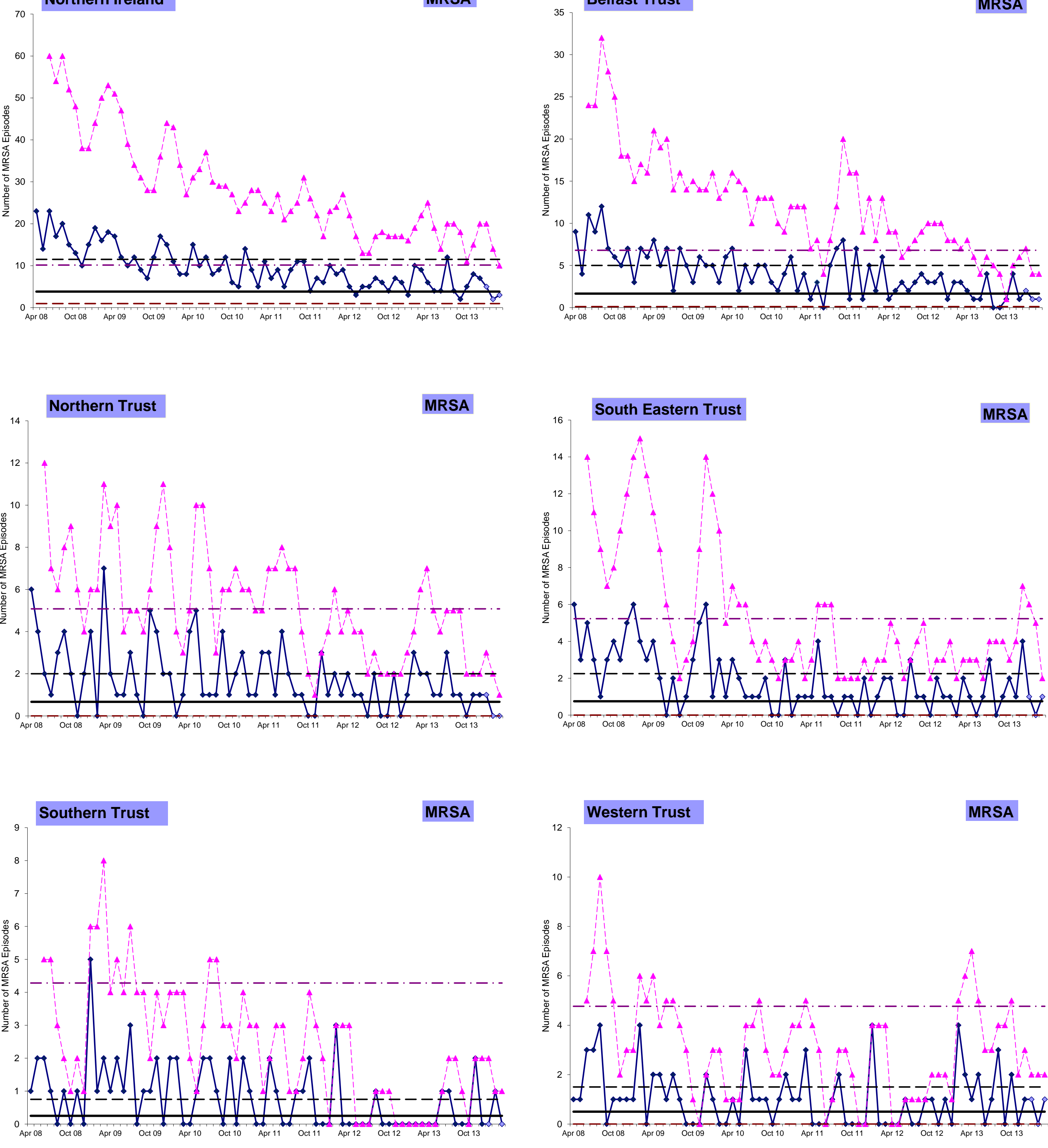
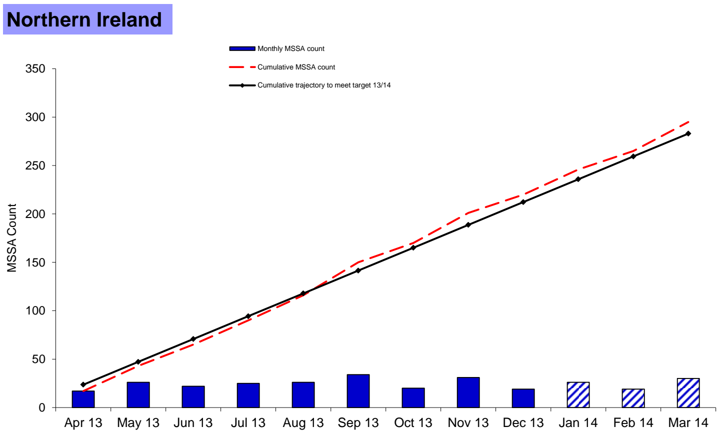
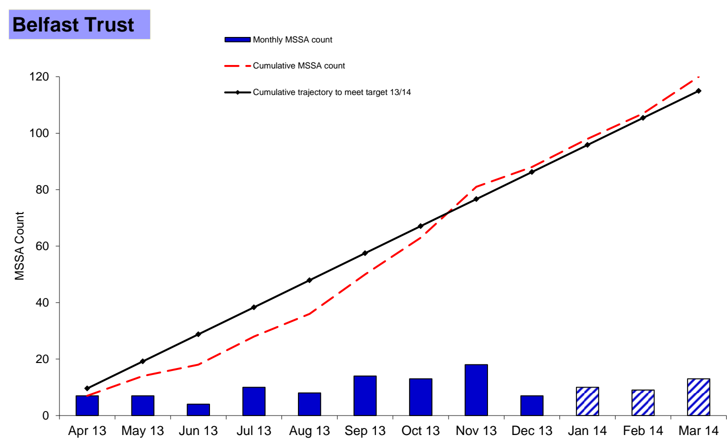
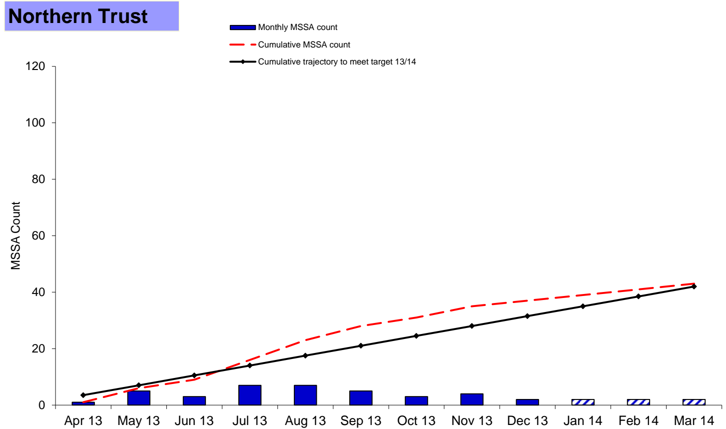
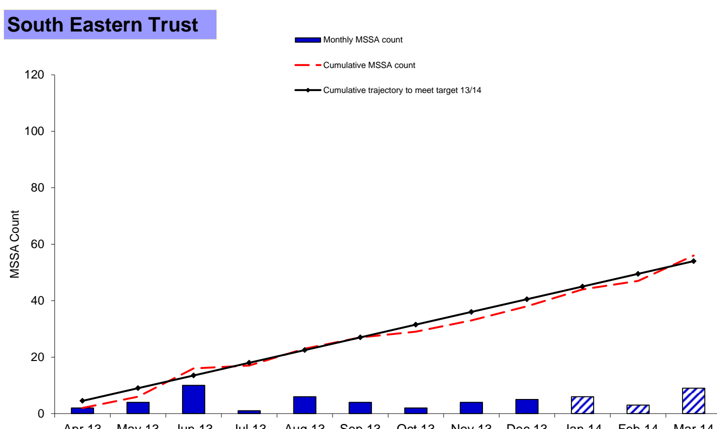


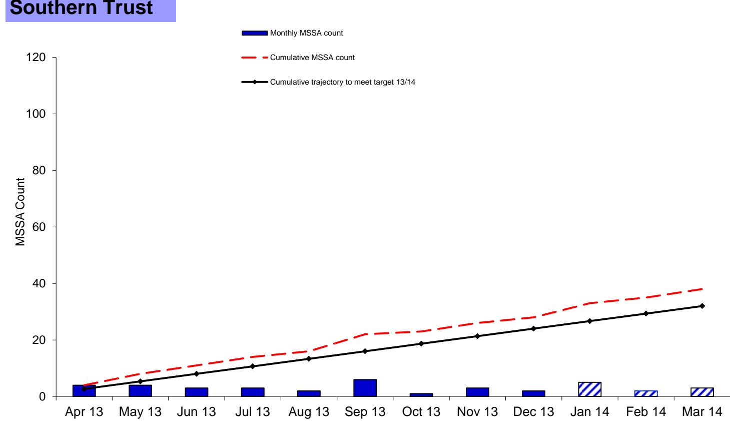
Figure 5: MSSA trajectory figures based on cumulative counts (see Appendix 1 for derivation).

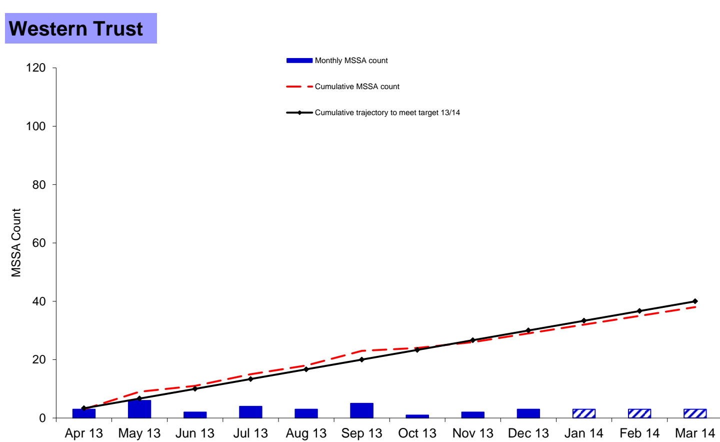












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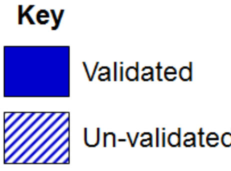
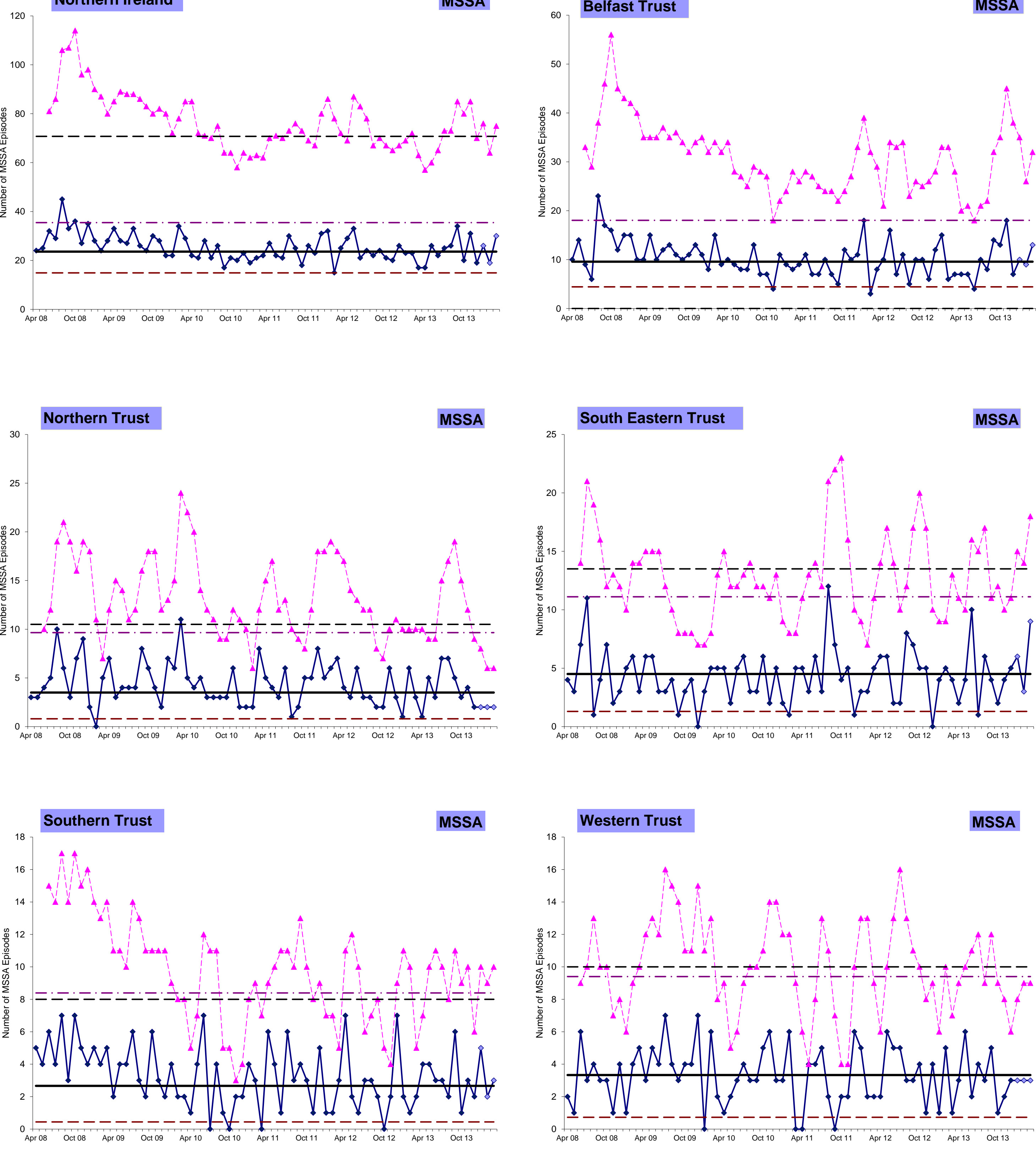


Validated

Un-validated

Figure 6: MSSA performance figures based on monthly data and 3 monthly rolling totals (see Appendix 1 for derivation and key).



Priorities for Action Targets

Northern Ireland

	BASELINE 2012/13 (FYR)	TARGET 2013/14 (FYR)	Target no. of cases per month***	March 2014 Episodes**	April 2013 - March 2014 Actual Episodes**
*C. difficile**	411	324	27	31	310
MRSA	70	46	4	3	62

Belfast Trust

	BASELINE 2012/13 (FYR)	TARGET 2013/14 (FYR)	Target no. of cases per month***	March 2014 Episodes**	April 2013 - March 2014 Actual Episodes**
*C. difficile**	163	130	11	14	110
MRSA	32	20	2	1	18

* *C difficile* figures are for inpatients aged 2 years and over and excludes psychiatric inpatients.
** 2013/14 figures are provisional.
*** Target number of cases per month have been rounded up.

Northern Trust

	BASELINE 2012/13 (FYR)	TARGET 2013/14 (FYR)	Target no. of cases per month***	March 2014 Episodes**	April 2013 - March 2014 Actual Episodes**
*C. difficile**	80	56	5	5	64
MRSA	14	8	1	0	12

South Eastern Trust

	BASELINE 2012/13 (FYR)	TARGET 2013/14 (FYR)	Target no. of cases per month***	March 2014 Episodes**	April 2013 - March 2014 Actual Episodes**
*C. difficile**	61	55	5	7	56
MRSA	13	9	1	1	15

* *C difficile* figures are for inpatients aged 2 years and over and excludes psychiatric inpatients.
** 2013/14 figures are provisional.
*** Target number of cases per month have been rounded up.

Southern Trust

	BASELINE 2012/13 (FYR)	TARGET 2013/14 (FYR)	Target no. of cases per month***	March 2014 Episodes**	April 2013 - March 2014 Actual Episodes**
*C. difficile**	42	33	3	3	32
MRSA	1	3	1	0	5

Western Trust

	BASELINE 2012/13 (FYR)	TARGET 2013/14 (FYR)	Target no. of cases per month***	March 2014 Episodes**	April 2013 - March 2014 Actual Episodes**
*C. difficile**	65	50	4	2	48
MRSA	10	6	1	1	12

* *C difficile* figures are for inpatients aged 2 years and over and excludes psychiatric inpatients.
** 2013/14 figures are provisional.
*** Target number of cases per month have been rounded up.

Appendix 1

Trajectory figures (figures 1, 3 and 5)

- The bar chart represents monthly numbers derived from figures supplied to Public Health Agency during the quarterly validation process. Shaded bars show un-validated figures.
- The cumulative trajectory line shows the monthly cumulative total based on the monthly trajectory figure.
- The cumulative count (dashed line) is the cumulative total of the monthly figures. If this line rises above the trajectory line, it indicates that the target will not be met.

Performance Figures (figures 2, 4 and 6)

Key

Monthly count
3 month rolling total
Trajectory
Quarterly Sum of Trajectory
Upper Monthly Warning Limit
Lower Monthly Warning Limit

- The circular points on the chart represent the monthly number of MRSA/MSSA or *C. difficile* episodes that have been reported by the Trust. These figures have been calculated using the validated quarterly figures supplied to the Public Health Agency. Points in lilac represent un-validated monthly figures.
- The trajectory line has been calculated for each Trust and represents the maximum number of episodes that a Trust can report in a month to remain on target.
- Due to the natural variation that can occur upper and lower warning limits have been calculated based on the **monthly trajectory target**. If the upper limit is exceeded and repeated this suggests that special cause variation is occurring, for example, an outbreak.
- A 3 monthly rolling total has been calculated to smooth out variation that can occur over shorter times (denoted by a triangle in each figure) and this can be compared to the quarterly sum trajectory line to determine if the Trust is on target over a 3 monthly period (represented by an x). These points will change as they require 3 months data to generate one point.

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Tables for *Clostridium difficile* and MRSA (Meticillin Resistant *Staphylococcus aureus*) cases 2006/07 to 2013/14*

CDI Episodes Hospital In-patients ≥65 years 2006/07 – 2013/14*

Trust	CDI Episodes (Inpatients 65+ yrs)							
	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14*
Belfast	336	280	327	163	147	117	124	90
Northern	172	297	172	102	103	75	73	56
South Eastern	256	199	135	98	80	72	50	50
Southern	130	134	164	37	17	28	33	25
Western	132	109	104	71	46	35	58	37
NI	1026	1019	902	471	393	327	338	258

CDI Episodes Hospital Inpatients ≥2 years 2008/09 – 2013/14*

Trust	CDI Episodes (Inpatients 2+ yrs)					
	2008/09	2009/10	2010/11	2011/12	2012/13	2013/2014*
Belfast	448	233	197	169	163	110
Northern	218	116	120	94	80	64
South Eastern	167	118	98	91	61	56
Southern	205	47	22	33	42	32
Western	139	99	64	50	65	48
NI	1177	613	501	437	411	310

Last Updated: 15/04/2014

MRSA Episodes 2006/07 – 2013/14*

Trust	MRSA Episodes							
	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/2014
Belfast	115	109	86	62	48	46	32	18
Northern	47	42	35	22	27	19	14	12
South Eastern	49	34	46	28	15	14	13	15
Southern	19	14	16	15	11	10	1	5
Western	18	22	20	11	15	7	10	12
NI	248	221	203	138	116	96	70	62

Please note:

2013/14* - covers period from 1st April 2013 to 31st March 2014 only.
January - March 2014 figures are provisional until validation.

Surveillance for CDI inpatients aged 2 years and over commenced 1st April 2008.

All data is validated on a quarterly basis and may be subject to amendment following validation.

There has been a change in the monitoring and reporting arrangement of *C.difficile* from 1st April 2013. All *C.difficile* isolates now reported are both GDH and toxin positive (previous reporting was based on toxin positivity only).

PHA/03/05/14

HALT Report 2013: Healthcare Associated Infections and Antimicrobial Use in Long-Term Care Facilities in Northern Ireland

May 2014

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	15 May 2014
Title of Paper	HALT Report 2013. Healthcare-associated infections (HCAI) and antimicrobial use in long-term care facilities in Northern Ireland
Agenda Item	9
Reference	PHA/03/05/14

Summary

PHA facilitated a point prevalence survey of HCAI and antimicrobial use in long-term care facilities in Northern Ireland (in partnership with Independent Sector care providers, HSCB and RQIA). The survey, known as HALT 2013, is part of a larger survey conducted across Europe during 2013. HALT was undertaken in Northern Ireland during May 2013 and included 1,503 residents in 42 long-term care facilities (nursing and residential homes). Thirty-one privately owned nursing homes and 11 Trust-managed residential homes participated in the survey.

Findings arising from the HALT 2013 survey in NI have been shared with each of the facilities that participated. Homes will share their results with staff in their own facility and with external staff (GPs) providing care for their residents. Each facility is encouraged to use their survey findings to plan future improvements.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This report was brought to AMT on 6 May 2014.
Recommendation / Resolution	For Noting
Director's Signature	CHarper
Title	Director of Public Health
Date	2 May 2014

Northern Ireland Prevalence Survey of Healthcare Associated Infections and Antimicrobial Use in Long Term Care Facilities (HALT)

Acknowledgements

This survey would not have been completed successfully without the co-operation and support of the staff within all of the participating care homes both nursing and residential. Their collaboration is gratefully acknowledged. The Public Health Agency would also like to acknowledge Regulation and Quality Improvement Authority (RQIA) for assisting with recruitment of care homes who volunteered to participate in this survey.

The project team are particularly grateful to members of the steering group who met throughout the survey and provided invaluable suggestions and support; they include: Dr Brian Smyth (PHA), Caroline McGeary (PHA), Eileen Kennedy (Health and Social Care Board), Lyn Buckley (RQIA) and Thomas Hughes (RQIA). Special thanks goes to colleagues in nursing homes who agreed to take part in the validation study; we are grateful to Marilyn Brown, Annie Frobisher and Kate McElwee who helped make this aspect of the survey a success.

Finally, we recognise and appreciate the role of the European HALT2 Management Team at the Scientific Institute of Public Health, Brussels, Belgium and the European Centre for Disease Prevention and Control, Stockholm, Sweden.

Authors

Lourda Geoghegan, Gerard McIlvenny, Mark McConaghy and Rachel Spiers

HCAI & AMR Team, PHA

Reference this report as:

Northern Ireland Prevalence Survey of Healthcare-Associated Infections and Antimicrobial Use in Long Term Care Facilities. 2013. Public Health Agency: Belfast. May 2014.

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Northern Ireland

BT2 8BS

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EXECUTIVE SUMMARY

Nursing Home Results

- 31 Nursing homes took part in the survey (12% of total Nursing homes)
- 1,243 eligible patients in Nursing homes were included

Risk factors in Nursing homes

- 46.3% of patients were over the age of 85 years
- 61.4% were incontinent (faecal/urinary)
- 57.8% were disorientated
- 52.9% were either bedridden or in a wheelchair
- 6.0% had a urinary catheter
- Vascular catheter use was uncommon
- 3.4% had pressure sores
- 5.6% had ‘other wounds’
- 0.8% had recent surgery

‘Condition of interest’ in Nursing homes

- 11.3% of patients were either receiving an antimicrobial or had an infection on the day of the survey.

Healthcare-associated infection (HCAI) in Nursing homes

- 5.5% HCAI prevalence (68 patients with 75 infections)
- HCAI prevalence ranged from 0% to 25% (median 4%).
- Six facilities (19%) recorded zero infections.
- 40% of infections were urinary tract infections
- 28% of infections were respiratory tract infections
- 25% of infections were skin/soft tissue infections

Antimicrobial use in Nursing homes

- 10.9% prevalence of antimicrobial use
- 48.5% of antimicrobials were prescribed for therapeutic reasons
- 51.5% of antimicrobials were prescribed for prophylaxis
- 5% of all patients were receiving uroprophylaxis
- The majority of antimicrobials were prescribed by a GP (94.9%)
- All therapeutic antimicrobials had an end/review date recorded
- 12.9% of prophylactic antimicrobials had an end date recorded

Residential Home Results

- 11 Trust controlled Residential homes participated
- 260 eligible patients in Residential homes were included

Risk factors in Residential homes

- 46.5% of patients were over the age of 85 years
- 44.6% were incontinent (faecal/urinary)
- 55.8% were disorientated
- 4.2% were either bedridden or in a wheelchair
- 3.1% had a urinary catheter
- 1.2% had pressure sores
- 3.9% had 'other wounds'
- 1.2% had recent surgery

'Condition of interest' in Residential homes

- 7.7% of patients were either receiving an antimicrobial or had an infection on the day of the survey.

Healthcare-associated infection (HCAI) in Residential homes

- 5.0% HCAI prevalence (13 patients with 14 infections)
- HCAI prevalence ranged from 0% to 13% (median 4.5%)
- Three facilities (27%) recorded zero infections
- 64% of infections were urinary tract infections
- 29% of infections were respiratory tract infections
- 7% of infections were skin/soft tissue infections

Antimicrobial use in Residential homes

- 7.7% prevalence of antimicrobial use
- 71.4% of antimicrobials were prescribed for therapeutic reasons
- 28.6% of antimicrobials were prescribed for prophylaxis
- 2.3% of all patients were on uroprophylaxis
- The majority of antimicrobials were prescribed by a GP (71.4%)
- End dates were recorded for 87% of therapeutic prescriptions
- None of the prescriptions for prophylaxis had an end date recorded

HALT 2013 RECOMMENDATIONS

This survey has captured important learning in relation to healthcare-associated infections (HCAIs), infection prevention & control (IPC) and antimicrobial stewardship (AMS) in long term care facilities (LTCFs) in Northern Ireland.

All LTCFs should have a robust action plan in place to ensure IPC remains a core priority, to address preventable HCAIs and to facilitate arrangements supporting AMS. Each facility's action plan should be used to drive continuous quality improvement and should address the risks identified within the particular facility and organisation. Actions progressed in each facility should reflect work undertaken locally and regionally by the Regulation and Quality Improvement Authority (RQIA), the Health and Social Care Board (HSCB) and the Public Health Agency (PHA).

1. Standards for care in Nursing and Residential Homes

Recommendations outlined in this report should be incorporated into the revised standards for care in Nursing homes which will replace the current DHSSPS Nursing Homes: Minimum Standards, January 2008 edition.

2. Leadership for Improvement

2.1 Results of this survey should be shared with all LTCFs, including those that did not participate in the survey. The results should be shared with all staff providing care, including: carers, medical staff, nursing staff, allied health professionals, managers and facility owners/proprietors. Findings should be used to plan future improvement programmes in each care facility.

2.2 In addition to a nominated lead person responsible for infection prevention & control, all LTCFs should have a nominated lead responsible for antimicrobial stewardship (AMS) within the facility. This person should be accountable to the facility manager and the care home proprietor, and should regularly receive appropriate training in AMS.

2.3 LTCFs should have an action plan to support improvement in healthcare-associated infections (HCAIs) and implementation of robust arrangements for antimicrobial stewardship. Implementation of the LTCF's action plan for HCAI and AMS should be the responsibility of all staff providing care and should be supported by the facility manager and care home proprietor.

2.4 In order to support implementation of this action plan, relevant staff should receive regular training in IPC and AMS to develop their skills and knowledge.

2.5 LTCFs should have a programme of audit to provide assurance that best practice for IPC and AMS is being implemented. Audit programmes should include structure, process and outcome indicators relating to IPC and AMS.

2.6 LTCFs should be encouraged to participate in public/staff information campaigns relating to IPC and AMS, for example World Health Organisation Hand-Hygiene Day (May), European Antibiotic Awareness day (November).

3. Improvement in Healthcare-Associated Infections

LTCFs should ensure that appropriate policies and procedures are in place to prevent HCAIs associated with known risk factors (such as immobility, older age, and urinary catheters) and to reduce inappropriate use of antibiotics. This is likely to include visible leadership for improvement, regular staff training, access to appropriate information resources, systems for assurance, audit programmes and regular staff and patient liaison.

3.1 LTCFs should review their policy and arrangements relating to the use of urinary catheters (insertion and maintenance) in line with NICE clinical guidelines 'CG139 Infection control, prevention of healthcare-associated infection in primary and community care' and 'CG171Urinary incontinence: the management of urinary incontinence in women' [1], [2].

3.2 LTCFs should aim to minimise the introduction and duration of urinary catheter use, particularly for those at higher risk of catheter-associated urinary tract infection or mortality from catheterisation such as elderly, women and patients with impaired immune systems. There should always be an appropriate indication for the use of urinary catheters and they should only be in place for as long as is needed [3].

3.3 Patients with suspected urinary tract infection (UTI) should have a urine specimen sent for culture as advised in 'Northern Ireland Management of Infection Guidelines for Primary Care 2013' [3]. Continuing antibiotic therapy for urinary tract infection should be based on reported culture and sensitivity results. See also Recommendation 4.3

3.4 To prevent/proactively manage the onset of urinary tract infection, the use of prophylactic antibiotics (antimicrobials) should be guided by the specific circumstances as outlined in the 'Northern Ireland Management of Infection Guidelines for Primary Care 2013' [3]. See also Recommendation 4.3

3.5 LTCFs should review their vaccination policies and procedures to ensure that regular influenza and pneumococcal vaccination is a component of their action plan for HCAI prevention and is in line with national guidance contained in 'Department of Health: Immunisation against infectious disease'. [4] All LTCF staff should be strongly encouraged to receive annual influenza vaccination.

3.6 Each facility should have a wound and soft tissue management protocol, which clearly outlines activities relating to prevention of pressure sores and care of patients with an established pressure sore. All LTCFs are strongly encouraged to:

- implement Pressure Ulcer Prevention Skin Bundle Care Plan for patients;
- participate in the Regional 'Your Turn' Campaign – http://www.your-turn.org.uk/ ;
- consider involvement in HSC Safety Forum - Nursing home collaborative http://www.publichealth.hscni.net/directorate-nursing-and-allied-health-professions/hsc-safety-forum

4. Improvement in Antimicrobial Stewardship

The 'Northern Ireland Management of Infection Guidelines for Primary Care 2013' provides an approach to the treatment of common infections. [3] These guidelines should be readily accessible in all LTCFs, GP Practices and Out-of-Hours Centres. The recommendations contained in these guidelines should guide all prescribing in primary and community settings..

4.1 LTCFs and GP Practices should have an agreed protocol in place to manage requests for acute prescription items, particularly antibiotics (antimicrobials). This should be agreed with all relevant parties. LTCF staff should be familiar with, and receive regular training on, use of this protocol.

4.2 Microbiological sampling should be used to support and underpin appropriate prescribing for LTCF patients with possible or actual infection.

4.3 Following review of microbiology results received from laboratory services, GP Practice staff should promptly inform LTCF staff of relevant information relating to confirmed infection.

4.4 Microbiological results must be used, in consultation with General Practitioner, to guide continuing treatment of identified infection.

4.5 LTCFs must retain responsibility for ordering prescriptions for their patients. LTCF staff should check all repeat prescriptions received from the GP Practice prior to submitting them to a community pharmacy for dispensing. Whilst community pharmacy can play a vital role in advising LTCFs on medication related issues and ensuring the continuity of on-going medication supply for patients, these roles should not be delegated to the community pharmacy by the LTCF.

4.6 All prescriptions for antibiotics should have a clear stop or review date. This includes antibiotics used for prophylaxis (prevention of infection).

- LTCF staff should facilitate and document when a review of antibiotic therapy is completed and/or when antibiotic therapy is completed.
- General Practitioners should review antibiotics used prophylactically for more than 6 months as per NI Management of Infection Guidelines 2013. The LTCF setting requires special consideration in this regard.

4.7 LTCFs should review antibiotic use on a regular basis (monthly or quarterly) to ensure the prudent use of antibiotics (antimicrobial stewardship). This review must be multidisciplinary, with input from facility manager, nominated lead person responsible for antimicrobial stewardship, infection control link staff member, nursing staff, GPs, and the pharmacy. All antibiotics should be reviewed to examine dose, duration, indication and the specific types of antibiotics used throughout the LTCF.

5. Future Point Prevalence Surveys

5.1 All LTCFs should regularly undertake a point prevalence survey to monitor the burden of HCAI and antibiotic (antimicrobial) use in their own facility. Ideally this should be performed on an annual basis using the protocol and tools used in 2013 HALT survey. The benefits of performing a regular local HALT survey include:

- providing up-to-date information on healthcare-associated infections, antimicrobial stewardship (prudent use of antibiotics) and IPC practice within the facility;
- enabling staff to plan continuous improvement in patient care, for example assurance of good practice, staff education, policy updates and resource allocation;
- enabling staff to demonstrate the benefit of improvement work implemented within the facility (thus demonstrating better patient care);
- providing resources to assist with staff education in relating to IPC, HCAI, AMS and surveillance providing 'information for action'.

5.2 A Northern Ireland point prevalence survey of IPC, HCAI and AMS in all LTCFs should be undertaken at 5-yearly intervals. This will provide important benchmarks, identify priorities and areas for improvement, evaluate the impact of interventions implemented and raise awareness of HCAI and AMS.

5.3 Northern Ireland region-wide point prevalence surveys in long term care facilities should coincide with future EU prevalence surveys of HCAI and antimicrobial use in LTCFs (EU surveys generally co-ordinated by the European centre for Disease Control, ECDC).

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Abbreviations

AM	Antimicrobial
CI	Confidence interval
ECDC	European Centre for Disease Prevention and Control
HALT	Healthcare-Associated Infections in Long Term Care Facilities
HCAI	Healthcare-Associated Infection
HSC	Health and Social Care
IPC	Infection Protection and Control
LTCF	Long Term Care Facility
MRSA	Meticillin resistant *Staphylococcus aureus*
NS	Not significant, i.e. p>0.05
PHA	Public Health Agency (Northern Ireland)
RQIA	Regulation and Quality Improvement Authority
UTI	Urinary tract infection

Definitions of terms used in HALT survey

Antibiotics are substances used to kill bacteria. Antibiotics are the same as antibacterials.

Antimicrobial Resistance - Micro-organisms are constantly evolving enabling them to efficiently adapt to new environments. Antimicrobial resistance is the ability of micro-organisms to grow in the presence of a chemical (antimicrobial) that would normally kill them or limit their growth.

Antimicrobial stewardship is an activity that promotes the appropriate use of antimicrobials (including antibiotics), improves patient outcomes, reduces microbial resistance, and decreases the spread of infections caused by multidrug-resistant organisms. The appropriate use of antimicrobials (including antibiotics) includes the appropriate selection of antimicrobials, the appropriate dosing of antimicrobials, the appropriate route and duration of antimicrobial therapy.

Antimicrobial is a general term for any compound with a direct action on micro-organisms used for treatment or prevention of infections. In this survey antimicrobials included antibiotics, antifungals and antiprotozoals. Topical antimicrobials, anti-viral agents and antiseptics were excluded from this survey.

Condition of interest is used to describe if a patient had an infection or was receiving antimicrobials on the day of the survey.

Patients are residents of Nursing and Residential homes.

Prevalence is the proportion of a population found to have a condition (in this survey the conditions were infections or receiving antimicrobials). It is arrived at by comparing the number of people found to have the condition with the total number of people studied, and is usually expressed as a percentage.

Point prevalence is the proportion of a population that had the condition at a specific point in time.

Prophylactic treatment is used to refer to an antimicrobial prescribed to prevent the occurrence of an infection.

Uroprophylaxis is a term used for an antimicrobial prescribed to prevent the occurrence of a urinary tract infection.

SECTION 1 HALT 2013

This report outlines the findings of a national survey conducted in May/June 2013 to assess the prevalence of healthcare-associated infections and antimicrobial prescribing practices in long-term care facilities in Northern Ireland. A similar survey was undertaken in 2010.

1.1 Background

Healthcare-associated infections (HCAI) and the consequences of increasing rates of antimicrobial resistance are potentially serious health threats for elderly people, including those living in long-term care facilities (LTCFs). Patients in Nursing homes have complicated underlying medical conditions and are from older age groups which have made them susceptible to infection [5, 6, 7]. Good infection prevention and control practices and antimicrobial stewardship is essential in all healthcare settings to prevent HCAI and the emergence of antimicrobial resistance.

1.2 Aims and objectives

The aims of the HALT survey were to:

- Evaluate the prevalence of HCAI and antimicrobial use in LTCFs
- Describe the related infection prevention & control and antimicrobial stewardship practices and resources in LTCFs.

The obtained data will be useful to:

- Quantify the prevalence of infections and antimicrobial use in LTCFs
- Identify needs for intervention, training and/or additional infection and protection (IPC) resources
- Identify priorities for national and local intervention and raise awareness
- Foster the safety of healthcare for patients in the LTCF and the ageing population in general

1.3 Methodology

The HALT survey in Europe was developed by ECDC and the Scientific Institute of Public Health, Brussels, Belgium for use in member states. The survey was conducted across Europe using standard forms and a protocol [8] which was adapted for use in Northern Ireland.

The HALT survey in Northern Ireland was coordinated by the Public Health Agency (PHA) and was overseen by a multi-disciplinary steering group. The HALT survey took place in Northern Ireland in May/June 2013. A letter of invitation was sent from PHA and Regulation and Quality Improvement Authority (RQIA) to all Nursing homes in Northern Ireland in April 2013. In addition a number of Trust controlled Residential homes expressed an interest in participating in the survey. During April 2013, healthcare workers attended one of eight regional training sessions to learn about the survey protocol and methodology. Only data from Nursing homes will be used for the analyses in a European report.

Forty-two LTCFs participated in the HALT survey (31 Nursing homes; 11 Trust Residential homes). A dedicated helpline was established at the PHA to address any queries that arose before, during and after the survey. Information leaflets were prepared for patients, their families and staff.

1.3.1 Collected data

Data were collected on two levels:

Institutional questionnaire (Appendix 1) collected general data (ownership, presence of a qualified nurse), denominator data (total number of available and occupied beds, for hospitalised patients, patients with signs/symptoms of infection, receiving antimicrobials, patients with a urinary/vascular catheter, with incontinence, pressure sores, wounds, disorientation or with an impaired mobility) and information on medical care and coordination, infection control structure and antibiotic policy.

Patient questionnaire (Appendix 2) was completed for each patient who had a 'Condition of interest', i.e. receiving antimicrobials on the day of the survey and/or had an infection on the day of the survey. Information was also collected regarding gender, year of birth, urinary/vascular catheter, incontinence [urinary/faecal], pressure sores, wounds, disorientation and impaired mobility [wheelchair/bedridden].

1.3.2 Data validation

Northern Ireland also contributed data to a European validation study [9]. This was designed to validate the HALT data collection across Europe. During May 2013, two coordinators from PHA visited two Nursing homes and conducted a parallel survey. The data, collected simultaneously by both the local team and the validation team, were returned to the European validation study coordinating team in Bologna, Italy for inclusion in a European HALT validation analysis.

1.3.3 Analysis of prevalence data

Using data from the patient and institutional questionnaires, the prevalence of infection and the use of antibiotics were determined. They were also used to identify patient characteristics as possible determinants. Data from the institutional questionnaire were used to identify Nursing/Residential home characteristics as possible determinants.

The ‘condition of interest’ prevalence results were calculated as the proportion of all patients that had an infection at the time of survey and/or receiving antimicrobials. The HCAI prevalence results were calculated as the proportion of all patients that had an infection at the time of survey. The number and distribution of the HCAI rates were also calculated. The prevalence of invasive devices and antimicrobial therapy were calculated as the proportion of all patients that had a device in-situ or had been prescribed an antimicrobial at the time of survey. The Wilson method was used to calculate 95% confidence intervals (CI) [10]. Univariate analyses based on logistic regression were carried out to examine the relationship between the intrinsic risk factors, the prevalence of ‘Condition of interest’, HCAI and p-values reported. Rates are reported to two decimal places.

SECTION 2 LONG TERM CARE FACILITIES

2.1 Long term care facilities participation

All Nursing homes were given the opportunity to participate in the Northern Ireland HALT survey. In addition, the Northern, Southern and South Eastern HSC Trusts submitted data from Trust-controlled Residential homes. Overall, thirty one private Nursing homes and eleven Trust controlled residential facilities participated in the survey during May 2013. The results focus primarily on Nursing homes; however, where appropriate, comparable data are given for Trust Residential homes.

2.1.1 Geographical location

Nursing homes

There were 249 Nursing homes in Northern Ireland in March 2013 (RQIA data). The majority of Nursing homes (71%) were located in the east of Northern Ireland (Antrim, Armagh, Down); and the remainder in the remaining western counties (29%), see Table 1. The distribution of facilities that submitted data was similar to this breakdown [Figure 1]. Thirty one Nursing homes submitted data to the PHA providing a response rate of 12%.

Residential homes

Eleven Trust controlled Residential performed the survey – six in the South Eastern HSC Trust, four in the Southern HSC Trust and one in the Northern HSC Trust.

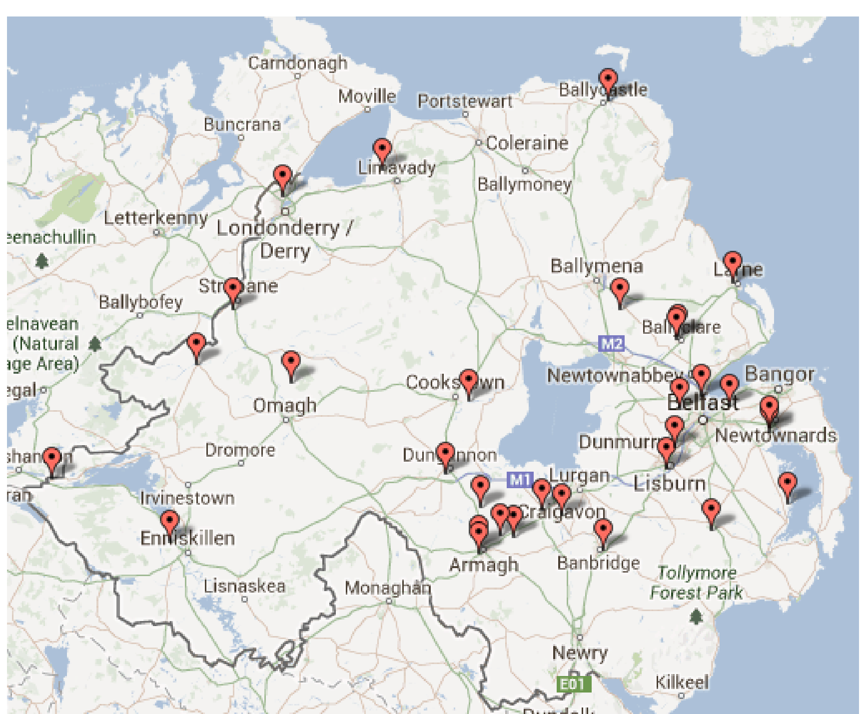


Figure 1 *Distribution of participating Nursing homes in Northern Ireland*

Table 1 *Comparative distribution by county and size of Nursing home*

	Total Nursing homes RQIA*		Nursing homes that 'opted-in'		Attended Training		Submitted data	
County	Number	%	Number	%	Number	%	Number	%
Antrim	101	40.6	24	45.3	18	39.1	9	29.0
Armagh	17	6.8	5	9.4	7	15.2	6	19.0
Down	59	23.7	10	18.9	8	17.4	6	19.0
Fermanagh	12	4.8	3	5.7	3	6.5	2	7.0
Derry/Londonderry	27	10.8	4	7.5	4	8.7	3	10.0
Tyrone	33	13.3	7	13.2	6	13.0	5	16.0
All	249	100.0	53	100.0	46	100.0	31	100.0

*Facilities with identical postcodes were grouped

2.1.2 Number of places in participating Nursing homes

In March 2013, there were 11,708 approved Nursing home places in Northern Ireland and the average number of places per home was 44 [Table 2]. Facilities that submitted data had on average 47 places. There was no significant difference in the size of all Nursing homes and those that submitted data.

Table 2 *Nursing home approved places and participation*

	Approved places (Data held by RQIA)	Average places
All Nursing homes in Northern Ireland (RQIA 249 NH)	11,708	44
Nursing homes accepted invitation to undertake survey (n=53)	2,391	45
Nursing homes that attended training (n=46)	2,158	47
Nursing homes that submitted data (n=31)	1,456	47

2.2 Characteristics of the participating long term care facilities

2.2.1 Nursing home characteristics

At the time of the survey, the 31 participating Nursing homes indicated that 1,441 beds were available. There were 1,255 occupied beds (157 unoccupied places and 29 patients were hospitalised on the day of the survey) giving an 87.1% occupancy rate. Patients were included in the survey if they lived full-time in the facility, were resident for at least 24 hours and were present at 8 a.m. on the day of the survey. After the eligibility criteria were applied, twelve patients were excluded; therefore, the number of Nursing home patients eligible for inclusion in the survey was 1,243. Participating Nursing homes ranged in size from 10 to 78 beds (median 33) and the proportion of single rooms per 100 beds ranged from 19.2% - 100% (median = 94%).

2.2.2 Residential home characteristics

The eleven participating Residential homes had 317 beds. The number of unoccupied beds was 43 (13.6%) and a further six patients were hospitalised at the time of the survey. Occupancy rate was 84.5% (268 occupied beds). Eight patients were excluded from the survey; leaving 260 eligible patients for inclusion in the survey. Participating Residential homes ranged in size from 11 to 37 beds (median 23) with the proportion of single rooms ranging from 90% - 100% (median = 100%).

Summary point:

- 12% of Nursing homes submitted data to HALT survey
- 31 Nursing homes submitted data on 1,243 eligible patients
- 11 Trust Residential homes submitted data on 260 patients

SECTION 3 RESULTS

3.1 Age, gender, care load indicators and risk factors

3.1.1 Age and gender

Nursing homes

In the 1,243 Nursing home patients, 46.3% were older than 85 years and varied between Nursing homes, ranging from 0% of the population to 75% of the population. There were 851 (68.5%) female patients, males accounted for 31.5%.

Residential homes

In Residential homes, 46.5% of the patients were older than 85 years. Females accounted for 69.2% of the Residential home population.

3.1.2 Care load indicators – comparison of Nursing and Residential homes

Three indicators for the care load in the LTCFs were explored during this survey: faecal and/or urinary incontinence, disorientation in time and/or in space and impaired mobility (wheelchair bound or bedridden). Figure 2 shows the prevalence of the care load indicators in Nursing homes and Residential homes. The incontinence rate was higher in Nursing homes (61.4%) compared to Residential homes (44.6%). A second care load indicator – disorientation in time and/or in space – scored 57.8% in Nursing homes compared to 55.8% in Residential homes. The prevalence of impaired mobility was much greater in the Nursing home population compared to the Residential home population (52.9% compared to 4.2%).

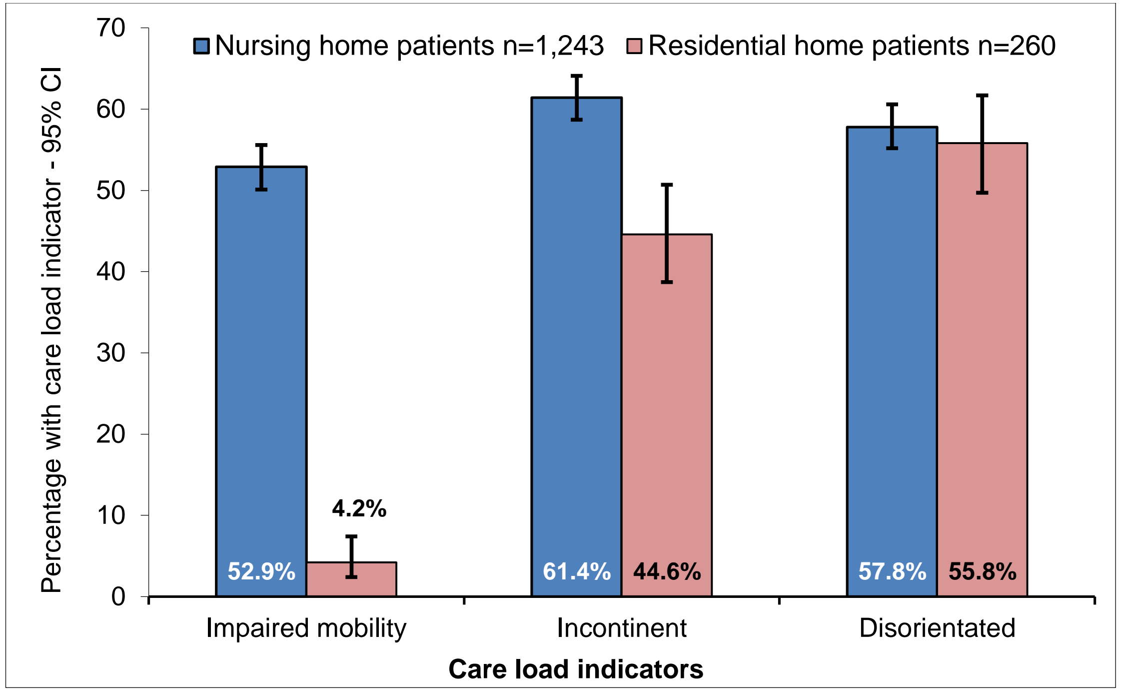


Figure 2 *Proportion of patients by care load indicators for Nursing and Residential homes*

3.1.3 Risk factors – comparison of Nursing and Residential homes

The risk factors examined were:

- Device usage, i.e. urinary catheters, vascular catheters,
- Categories of wounds were applied as risk factors: 'pressure sores' and 'other wounds', e.g. leg ulcers, traumatic or surgical wounds, insertion sites for gastrostomy, tracheostomy.
- Surgery (within 30 days prior to the survey).

Nursing home patients were more likely than Residential home patients to have a urinary catheter, vascular catheter, pressure sore and other wounds, however, the differences were not statistically significant [Figure 3].

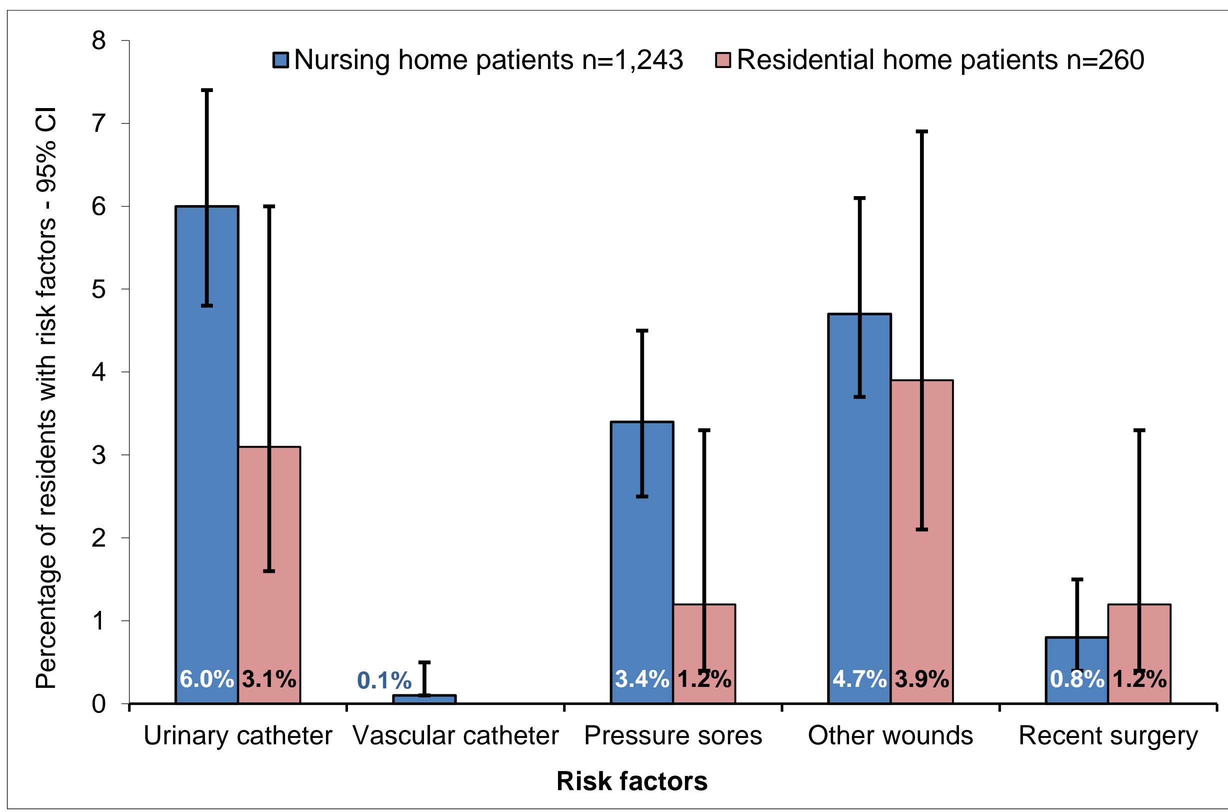


Figure 3 *Comparison of the prevalence of risk factors in Nursing and Residential homes.*

3.2 Condition of interest

In the 31 Nursing homes and 1,243 eligible patients, there were 141 patients (11.3%) with a 'condition of interest', i.e. were either receiving an antimicrobial or had an infection on the day of the survey [Figure 4].

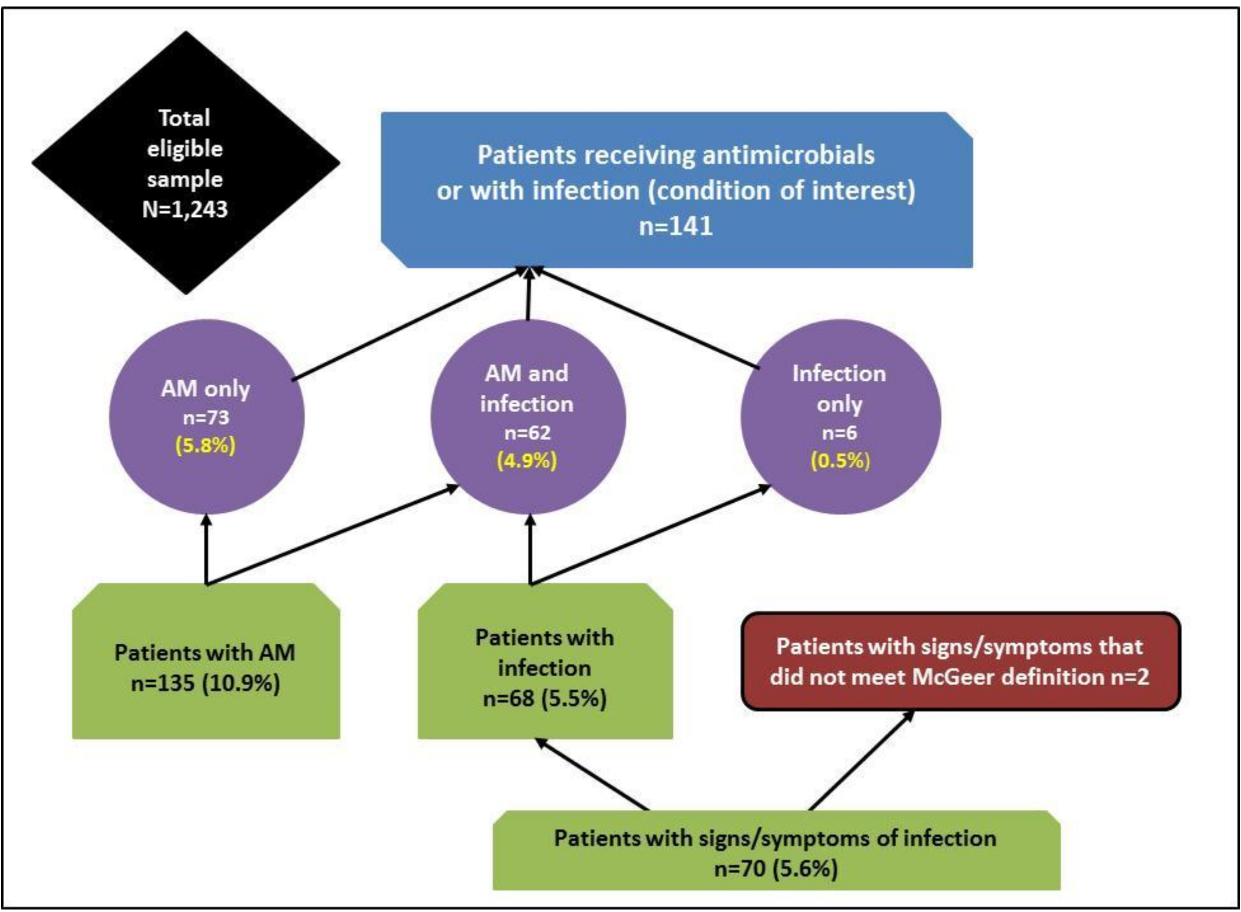


Figure 4 *Characteristics of patients in Nursing homes with signs and symptoms of infection and/or receiving antimicrobial therapy*

There were more females (68.5%) than males (31.5%) in the eligible Nursing home population. Patients with faecal and/or urinary incontinence, disorientation in time and/or in space and impaired mobility (wheelchair bound or bedridden) had significantly higher prevalence of the condition of interest compared to patients that did not have these risk factors. Prevalence of condition of interest increased significantly if patients had recorded risk factors, i.e. urinary catheterisation, surgery in the previous 30 days, pressure sores or other wounds [Table 3].

Table 3 *Prevalence of Condition of interest in Nursing homes according to patient characteristics*

	Number of patients (percentage of patients) *	Number with condition of interest*	Prevalence of condition of interest (95%CI)	Odds ratio (95% CI)	Chi-Square test
Gender					NS
Male	392 (31.5)	37	9.44 (6.93 – 12.74)	1.00	
Female	851 (68.5)	103	12.10(10.08 – 14.47)	1.32 (0.87 – 2.00)	
Age					NS
85 and under	667 (53.7)	61	9.15(7.19 – 11.57)	1.00	
>85	576 (46.3)	70	12.15(9.73 – 15.07)	1.37 (0.94 – 2.01)	
Incontinence					P<0.01
No	480 (38.6)	37	7.71(5.64 – 10.44)	1.00	
Yes	763 (61.4)	104	13.63(11.38 – 16.25)	1.89 (1.25 – 2.86)	
Disorientation					P<0.01
No	524 (42.2)	41	7.82(5.82 – 10.44)	1.00	
Yes	719 (57.8)	95	13.21(10.93 – 15.88)	1.79 (1.20 – 2.67)	
Impaired mobility					P<0.01
No	586 (47.1)	45	7.68(5.79 – 10.12)	1.00	
Yes	657 (52.9)	94	14.31(11.84 – 17.19)	2.44 (1.65 – 3.62)	
Urinary catheter					P<0.01
No	1173 (94.0)	124	10.57(8.94 – 12.46)	1.00	
Yes	74 (6.0)	16	21.62(13.77 – 32.27)	2.56 (1.37 – 4.73)	
Surgery <30 days					P<0.01
No	1233 (99.2)	136	11.03(9.40 – 12.90)	1.00	
Yes	10 (0.8)	5	50.00(23.66 – 76.34)	8.07 (2.00 – 32.54)	
Pressure sores					P<0.01
No	1201 (96.6)	124	10.32(8.73 – 12.17)	1.00	
Yes	42 (3.4)	14	33.33(21.01 – 48.45)	5.79 (3.36 – 9.96)	
Other wounds					P<0.01
No	1174 (94.4)	118	10.05(8.46 – 11.90)	1.00	
Yes	69 (5.6)	19	27.54(18.39 – 39.05)	3.40 (1.87 – 6.15)	

* Numbers may vary due to non-response. Base 1,243 patients, 141 with condition of interest

Summary point:

- 46% of patients were aged over 85 years
- 61% were incontinent
- 58% were disorientated
- 53% were either in a wheelchair or bedridden
- 6% had a urinary catheter in-situ
- 9% had a wound(3.4% pressure sores; 5.6% other wounds)
- 11.2% of patients had an infection and/or received antimicrobials
- Patients with a urinary catheter, surgery in the previous 30 days, pressure sores or other wounds were significantly more likely to have an infection and/or receiving antimicrobials
- 11 Trust-controlled Residential homes submitted data on 260 residents

3.3 Healthcare-Associated Infection (HCAI)

3.3.1 Prevalence of HCAI in Nursing homes and patient characteristics

There were 68 Nursing home patients with one or more healthcare-associated infections giving a prevalence of 5.47% (95%CI 4.3-6.9). In total, there were 75 infections in 68 patients; of these patients 61 (89.7%) had only one infection and 7 (8.4%) had two infections. HCAI prevalence in Nursing homes ranged from 0% to 25.0% of patients (median 4.0%) [Figure 5]. Six of the 31 Nursing homes (19.4%) recorded zero infections.

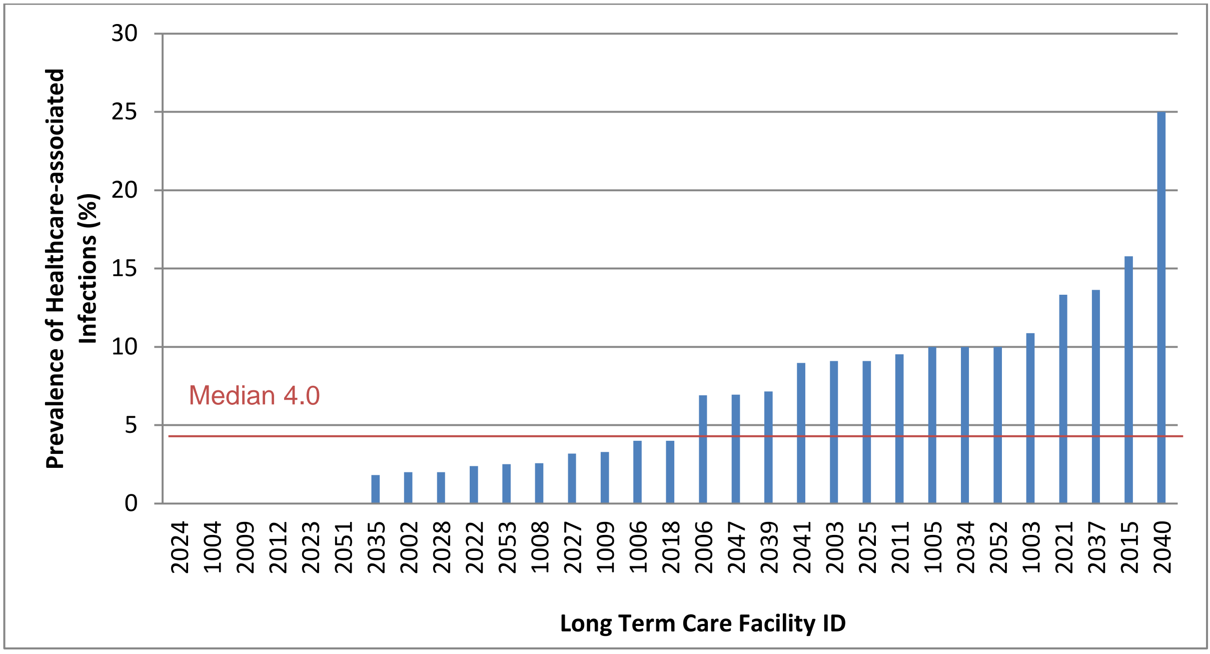


Figure 5 *Prevalence of HCAI in Nursing homes*

The HCAI prevalence was compared in patients with and without care load indicators (incontinence, disorientation, impaired mobility); patients with and without risk factors (urinary catheter, surgery in last 30 days, pressure sores and other wounds). Prevalence was also compared by age and gender [Table 4].

Table 4 *Prevalence of HCAI in Nursing homes according to patient characteristics with odds ratio*

	Number of patients (percentage patients)*	Number with HCAI*	Prevalence of HCAI (95%CI)	Odds ratio (95% CI)	Chi-Square test
Gender					NS
Male	392 (31.5)	19	4.85 (3.12 – 7.45)	1.00	
Female	851 (68.5)	49	5.76(4.38 – 7.53)	1.20 (0.68 - 2.14)	
Age*					P=0.04
85 and under	667 (53.7)	26	3.90(2.67 – 5.65)	1.00	
>85	576 (46.3)	37	6.42(4.70 – 8.73)	1.69 (0.98 - 2.92)	
Incontinence					P=0.03
No	480 (38.6)	18	3.75(2.39 – 5.85)	1.00	
Yes	763 (61.4)	50	6.55(5.01 – 8.54)	1.80 (1.01 – 3.25)	
Disorientation					P=0.02
No	524 (42.2)	19	3.63(2.33 – 5.59)	1.00	
Yes	719 (57.8)	47	6.54(4.95 – 8.58)	1.86 (1.05 – 3.33)	
Impaired mobility					P=0.02
No	586 (47.1)	23	3.92(2.63 – 5.82)	1.00	
Yes	657 (52.9)	45	6.85(5.16 – 9.04)	1.80 (1.05 - 3.11)	
Urinary catheter					P<0.01
No	1173 (94.0)	58	4.94(3.84 – 6.34)	1.00	
Yes	74 (6.0)	10	13.51(7.51 – 23.12)	3.16 (1.44 - 6.75)	
Surgery <30 days					P<0.01
No	1233 (99.2)	65	5.27(4.16 – 6.66)	1.00	
Yes	10 (0.8)	3	30.00(10.78 – 60.32)	7.70 (1.54 – 34.04)	
Pressure sores					P<0.01
No	1201 (96.6)	54	4.50(3.46 – 5.82)	1.00	
Yes	42 (3.4)	13	30.95(19.07 – 46.03)	9.52 (4.41 – 20.34)	
Other wounds*					P<0.01
No	1174 (94.4)	51	4.34(3.32 – 5.67)	1.00	
Yes	69 (5.6)	15	21.74(13.64 – 32.82)	6.12 (3.08 – 12.04)	

* Numbers may vary due to non-response. Base 1,243 patients, 68 patients with infection.

HCAI prevalence was significantly higher in Nursing home patients with:

- a urinary catheter HCAI prevalence 13.51%; patients without urinary catheter HCAI prevalence 4.94% (odds ratio of 3.2 95%CI 1.4 to 6.8);
- surgery in the previous 30 days HCAI prevalence 30% compared to patients with no surgery HCAI prevalence 5.27% (odds ratio 7.7 95%CI 1.5 to 34.0);
- pressure sores HCAI prevalence 30.95% compared to patients without pressure sores HCAI prevalence 4.5% (odds ratio 9.5 95%CI 4.4 to 20.3);
- wounds HCAI prevalence 21.7% compared to those without wounds HCAI prevalence 4.34% (odds ratio 6.1 95%CI 3.1 to 12.0)

3.3.2 Prevalence of HCAI in Residential homes

The number of infections recorded in Residential homes was 14; these were recorded in 13 patients (1 patient had 2 infections). The crude HCAI prevalence in Residential homes was 5.0% (13 of 260). HCAI prevalence in Residential homes ranged from 0.0% to 13.0% (median 4.5%) [Figure 6]. Three Residential homes recorded zero infections.

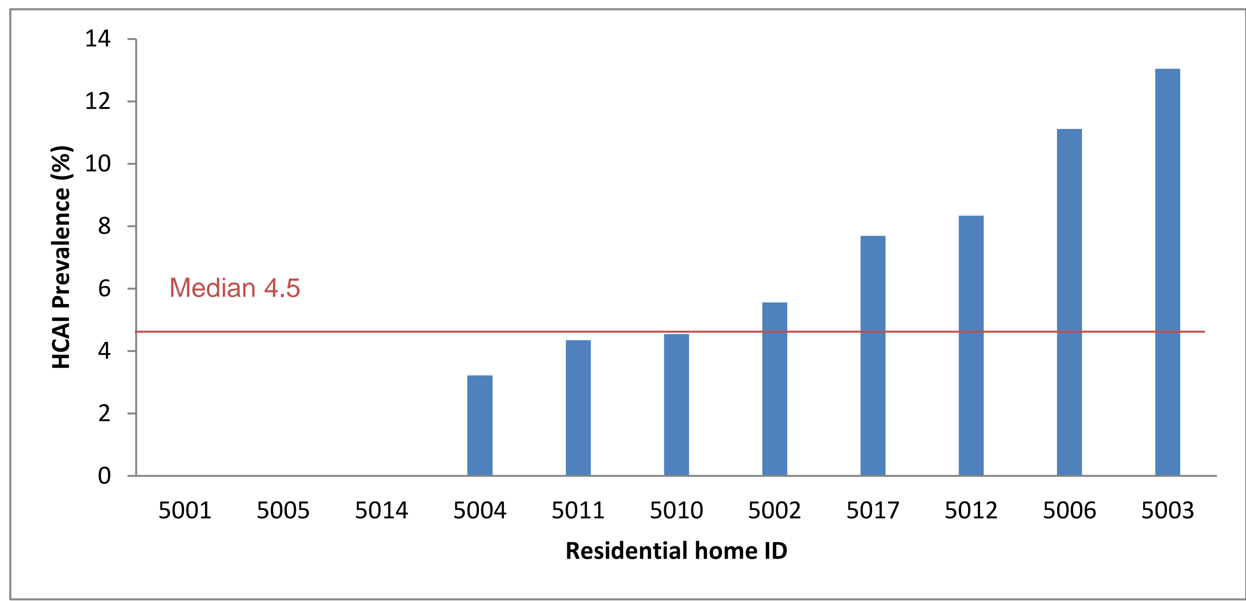


Figure 6 *Prevalence of HCAI in Residential homes.*

Summary point:

- 5.5% of Nursing home patients had an infection
- HCAI prevalence was significantly higher in Nursing home patients with:
  - Urinary catheter HCAI prevalence 13.5% compared to without urinary catheter (HCAI prevalence 4.9%)
  - Surgery in previous 30 days HCAI prevalence 30%; no surgery 5.3%
  - Pressure sores HCAI prevalence 31%; without pressure sores 4.5%
  - Wounds HCAI prevalence 21.7%; without wounds prevalence 4.3%.

Summary point:

- 5.0% of Residential home patients had an infection

3.3.3 Distribution of healthcare-associated infections in LTCFs

Urinary tract infections, respiratory tract infections and skin infections were the most commonly reported infections in both nursing and Residential homes [Figures 7 & 8]. There were no recorded cases of genital tract infections, unexplained fever or systemic infection.

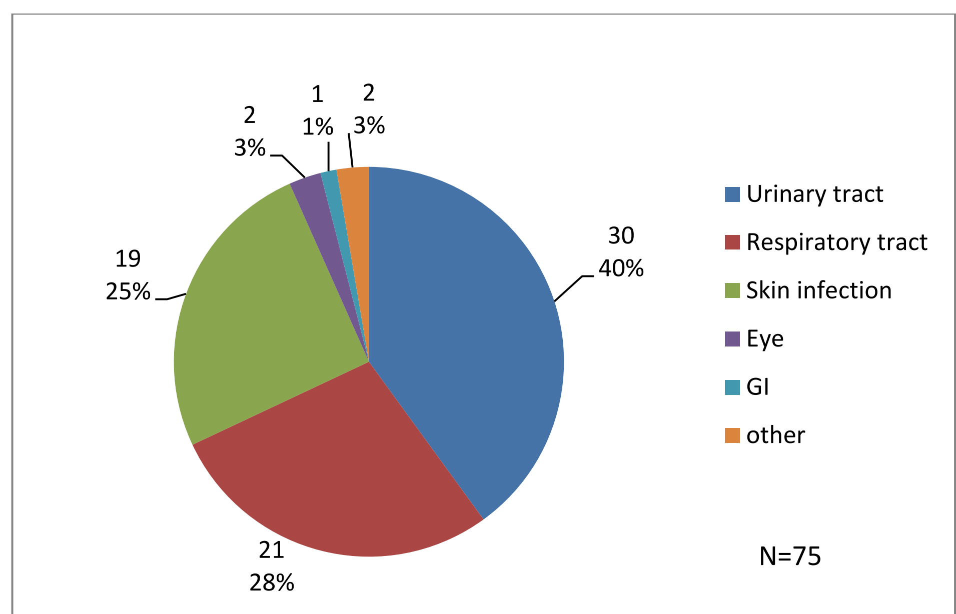


Figure 7 *Distribution of HCAI in Nursing homes*

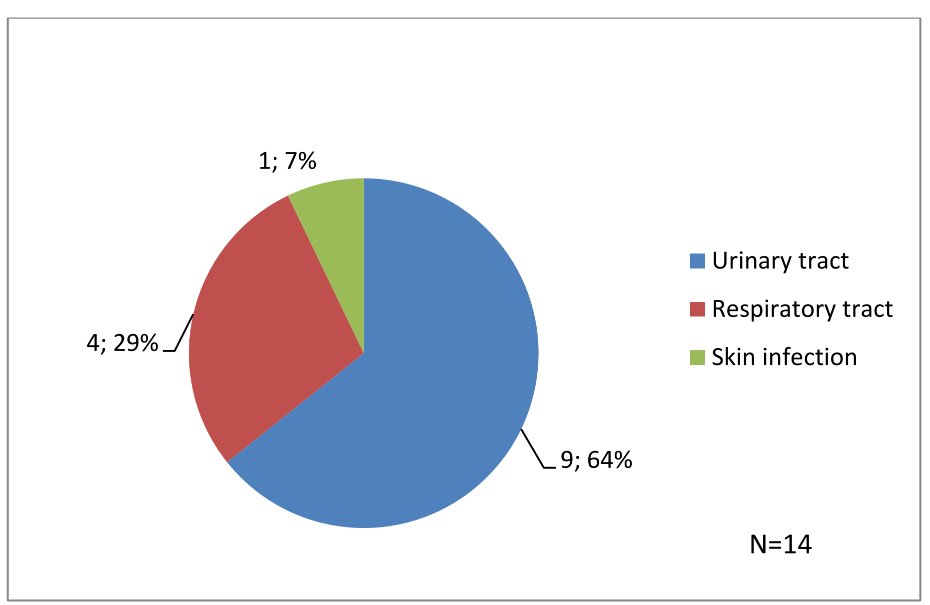


Figure 8 *Distribution of HCAI in Residential homes*

Summary point:

Urinary tract infections, respiratory tract infections and skin infections were the most commonly reported infections in both Nursing and Residential homes.

3.4 Antimicrobial use

3.4.1 Prevalence of antimicrobial use

Nursing homes

The prevalence of antimicrobial use in Nursing homes was 10.9% (135 patients received antimicrobials out of 1,243 patients) and ranged from 0.0% - 29.5% (median 9.5%)[Figure 9]. Six patients with infection were not receiving antimicrobials at the time of the survey and three patients received more than one antimicrobial. There were five Nursing homes where no-one was on antimicrobials.

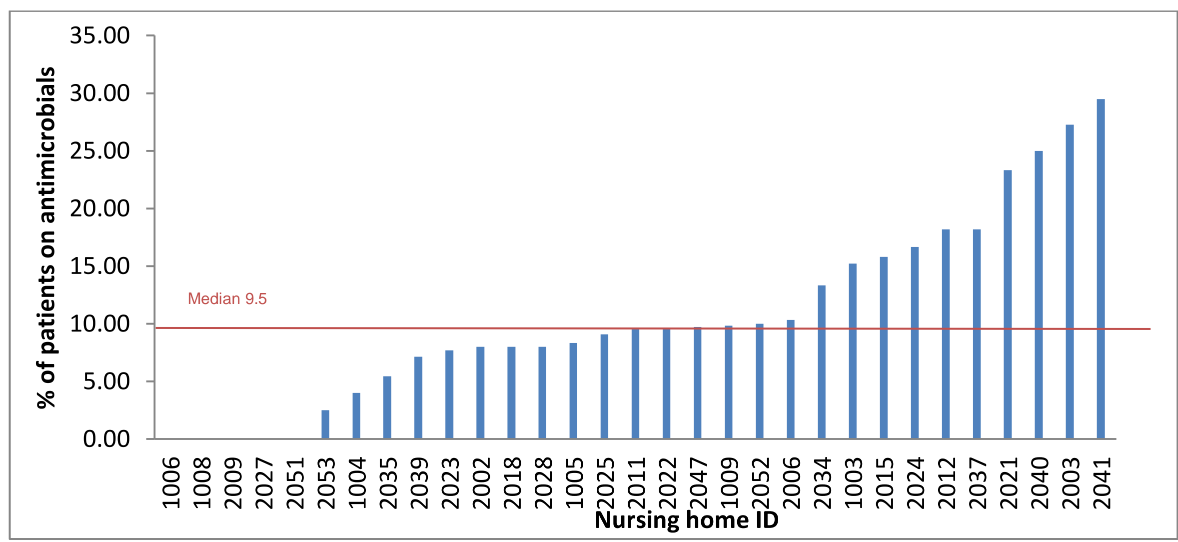


Figure 9 *Prevalence (%) of antimicrobial use in Nursing homes*

Residential homes

The prevalence of antimicrobial use in Residential homes was 7.7% (20 patients receiving antimicrobials/ 260 eligible patients) and ranged from 0.0% to 21.7% (median 8.3%) [Figure 10]. One patient was receiving two antimicrobials. In one home, no one was receiving antimicrobials.

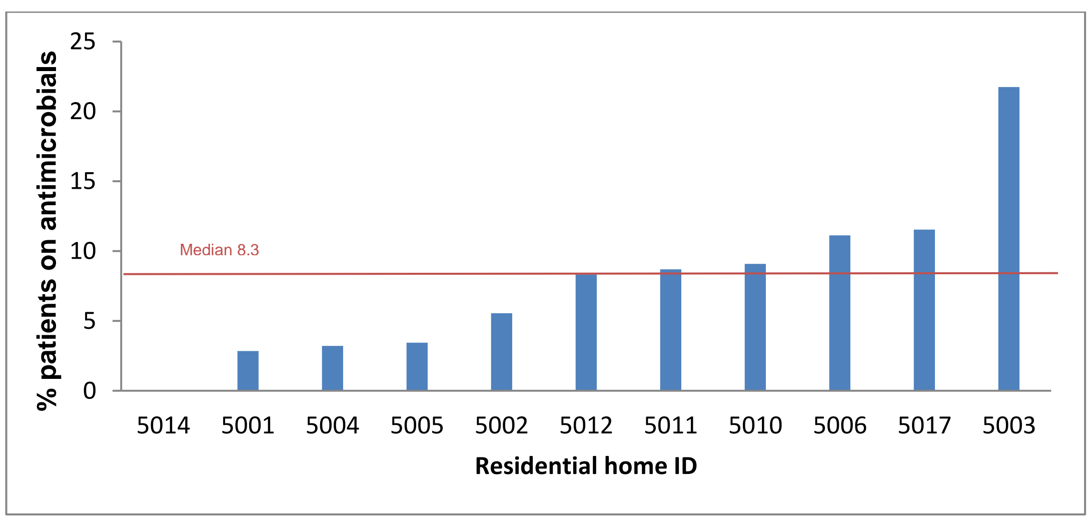


Figure 10 *Prevalence of antimicrobial use in Residential homes*

3.4.2 Antimicrobial prescribers and prescribing location

Nursing homes

The majority of antimicrobials in Nursing homes were prescribed by a GP (94.9%; 131/138) and most of these were prescribed within the Nursing home (78.3%, 108/138) [Table 5]. There were 23 prescriptions (16.7%) prescribed elsewhere (possibly in GP's surgery out of hours or at home – although this was not indicated). Five patients (3.6%) were prescribed antimicrobials in hospital [Table 5].

Table 5 *Location and prescriber information for antimicrobial prescriptions*

Who and where prescribed	*Number*	*% of patients on antimicrobials*
GP	**131**	**94.9**
Nursing home	108	78.3
Elsewhere (possibly GP surgery)	23	16.7
Specialist in the hospital	**5**	**3.6**
Unknown	**2**	**1.4**

Residential homes

In Residential homes, 15 out of 21 antimicrobials were prescribed by a GP (71.4%), Three (14%) were prescribed by another medical doctor and three (14%) were prescribed by a specialist in hospital.

3.4.3 Route of administration

Almost all antimicrobials in Nursing homes were administered orally (95%) and only two antimicrobials were delivered parenterally, i.e. intravenous received intravenous antimicrobials [Table 6]. One patient received antimicrobials via eye drops. All Residential home prescriptions were for oral antibiotics (21; 100%).

Table 6 *Route of antimicrobial administration in Nursing homes*

Route	*Number prescriptions*	*% of all antimicrobials*
Oral	131	94.9
Parenteral	2	1.4
Other	1	0.7
Unknown	4	2.9

Summary point:

- 10.9% of patients in Nursing homes were on antimicrobials;
  - 95% administered orally
  - 95% prescribed by a GP
- 7.7% of patients in Residential homes were on antimicrobials
  - 100% of antimicrobials in Residential homes were administered orally
  - 71% prescribed by a GP

3.4.4 Treated infection site

Nursing homes

Regardless of the type of treatment (prophylactic or therapeutic) antimicrobials were prescribed mainly as treatment for urinary tract infections (90 prescriptions; 65.2% of all prescribed antimicrobials), followed by respiratory tract (24 prescriptions; 17.4%) and skin or wounds (16 prescriptions; 11.6%) [Table 7]. Over half of prescriptions (51.5%; 70/136) were given as prophylaxis and 48.5% were prescribed for therapeutic reasons. Almost half of prescriptions (47.1%) were for uroprophylaxis.

Table 7 *Number and prevalence of antimicrobials by site and by infection*

Treated Site	***Type of Treatment***	
	Prophylaxis (%)	***Therapeutic (%)***
UTI (n=90)	72.2	27.8
Respiratory (n=24)	16.6	83.3
Skin (n=16)	6.3	93.8
Gastrointestinal (n=1)	0.0	100.0
Oral, Ear, Nose and Mouth (n=2)	0.0	100.0
Eye (n=2)	0.0	100.0
Unknown (n=3)	-	-
TOTAL (n=138)	51.5	48.5

Residential homes

There were 21 antimicrobial prescriptions in Residential homes. 17 were prescribed for urinary reasons (11 therapeutic; 6 prophylaxis), 3 (therapeutic) for respiratory infection and one (therapeutic) for skin/wound. In Residential homes 29% (6 of 17) of antimicrobials were for uroprophylaxis, i.e. 2.3% of all residential home patients.

Summary point:

- Nursing homes
  - 72% of UTI prescriptions were for prophylaxis
  - 17% of prescriptions for respiratory tract were for prophylaxis

3.4.5 Review or end date for antimicrobials

Nursing homes

Participating Nursing homes were asked if antimicrobials had a review or end date. This information was recorded for 134 cases of the 138 antimicrobials. All therapeutic antimicrobials had an end/review date but only 12.9% of prophylactic antimicrobials had an end/review date. An end/review date was indicated for 11% of patients receiving uroprophylaxis (7/63) and only 25% of patients receiving prophylaxis for respiratory infections had an end/review date (1/4).

Residential homes

There was an end/review date for 13 of the 15 therapeutic prescriptions given in Residential homes (87%); however, none of the prophylaxis prescriptions had an end/review date (0/6).

3.4.6 Antimicrobial class administered in Nursing homes

The most frequently prescribed class of antimicrobials was sulfonamides and Trimethoprim (31%), followed by Beta-lactams (24%) and ‘other’ antibacterials (23%). The least prescribed groups were the quinolones (1.5%), tetracycline (1.5%), antifungals (1%), antiprotozoal (1%) and the amphenicols (1%) [Figure 11].

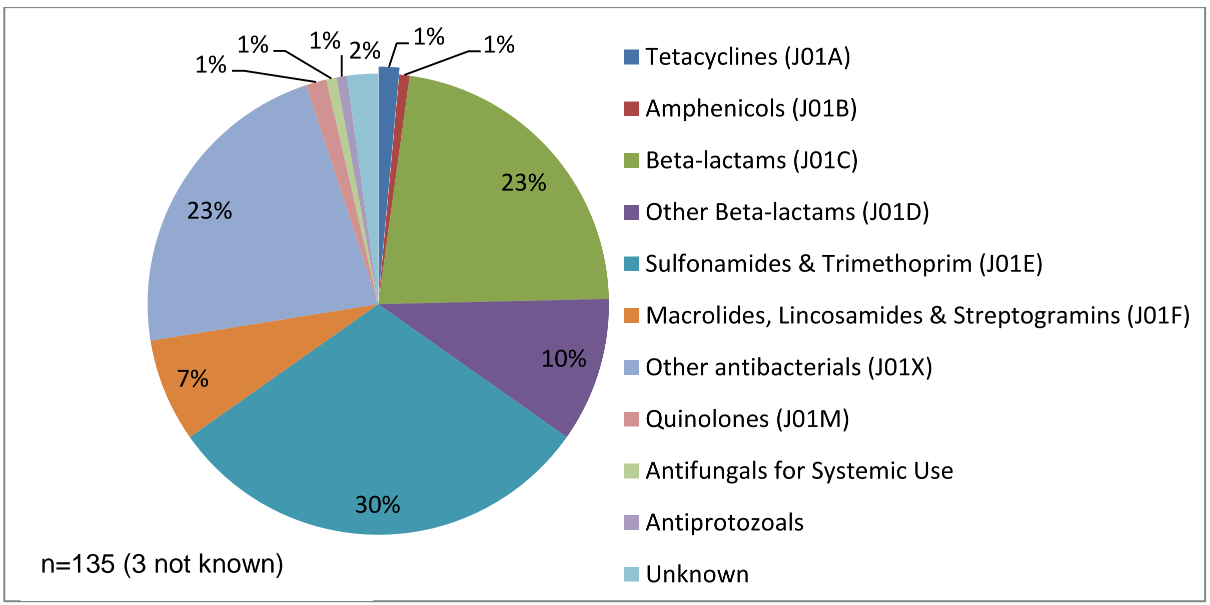


Figure 11 *Classification of antimicrobials prescribed in Nursing homes*

3.4.7 Antimicrobials prescribed in Nursing and Residential homes

Patients in Nursing homes were prescribed 17 different antimicrobial agents, whereas, only 6 different agents were used in Residential homes [Table 8]. The most commonly prescribed antimicrobial agents were trimethoprim (30.4% of all antimicrobials in Nursing homes; 35% in Residential homes) and nitrofurantoin (21.7% of all antimicrobials in Nursing homes; 7.1% of all antimicrobials in Residential homes). Two patients in Nursing homes were receiving IV antimicrobials.

Table 8 *Antimicrobials prescribed in LTCFs*

Antimicrobial	Nursing homes		Residential homes	
	Frequency	%	Frequency	%
Trimethoprim	42	30.4	7	35.0
Nitrofurantoin	30	21.7	5	7.1
Amoxicillin	14	10.1	2	2.9
Cefalexin	12	8.6	3	4.3
Flucloxacillin	9	6.5	1	1.4
Co-Amoxiclav	8	5.8	2	2.9
Clarithromycin	6	4.3	0	0
Ciprofloxacin	2	1.4	0	0
Doxycycline	2	1.4	0	0
Erythromycin	2	1.4	0	0
Azithromycin	2	1.4	0	0
Fluconazole	1	0.7	0	0
Metronidazole	1	0.7	0	0
Cefradine	1	0.7	0	0
Ceftriaxone (**IV**)	1	0.7	0	0
Chloramphenicol	1	0.7	0	0
Cubicin (**IV**)	1	0.7	0	0
Unknown Agent	3	2.2	0	0
Total	138	100.0	20	100.0

3.4.8 Microorganisms and antimicrobial resistance

Nursing homes

A culture sample was taken for 31.6% of patients receiving antimicrobials (42/133 patients). Of these, 27 (64.3%) were cultured for prophylactic reasons and 15 (35.7%) cultured for therapeutic reasons. Microbiology results were sent to GPs and were not routinely passed on to the Nursing homes. There were only 2 microbiology results available; *Staphylococcus aureus* - methicillin resistant (MRSA) from an eye infection and a parasite (*Giardia lamblia*) identified from a gastrointestinal infection.

Residential homes

In Residential homes, 52.4% (11/21) of patients on antimicrobials had a culture sample taken. Only 2 microbiology results were available (both *Escherichia coli).*

SECTION 4 COMMON CONDITIONS OF INTEREST

This section presents an in-depth analysis of the three most prevalent conditions of interest (patients with infection and/or receiving antimicrobials) in Nursing homes, i.e. urinary tract, respiratory tract and skin/wound infections.

4.1 Urinary tract

4.1.1 Urinary tract - condition of interest

There were 93 patients with a urinary tract infection and/or were receiving antimicrobials for urinary tract reasons on the day of the survey. Therefore the prevalence of urinary tract 'condition of interest' was 7.45/100 eligible patients.

4.1.2 Urinary tract – care load indicators and risk factors

Patients with a urinary tract infection or were receiving antimicrobials for a urinary tract indication infection were more likely to be female, have a urinary catheter in place, incontinent, disorientated, and had impaired mobility ($p<0.05$, $p<0.01$, $p<0.01$, $p<0.01$ and $p<0.01$ respectively) [Table 9].

Table 9 *Prevalence of Urinary tract condition of interest - patient characteristics with odds ratio*

	Number of patients (percentage of total)*	Number with Urinary tract condition of interest*	Prevalence of Urinary tract condition of interest (95% CI)	Odds ratio (95% CI)	Chi-Square test
Gender					P<0.05
Male	392 (31.5)	19	4.85(3.12 – 7.45)	1.00	
Female	851 (68.5)	73	8.58(6.88 – 10.65)	1.84 (1.07 – 3.21)	
Age					NS
85 and under	667 (53.7)	43	6.45(4.82 – 8.57)	1.00	
>85	576 (46.3)	43	7.47(5.59 – 9.90)	1.17 (0.74 – 1.86)	
Incontinence					P<0.01
No	480 (38.6)	23	4.79(3.21 – 7.09)	1.00	
Yes	763 (61.4)	70	9.17(7.33 – 11.43)	2.00 (1.20 – 3.35)	
Disorientation*					P<0.01
No	524 (42.2)	25	4.77(3.25 – 6.95)	1.00	
Yes	719 (57.8)	64	8.90(7.03 – 11.21)	1.95 (1.18 – 3.23)	
Impaired mobility*					P<0.01
No	586 (47.1)	31	5.29(3.75 – 7.41)	1.00	
Yes	657 (52.9)	60	9.13(7.16 – 11.58)	1.80 (1.12 – 2.89)	
Urinary catheter*					P<0.01
No	1173 (94.0)	79	6.73 (5.44 – 8.31)	1.00	
Yes	74 (6.0)	13	17.57(10.56 – 27.77)	2.95 (1.47 – 5.81)	
Surgery <30 days					NS
No	1233 (99.2)	91	7.38(6.05 – 8.98)	1.00	
Yes	10 (0.8)	2	20.00(5.67 – 50.98)	3.14 (0.32 – 16.02)	
Pressure sores					P=0.03
No	1201 (96.6)	83	6.91(5.61 – 8.49)	1.00	
Yes	42 (3.4)	7	16.67(8.32 – 30.60)	2.69 (0.98-6.40)	
Other wounds					NS
No	1174 (94.4)	83	7.07(5.74 – 8.68)	1.00	
Yes	69 (5.6)	7	10.14(5.00 – 19.49)	1.48 (0.60 – 3.50)	

* Numbers may vary due to non-response. Base 1,243 patients - 93 with condition of interest

4.1.3 Urinary tract infections (UTIs)

Urinary tract infections were the most commonly reported HCAI accounting for 40% of all infections. There were 30 UTIs reported (Prevalence 2.4 per 100 eligible patients):

- 23.3% of UTIs were catheter related (urinary catheter *in situ*); n=7;
- 26.7% of UTIs had signs and symptoms and a urine culture positive, i.e. confirmed UTI (as defined by the definitions); n=8
- 73.3% of UTIs had signs and symptoms and urine culture not done, negative or results unknown i.e. probable UTI (as defined by the definitions); n=22.

4.1.4 UTI prescribing

89 (64.5% of all antimicrobials) antimicrobials were prescribed for urinary reasons [Figure 12]. 69 (77.5%) of these patients were female. Almost three quarters of prescriptions for urinary indication were for prophylaxis (65/89; 72%); therefore in the total Nursing home population (1,243) the prevalence of uroprophylaxis was 5.15 per 100 patients. 5.9% of all females and 3.3% of males in Nursing homes were receiving urinary prophylaxis (50/851 females; 13/392 males). Two antimicrobials accounted for 74% of all antimicrobials prescribed for the treatment for UTI: trimethoprim (9 prescriptions) and nitrofurantoin (8 prescriptions).

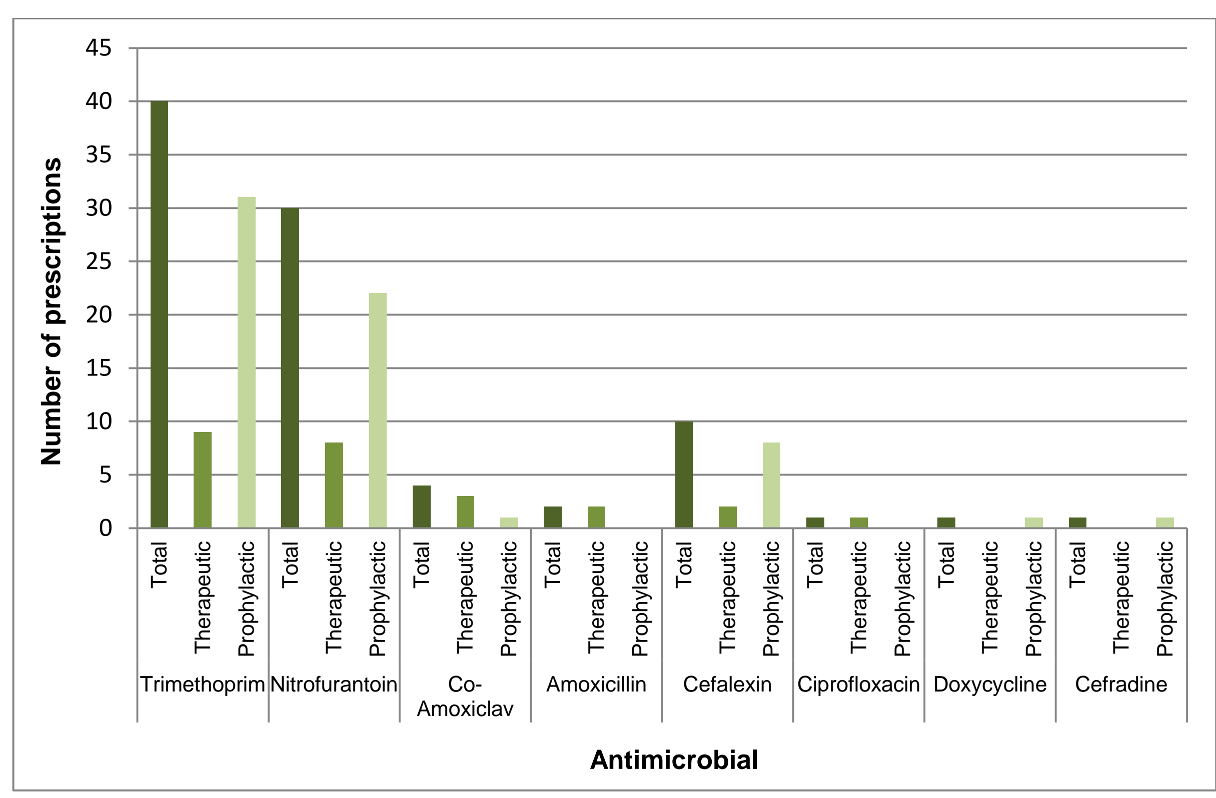


Figure 12 *Antimicrobials for the treatment of urinary tract infections (prophylactic/therapeutic)*

4.1.5 UTI - adherence to 2010 prescribing guidelines

In only 74% of cases was the choice of antimicrobial agent (Trimethoprim and Nitrofurantoin) in line with Northern Ireland Antimicrobial Guidelines for Primary Care 2010 [11], therefore 26% of patients receiving antimicrobials for urinary tract reasons were given antimicrobials not in line with guidance. It should be noted new guidelines [12] have since been published and were not available during the survey period. The therapeutic use of co-amoxiclav; amoxicillin and cefalexin are not in line with 2010 guidelines. No other information was available to confirm if this use was supported by culture results.

No information on prophylactic use of antibiotics for UTIs was included in the 2010 guidelines, however, the updated 2013 guidelines [12] include a recommendation of up to 6 months prophylactic use of Trimethoprim or Nitrofurantoin in specific circumstances; other agents given as prophylaxis are not in line with 2013 guidance, i.e. cefalexin, doxycycline and cefradine.

Summary point:

- The prevalence of urinary tract 'condition of interest' was 7.5%
- Patients with a 'condition of interest' were more likely to be female, have a urinary catheter, be incontinent, disorientated and have impaired mobility
- UTI was the most commonly reported HCAI (40%)
- 74% of antimicrobials prescribed for UTI were in line with current guidelines and just over 1 in 4 (26%) were not in line with the guidance

4.2 Respiratory Tract

4.2.1 Respiratory tract - condition of interest

There were 29 patients with a respiratory tract infection and/or were receiving antimicrobials for respiratory tract reasons on the day of the survey.

4.2.2 Care load indicators and risk factors – respiratory tract

Patients with a respiratory tract infection and/or were receiving antimicrobials for a respiratory tract indication were more likely to be incontinent ($p<0.05$), have impaired mobility ($p<0.01$) and had recent surgery ($p<0.05$); see Table 10.

Table 10 *Prevalence of Respiratory tract condition of interest - patient characteristics with odds ratio*

	Number of patients (percentage of total patients) *	Number with Respiratory tract condition of interest*	Prevalence of Respiratory tract condition of interest (95% CI)	Odds ratio (95% CI)	Chi-Square test
Gender					NS
Male	392 (31.5)	9	2.30(1.21 – 4.31)	1.00	
Female	851 (68.5)	20	2.35(1.53 – 3.60)	1.02 (0.44 – 2.45)	
Age					NS
85 and under	667 (53.7)	13	1.95(1.14 – 3.31)	1.00	
>85	576 (46.3)	14	2.43(1.45 – 4.04)	1.25 (0.55 – 2.86)	
Incontinence					P=0.05
No	480 (38.6)	6	1.25(0.57 – 2.70)	1.00	
Yes	763 (61.4)	23	3.01(2.02 – 4.48)	2.45 (0.96-7.39)	
Disorientation					NS
No	524 (42.2)	7	1.34(0.65 – 2.73)	1.00	
Yes	719 (57.8)	21	2.92(1.92 – 4.42)	2.22 (0.89 – 5.79)	
Impaired mobility					P<0.01
No	586 (47.1)	6	1.02(0.47 – 2.22)	1.00	
Yes	657 (52.9)	23	3.50(2.34 – 5.20)	3.51 (1.34 – 9.67)	
Urinary catheter					NS
No	1173 (94.0)	27	2.30(1.59 – 3.33)	1.00	
Yes	74 (6.0)	2	2.70(0.74 – 9.33)	1.18 (0.13 – 4.85)	
Surgery <30 days					P=0.02
No	1233 (99.2)	27	2.19(1.51 – 3.17)	1.00	
Yes	10 (0.8)	2	20.00(5.67 – 50.98)	11.17 (1.10 – 59.39)	
Pressure sores					NS
No	1201 (96.6)	25	2.08(1.41 – 3.05)	1.00	
Yes	42 (3.4)	3	7.14(2.46 – 19.01)	3.62 (0.83 – 13.33)	
Other wounds					NS
No	1174 (94.4)	24	2.04(1.38 – 3.02)	1.00	
Yes	69 (5.6)	4	5.80(2.28 – 13.98)	2.95 (0.84 – 9.31)	

* Numbers vary due to non-response. Base 1,243 - 29 with a respiratory tract condition of interest.

4.2.3 Respiratory tract infections

Respiratory tract infections were the second most commonly reported HCAI accounting for 28% of all infections in Nursing homes. There were 21 Respiratory tract infections:

- 66.7% 'lower RTIs', n=14
- 28.6%'common cold/pharyngitis', n=6
- 4.8% 'Flu'; n=1*
- 0 pneumonia

*Normally, symptoms of flu should not be reported outside the flu season (as in this survey, May-June), however, since a flu infection was confirmed, it was not excluded.

4.2.4 Respiratory prescribing

Figure 13 shows the distribution of antimicrobials prescribed for treatment or prophylaxis of respiratory infections. The most frequently prescribed antimicrobial was amoxicillin (11 prescriptions) followed by clarithromycin (5 prescriptions). There was no common choice of prophylaxis for respiratory tract indications – clarithromycin, co-amoxiclav, azithromycin and trimethoprim were prescribed once during the survey.

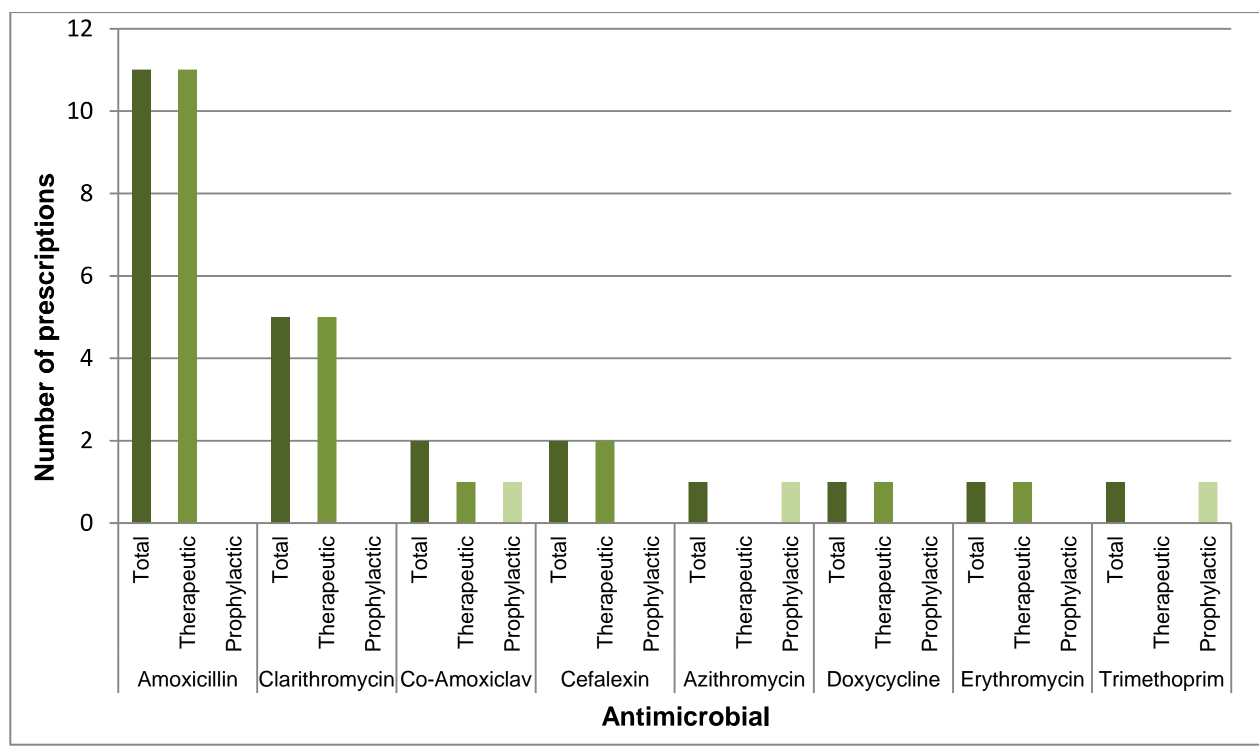


Figure 13 *Antimicrobials for treatment of respiratory infection (prophylactic/therapeutic)*

4.2.5 Respiratory tract – adherence to prescribing guidelines

The choices of the commonly prescribed antimicrobials for respiratory indications (amoxicillin and clarithromycin) are compliant with the 2010 guidelines [[11]]. Co-amoxiclav was in 2010 guidelines for treatment of chronic obstructive pulmonary disease (COPD) exacerbation. Cefalexin is not in 2010 guidelines for respiratory indications. These guidelines did not include recommendations for prophylaxis of respiratory tract infections. There is no information to determine if patients were prescribed prophylactic antimicrobials for respiratory tract infections on the recommendation of a respiratory physician.

Summary point:

- The prevalence of respiratory tract ‘condition of interest’ was 2.3%
- Respiratory tract infections were second most commonly reported HCAI (28%)
- Patients with a respiratory tract ‘condition of interest’ were more likely to be incontinent, have impaired mobility and to have had recent surgery

4.3 Skin/wound

4.3.1 Skin/wound - condition of interest

There were 18 patients with a skin/wound infection and/or were receiving antimicrobials for skin/wound reasons on the day of the survey. Therefore the prevalence of skin/wound 'condition of interest' was 1.45 per 100 eligible patients.

4.3.2 Care load indicators and risk factors – skin/wound

Patients with a skin/wound infection and/or were receiving antimicrobials for a skin/wound indication were more likely to have pressure sores (p<0.01) or other wounds (p<0.01) e.g. leg ulcers, traumatic or surgical wounds, insertion sites for gastrostomy, tracheostomy [Table 11].

Table 11 *Prevalence of skin/wound condition of interest - patient characteristics with odds ratio*

	Number of patients (percentage of total patients) *	Number with Skin condition of interest*	Prevalence of Skin condition of interest (95%CI)	Odds ratio (95% CI)	Chi-Square test
Gender					NS
Male	392 (31.5)	9	2.30(1.21 – 4.31)	2.20 (0.80 – 6.08)	
Female	851 (68.5)	9	1.06(0.56 – 2.00)	1.00	
Age					NS
85 and under	667 (53.7)	7	1.05(0.51 – 2.15)	1.00	
>85	576 (46.3)	10	1.74(0.95 – 3.17)	1.67 (0.58 – 4.88)	
Incontinence					NS
No	480 (38.6)	7	1.46(0.71 – 2.98)	1.01 (0.35 – 2.84)	
Yes	763 (61.4)	11	1.44(0.81 – 2.56)	1.00	
Disorientation					NS
No	524 (42.2)	8	1.53(0.78 – 2.98)	1.10 (0.39 – 3.04)	
Yes	719 (57.8)	10	1.39(0.76 – 2.54)	1.00	
Impaired mobility					NS
No	586 (47.1)	6	1.02(0.47 – 2.22)	1.00	
Yes	657 (52.9)	12	1.83(1.05 – 3.17)	1.80 (0.62 – 5.41)	
Urinary catheter					NS
No	1173 (94.0)	16	1.36(0.84 – 2.20)	0.50 (0.11 – 3.17)	
Yes	74 (6.0)	2	2.70(0.74 – 9.33)	1.00	
Surgery <30 days					NS
No	1233 (99.2)	18	1.46(0.93 – 2.30)		
Yes	10 (0.8)	0	0.00(0.00 – 29.17)	0 (0.00 – 38.66)	
Pressure sores					P<0.01
No	1201 (96.6)	13	1.08(0.63 – 1.84)	1.00	
Yes	42 (3.4)	5	11.90(5.19 – 25.00)	12.35 (3.63 – 39.85)	
Other wounds					P<0.01
No	1174 (94.4)	9	0.77(0.40 – 1.45)	1.00	
Yes	69 (5.6)	8	11.59(5.99 – 21.25)	16.98 (5.73 – 50.07)	

* Numbers may vary due to non-response. Base 1,243 - 18 with a skin/wound condition of interest.

4.2.3 Skin/wound infections

A quarter of all HCAI in Nursing homes were skin/wound infections. These infections were further sub-divided:

- 17 cellulitis/soft tissue/wound infections
- 1 fungal skin infection
- 1 herpes simplex or zoster infection

4.2.4 Skin infection prescribing

Figure 14 illustrates the distribution of antimicrobials prescribed for treatment and prophylaxis of skin/wound infections (agents=8; prescriptions=16). Flucloxacillin accounted for most of the prescriptions (8/16; 50%).

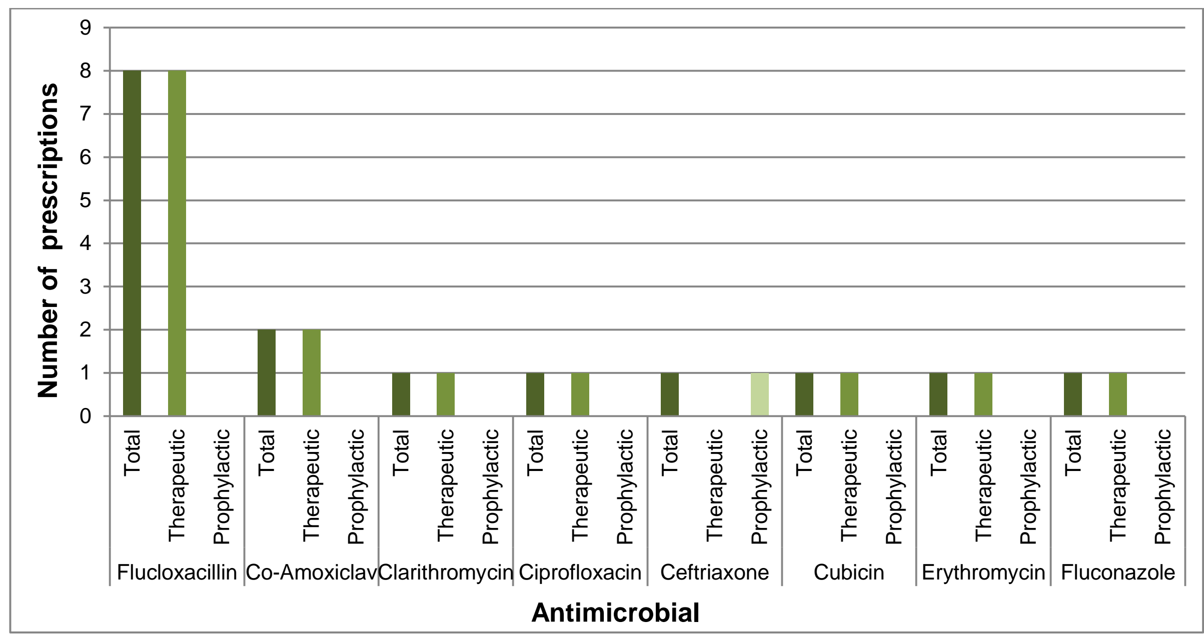


Figure 14 *Antimicrobials for treatment of skin/wound infection (prophylactic/therapeutic)*

4.2.5 Skin/wound – adherence to prescribing guidelines

Flucloxacillin, clarithromycin and erythromycin use for skin/wound infections is in line with 2010 guidelines. Co-amoxiclav is in line with the 2010 guidelines [[11]] only for treatment of bites (no information available on specific indication for prescribing). The 2010 guidelines did not include information on anti-fungal treatment. Ciprofloxacin use for skin/wound infections is not recommended in 2010 guidelines. Information on intravenous (IV) antimicrobials was not included in these guidelines, however, ceftriaxone and cubicin are both licenced for skin/soft tissue infections. Prophylactic use of ceftriaxone (IV) appears unusual.

Summary point:

- Prevalence of skin/wound infections in Nursing home patients was 1.5%

SECTION 5 FACILITY COORDINATION

This section deals with elements from the institutional questionnaire regarding medical care and coordination, infection control structure and antimicrobial policy.

5.1 Medical care and coordination

5.1.1 Nursing homes

Medical care was provided by personal General Practitioners (GPs), or group practices in all Nursing homes (100%). None of the homes surveyed had directly employed medical staff. Ten Nursing homes indicated coordination of medical activities (10/31; 32%); with 9 reporting that a physician from outside the home coordinated medical activities and one Nursing home indicating joint coordination between an internal physician and other external physicians. However, when the tasks performed by the coordinating physician were examined; three did not record any of the specified tasks; five indicated solely 'Medical resident care'; with only two Nursing homes recording tasks other than 'Medical resident care' only three Nursing homes indicated coordination of medical activities.

5.1.2 Residential homes

In common with Nursing homes, medical care was provided by GPs for 100% of patients in Trust-controlled Residential homes. Ten Residential homes (91%) reported that there was no internal or external coordinating physician. One home indicated that an external physician was responsible for coordinating 'Medical resident care'.

5.2 Infection prevention & control practice

5.2.1 Nursing homes

All Nursing homes, n=31, indicated the availability of a nurse with training in infection control and prevention. Most worked in the Nursing home (74.2%); in 7 Nursing homes (22.6%) there was access both to internal and external infection control expertise. One Nursing home indicated that they had access to an external person. No medical doctors with training in infection control and prevention were identified.

5.2.2 Residential homes

All Residential homes reported access to persons with training in infection control and prevention. The majority were external to the Residential home (n=9) but 2 Residential homes indicated that they had access to both an internal and external person with training in infection control and prevention.

5.3 Infection control committee

5.3.1 Nursing homes

Overall, 11 (35.5%) Nursing homes reported the existence of an infection control committee either internal or external, however, the majority 19 (61.3%) did not have an infection control committee and one home did not answer. Six Nursing homes reported four meetings in the last year; 1 reported three meetings; 2 two meetings and 2 homes reported one meeting. One home, with an infection control committee, reported that no meetings had taken place in the preceding year.

5.3.2 Residential homes

All eleven Residential homes (100%) indicated that they had an infection control committee. Seven of the Residential homes reported that they met at least once in the last year; four homes did not indicate the frequency of meetings.

5.4 Written protocols

5.4.1 Nursing homes

During the survey the availability of five written protocols was explored. Almost all Nursing homes had written protocols on: hand hygiene, MRSA, management of enteral feeding and management of urinary catheters (95%-100% of responses). Protocols on the management of vascular catheters were only available in 7 Nursing homes (22.6%); this result is not surprising given infrequent use in Nursing homes.

5.4.2 Residential homes

All Residential homes reported availability of written protocols for management of MRSA and for hand hygiene and ten out of eleven had guidelines on the management of urinary catheters. About half of Residential homes reported availability of guidance/protocols for management of venous catheters and management of enteral feeding (n=6; 55% for both).

5.5 Surveillance

Surveillance of healthcare-associated infections in Nursing homes was uncommon; only 32.3% (n=10) indicated that surveillance of HCAIs was performed. None of the Residential homes indicated that surveillance was performed.

5.6 Hand hygiene

5.6.1 Nursing homes

The majority of Nursing homes had organised a hand hygiene training session in the preceding year, 87.1% (n=27). The categories of staff invited to the hand washing training session were: nursing and nurse aides, and cleaning staff. The modal products available for hand hygiene in Nursing homes were: liquid soap (n=30) and alcohol rub solution (n=29). Alcohol impregnated wipes were used in about half of the homes (n=16). A minority of homes reported use of bar soap in clinical areas (n=3; 10%). The most frequently used hand hygiene method was hand washing with water and antiseptic soap (n=21), followed by water and a non-antiseptic soap (n=8). The personal protective equipment most available to staff in homes were: gloves (n=30; 97%), gown - long sleeves (n=30; 97%) and aprons - no sleeves (n=30; 97%). The availability of masks was identified in about two thirds of homes (n=21; 68%) and protective goggles in around half of homes (n=16; 52%).

5.6.2 Residential homes

All Residential homes reported that formal training in hand hygiene had taken place in the preceding year, and that this had been attended by nursing staff in all facilities (n=11; 100%) and by domestic staff in approximately half (n=6; 55%).

5.7 Antimicrobial stewardship resources

Current antimicrobial stewardship resources were explored as they can optimise antimicrobial prescribing and slow down the spread of antimicrobial resistance.

5.7.1 Nursing homes

Only one Nursing home indicated use of a restrictive list of antimicrobials i.e. prescription requiring either the permission of a designated person, or not to be used for intravenously administered antibiotics. In terms of antimicrobial stewardship, a range of factors were identified as good practice [Figure 15]. Overall 14 (45.2%), said that none of the practices existed within their facilities. Of those that identified good practice in antimicrobial prescribing the most frequent items present were; a system to remind healthcare workers of the importance of microbiological samples to inform the best antimicrobial choice (n=7); written guidelines for appropriate antimicrobial prescribing (n=6), advice from a pharmacist for antimicrobial not included in the formulary and local/regional antimicrobial resistance profile summaries available in the home or in the GP surgeries who prescribe (n=5).

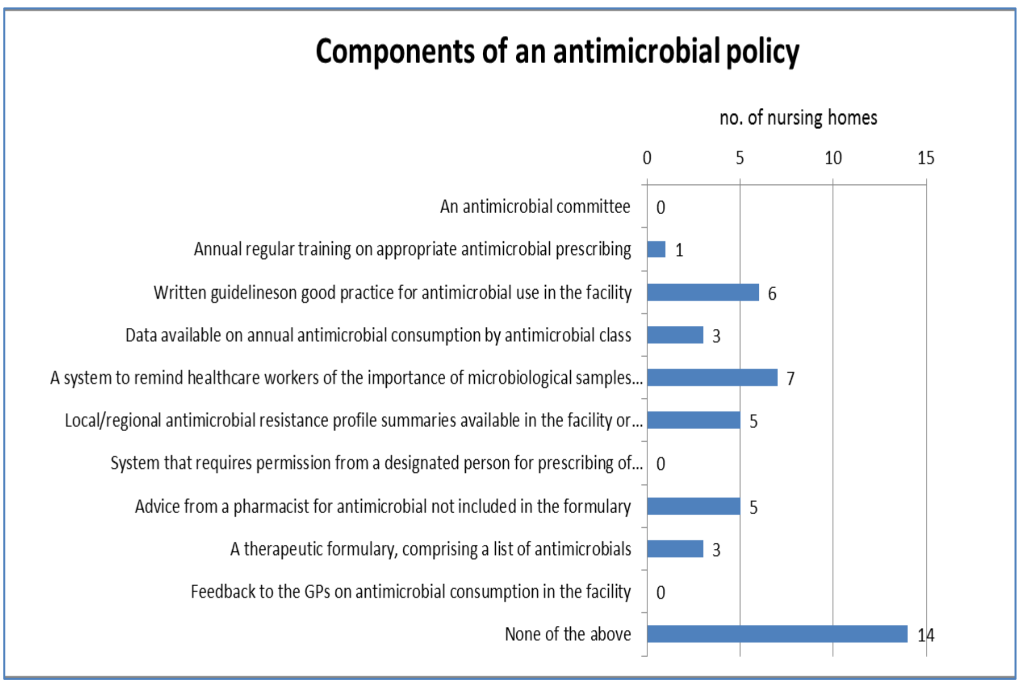


Figure 15 *Antimicrobial policy in Nursing homes*

5.7.2 Residential homes

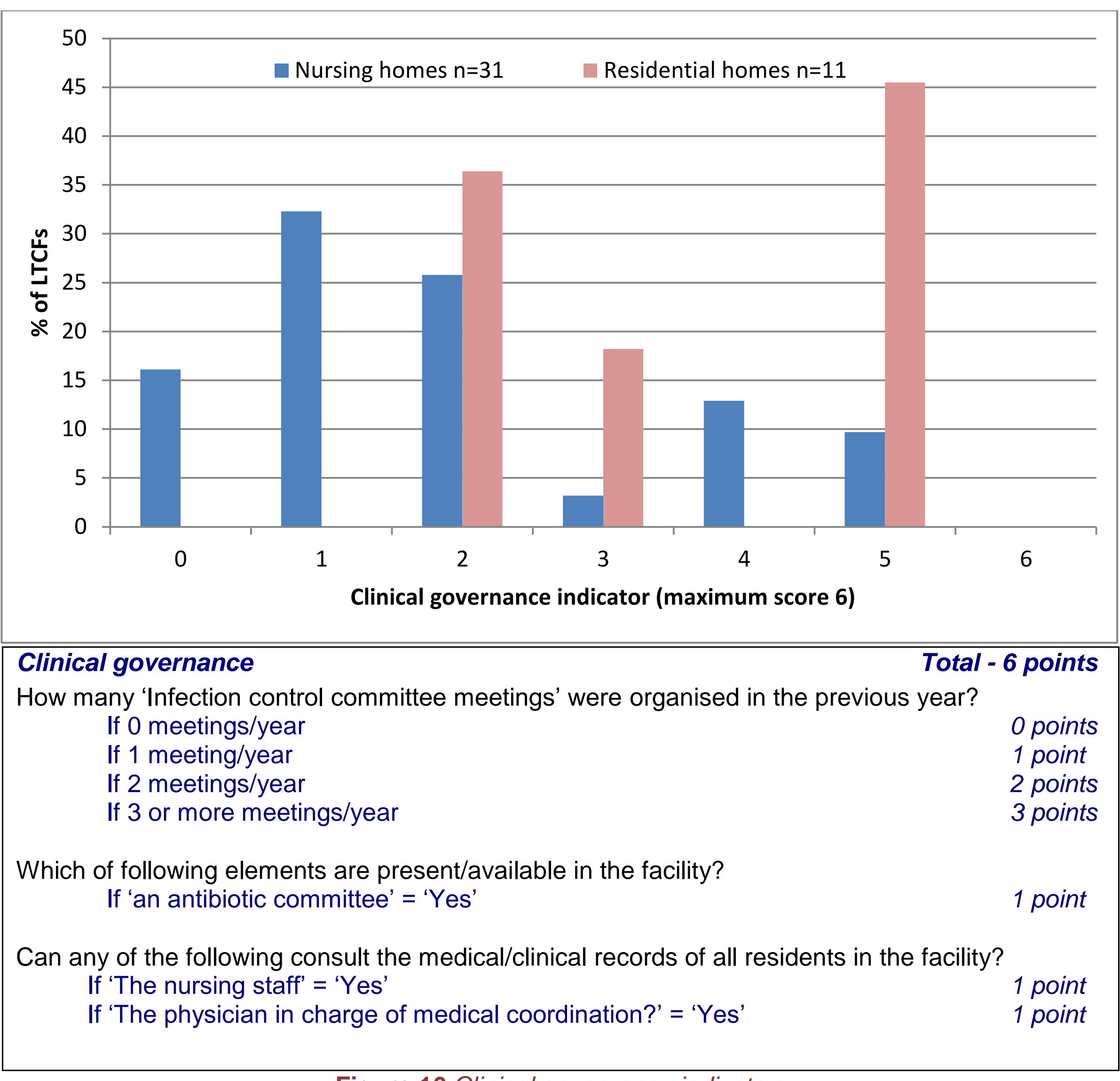
None of the Residential homes reported use of a restrictive list of antimicrobials. In terms of good antimicrobial stewardship practices, 5 (45.5%) Residential homes reported none of these formal activities, similar to the result for Nursing homes. The items identified most often were ‘a system to remind healthcare workers of the importance of microbiological samples’ (n=7), followed by ‘written guidelines on good practice for antimicrobial prescribing in the facility’ (n=6).

5.8 Infection control and antimicrobial stewardship resources

An important aim of the HALT survey was to develop a tool for measuring available resources for the prevention and control of infections and to assess the appropriate use of antimicrobials in LTCFs. This scoring system serves merely to get an overview of the status in the facilities. The system allowed us to measure the evolution of the infection control resources and antibiotic policy over time; in total, and by facility. Based on questions in the institutional questionnaire elements were grouped into categories **(Appendix 3).** Below you will find the seven categories of performance indicators, the elements that build up these categories and the score per answer. The analysis below describes the pattern of results obtained for each item for Nursing homes and Residential homes that took part in the survey.

5.8.1 Clinical governance

This included organisational factors concerning infection control resources, AB policy and patient care present in the facility. The maximum score was set at 6 points. For participating Nursing homes the average score was 1.94 (median 2). In comparison the mean value for the group of Residential homes was 3.5 (median 3).

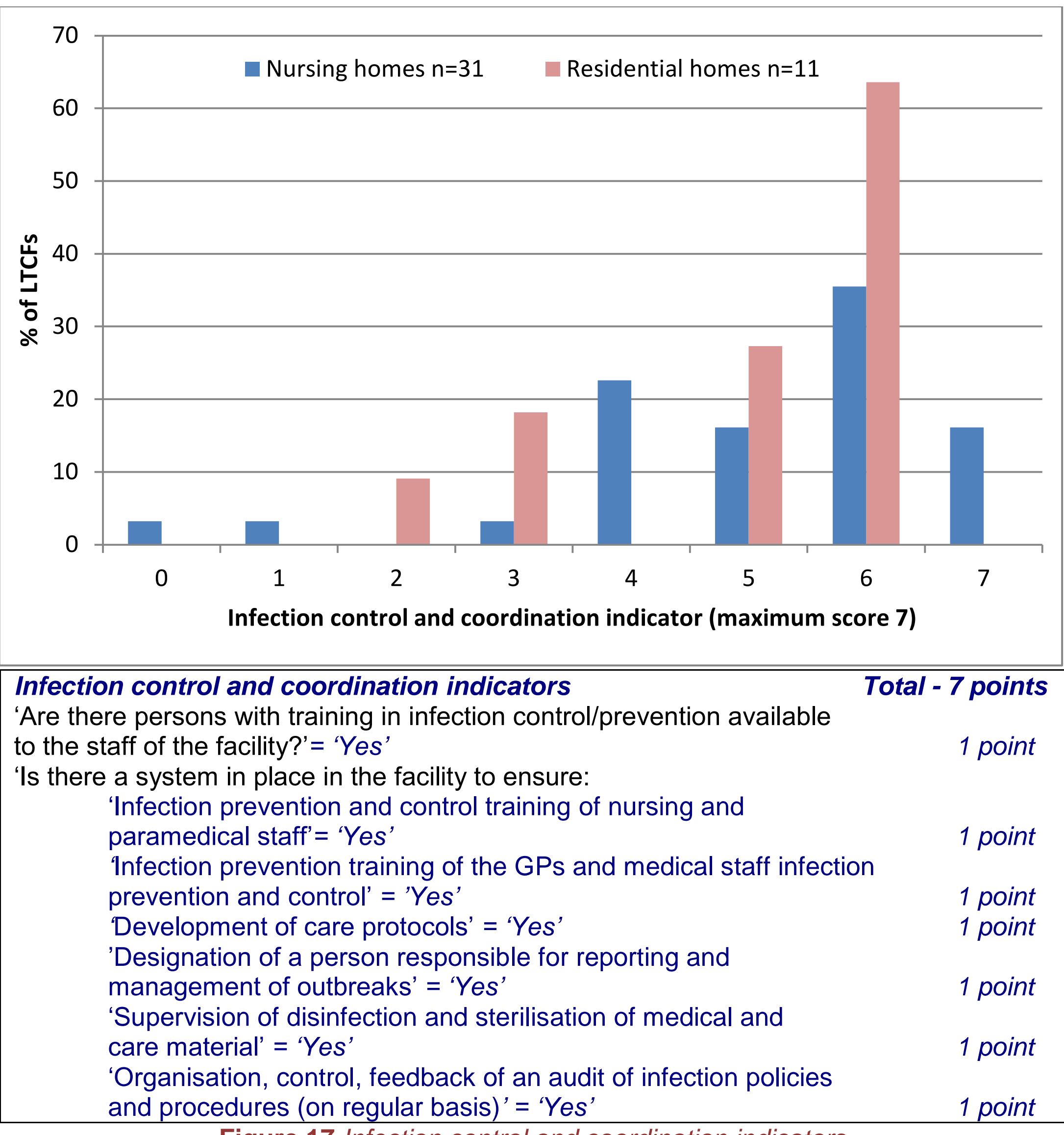


Clinical governance	***Total - 6 points***
How many 'Infection control committee meetings' were organised in the previous year?	
If 0 meetings/year	*0 points*
If 1 meeting/year	*1 point*
If 2 meetings/year	*2 points*
If 3 or more meetings/year	*3 points*
Which of following elements are present/available in the facility?	
If 'an antibiotic committee' = 'Yes'	*1 point*
Can any of the following consult the medical/clinical records of all residents in the facility?	
If 'The nursing staff' = 'Yes'	*1 point*
If 'The physician in charge of medical coordination?' = 'Yes'	*1 point*

Figure 16 *Clinical governance indicators*

5.8.2 Infection control and coordination indicators

Infection control indicators concerned activities and efforts to prevent infections and the spread of resistant pathogens.The maximum possible score was 7. Average score for Nursing homes was 5.1 (median score 6); Residential homes averaged 5.4 (median 6).

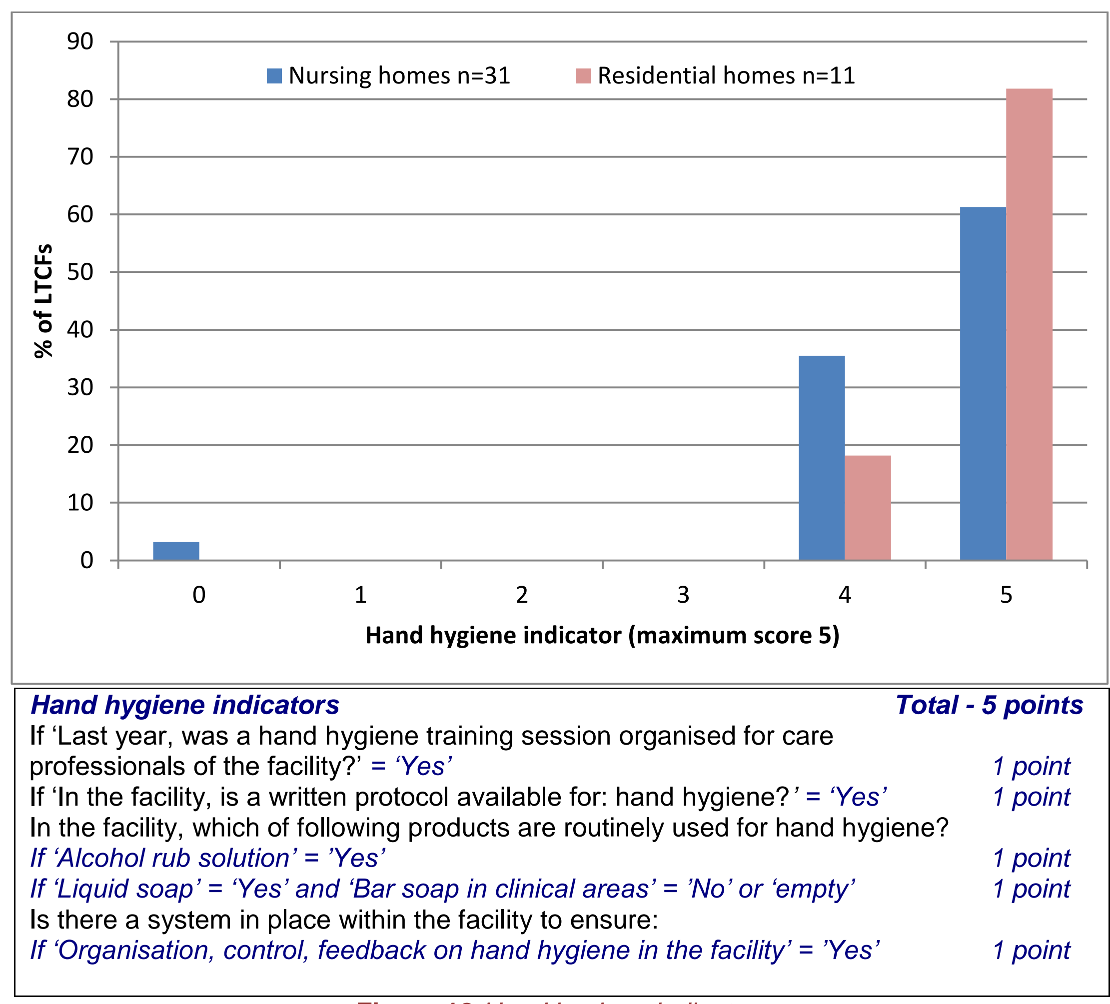


Infection control and coordination indicators	***Total - 7 points***
'Are there persons with training in infection control/prevention available to the staff of the facility?'= *'Yes'*	*1 point*
'Is there a system in place in the facility to ensure:	
'Infection prevention and control training of nursing and paramedical staff'= *'Yes'*	*1 point*
'Infection prevention training of the GPs and medical staff infection prevention and control' = *'Yes'*	*1 point*
'Development of care protocols' = *'Yes'*	*1 point*
'Designation of a person responsible for reporting and management of outbreaks' = *'Yes'*	*1 point*
'Supervision of disinfection and sterilisation of medical and care material' = *'Yes'*	*1 point*
'Organisation, control, feedback of an audit of infection policies and procedures (on regular basis)' = *'Yes'*	*1 point*

Figure 17 *Infection control and coordination indicators*

5.8.3 Hand hygiene

This item refers to practices and efforts for the improvement of hand hygiene in the facility. The maximum score was 5. In Nursing homes, the average score was 4.5 (median 5), the comparable score for Residential homes was 4.8 (median 5).

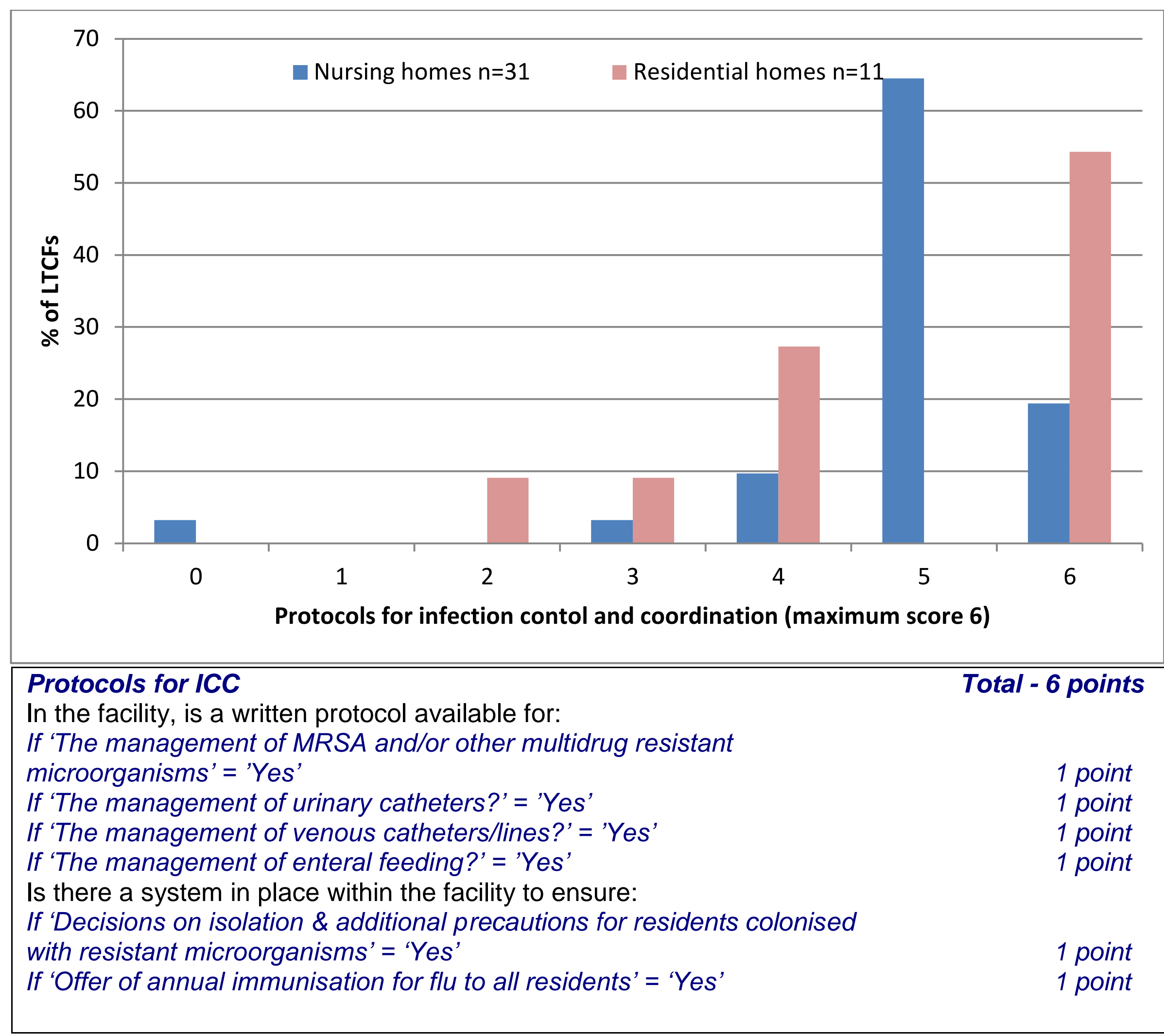


Hand hygiene indicators	***Total - 5 points***
If 'Last year, was a hand hygiene training session organised for care professionals of the facility?' = *'Yes'*	*1 point*
If 'In the facility, is a written protocol available for: hand hygiene?*' = 'Yes'*	*1 point*
In the facility, which of following products are routinely used for hand hygiene?	
If 'Alcohol rub solution' = 'Yes'	*1 point*
If 'Liquid soap' = 'Yes' and 'Bar soap in clinical areas' = 'No' or 'empty'	*1 point*
Is there a system in place within the facility to ensure:	
If 'Organisation, control, feedback on hand hygiene in the facility' = 'Yes'	*1 point*

Figure 18 *Hand hygiene indicators*

5.8.4 Protocols for infection control and coordination

Protocols for infection control reflect the presence of written care protocols and guidelines with regard to infection prevention in the facility. The maximum possible score for this item was 6. Overall, participating Nursing homes had an average score of 4.9 (median 5) and the residential facilities scored an average of 4.8 (median 6).

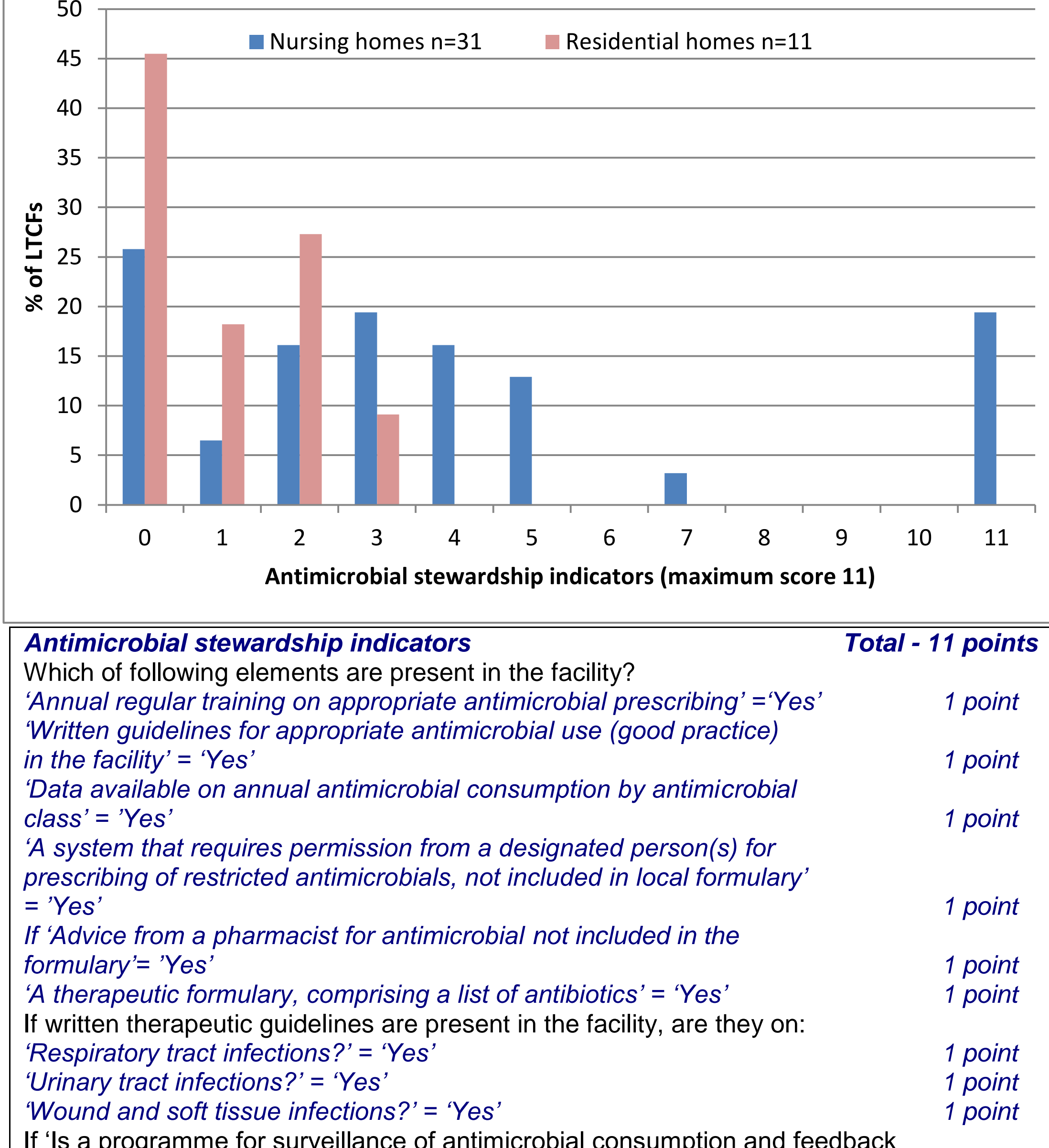


Protocols for ICC	***Total - 6 points***
In the facility, is a written protocol available for:	
If 'The management of MRSA and/or other multidrug resistant microorganisms' = 'Yes'	*1 point*
If 'The management of urinary catheters?' = 'Yes'	*1 point*
If 'The management of venous catheters/lines?' = 'Yes'	*1 point*
If 'The management of enteral feeding?' = 'Yes'	*1 point*
Is there a system in place within the facility to ensure:	
If 'Decisions on isolation & additional precautions for residents colonised with resistant microorganisms' = 'Yes'	*1 point*
If 'Offer of annual immunisation for flu to all residents' = 'Yes'	*1 point*

Figure 19 *Protocols for infection control and coordination*

5.8.5 Antimicrobial stewardship indicators

Antimicrobial stewardship indicators are related to the presence of activities to optimise rational antimicrobial use in the facilities. There were eleven elements to this item, providing a maximum score of 11. The average score for participating Nursing homes was 2.5 out of 11 (median 3), which compared to an average score for Residential homes of 1.0 out of 11 (median 1.0).

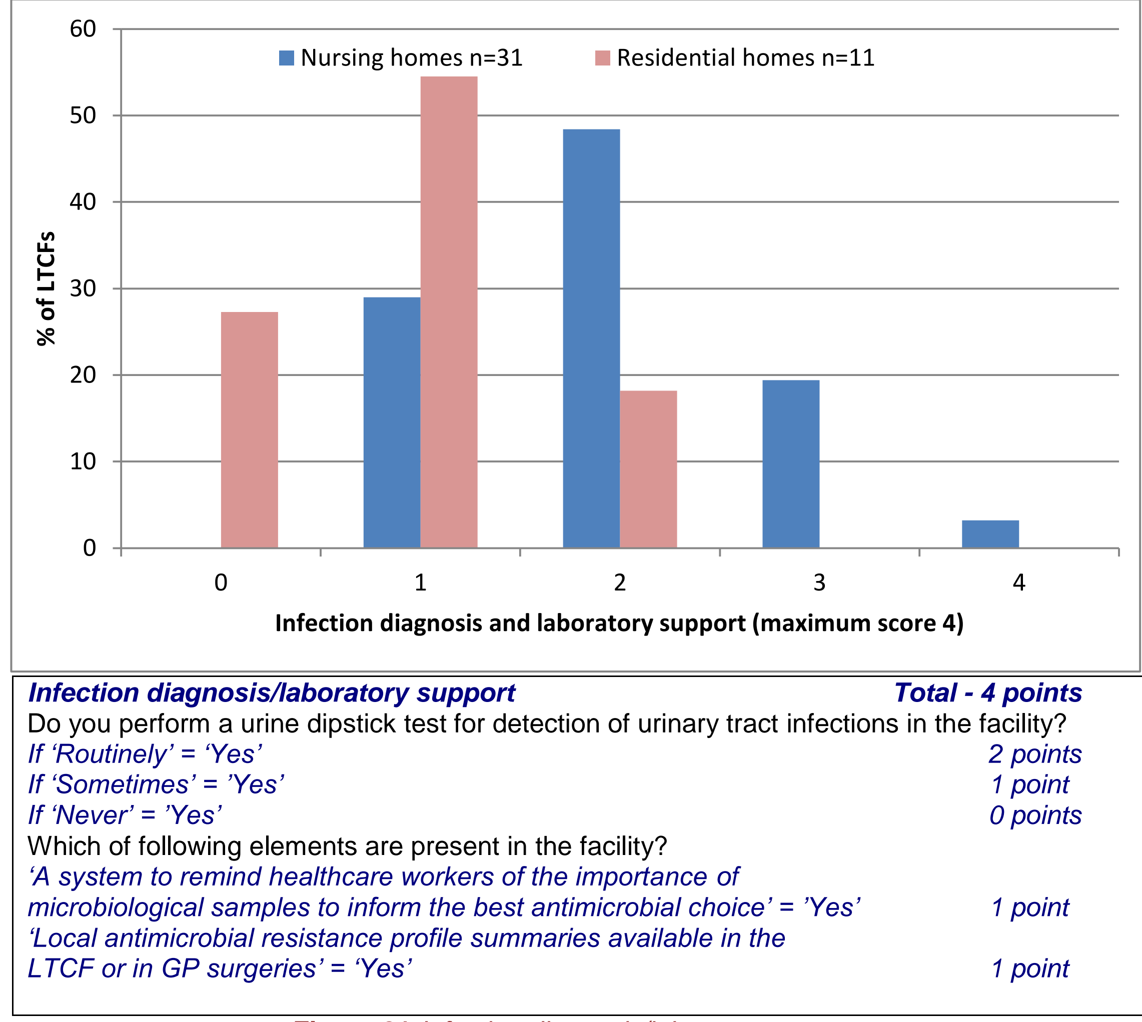


Antimicrobial stewardship indicators	***Total - 11 points***
Which of following elements are present in the facility?	
'Annual regular training on appropriate antimicrobial prescribing' ='Yes'	*1 point*
'Written guidelines for appropriate antimicrobial use (good practice) in the facility' = 'Yes'	*1 point*
'Data available on annual antimicrobial consumption by antimicrobial class' = 'Yes'	*1 point*
'A system that requires permission from a designated person(s) for prescribing of restricted antimicrobials, not included in local formulary' = 'Yes'	*1 point*
If 'Advice from a pharmacist for antimicrobial not included in the formulary'= 'Yes'	*1 point*
'A therapeutic formulary, comprising a list of antibiotics' = 'Yes'	*1 point*
If written therapeutic guidelines are present in the facility, are they on:	
'Respiratory tract infections?' = 'Yes'	*1 point*
'Urinary tract infections?' = 'Yes'	*1 point*
'Wound and soft tissue infections?' = 'Yes'	*1 point*
If 'Is a programme for surveillance of antimicrobial consumption and feedback in place in the facility?' = *'Yes'*	*1 point*
If 'Does the facility use a restrictive list of antimicrobials to be prescribed? *(requiring permission of a designated person or not to be used)' = 'Yes'*	*1 point*

Figure 20 *Antimicrobial stewardship indicators*

5.8.6 Infection diagnosis/laboratory support

Infection diagnosis/laboratory support concerns the application of practices for supporting the diagnosis of infections in the facility in order to guide appropriate antimicrobial treatments. The maximum possible score was 4 points. The average score for Nursing homes was 1.97 (median 2), for Residential homes the average score was 0.9 (median 1).

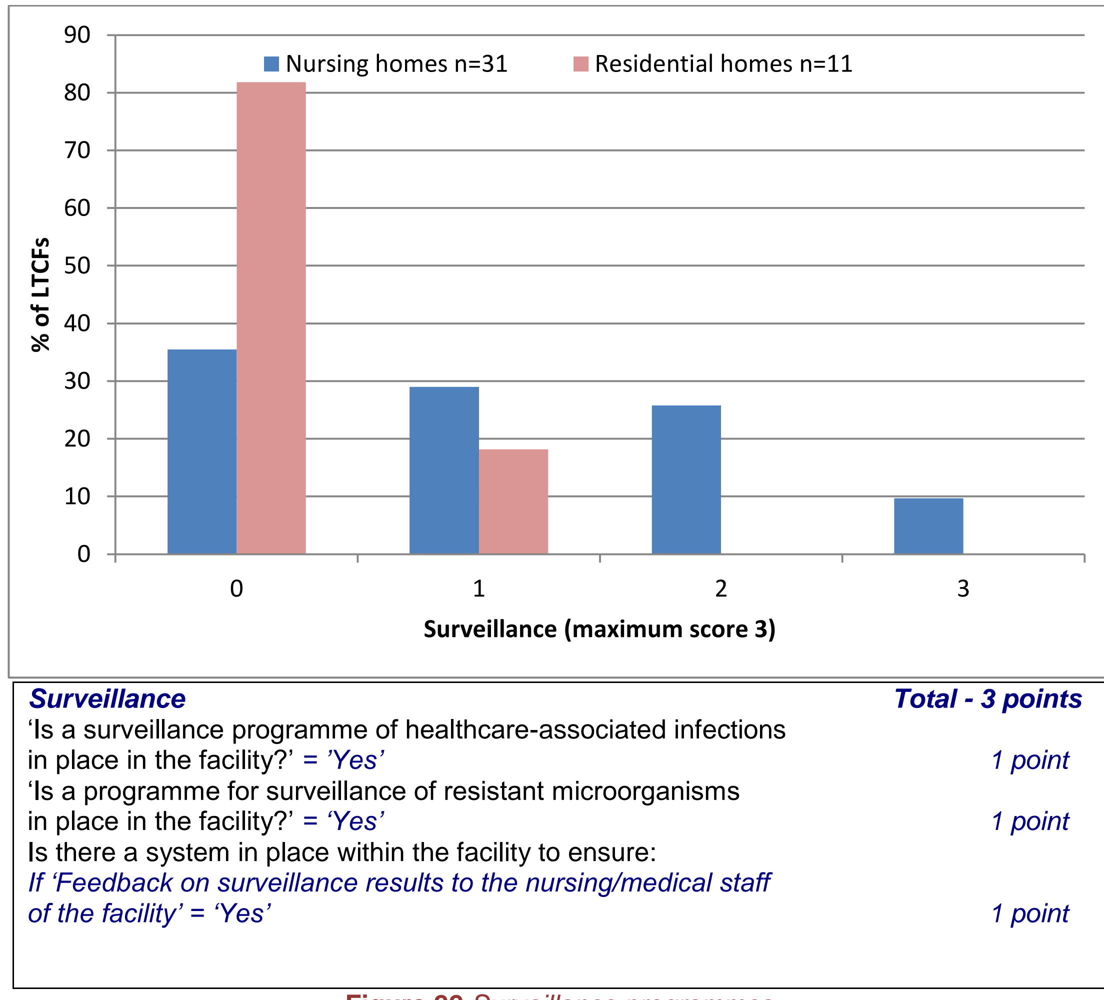


Infection diagnosis/laboratory support	***Total - 4 points***
Do you perform a urine dipstick test for detection of urinary tract infections in the facility?	
If 'Routinely' = 'Yes'	*2 points*
If 'Sometimes' = 'Yes'	*1 point*
If 'Never' = 'Yes'	*0 points*
Which of following elements are present in the facility?	
'A system to remind healthcare workers of the importance of microbiological samples to inform the best antimicrobial choice' = 'Yes'	*1 point*
'Local antimicrobial resistance profile summaries available in the LTCF or in GP surgeries' = 'Yes'	*1 point*

Figure 21 *Infection diagnosis/laboratory support*

5.8.7 Surveillance

Surveillance included the presence of certain surveillance activities with a maximum score of 3. The average score was 1.1 (median 1), comparable average score for Residential homes was 0.2 (median 0).



Surveillance	***Total - 3 points***
'Is a surveillance programme of healthcare-associated infections in place in the facility?' = *'Yes'*	*1 point*
'Is a programme for surveillance of resistant microorganisms in place in the facility?' = *'Yes'*	*1 point*
Is there a system in place within the facility to ensure: *If 'Feedback on surveillance results to the nursing/medical staff of the facility' = 'Yes'*	*1 point*

Figure 22 *Surveillance programmes*

5.8.8 Comparison of Nursing home scores in 2013 with 2010 survey

While the sample of Nursing homes that completed the survey in 2010 [13] was small, we examined the overall scores for the infection control and antimicrobial stewardship items in order to assess if there were any similarities or differences in the aggregate scores calculated. Generally, the distribution was similar between 2010 and 2013. As in 2010, average scores calculated for the 2013 data were higher for: hand hygiene, infection coordination and control, availability of protocols, but lower for clinical governance, infection diagnosis/laboratory support, antimicrobial stewardship and surveillance systems.

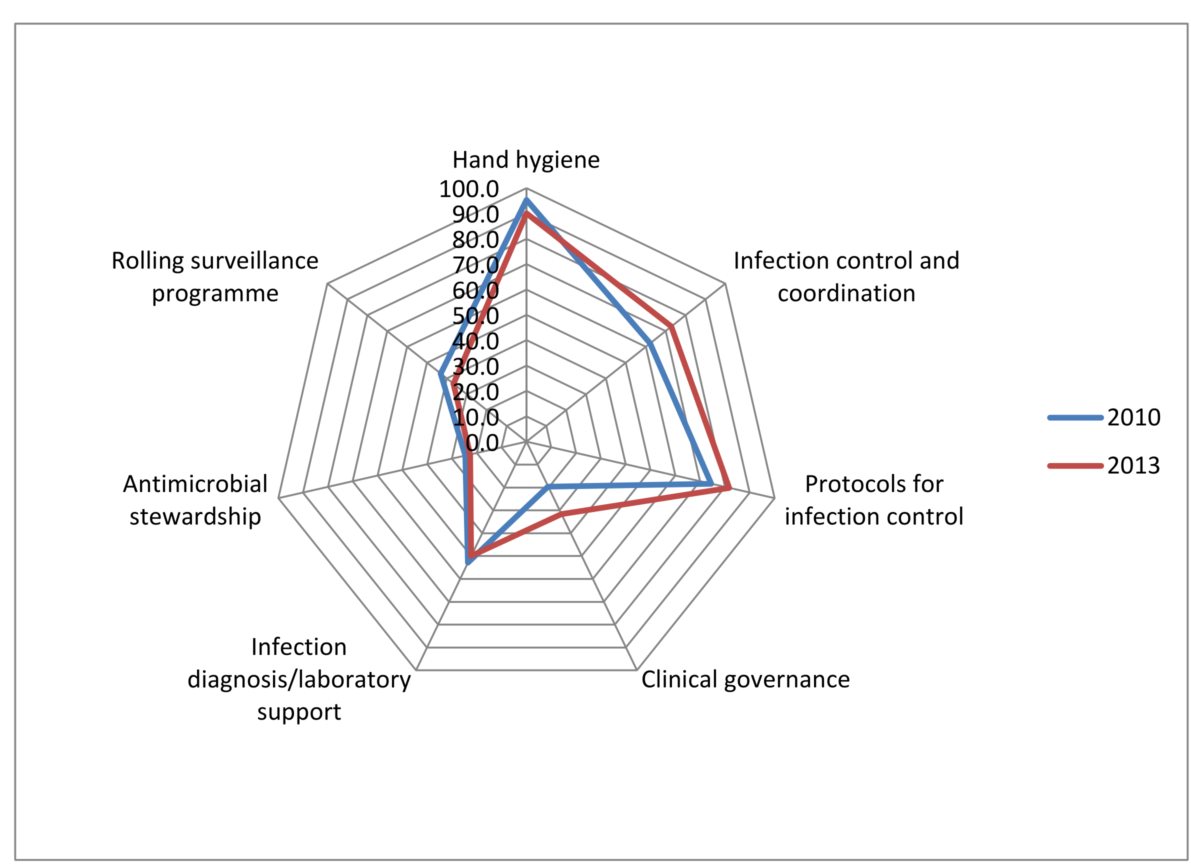


Figure 23 *Comparison of infection control indicators between 2010 and 2013*

SECTION 6 DISCUSSION

This report presents the prevalence of HCAI and antimicrobial prescribing in 42 Northern Ireland long-term care facilities (31 Nursing homes and 11 Trust-controlled Residential homes). In Northern Ireland, all Nursing homes that participated in the survey were privately run; mostly for profit (only one Nursing home was run on a non-profit basis). All patients had their own General Practitioner, so there was no common antibiotic stewardship in the facilities.

There are important caveats that must be acknowledged and the results should be interpreted with caution. Whilst prevalence surveys offer a fast, consistent and robust method for measuring HCAI in settings without resources for incidence surveillance, they measure a snapshot in time and are subject to variation.

6.1 Prevalence and distribution of HCAI

This survey was conducted during May/June 2013. On the day of survey, the prevalence of HCAI in Nursing homes was 5.5% and varied across homes from 0% to 25%. This result is higher than that reported for the 2010 HALT survey in 18 Nursing homes of 5.0%. However, caution should be used when comparing the 2013 and 2010 HALT results because of differences in protocols, definitions adopted and the Nursing homes taking part (only two Nursing homes took part in both studies).

In a prevalence survey performed in the acute care setting in 2012, the prevalence of infection in 'Care of the elderly' specialty' was 5.7%; which is similar to the 5.5% HCAI prevalence in Nursing homes and 5% HCAI prevalence in Residential homes in this survey [14]. As the long-term care facility and hospital populations are dynamic with continual movement, the prevalence of HCAI in the acute setting may have an impact on infection rates within long-term care settings and vice versa. Older people living in long-term care homes are also encouraged to remain a part of the community and are therefore exposed to infections circulating within the community. For these reasons, it is not possible to determine whether the infections identified in this survey were community, hospital or care home associated infections.

This survey identified that incontinence, non-ambulant mobility, presence of urinary catheter and presence of pressure sores and other wounds were associated with an increased prevalence of HCAI.

Urinary tract infections (UTI) are a major challenge in both Nursing and Residential homes (UTIs accounted for 43.8% of all of the HCAIs identified). The survey identified areas of concern around the frequency of uroprophylaxis and lack of end/review dates.

One of the most common infections recorded was respiratory infection. LTCFs should review their vaccination policies and ensure that influenza and pneumococcal vaccination protocols are in line with national guidance and part of an infection prevention and control plan. This vaccination policy must include annual influenza vaccination of LTCF staff.

Patients of Nursing homes with pressure sores and other wounds (9% of the total population) were at greater risk of developing an infection than patients who did not. Approximately one in every four patients with either a pressure sore or other wound developed an infection compared to less than 1 in 25 patients without pressure sores/wounds who developed an infection.

A strategy for the prevention and control of HCAI in LTCFs should be developed to include antimicrobial stewardship and be implemented in conjunction with relevant PHA clinical care, quality and patient safety programmes, prescribers and LTCF staff. Clear roles and responsibilities should be outlined within the strategy.

6.2 Infection control provision in long term care facilities

Only one third of Nursing homes reported having an infection control committee and the frequency of meetings varied from 4 per year to zero meetings in the previous year. All Residential homes had an infection control committee. All Nursing homes indicated that they had access to staff with training in infection control, although, there was no indication as to the level of infection control expertise. In Residential homes 100% reported access to either the local Trust-based IPCT.

Written protocols for the management of: hand hygiene, MRSA carriers, management of urinary catheters and management of enteral feeding were reported in most Nursing homes and Residential homes. LTCFs should ensure that procedures are in place (e.g. care bundles) to prevent HCAI associated with risk factors including medical devices such as: urinary catheters, wounds and inappropriate antibiotic use. As relevant national guidelines are published, they should be implemented accordingly.

There is a need for an organised infection control structure within each LTCF. A person responsible for infection control (ideally a physician/nurse) should be identified in each LTCF. If there is external responsibility for infection control, e.g. individual in charge of infection control in several LTCFs, then the LTCF should have a ‘reference person’ working in close collaboration with the external infection control person. Those designated responsible for infection control should have training and responsibility for standard precautions, hand hygiene, management of additional precautions around antimicrobial resistance and antimicrobial stewardship.

Regional training courses specifically for those with responsibility for infection control staff in LTCFs should be organised on an annual basis.

6.3 Prevalence of antimicrobial use

The prevalence of antimicrobial use in Nursing homes was 7.3% (95% CI 6.6-8.1) and ranged from 0% to 27.8%. Prudent prescribing is a continuing challenge in the care home setting and it is important to highlight that in Northern Ireland long-term care facilities do not have the responsibility for prescribing; this responsibility lies with individual GPs who coordinate medical care for patients within these settings. This survey has shown that patients’ medical care is predominately provided by external physicians, i.e. a patient’s own general practitioner; unfortunately the numbers of GPs providing medical care was not collected in this survey.

LTCFs should have a protocol in place to manage requests for acute prescription items, including antimicrobials. This may include use of a standard template to relay information to a patient’s GP, e.g. temperature, heart rate, respiratory rate, blood pressure, recent lab results, dipstick results, symptoms and duration of symptoms, recent antimicrobial treatment and other therapy and if patient has been seen by out-of-hours medical services or had recent hospital admission.

Results indicate that 89% of patients receiving urinary tract prophylaxis did not have an end/review date for the prophylaxis. All prescriptions for antimicrobials should have a stop or review date. Printing the stop/review date on prescriptions is good practice. Community pharmacies who prepare medication administration records or similar from prescriptions should ensure this information is transferred; they should also alert prescriber and Nursing home when this date is passed if a repeat prescription is requested. There is no evidence that prophylactic antimicrobials

prevent the onset of urinary tract infection in elderly patients therefore their use should be restricted only for specific circumstances as outlined in 2013 guidelines [12].

In only 2 (3%) of the 70 infections identified in the survey were the results of microbiological tests available, i.e. in 68 infections neither the bacteria nor antibiogram was available. Urinary dipsticks should be used to help diagnose a UTI. A patient with a suspected UTI should have a specimen sent for culture before antibiotic therapy is commenced. Following review of microbiology results GPs should promptly inform staff in LTCFs of presence of HCAI or any other infections. Antibiotic therapy should be based on culture and susceptibility results.

6.4 Conclusions

Due to demographic changes, more and more elderly people in the coming years will depend on qualified nursing at home or in care facilities. This survey has provided an invaluable insight into the prevalence of HCAI and antimicrobial prescribing in such facilities in Northern Ireland. The methodology may be used in future to identify key infection types and antimicrobial practices for targeted interventions at a local and national level. Service providers are encouraged to use these data to target local HCAI prevention and control efforts appropriately.

This report has contributed to the understanding of antimicrobial prescribing practice within care home settings across Northern Ireland. Prudent antimicrobial prescribing in long term care home settings is essential to reduce the risk of *Clostridium difficile* infection and to slow the development of antimicrobial resistance.

This survey has highlighted a number of potential risk areas for infections, antimicrobial use and antimicrobial resistance at the institutional level and the patient level. Institutional risk factors identified included: infection and control expertise availability, empirical prescriptions based on microbiological sampling prior to prescription and numerous antimicrobial prescribers. Patient risk factors identified during the survey included, frailty (age), disabilities (mobility), incontinence (faecal/urinary) and wounds. The results of this survey provided evidence of the need to effectively implement Northern Ireland Management of Infection Guidelines for Primary Care 2013 [12].

This data can serve as a baseline for future surveillance studies in Ireland long-term care facilities, thus giving an opportunity for observation of trends.

Improvement in diagnosis & therapy of UTI could avoid a lot of unnecessary antimicrobial use. GPs rely on nurses' observations sometimes without examination of the patient before clinical decisions. Both nurses and GPs need clear definitions of UTIs, guidelines on diagnosis, prevention and treatment, and training on:

- value of positive dipstick/urine culture
- indications for prophylaxis
- management of recurrent UTIs
- indications for urinary catheter & management

Actions are required around prudent use of antibiotics and infection prevention & control in LTCFs in order to prevent healthcare-associated infections and avoid unnecessary antimicrobial therapy. There is a need to develop a framework plan for patient safety in LTCFs in Northern Ireland, including infection prevention & control and prudent use of antimicrobial agents.

All the Northern Ireland homes taking part in the survey will be supplied with the aggregate regional data as well as those relating to their particular home. The data will be discussed with the homes and the GPs in order to achieve further improvements in antibiotic therapy and restrictions for the use of invasive medical devices, which are well-known risk factors for HCAIs.

Because of the standardised and harmonised methodology used in this survey, it will be possible to compare the data from various HALT surveys in other European countries (although we caution about the coverage and representativeness of the samples). Such comparisons can help to prevent infections and the increase in the prevalence of multidrug-resistant organisms.

The Public Health Agency will continue to work in partnership with Regulation and Quality Improvement Authority to facilitate, promote and sustain evidence based practice in infection prevention & control and use this practice to support regulatory activities to improve quality of care and safety for people living in care homes. A full EU-wide report containing Northern Ireland data is due to be published by ECDC in May 2014.

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Appendix 1 – Institutional Questionnaire

Institutional Questionnaire (Page 1)

Healthcare associated infections and antimicrobial use in European long-term care facilities (HALT-2)

INSTITUTIONAL QUESTIONNAIRE

Remark: It is **essential** that each facility enrolled in HALT-2 completes this questionnaire as it collects vital data on structural & functional characteristics, denominators and antimicrobial and infection prevention & control policies in the participating settings. From our HALT-1 experience, we recommend that the person completing this questionnaire should be the one in charge of the facility. If s/he cannot answer some of the questions, s/he should please forward the questionnaire to other(s) who are able to answer those specific questions. This is **especially relevant to the antimicrobial questions**.

A – GENERAL INFORMATION

DATE OF THE SURVEY IN YOUR FACILITY __ __ / __ __ / 2 0 1 3

FACILITY STUDY NUMBER (*allotted by your national HALT-2 coordinator*) __ __ __ __ __ __ __

OWNERSHIP OF THE FACILITY ☐ *Public* ☐ *For Profit* ☐ *Not for profit*

QUALIFIED NURSING CARE AVAILABLE 24/24h IN THE FACILITY ☐ *Yes* ☐ *No*

IN THE FACILITY:

Total number of RESIDENT ROOMS __ __ __ __ *Rooms*

Total number of SINGLE RESIDENT ROOMS __ __ __ __ *Single rooms*

B – DENOMINATOR DATA

This table when completed will summarize the data collected in each ward (ward list) for the total population

IN YOUR FACILITY, ON THE DAY OF THE SURVEY, TOTAL NUMBER OF:

BEDS IN THE FACILITY (*both occupied and non-occupied beds*) __ __ __ __

RESIDENTS ABSENT DUE TO HOSPITALISATION IN AN ACUTE CARE HOSPITAL __ __ __ __

OCCUPIED BEDS __ __ __ __

ELIGIBLE RESIDENTS, PRESENT (at 8 AM) IN THE FACILITY FOR AT LEAST THE PREVIOUS 24 h __ __ __ __

- RESIDENTS OVER 85 YEARS __ __ __ __
- MALE RESIDENTS __ __ __ __
- RESIDENTS RECEIVING ANY SYSTEMIC ANTIMICROBIAL THERAPY __ __ __ __
- RESIDENTS WITH SIGNS OR SYMPTOMS OF AN INFECTION __ __ __ __
- RESIDENTS WITH ANY URINARY CATHETER __ __ __ __
- RESIDENTS WITH ANY VASCULAR CATHETER __ __ __ __
- RESIDENTS WITH PRESSURE SORES __ __ __ __
- RESIDENTS WITH OTHER WOUNDS __ __ __ __
- RESIDENTS DISORIENTED IN TIME AND/OR SPACE __ __ __ __
- RESIDENTS USING A WHEELCHAIR OR BEDRIDDEN __ __ __ __
- RESIDENTS WITH SURGERY IN THE PREVIOUS 30 DAYS __ __ __ __
- RESIDENTS WITH URINARY AND/OR FAECAL INCONTINENCE __ __ __ __

HALT-2 Institutional Questionnaire 2013 1

Institutional questionnaire collected general data (ownership, presence of a qualified nurse…), denominator data (total number of available and occupied beds, of hospitalised patients, of patients with signs/symptoms of infection, of AB users, of patients with a urinary/vascular catheter, with incontinence, pressure sores, wounds, disorientation or with an impaired mobility) and information on medical care and coordination, infection control structure and antibiotic policy in the LTCF.

Appendix 2 – Patient Questionnaire

Patient Questionnaire (Page 1)

RESIDENT STUDY NUMBER |_|_|_|_|

Healthcare-associated infections and antimicrobial use in European long-term care facilities (HALT-2)

HSC Public Health Agency

RESIDENT QUESTIONNAIRE

RESIDENT DATA

GENDER	*Male*	*Female*	
BIRTH YEAR	|_|_|_|_| *(YYYY)*		
LENGTH OF STAY IN THE FACILITY	*Less than one year*	*One year or longer*	
ADMISSION TO A HOSPITAL IN THE LAST 3 MONTHS	*Yes*	*No*	
SURGERY IN THE PREVIOUS 30 DAYS	*Yes*	*No*	
PRESENCE OF:			
URINARY CATHETER	*Yes*	*No*	
VASCULAR CATHETER	*Yes*	*No*	
INCONTINENCE (URINARY AND/OR FAECAL)	*Yes*	*No*	
WOUNDS			
- PRESSURE SORE	*Yes*	*No*	
- OTHER WOUNDS	*Yes*	*No*	
DISORIENTATION (IN TIME AND/OR SPACE)	*Yes*	*No*	
MOBILITY	*Ambulant*	*Wheelchair*	*Bedridden*

On the day of the survey, the resident:

☐ *RECEIVES **ANTIMICROBIAL THERAPY*** → *COMPLETE PAGE 2 OF THIS QUESTIONNAIRE*
This includes: (i) Residents on prophylactic antimicrobials
OR (ii) Residents on therapeutic antimicrobials (if commenced prior to admission, no signs/symptoms should be recorded)

☐ *PRESENTS **SIGNS/SYMPTOMS** OF AN INFECTION* → *COMPLETE PAGE 3 TO 6 OF THIS QUESTIONNAIRE*
*Signs/symptoms not present or incubating at admission **AND** patient not on antimicrobials*

☐ *BOTH: **ANTIMICROBIAL USE AND SIGNS/SYMPTOMS (S/S)** OF AN INFECTION* → *COMPLETE ALL PAGES*
This includes: (i) Residents with s/s AND on antimicrobials today (whether or not linked to same infection site)
OR (ii) Residents whose s/s have resolved but who are still receiving antimicrobials for that infection

Important remark:
We strongly recommend you to write the resident study number on each of following pages (right top of each page), in order to keep data of one single resident together.

HALT-2 Resident questionnaire 2013 1

Patient questionnaire was completed for each patient who had *'Condition of interest'*, i.e. **a**] antibiotic use on the day of the survey and/or **b**] infection on the day of the survey. Information was also collected regarding gender, year of birth, urinary/vascular catheter, incontinence [urinary/faecal], pressure sores, wounds, disorientation and impaired mobility [wheelchair/bedridden]:

a) *Antibiotic use on the day of the survey:*

All oral, rectal, intramuscular (IM) and intravenous (IV) treatments with antibacterials and antimycotics for systemic use, drugs for the treatment of tuberculosis and AB treatment by inhalation (aerosol therapy) were included. Antiseptics, antivirals and antimicrobials for topical use were excluded from this survey. The use of local antibiotics was only explored (as a yes/no question) for patients with signs/symptoms of a skin or wound infection or of conjunctivitis. Questions were asked on isolated microorganisms:

- If a culture sample was taken before or at the time the antibiotic was prescribed.
- isolated microorganisms with regard to the treated infection
- antibiotic resistance pattern for eight microorganisms of interest , i.e. *Acinetobacter baumannii* - carbapenem resistant, Enterobacter - 3rd generation cephalosporin R, Enterococcus - glycopeptides R, Escherichia coli - 3rd generation cephalosporin R, *Klebsiella pneumoniae* - 3rd generation cephalosporin R, *Proteus mirabilis* - 3rd generation cephalosporin R, *Pseudomonas aeruginosa* - carbapenem R

b) Infected patient on the day of the survey

Only infections not already present or in incubation at the time of (re)admission could be included. All signs/symptoms (s/s) of an infection presented by the patient on the day of the survey had to be indicated, as well as all signs/symptoms of an infection no longer present on the survey day but present in the preceding days in a patient who was still being treated with an antimicrobial on the survey day.
In order to confirm infections specific criteria were applied. These were based on the McGeer [15] definitions for infection surveillance in LTCFs. Not all of the patients presenting with signs/symptoms of an infection met the criteria required in the definition. The signs/symptoms were not forwarded to the Public Health Agency. Infections recorded were urinary tract infections, skin infections (including cellulitis/soft tissue/wound infections, fungal skin infections, herpes simplex and herpes zoster infections and scabies), respiratory tract, gastrointestinal tract infections, eye/ear/nose/mouth infections, systemic infections (primary bloodstream infections), unexplained febrile episodes and other infections.

Appendix 3 – Infection control and antibiotic stewardship

The institutional questionnaire sought information on medical care and coordination, infection control practice and antimicrobial policy. Some questions within these sections were used to assess seven categories of performance indicators:

I. Clinical governance
II. Infection control (ICC) indicators
III. Hand hygiene (HH) indicators
IV. Protocols for ICC
V. Antimicrobial stewardship indicators
VI. Infection diagnosis/laboratory support
VII. Surveillance

The composition of these performance indicators were built up by attributing a score to the response to specific questions. This information was not passed to the participating facilities in order to prevent manipulation of data to influence the results. The seven categories of performance indicators, the elements that build up these categories, the relevant questions and the score per answer are shown below:

I – Clinical governance **6 points**

D 6. How many 'Infection control committee meetings' were organised in the previous year?

If 0 meetings/year	*0 points*
If 1 meeting/year	*1 point*
If 2 meetings/year	*2 points*
If 3 or more meetings/year	*3 points*

E 4. Which of following elements are present/available in the facility?

If 'an antibiotic committee' = 'Yes'	*1 point*

C 6. Can following persons consult the medical/clinical records of all residents in the facility?

If 'The nursing staff' = 'Yes'	*1 point*
If 'The physician in charge of medical coordination in the setting?' = 'Yes'	*1 point*

II – Infection control (ICC) indicators — 7 points

D 7. If 'Has the facility access to expert Infection Control (IC) advice?' = 'Yes' — *1 point*

D 4. Which of the following tasks are in operation in the facility?

- If 'infection prevention training of the nursing and paramedical staff = 'Yes' — *1 point*
- If 'infection prevention training of the GPs and medical staff = 'Yes' — *1 point*
- If 'developing care protocols' = 'Yes' — *1 point*
- If 'designation of a person responsible for reporting and management of outbreaks' = 'Yes' — *1 point*
- If 'supervision of disinfection and sterilisation of medical and care material' = 'Yes' — *1 point*
- If 'organisation, control, feedback of an audit of infection policies and procedures (on regular basis)' = 'Yes' — *1 point*

III – Hand hygiene (HH) indicators — 5 points

D 12. If 'Last year, was a hand hygiene training session organised, including all the health care professionals from the facility?' = 'Yes' — *1 point*

D 8. If 'In the facility, is a written protocol available for: hand hygiene?*'* = *'Yes'* — *1 point*

D 10. In the facility, which of following products are routinely used for hand hygiene?

- If 'Alcohol rub solution' = 'Yes' — *1 point*
- If 'Liquid soap' = 'Yes' and 'Bar soap' = 'No' or 'empty' — *1 point*

D 4. Which of the following tasks are in operation in the facility?

- If 'Organisation, control, feedback on hand hygiene in the facility' = 'Yes' — *1 point*

IV – Protocols for ICC — 6 points

D 8. In the facility, is a written protocol available for:

- If 'the management of MRSA carriers?' = 'Yes' — *1 point*
- If 'the management of urinary catheters?' = 'Yes' — *1 point*
- If 'the management of venous catheters/lines?' = 'Yes' — *1 point*
- If 'the management of enteral feeding?' = 'Yes' — *1 point*

D 4. Which of the following tasks are in operation in the facility?

- If 'Decision on isolation & additional precautions for residents colonised with resistant microorganisms' = 'Yes' — *1 point*
- If 'Offering immunisation for flu to all residents' = 'Yes' — *1 point*

V – Antimicrobial stewardship indicators — 11 points

E 4. Which of following elements are present/available in the facility?

- If 'annual regular training on appropriate antibiotic prescribing' = 'Yes' — *1 point*
- If 'written guidelines for appropriate AB use in the facility' = 'Yes' — *1 point*
- If 'data available on annual AB consumption by AB class' = 'Yes' — *1 point*
- If 'permission from a designated person(s) for prescribing of restricted ABs, not included in local formulary' = 'Yes' — *1 point*

If 'pharmacist providing advice on ABs not included in the formulary' = 'Yes' *1 point*
If 'therapeutic formulary, comprising a list of antibiotics' = 'Yes' *1 point*

E 5. If written therapeutic guidelines are present in the facility, are they on:
If 'Respiratory tract infections?' = 'Yes' *1 point*
If 'Urinary tract infections?' = 'Yes' *1 point*
If 'Wound and soft tissue infections?' = 'Yes' *1 point*

E 7. If 'Is a programme for surveillance of antimicrobial consumption and feedback in place in the facility?' = 'Yes' *1 point*

E 2. If 'Does the facility use a restrictive list of ABs to be prescribed? *(prescription requiring permission of a designated person or not to be used)' = 'Yes'* *1 point*

VI – Infection diagnosis/laboratory support **4 points**

E 6. Do you perform a urine dipstick test for detection of urinary tract infections in the facility?

If 'Routinely' = 'Yes' *2 points*
If 'Sometimes' = 'Yes' *1 point*
If 'Never' = 'yes' *0 points*

E 4. Which of following elements are present/available in the facility?

If 'microbiological samples taken for guidance of best AB choice' = 'Yes' *1 point*
If 'Local (i.e. for that region/locality or national if small country) antimicrobial resistance profile summaries' = 'Yes' *1 point*

VII – Surveillance **3 points**

D 9. If 'Is a surveillance programme of healthcare-associated infections in place in the facility? *(annual summary report of number of urinary tract infections, respiratory tract infections, etc…)' = 'Yes'* *1 point*

E 8. If 'Is a programme for surveillance of resistant micro-organisms in place in the facility? (*annual summary report for MRSA, Clostridium difficile, etc…*)' = 'Yes' *1 point*

D 4. Which of the following tasks are in operation in the facility?

If 'Feedback on surveillance results to the nursing/medical staff of the facility' = 'Yes' *1 point*

Public Health Agency, 12–22 Linenhall Street, Belfast BT2 8BS. Tel: 0300 555 0114 (Calls charged at local rate).
www.publichealth.hscni.net

05/14

PHA/04/05/14

Performance Management Report – Corporate Business Plan and Commissioning Plan Direction Targets for Period Ending 31 March 2014

May 2014

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	15 May 2014
Title of Paper	Performance Management Report – Corporate Business Plan and Commissioning Plan Directions Targets for Period Ending 31 December 2013
Agenda Item	10
Reference	PHA/04/05/14

Summary

This report provides an update on achievement of the targets identified for the PHA in the Commissioning Plan Directions (Northern Ireland) 2013 and in the PHA Corporate Business Plan 2013-14.

The updates provided are for the period ending 31st March 2014.

The update includes the FIVE Commissioning Plan Direction targets which are highlighted and a further 88 key targets from the Corporate Business Plan. These updates on progress toward achievement of the targets were provided by the Lead Officers responsible for each target. Monthly updates on the Commissioning Plan Direction targets are provided to the DHSSPS.

There are a total of 93 targets. Of these **80** are coded as green for achievability (previously 81 in December), **10** as amber (previously 11) and **3** as red (previously 1).

The status of 7 targets changed during the last reporting period:

- 2 moved from Amber to Red (Target 2.1 linked to Smoking Cessation rates and target 3.19 linked to Tele-monitoring)
- 3 moved from Green to Amber (ref targets 2.18, 3.14 and 6.14)
- 2 moved from Amber to Green (ref targets 4.2 and 6.5)

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This report was brought to AMT on 6 May 2014.
Recommendation / Resolution	For Noting

Director's Signature	
Title	Director of Operations
Date	2 May 2014

DRAFT

PERFORMANCE MANAGEMENT REPORT

Monitoring of Targets Identified in

The Commissioning Plan Directions &

Corporate Business Plan 2013 - 2014

March 2014

Overview

This report provides an update on achievement of the targets identified for the PHA in the Commissioning Plan Directions (Northern Ireland) 2013 and in the PHA Corporate Business Plan 2013-14.

The updates provided are for the period ending 31st March 2014. The previous update related to the period ending 31st December 2013.

The update includes the FIVE Commissioning Plan Direction targets which are highlighted and a further 88 key targets from the Corporate Business Plan. These updates on progress toward achievement of the targets were provided by the Lead Officers responsible for each target. Monthly updates on the Commissioning Plan Direction targets are provided to the DHSSPS.

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The status of 7 targets changed during the last reporting period:

- 2 moved from Amber to Red (Target 2.1 linked to Smoking Cessation rates and target 3.19 linked to Tele-monitoring)
- 3 moved from Green to Amber
- 2 moved from Amber to Green

1. PROTECTING HEALTH

Target from Corporate Business Plan	Progress	Achievability June	Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
1.1) Work with emergency preparedness colleagues in the HSCB and BSO and multi-agency partners to prepare for major events in Northern Ireland in 2013.	The Major events Project Group (PHA: HSCB: Trusts & DHSSPS) was established in January 2013. This Project is managed by Dr A Wilson and reports to the FWME group. As of the 31ST Dec – three major events have been successfully managed during 2013.	G	G	G	G	
1.2) Introduce new and revised vaccination programmes directed by DHSSPS, specifically rotavirus, meningococcal, shingles and expanded flu vaccinations.	Progress: "Changes made to infant Men C programme from 1 June on schedule, no significant problems encountered. Introduction of Men C vaccine for year 11 children on schedule for introduction in new school year. Rotavirus vaccine successfully introduced from 1 July, again no significant problems with introduction. Extensive training for both programmes was held throughout NI in April and May. Plans for introduction of shingles vaccine and flu vaccine for healthy children (2 & 3 year olds and P6s this year) are on course. There are significant logistical problems associated with both programmes but these are being addressed and it is anticipated that they will both proceed satisfactorily."	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
1.3) **By March 2014, secure a further reduction of 23% in MRSA and Clostridium difficile infections compared to 2012/13** **(DHSSPS Commissioning Directions target)**	This HCAI reduction target is a composite target comprising individual Trust reductions in MRSA and CDI cases to be delivered during 2013-14 financial year. The regional CDI improvement target for 13/14 was delivered – 310 cases were reported compared to an upper target of 324 cases. Within this regional position three Trusts (Belfast, Southern and Western) delivered their individual CDI targets. South-Eastern Trust was very slightly above its individual CDI target (56 cases reported v's 55 cases target). Northern Trust breached its individual CDI target (64 cases reported v's 56 cases target). The regional MRSA improvement target for 13/14 was not delivered - 62 cases were reported compared to an upper target of 46 cases. Within this regional position one Trust (Belfast) delivered its individual MRSA target. The remaining four Trusts breached their individual target for MRSA - Western 12 cases (target = 6); Northern 12 cases (target = 8 cases); Southern 5 cases (target = 3); South-Eastern 15 cases (target = 9).	*A*	*A*	*A*	*A*	A joint PHA/HSCB Team met with Western and Northern Trusts in late 2013 to discuss MRSA cases reported in-year and to reflect/identify learning for further improvement. The MRSA position has been discussed at CMO/Medical Leaders Forum meeting on 24th Feb and at DPH/Med Directors meeting on 10th Mar 14. PHA is leading a short-study of MRSA across all Trusts. This work will identify areas for focus and targeted improvement going forward. PHA HCAI Team has completed the first phase of data analysis supporting peer-group comparisons for MRSA and CDI (NI Trusts with peer group Trusts in England). Phase 1 analysis has been shared with all Trusts. A second phase of analysis is also being undertaken to further support discussions relating to MRSA and CDI improvement in-year (14/15 FYR). Based on peer group analyses and related discussions with Trusts, PHA will make recommendations to DHSSPS in respect of 14/15 reductions/targets.

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
1.4) The PHA will plan, coordinate and implement appropriate health protection public information campaigns, in accordance with the new Government Advertising Unit protocols for campaign development.	Sign-off by DHSSPS of allocation for campaign advertising for 2013-13. Campaign planning (to include health intelligence) completed for flu immunisation, obesity, and stroke.	*G*	*G*	*G*	*G*	
1.5) Ensure that the Northern Ireland Flu Pandemic Preparedness and Response Guidance is incorporated in PHA/HSCB/BSO Pandemic Flu Plans.	Currently on track.	*G*	*G*	*G*		

2. IMPROVING HEALTH AND WELLBEING & TACKLING HEALTH INEQUALITIES						
Target from Corporate Business Plan	**Progress**	**Achievability**				**Mitigating actions where performance is Amber / Red**
		June	Sept	Dec	Mar	
Give Every Child the Best Start in Life						
2.1) Extend the Roots of Empathy programme with schools on a planned basis with 46 new schools recruited to the programme and ongoing research through RCT.	Roots of Empathy is being delivered in 119 primary schools in Northern Ireland within 2013/14 including 20 new schools and 99 continuing schools. The programme is particularly relevant where school populations are diverse. 6 of the current schools have Traveller children attending. The overall profile of schools running the programme exceeds the growth and phased development target of 70 schools set for 2012/13. RCT research is continuing and interim findings recorded.	G	G	G	G	
2.2) Commission delivery of an Infant Mental Health Training Plan for key staff, on parent child interaction which will promote infant brain and emotional development including Infant Mental Health Diploma, Video Interactive Diploma, Video Interactive Guidance, Solihull approach and short courses.	Video Interactive Training has taken place in Belfast and has recruited staff from all five Trusts and from Surestarts, Barnardos and Action for Children. The M9 Diploma in Infant Mental Health has fully recruited staff delivering family support across all areas of Northern Ireland including from Surestarts, Barnardos and Action for Children. The Solihull training programme has been set up through the Clinical Education Centre and will recruit and deliver within all five Trust areas to 100 Early Years and Health and Social Care (HSC) staff.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
2.3) Commission delivery of five new Early Years Intervention Programmes through Government's Delivering Social Change initiative: Incredible Years, Strengthening Families Programme, Parenting ur Teen, Triple P and Infant Mental Health Training.	Incredible Years, Parenting Your Teen programme and Infant Mental Health training have all been commissioned and are being delivered. An outline business case for 'Triple P' was developed with a view to potential procurement in 2014/15, however, based on considerable local engagement, feedback has indicated that the programme commissioned for Tier 3 families has not proved to be successful locally. In addition, there are concerns with the research findings of the programme elsewhere in the UK, combined with the multi-media commissioning of this programme. The resources will be diverted to expand the remaining 4 key signature parenting programmes.	G	A	A	A	The Department for Health Social Services and Public Safety (DHSSPSNI) has informed stakeholders regarding the re-profiling of funding and targets for the programme in Years 2 and 3. A tender specification and procurement process is being developed for 2 year services. Strengthening Families Programme additional services have been agreed and implemented for northern, south eastern and western areas and a specification for new services has been developed for Belfast and southern areas for delivery within 2013/14-2015/16.
2.5) Develop breastfeeding peer support programmes in areas where breastfeeding rates are low; monitor the impact and expand capacity incrementally over the next three years, with support workers making contact with a minimum of 60% of all breastfeeding mothers.	Baby friendly initiative (BFI) assistant has been appointed to provide peer support in BHSCT area. WHSCT and SHCT currently recruiting a similar post. NHSCT area now also included in the programme and a post currently being 'matched' by HR.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
2.6) Scope existing health improvement programmes for those with physical and sensory disability and develop/adapt public health information to meet the needs of people with physical and sensory disability.	Progress continues with piloting input from physical and sensory disabled service users in relation to AAA Screening Programme, to ensure all needs are considered and to potentially increase uptake of service. Final draft of a AAA case study will be tabled at the Information and Training Workstream in April 2014. A Checklist is in early developmental stages. It is anticipated that this resource could be added to the PHA Communication Toolkit and will be used by staff when developing public health campaigns/resources. Early exploration of the development of a resource to include prevention messages for people with hearing loss.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
2.7) **Improve long-term outcomes for the children of teenage mothers by rolling out the Family Nurse Partnership Programme to commence work on one further site** **(DHSSPS Commissioning Directions target)**	Family Nurse Partnership (FNP) is becoming well established in NI and last year has been the consolidation of the programme in the West as well as the establishment of two new teams – one in Belfast and one in the Southern area. The Western team have 112 mothers enrolled, Southern 53 mothers (commenced September 2012) and Belfast has 23 mothers (commenced January 2013). The PHA as the FNP licence holder provides the leadership and strategic direction through a small central team. The central team have well developed priorities and plans in place and are currently developing quality infrastructure and information systems. The central team have drafted the first annual report which is due for approval by the PHA in the coming weeks. The report has been shared with the FNP International team for comment. In addition, Family Advisory Boards has been successfully established and have met on two occasions. Board members have now developed and approved an extensive plan for stakeholder engagement. Plans are being progressed to establish a Regional Programme Board and initial discussions with the Chief Executive regarding leadership of the programme board have taken place. The PHA Chief Executive, Director of Nursing and Central team have had the first accountability review meeting with the international team. The progress was well received by the international team.	G	G	G	G	

	The three FNP teams continue to recruit to the Programme. The Family Nurses are learning to deliver the programme well. The Information System is up and running and the teams are now able to monitor programme fidelity and client outcomes. At the end of this quarter, there are 222 Clients enrolled on the Programme. The West team has 114 clients, the Southern team has 80 clients and the Belfast team has 38 clients. Preliminary planning is underway to consider the expansion of FNP to South Eastern and Northern Trusts. Satisfactory Progress achieved-The West team has now126 clients ,the Southern teams now has 100 clients and Belfast team has 52 clients. Satisfactory progress achieved with Programme implementation. The West site has 229 mothers, Southern site has 102 mothers and Belfast site has 54 mothers. The quality testing of the database reports is underway.					

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
Ensure a Decent Standard of Living						
2.8) Develop and implement programmes which tackle poverty (including fuel poverty) and maximise access to benefits, grants and a range of services, including delivery of the detailed action plan for the MARA programme.	MARA project rollout is progressing as planned with all locality offices now engaged. Over 10,525 first visits and almost 7,000 follow up visits completed • levered £1,288,832 energy efficiency • 3,783 households accessed Home Safety advice and equipment • welfare claims £534,526 so far • 509 referrals to rural transport • 34 Smart Pass • 301 boiler replacements £199,300	G	G	G	G	
2.9) Establish programmes that address employability and the needs of long term unemployed people with a focus on skills development and opportunities for training and employment within the health and social care sector, including development of 'Belfast Works' model.	The development of a Belfast Works Model has been proposed to the Belfast Strategic Partnership as a demonstration model for collaborative activity to address employability. Scoping exercise well advanced. Study visit to Glasgow complete. Application to Strategic Investment Fund has progressed to decision-making stages.	A	*A*	A	A	The implementation of this model in the short term is reliant on the outcome of a Social Investment Fund (SIF) application for west Belfast. BSP project would bring a unique role of the SIF proposal which would enable progress in the short term. If the SIF application is unsuccessful, this programme will require more long-term development.

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
2.10) Support social economy businesses and community skills development using the power of the HSC sector through public procurement; including 'Possibilities Programme' which aims to develop capacity of social economy businesses.	The Possibilities programme ran successfully until end March 2013. However, after seeking advice from BSO PaLS, the decision has been taken not to proceed to tender for an organisation to provide support to social economy businesses going forward, as new guidance is clear that PHA should not provide capacity building support in relation to HSC procurement.	G	G	R	R	PHA will now investigate how it can raise awareness of HSC procurement opportunities with social enterprises and community and voluntary sector organisations, and work with local authorities and others to build skills and capacity within SE and C+V sectors.
Build Sustainable Communities						
2.11) Support incremental expansion of programmes to support development in the most disadvantaged communities, including Northern Ireland New Entrant Service and mapping of community assets for health and wellbeing in top 20% most disadvantaged areas in NI.	The Northern Ireland New Entrant Service (NINES) provides screening and health promotion clinics.	A	A	A	A	The NI New Entrant Service (NINES) continues to experience a high demand for services. A business case has been submitted from HSC Trusts for additional funding to meet service pressures. Service to be provided in partnership with LCGs and is anticipated to progress during 14-15.
2.12) Establish a cross-sectoral coordinated approach and agreed Action Plan to meeting the health and wellbeing needs of homeless people, in line with DSD Social Inclusion Strategy.	The PHA has established a Regional Working Group on Health and Homelessness. Action plan has been agreed with a number of workstreams in place.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
2.13) Contribute to the delivery of the Northern Ireland Prison Service and Social Wellbeing strategy through 'Whole Prison Approach'.	Appointment of a Health and Social Wellbeing Improvement Officer in the south eastern area completed. Health Development Specialist for Suicide and Prison Services commenced employment in March 2014. Links with Northern Ireland Prison Service staff continues to be made embedding the 'Whole Prison' approach into training for new recruits and existing staff.	A	A	G	G	
2.14) Develop a coordinated approach to the provision of training for HSC staff to increase their understanding of the specific health needs of LGB&T to ensure that services are 'LGB&T friendly'.	An e-learning package entitled 'Lesbian, Gay, Bisexual and Transgender (LGB&T) – Creating inclusive workplaces' has been developed and circulated to Health and Social Care (HSC) organisations. This supports staff to address health and social wellbeing inequalities faced by LGB&T people and to inform them of differences between sexual orientation, gender identity and the wider equality implications. A dedicated website also been developed and is scheduled to be launched in 2014.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
2.15) Establish a new model of services to reduce social isolation of older people and increase social engagement opportunities.	New investment in 2013/14 (£320k) has been used to reduce the risk of social inclusion and lever additional support from HSCB/LCG. The model taken in utilising this resource focuses on two core approaches: firstly maintaining opportunities for older people to remain engaged with their peers and others in their immediate community, such as through participation in health programmes, supporting the maintenance of social networks, improving signposting and support to access services across local communities and new opportunities to engage in alternative approaches and social activities such as arts and health programmes. Secondly, through targeted services aimed at those who are "at risk" of social isolation through the development of targeted interventions such as befriending and volunteer visiting and targeted help to improve access to help services from across a range of agencies and providers such as day care, community safety services, neighbourhood support programmes and so forth.	G	G	G	G	
2.16) Ensure the provision of coordinated advice, information and signposting to improve access and uptake of HSWI services by older people in all five localities.	Work continues in all five localities with Local Commissioning Groups (LCGs) and HSC Trusts as part of the Transforming Your Care (TYC) reform and modernisation programme for older people's services. Support has been given to the development of service modernisation plans and joint working to develop and invest in new service models such as 'community navigators' is underway.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
2.17) Establish a coordinated, multi-faceted Falls Prevention Service in line with NICE guidance that will improve the provision of advice and information, signposting to vision and audiology screening, strength and balance training and other support services.	Regional workshop completed to consider evidence and position paper produced to inform PHA position in line with NICE guidance. Work is ongoing in each of the five localities with LCGs, IPTs and Trusts to agree a coordinated way forward that will support compliance with the Older Peoples Service Framework and Regional Commissioning Specifications. Work also continues with PHA Nursing and AHPs to improve linkage across falls service developments.	G	G	G	G	
Make Healthier Choices Easier						
2.18) Extend the service model for alcohol and substance misuse liaison services within the hospital setting, ensuring that such services can respond to drug misuse, self-harm and associated mental health issues.	This area is included in the HSC Board/PHA commissioning plan and identified as a priority for funding by HSCB. HSCB is still finalising its Investment Plan in light of wider financial pressures that need to be considered. Service development proposal will be considered at the Hospitals Related Commissioning Team group meeting 8 April 2014.	A	G	G	A	HSCB has submitted a bid for additional funding under the June monitoring round to secure the necessary funding to allow this development to progress in 2014/15.

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
2.19) Increase uptake of stop smoking services, in particular with young people, pregnant smokers and disadvantaged adults by 10%.	Approximately 9% of smokers in NI used the NI Stop Smoking Services in 2012/13 year, however there was a 17% decrease in overall uptake of services compared to 2011/12. Monitoring data downloaded on 3rd March for 13/14 year has shown service uptake is continuing to show a decrease in all target groups. Based on 12/13 – 13/14 comparisons, Uptake overall is down by 21% Uptake by pregnant smokers is down by 11%, 11-16 year old uptake is down by 8% and uptake of routine and manual smokers is down by 20%. It is anecdotally reported that e-cigarettes are having a negative impact on service uptake. On a more positive note, quit rates have climbed to 58%, compared to 56% in the first three quarters of 2012/13.	A	A	A	R	The new NI smoking campaign 'Make them proud' and 'Stop for good' was released on 10 September 2013. The campaign was aired September through October and December through to March 2014. In addition, a promotional/signposting campaign across NI, using a bus during the month of February 2014 is to be implemented. Advertising and No Smoking Day activities will be undertaken to increase recruits to services. KPIs have been set to increase service uptake in 2013/14, which detail LCG area targets for all smokers and in relation to the specific target groups within the Ten Year Tobacco Strategy. Service uptake will continue to be monitored on a quarterly basis. With only one quarter of the year remaining, it is unlikely the overall target will be met, but local discussions indicate that targets may be met for pregnant smokers. Targets will be revised for 2014/15 when full year data is available (June 2014). 2014/15 year targets will be set in conjunction with TSISG.

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
2.20) Lead and support implementation of the PHA 'Weight4Baby' pilot project which will target all pregnant women with a BMI> 40 with the aim of limiting gestational weight gain and helping obese mothers to lose weight following birth.	Pilot has commenced as planned in all HSC Trusts, training of support staff remains on going. Evaluation tender has been awarded to University of Ulster.	G	G	G	G	
2.21) Develop a pilot Community Pharmacy Emergency Hormonal Contraception Service taking into account the outcomes of the RQIA review, working closely with Integrated Care Pharmacy Services.	PHA continues to work with the Department of Integrated Care, Pharmacy Division. A specification for the service is in place and the Patient Group Direction (PGD) is completed. Community Pharmacies in North and West Belfast have received training.	G	G	G	G	
2.22) The PHA will plan, co-ordinate and implement a range of appropriate health improvement related Public Information Campaigns in accordance with the new Government Advertising Unit protocols for campaign development.	Sign-off by DHSSPS of allocation for campaign advertising for 2013-14. Campaign planning (to include health intelligence) completed for mental health, smoking and bowel cancer and organ donation.	G	G	G	G	

3. IMPROVING THE QUALITY OF HSC SERVICES						
Target from Corporate Business Plan	**Progress**	**Achievability**				**Mitigating actions where performance is Amber / Red**
		June	Sept	Dec	Mar	
3.1) Through our commissioning arrangements, PHA will work with HSCB to develop a Commissioning Plan and secure Board approval	The PHA has continued to work with the HSCB to ensure that the Commissioning Plan is developed in line with the Commissioning Plan Directions 2014/15, Departmental guidance and timescales. PHA Board approved the draft plan in March 2014.	G	G	G	G	
3.2) Work with HSC and DHSSPS to implement the Quality 2020 Strategy, and develop proposals for Phase 2.	All tasks are progressing well. Four of the Task Groups for 2013/14 will be continuing their work into 2014/15. These will be: Task 2 – Annual Quality Reports; Task 3 – Policy Framework; Task 4 – Leadership competency framework and system; Task 5 – E-learning system design and procurement (this will expand to develop minimum training content for Nurses and Social Workers). The work of these groups will continue as they have now evolved into new phases of development and delivery.	G	G	G	G	

	Four New Tasks for 2014/15 have been discussed with the Steering Group. At present, Task 10 – WHO Curriculum on patient safety, to be included in all undergraduate training for all health and social care professionals, has been agreed. Initial work has started on the Terms of Reference and project objectives for a Task Group. A scoping exercise is being carried out around Task 11- Minimise Variation in Trust operational processes to lead to the creation of 'a single regional approach across the HSC to key issues'. Task 8 and 9 are currently being discussed further with the Co-chairs and key senior staff within the Department of Health.					

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.3) Continue to roll out the implementation and monitoring of the Patient and Client Experience Standards throughout the HSC Trusts by: • Developing and agreeing an annual workplan with HSC Trusts and the mechanisms for reporting on findings; • Collecting up to 10,000 patient stories to inform the effective delivery and commissioning of high quality, person centred services.	Monitoring and improvement has been on-going throughout 2013/14 – an annual analysis report will be completed at end of year (June 2014). A workshop was held in March 2014 and work plan, which focuses heavily on improvement whilst continuing an element of monitoring for 2014/15 was agreed. This will be presented to the PCE Steering Group for approval. **10,000 voices** Phase one, which focused on unscheduled care has been completed but will remain live until 31st March. Phase two which focuses on 'Care in the Home' is now live. A NIAS specific survey is on-going which focuses on both emergency and non-emergency vehicles. In addition, a KPI survey has been on-going in parallel with other surveys and the Trust facilitators focus a proportion of their time on this area. Analysis workshops have taken place throughout each of the Trusts and both local and regional reports have been developed which identify local priorities with associated action plans for implementation.. 2800+stories have been collected in total.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.4) Develop a range of nurse sensitive KPIs and methods for collecting regular data and information.	Three regional KPIs which were tested and piloted in 2013/14 have been agreed for 2014/15, these include: • Pressure Ulcer • Falls • omitted medicines – currently considering looking at critical medicines omissions Consideration is being given to develop a KPI around the area of work-force. **Phase Two** • 3 KPIs below being considered as part of phase 2, to include the compliance assessment and reporting arrangement document: 1. Early warning scores 2. Professionalism 3. Nutrition • Regional approach for data input, analysis, results and monitoring approved. Agreement gained that HSC Trusts will report to PHA quarterly. Definitions of each indicator to be agreed.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.5) Carry out nurse workforce planning exercises in a range of acute hospital areas as agreed by the DHSSPS.	The PHA has completed the first phase of the normative staffing project. This first phase examined the range of nurse staffing required to provide safe and effective care within acute general medical and surgical settings. A framework document has been produced and is currently being published. The work is led by the PHA Nursing Team as requested by the Minister and supported by NIPEC. The work was signed off as a policy document by the Minister this year. A regional Task and Finish Group has been set up led by the PHA, to determine the investment implications of **Phase 1.** The aim of this group will be to implement the DHSSPS policy recommendations of the Phase 1 report alongside a mapping exercise of baseline data submitted from HSCTs from Acute medical and surgical wards. Work is progressing with HSCB members of the Task and Finish Group to complete a financial analysis of the total nursing costs submitted by the HSCTs and compare the indicative costs for normative nursing levels to be in place across all surgical and medical wards in Acute Hospital sites. **Phase 2** of the work focused on the workforce requirements for ED services. This work has been now been reinstated since February 2014. A workshop was held on the 3rd March 2014 with ED nursing staff from all HSCTS . The RCN lead for Best, JP Nolan, presented the national Audit findings of the use of the BEST tool in the UK. It has been agreed that the application of the Audit	G	G	G	G	

	exercise would need to be ongoing in all HSCTs in Northern Ireland. The PHA are co-ordinating a visit to Northern Ireland for JP Nolan to present the findings to senior staff and Unscheduled commissioning staff to agree a process to take this phase forward as part of the implementation. A review of the Scottish ED tool will also be considered in May. **Phase 3** of the work plan involves a review of District nursing workforce in Northern Ireland. A literature review is under way with the University of Ulster, funded by the PHA. This work will be completed in May 2014. A regional benchmarking exercise is underway to scope the current workforce within district nursing across all HSCTs . The development of version 4 of a regional eCATS tool for caseload analysis for community nurses has been developed regionally. This tool will be utilised to inform the development of a regional workforce tool for Northern Ireland and assist with testing and benchmarking against national tools including Scotland. It has been agreed that a caseload range and workforce range per population size will be developed for core district nursing teams in Northern Ireland. This work should be completed by the end of 2014. **Phase 4** of the work focuses on Health Visiting. This phase will build on the work completed by the PHA to develop consistent caseload profiles and activity for health visiting teams in line with Healthy Child Healthy Future. In addition, a competency					

	framework for introduction of regional skill mix is being developed. The implementation and roll out regionally of the eCATS (electronic caseload weighting tool) has resulted in generation, retrieval and use of data to give an initial indication of regional caseload size, make up and context. Building on the regional improvement work that is underway, a work plan has been established by the Public Health Agency to review the existing models of practice and to develop an HSCB/PHA commissioning framework for community nursing. The purpose is to ensure that current service models and workforce meets the requirements and needs of patients in the community. This work plan will result in the development of a commissioning framework including a review of the models of service that incorporate agreed levels of intervention at local geographical area for district nursing services, how they integrate with primary care partners, and what recommendations need to be considered for any areas of improvement. A steering group will take forward this element as a Task & Finish Group in early 2014.					

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.6) Lead, on behalf of the DHSSPS, the implementation of the Northern Ireland Maternity Strategy, including promoting safe and effective care.	This is a shared objective with the HSC Board. A project manager took up post on 1st October 2013. A number of pieces of work have been ongoing to progress the strategy: PHA are leading on a significant number of health improvement programmes targeting women of child bearing age and women both ante and postnatal. Promotion of the normalisation of pregnancy and birth is being led by a Maternity Quality Improvement Group facilitated by the HSC Safety Forum and all HSC Trusts have agreed to be a part of this process. All Trusts have developed and are implementing 'Normalising Birth' action plans. Significant work has been taken forward on information and data systems including NIMATs. The PHA in conjunction with NIPEC have commenced a regional review of community maternity care which will help to progress the Maternity Strategy's objectives. A scoping study of the maternity needs of minority ethnic and migrant women in Northern Ireland has been undertaken. The regional maternity hand held record is being updated and the 'Pregnancy Book' has been updated for 2014/15. These are provided to all pregnant women to keep them informed about their pregnancy. A regional communication pathway between	A	G	G	G	

	midwives and health visitors has been developed. The PHA (Mrs Cullen and Dr Harper) are Chairing a new Maternity Strategy implementation group and the first meeting will be on 16 May. This group will have all key stakeholders involved including PHA, HSCB, Trust, DHSSPS and User membership and will aim to co-ordinate all the on-going projects to implement the maternity strategy A regional project to develop a pathway for multiple pregnancies is being taken forward by the PHA/HSCB. In conjunction with this Trusts are to develop a regional networked service model and care pathways for the management of multiple pregnancies in line with NICE CG 129. A meeting with Trust clinical staff is to happen in early April to try to agree a draft regional pathway. A workshop is to happen in June to discuss the regional pathway for diabetes in pregnancy to ensure that practice in NI reflects NICE guidelines. The Maternity strategy team have agreed to take on production of the regional maternity dashboard on a monthly basis and this is now available for all trusts on a monthly basis from NIMATS, with some input from PAS. The report format is being finalised and will be shared with Patient Safety Forum colleagues and then trusts. It is intended that this data will form part of the core dataset that will be generated each month for use by trusts, PHA and HSCB to understand key trends in relation to maternity services.					

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.7) Lead, on behalf of the DHSSPS, the implementation of the Promoting Good Nutrition Strategy.	• Promoting Good Nutrition Regional Steering Group meet regularly • Further work need to be completed to confirm a work plan, with the focus on protected meal times and food first. • Promoting Good Nutrition will continue to link with the specialist services team members to progress the regional model for parenteral nutrition. • A Project Initiation Document to undertake review of multi-professional education and training is complete. • Work is continuing with the parental nutrition sub – group including commissioning on the development of a regional service model for patients with Intestinal failure including those requiring long-term parental nutrition. • Trusts continue to implement the 10 key characteristic across services • A scoping exercise across all Trusts is completed, to establish what has been achieved locally on the strategy implementation in all care groups. • Regular meetings have been held with CNO regarding the three strands of Promoting Good Nutrition. In addition, further meetings between PHA and CNO have been arranged to discuss progress and how to advance this work. • NIPEC resources on nutrition were launched at the CNO conference and are now available on line through the DHSSPS web-site and also link with the regional ECR project. • Workshop was held in Feb to review workplan for 2013/14 and develop projects for 2014-15.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.8) Implement the pilot phase of the Regional Adverse Incident Learning System (RAIL) and work towards development of the Full Business Case.	• Business Case submitted to DHSSPS in April 2013. • DHSSPS plan to commission RQIA to conduct a 6-9 month review of all incident reporting systems and how assurances are gained. • Regional Learning System project team based in PHA to undertake a review of reporting systems (external project team).	G	G	G	G	
3.9) Monitor and report on the performance of the Trusts against their Quality Improvement Plans (QIPs) and action plans which have been submitted to the PHA (the QIPs will reflect the commissioning plan targets/indicators).	Framework developed focus on the Quality Improvement Plans 2014/15. In line with commissioning requirements, HSC Trusts are required to submit for approval their Quality Improvement Plan (QIP), which will take account of quality improvement indicators and priorities required by the Commissioner in response to DHSSPS Commissioning Plan Direction. HSC Trusts are expected to include local quality improvement priorities in addition to the core commissioning requirements. • HSC Trusts provide quarterly assurance reports. The PHA has developed a standardised reporting mechanism to obtain statistical data on core quality improvement indicators. A reporting schedule has been developed to ensure timely review of data received - reports from Trusts, received, analysed and monitored quarterly • Annual work plan established - Indicators, Definitions and framework agreed. • Engagement with PMSI and Health Intelligence support. • Schedule of reporting established, SharePoint submissions template agreed and in use.	G	G	G	G	

	• Provide Senior Management Team with reports on Trusts performance with Commissioning plan quality and safety indicators. • New reporting schedule proposed for VTE • 2014-15: 4 QIPs identified in Commissioning Plan: Falls, Pressure Ulcers, VTE and Sepsis 6. • Workshop held (March 2014) to agree definitions and reporting schedule for 2014/15 QIPs. • Concerns escalated to DoN and Directors Bi-Monthly performance meeting.					
3.10) Develop a regional collaborative to promote the concepts and clinical practices which underpin Normalising Childbirth in line with the 2012 Regional Maternity Strategy.	• Maternity QI Advisory group established with the first meeting held 6th July – Chaired by an Obstetrician • Driver Diagram for the collaborative agreed • Regional maternity dashboard agreed • Maternal combined antenatal/postnatal EWS in pilot stage • Regional In Utero transfer proforma finalised • Regional Intrapartum CTG sticker updated, antenatal version in developmental stage. • First learning session planned 1st November 2013 • Maternity advisory (sub)group has developed EWS for antenatal and postnatal patients as requested. • Planned revision (after 18 months) of CTG sticker completed. • Returns from Trust re Maternity dashboard improving. • First LS for Normalising childbirth in late October. All Trusts have given commitment to attend. • 2nd Learning Set held in April 2014 with focus on management of maternal sepsis	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.11) Develop a regional approach to improving care of the deteriorating adult patient – to include use of a physiological early warning scoring tool and arrangements for appropriate intervention and escalation as outlined in HSS(MD) 39/2012 and the NCEPOD report 'A time to intervene.'	Regional NEWS Working Group established. Agreement from all Trusts to develop unified regional approach. All Trusts agreed to adopt the National Early Warning Score Chart Trusts ensuring response and escalation protocols in place as per NEWS system. Trusts co-ordinating training of staff using e-learning system for NEWS. This will facilitate a standardised system for early detection of acutely unwell patients. Also, Safety Forum spoke at new Junior Doctors Induction in Lagan Valley Island on 5.8.13 to raise awareness re NEWS. All Trust on track re staff training and escalation plans. All Trusts agreed to meet in Nov to review escalation arrangements and agree audit on NEWS effectiveness in Q4 Delay in some Trusts due to hold up in printing of NEWS charts. Expected to be resolved before end of October. All Trusts have now moved to using NEWS Trusts agreed regional audit chart and audit carried out in February 2014	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.12) Continue the regional collaborative in Emergency Medicine, building on the agreed quality indicators and extending the work to promote improvement in other significant areas of practice.	Sustained improvement in the timely management of severe sepsis as evidenced by compliance with severe sepsis care bundle. Advisory Group continue to meet to steer the work of the collaborative. Now working on measures of crowding and ways to avoid or mitigate. Learning session planned for the 1st November to look at flow and crowding in the ED. Mike Davage from the 1000 lives programme in Wales is attending. Work commenced with NIAS around standardisation of ambulance handovers and definitions of stand by calls	G	G	G	G	
3.13) Continue the regional collaborative in Nursing Homes, sustaining the progress on falls prevention and spreading this across the system. To promote improvement in other areas of practice including hydration, nutrition and preventing skin pressure damage.	Learning Set 5 of the Nursing Home collaborative was held in May 2013. Homes continue their work on falls prevention. There has been a reduction in the falls rate per 1000 beds days of approximately 25% across all participating homes. A 2nd focus of improvement work has now begun on prevention dehydration with homes being asked to test out a number of interventions. A Driver Diagram has been developed and a learning set was held in November 2013. Homes in the collaborative continue to use the FALLS PREVENTION toolkit which is now available on PHA website for spread but poor uptake by NHS in general.	G	A	G	G	

	Have had discussions with RQIA as to how we might encourage uptake. Homes in collaborative have commenced work on ensuring HYDRATION. There has been some difficulty in progress due to staff turnover in homes, release of staff and management changes. The Safety Forum are currently in talks with RQIA regarding this increasing interest. At learning set in November, participating homes proposed further QI work to link with forthcoming RQIA themes for inspection 14/15 Safety Forum met with RQIA and this was agreed then attended Provider Sessions in February to ask for expressions of interest from other nursing homes Learning Set 8 held on 1.4.14 with focus on nutrition and pressure ulcer prevention Additional homes joined Learning Set					

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.14) Review AHP support for Children with Special Needs within Special Schools and Mainstream Education, through a scoping exercise of current provision and current delivery models.	The review of AHP support for children with statements of special educational needs is underway. The Project Chair is Dr Eddie Rooney, Chief Executive of the Public Health Agency and the Project Lead is Mary Emerson, AHP Consultant. The aim of this review is to agree a proposed regional model to best meet the assessed AHP needs of these children. The Project Board is meeting approximately every 6 weeks. All project documents are available on the Public Health Agency website for all stakeholders. The review relates to AHP support for children with statements of special educational needs in both special schools and mainstream education. It is focusing mainly on services for children from Occupational Therapy, Physiotherapy, Speech and Language Therapy, Orthoptics, Dietetics and Podiatry. However, there will also be opportunity for engagement with representatives from other AHP professions working with children, as appropriate. It is planned that the review will be carried out in 3 phases. The decision was taken to focus on AHP support for children in special schools in phase 1 of the review. The end of phase 1 is planned for March 2014.	G	G	G	A	Most actions for phase 1 of the review are complete. However, it was recognised at the outset that data gathering would be a challenge. Data is still coming back from Trusts and from parents/carers and needs to subsequently be analysed by Health Intelligence colleagues who are dedicated to this project. In addition, it was agreed by the Project Board that engagement with children would be most appropriate with a 3rd party organisation skilled and experienced in hearing the views of children with disabilities. However, there were no applications to carry out this work when it first went to tender. This has gone through procurement again and a third party has now been appointed. This delay is therefore temporary.

	Phase 2 will focus on AHP support for children with statements of special educational needs in mainstream schools.(Envisaged timescale April 2014-March 2015) Phase 3 (envisaged timescale April 2015-August 2016) will focus on agreeing a proposed regional model of AHP provision for these children and an implementation plan. Engagement is ongoing with relevant key stakeholders, e.g. Parents/Carers, Children/Young People, Special Schools, Department of Health, Department of Education, Education Boards, AHPs, Health and Social Care Trusts, NICCY, Children's Law Centre, CINI.					

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.15) Implement the role of Medicine Management Dietitians in Northern Ireland through establishing a Regional implementation group with key linkages with Dietetic Services within Trusts. The recruitment of Medicines Management Dietitians will be progressed and reporting arrangements for the delivery of the Medicines Management Dietitian Regional Initiative will be developed.	The Medicines Management Dietitian (MMD) Initiative Steering Group has been established and is lead collaboratively between the AHP PHA Team and the Medicines Management Team HSCB. The Medicines Management Dietetic Initiative Steering Group have an advisory function to support the implementation of this oral nutritional supplement initiative to ensure the appropriate use of oral nutritional supplements across Northern Ireland. This is under the Pharmaceutical Clinical Effectiveness programme and is a key element of the Promoting Good Nutrition Strategy. The current work includes the standardisation of operating procedures, evaluation plan and care pathway development. Clinical assessment of patients has begun with 150patients met inclusion criteria and seen by the MMD 85% of these 150 patients were able to meet their nutritional requirements by dietary manipulation through advice and utilisation of dietitian skills	G	A	G	G	
3.16) Take forward the implementation of the AHP Strategy establishing an implementation group with key stakeholders prioritising actions to be implemented in 2013.	The AHP strategy is now with the Public Health Agency. A regional implementation group has been established and a year 1 action plan agreed. The AHP Strategy Group has met and endorsed the year 1 action plan and key actions are on target for delivery.	G	A	G	G	

Target from Corporate Business Plan	Progress	Achievability June Sept Dec Mar				Mitigating actions where performance is Amber / Red
3.17) Establish a regional working group with all key stakeholders and develop an action plan and communication plan to take forward direct access physiotherapy	• Engagement with stakeholders TYC (HSCB) / information / AHP Leads / Physiotherapy & Chartered society of physiotherapy • Project team finalised during August 2013 • Project board meeting arranged for 3rd November & bimonthly afterwards • First Project team meeting arranged for Nov 2013 & monthly afterwards • PRINCE project structure being formalised through TYC • Expressions of Interest invited Dec 2013 from Trusts to be considered as an early implementer. • Recommendation made to Project Board Jan 14 for SET as early implementer approved • Work ongoing with Trust and Project team to define metrics and shape early implementation plan in SET. • Early implementation plan to be presented to project board March with commencement April. • EI scheduled to begin on 1st May 2014 • Communications engagement in PHA for PR message & for additional comms support with leaflets & publicity • Internal HSCB updates • Briefed LCG Lead for SE LCG • Ongoing preparatory work	R	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.18) Establish a working group of all key stakeholders to develop a neuro physiotherapy model for Northern Ireland, taking account of models of good practice.	• Target date for completion of review in specialist neurophysiotherapy (September 2013) • Engaged with Health Intelligence and Physiotherapy profession • Report will be presented to the Neurology subgroup • Scoping of current neurophysio services complete report compiled. Health Intelligence report being finalised for end of October 2013 on target • Report to neurology subgroup Feb 2014 • HRSCT has agreed a process for the Reform and Modernisation of Neurology Services. Neurological Conditions Subgroup stood down to feed into task & finish groups in new arrangements	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.19) **By 31 March 2014, deliver 500,000 Telehealth Monitored Patient Days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI contract. Projected outturn for 2012/13 against a target of 400,000 days is 300,000 MPD.** **(DHSSPS Commissioning Directions target)**	At the end of March 2014 a total of 435,820 Monitored Patient Days have been delivered with 2,172 people benefitting from the service. This is 87% of the MPD target and 78% of patient target.	G	G	A	R	For the year 2014-15 the target will remain at 500,000 MPD and it is anticipated that this will be met. Currently Trusts are allocated target based on their capitation share, in 2014-15 this will not be the case. Belfast Trust, who have struggled to achieve 40% of their target will have a lower target set with their funding allocation being adjusted accordingly. Other Trusts have indicated they could do more activity if further funds were available.

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.20) **By 31 March 2014, deliver 720,000 Telecare Monitored Patient Days (equivalent to approximately 2,100 patients) from the provision of remote telecare services including those provided through the Telemonitoring NI contract. (DHSSPS Commissioning Directions target**	At the end of March 2014 of a total of 780,090Monitored Patient Days (8% above target) have been delivered to 2,811 clients (34% above target)	G	G	G	G	
3.21) Establish the Long Term Conditions Implementation Group to ensure good practice in long term management, other priorities in Service Frameworks and related NICE Guidance, and support the introduction of patient education programmes as outlined in PFG. Produce an Action Plan within six months.	The LTC Steering Group held a workshop in September to get stakeholder input to the Action Plan. The final Action Plan has now been sent to the Group for sign off prior to submission to DHSSPS by 31 October '13.	G	G	A	A	Negotiations are ongoing with DHSSPS on the final action plan. It is hoped that the final plan will be agreed with DHSSPS by 31 March'14.

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.22) Support implementation of the Eye Care Strategy with HSCB and others.	On schedule as planned	G	G	G	G	
3.23) With HSCB, seek assurance on implementation of the RQIA Report on Children Under 18 in Adult Wards.	On schedule as planned	G	G	G	G	
3.24) Work with HSCB to take forward actions under the Bamford Taskforce.	Joint Commissioning Team (PHA/HSCB) – actions underway.	G	G	G	G	
3.25) Work with HSCB to take forward implementation of Service Frameworks – cardiovascular, respiratory, cancer and mental health.	On schedule as planned	G/ A	G/ A	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.26) Provide an assurance to the Department that HSC Trusts and Family Practitioners Services are meeting their requirements regarding the promotion of reporting, management of and implementation of learning from serious adverse incidents/ adverse incidents and near misses	Arrangements in place regarding dissemination of learning from SAIs, and implementation of Safety Alerts and related correspondence. A review of the Procedure for Reporting and follow-up of SAIs has been completed and approved for dissemination and full implementation by 1st April 2014. Training in relation to SEAs, RCAs and role of DRO has been provided to support this implementation. Regional SAI review Meeting reviews issues and identified regional learning. Dissemination of learning through learning letters and Learning Matters newsletter. Review and analysis of SAIs. Thematic reviews are undertaken when 'clustering' of incidents are identified. Safety Quality Alerts team ensures assurance is gained on regional, departmental advice and policy. Regional Learning System: Project team to be based in PHA and to undertake review of the reporting mechanisms.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.27) Living Matters: Dying Matters – The Palliative and End of Life Care Strategy for Adults in NI. Work will continue to increase the quality of life for people in the last year of life by ensuring that palliative care measures run alongside acute intervention for people with cancer, cardiovascular and respiratory disease , diabetes dementia , frail elderly and those with a physical disability who are at the end of life. This includes in the implementation of the ELCOS model.	The Living Matter, Dying Matters Strategy continues to be implemented across the sectors regional and across both cancer and non- cancer. The implementation of the ELCOS model continues including the capturing the number of people identified with end of life care needs in each of the trust areas continues, the implementation of the keyworker function, and advance care planning. Roll out of postgraduate training across the region on themes such as e.g. advance communication skills, Advance care planning continue across professional groups and specialties. Development of KIS for palliative Care There have been a number of key achievements in the area of palliative care including : • The completion ad positive evaluation of the regional education and development programmes for Nursing Homes. • The Launch of the GAIN and RQIA Guidelines for Palliative and End of Life Care in Nursing Homes. • Delivering Choice - Transforming Your Palliative and End of Life Care programme has commended. The aim is to design and support the delivery of coordinated services to enable people with palliative and end of life care needs to have their choice in their preferred place of care working in partnership with all providers, voluntary sector and communities.	G	G	G	G	

	• Recruitment of the Programme Team has been completed. • Engagement and involvement of all stakeholders has begun at both through regional and locality level through six programme boards. • Data gathering and scoping , has been completed , with the completion of a high level literature review • Identification of the issues has also be completed.					
3.28) Produce a report summarising best practice in PPI across all HSC bodies, as well as identifying any barriers to effective personal and public involvement and means of overcoming same.	The PHA has negotiated an extension to this target to March 2015 with the DHSSPS. This has been formally signed off by the DHSSPS. The call for PPI Research proposals was issued in the summer and closed on the 6th September. Two formal submissions were received. These have been formally evaluated and by an Evaluation Panel co-ordinated by PHA R&D department, this brought together academic researchers, members of the PHA, PCC and service user and carer representatives. Neither proposal was considered sufficient to meet the research specification. Discussions have taken place with PHA R&D colleagues and the PCC. It was agreed to re-work the original PPI Research Call and issue through the Enabling Awards Scheme. This was issued on the 4th February, with a closing date of the 13th June. Subject to securing an acceptable proposal, it is still anticipated that the timescales set by the DHSSPS are capable of being met.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.29) Lead the implementation of the PPI Strategy through the delivery an Action Plan and effective leadership of the Regional Health and Social Care, Personal and Public Involvement (PPI) Forum.	The PHA continues to lead the implementation of the PPI Strategy through the delivery of the PHA PPI Action Plan and working through the Regional HSC PPI Forum. The PHA PPI Action Plan has been formally approved by PHA AMT and a number of actions are being progressed, including: 1.Establishment of PHA PPI Leads Group 2.Initiating PHA PPI Monitoring 3.Promotion of PPI through funding 4.Provision of professional advice and guidance on PPI 5. Working to embed PPI into culture and practice of the HSC through pre and post registration training of HSC professionals. The PHA continue to provide leadership to the Regional HSC PPI Forum and are progressing a number of work streams in collaboration with the Forum, including: • PPI Training • PPI Standards • Forum Action Plan / Communications • Development of a Performance Management System.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.30) Develop and initiate a programme of performance management for PPI – both internally within the PHA and across the HSC.	Internal A programme for Internal PPI Monitoring & Performance Management in the PHA has been agreed. An internal PPI Leads group, with an agreed Terms of Reference has been established. An initial pilot monitoring and performance management template was developed for use in the process. Returns have been secured from across the various PHA Divisions. This has been reviewed and analysed. The structure of the monitoring template is being updated with input from the PPI Leads and it will be re-issued for a 2nd round of monitoring, with returns due back by the end of June 2014. External A subgroup of the Regional HSC PPI Forum has been established to support the PHA in the development of a pilot HSC PPI Monitoring & Performance Management programme. An initial monitoring & performance management template has been developed and has been piloted across all HSC Trusts. The pilot has been reviewed and the feedback is being considered by the PHA and the Forum Monitoring & Performance Management sub group for further development and roll out in 2014/15	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
3.31) Re-design, re-launch and provide ongoing management of the Engage Website to provide a web based resource to promote and advance PPI across the HSC.	PHA has focused on securing DHSSPS funding for the re-design, re-launch and ongoing management of the Engage website. The Department has now requested a formal submission of a Business Case for recurrent funding.	A	A	A	A	The Business Case for the redevelopment of the Engage website and the establishment of the associated PPI outreach development programme has been completed. It has been submitted by the PHA to the DHSSPS for consideration.

4. IMPROVING THE EARLY DETECTION OF ILLNESS						
Target from Corporate Business Plan	**Progress**	**Achievability** June	Sept	Dec	Mar	**Mitigating actions where performance is Amber / Red**
4.1) Introduce screening surveillance for women at high risk of breast cancer through the NI Breast Screening Programme	Introduced – April 2013 as planned.	G	G	G	G	
4.2) Improve informed choice in cancer screening (particularly amongst hard to reach groups)	This is being taken forward through the Promoting Informed Choice Action Plan which has 27 recommendations due for completion by March 2014. Nearly all actions due for completion by March 14 have been completed. Progress has been made against the small number of outstanding actions. The action plan is monitored at regular QARC team meetings and by Regional QA Groups	A	A	A	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
4.3) **Prepare for the extension of the Bowel Cancer Screening Programme to invite people up to the age of 74 years, to invite in 2013/14 50% of all eligible men and women aged 60-71, with a screening uptake of at least 55% in those invited, and will have in place all the arrangements necessary to extend bowel cancer screening to everyone aged 60-74 from April 2014.** **(DHSSPS Commissioning Directions target)**	The programme has achieved the target to invite 50% of the eligible population during 2013/14 (55.45% invited by end March 2014). Uptake of the programme across Northern Ireland is monitored monthly and described at 12 weeks and 6 months from the issue of the invitation. Uptake continues to improve: cumulative uptake at 6 months post invite for April 2013 – Oct 2013 is 53.39%. Three of the five Trusts achieved an uptake of >55% for quarter 2 of 2013/14 (range: 46.4% in Belfast to 59.2% in South Eastern). The media campaign ran again from August to February 2014 aiming to promote awareness of the screening programme. A peer facilitator programme, incorporating a module on bowel screening, is being delivered to community groups by WRDA in the Belfast and South Eastern Trust areas. An awareness and information session has been undertaken with staff of Cancer Focus NI who facilitate a Men's Health programme. A pilot of using teaser letters as a precursor to the screening invite was undertaken in February 2014. A project plan is in place and on track to implement age extension from 1 April 2014.	G	G	G	G	
4.4) Commence roll out of digital mammography.	The Business Case has full DFP approval and procurement is expected to commence in autumn with the installation of digital mammography in Linenhall Street and Altnagelvin Area Hospital during this financial year in accordance with the implementation plan.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
4.5) Ensure robust processes are in place for booking of DRSP patients, maintaining the screening interval and promoting high uptake.	With Screening Interval at 12 months – significant pressure has moved to the image grading process. PHA and BHSCT have agreed plans to deal with backlog	A	G	A	A	
4.6) Implementation of DHSSPS 2011 standards in Antenatal infections.	On schedule as planned.	G	G	G	G	
4.7) Work with BSO and Trusts to co-ordinate and support the implementation of electronic linkage within the Newborn Blood Spot Programme including universal use and application of H&C numbers.	On schedule as planned.	G	G	G	G	
4.8) Work with BSO and Trust staff (screening, CHS, audiology, health visiting, neonatalogy and paediatrics) to implement the Northern Ireland Newborn Hearing Screening Programme Guidance on responsibilities for referral and follow-up of infants resident in NI up to 6months of age.	On schedule as planned.	G	G	G	G	

5. USING EVIDENCE, FOSTERING INNOVATION AND REFORM						
Target from Corporate Business Plan	**Progress**	**Achievability**				**Mitigating actions where performance is Amber / Red**
		June	Sept	Dec	Mar	
5.1) Support the expansion of the Northern Ireland Public Health Research Network Expand the membership of the NIPHRN and establish Research Design Groups Facilitate the formation of RDGs and their delivery of PH research proposals Review the success of the NIPHRN Special Interest Groups	On schedule	G	G	G	G	
5.2) Explore the potential of using routinely collated datasets for HSC research purposes Assist the HSC exploit the opportunities flowing from the Admin Data Taskforce Work with colleagues to advance the research dimension of the DHSSPS MOU – Honest Broker Service	Funding secured for Northern Ireland ADRC Two researchers invited to test the Honest Broker Service Additional support agreed with DHSSPS Statistics Branch for creation of metadata for 2014-15 & 2015-16	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
5.3) Agree regional R&D permissions metrics and monitor implementation of permissions metrics in HSC R&D.	Baseline median metric figures established. Monitoring ongoing at six monthly intervals. Agreement being sought through research governance operational sub-group and R&D Director's Group	G	G	G	G	
5.4) Develop and issue guidance for management of R&D permissions for cross-border studies in conjunction with other administrations.	Ongoing work by UK Compatibility Group is feeding into HRA Assessment project. Elements completed include UK-wide R&D checklist, review criteria, amendments process etc.	G	G	G	G	
5.5) Participate in UK-wide working groups to apply and interpret AcoRD. Provide training programme for Research Managers, researchers and research funders on AcoRD.	NI ACoRD Working Group established. Part-time AcORD lead Programme Manager and Finance Manager appointed and attending national implementation group meetings	*G*	*G*	*G*	G	
5.6) Support researchers to access funding opportunities under the US-Ireland Partnership Funding Scheme.	4 bids have been submitted with 6 in the pipeline	*G*	*G*	*G*	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
5.7) Assist with implementation of a local portfolio management system to support research management and governance processes within HSC Trust Research Offices, NICTN, and NICRN.	System is currently being implemented in Trusts and Networks	G	G	G	G	
5.8) Commission a research call in Dementia in Care.	Three awards made and 2nd call planned for 2014/15	G	G	G	G	
5.9) Commission a call in Public Health Suicide Research	UK-wide call issued February 2014, includes reference to forthcoming HSC R&D Division call	*G*	*G*	*G*	*G*	

6. DEVELOPING OUR STAFF AND ENSURING EFFECTIVE PROCESSES						
Target from Corporate Business Plan	**Progress**	**Achievability**				**Mitigating actions where performance is Amber / Red**
		June	Sept	Dec	Mar	
6.1) Continue to take forward actions to embed a culture which places value on staff, ensures clear and known organizational priorities and establishes a clear, transparent leadership and accountability framework	Following the Lagan Valley island event, the PHA OWD group has been established. Communications has been sent to all staff. An action plan has been developed and is being taken forward, with regular reports to AMT. "Emphasis" has been launched including OWD programme.	G	G	G	G	
6.2) Continue to implement the absence management policy and monitor and report on staff absence, taking actions where appropriate to reduce absenteeism.	Monitoring of absence will continue with monthly staff absence reports sent PHA Corporate Services. Managers can also access absence information on staff for whom they line manage via HRPTS. Contact meetings and specific appropriate action on an individual basis will also continue.	G	G	G	G	
6.3) Ensure that by 30th June 2013 90% of staff will have had an annual appraisal of their performance during 2012/13	Target achieved as at quarter ending 31st December 2013.	*A*	*A*	*G*	*G*	
6.4) Ensure that by 31 March 2014 100% of doctors working in PHA have been subject to an annual appraisal	On target – currently 100%. All doctors in PHA who are required to complete an appraisal, have completed an appraisal meeting with their appraiser.	*G*	*G*	*G*	*G*	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
6.5) Work with HR to identify key steps and milestones to ensure implementation of the knowledge and skills framework	Implementation of KSF has been incorporated into the PHA's Organisational Development Work plan and will be rolled out over the coming months commencing with staff briefings.	*G*	*G*	*A*	*G*	
6.6) Prepare for the auto enrolment of staff on pension schemes	The HSC has deferred auto enrolment until 2017 for current employees. New entrants will be auto enroled wef the organisational staging date which for PHA is Autumn 2014.	G	G	G	G	
6.7) Develop with the local government steering group a shared framework of action including mutual governance arrangements.	Discussions are ongoing with local government and a proposed framework of actions and way forward, including governance arrangements, has been agreed with SOLACE.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability June	Sept	Dec	Mar	Mitigating actions where performance is Amber / Red
6.8) Commission the design and development of a generic multi-faceted PPI Awareness Raising and Training Programme for the PHA and across the HSC.	The Business Case was completed and submitted to the DHSSPS for consideration in June. DHSSPS approval was received and a Tender process was initiated. One submission was received. This submission was reviewed by an Evaluation Panel and did not successfully meet the tender specification. The tender invitation was reissued in early 2014. A proposal was selected and a team have been appointed to design and develop the envisaged awareness raising and training programme.	*G*	*G*	*G*	*G*	
6.9) Continue to review and update governance and reporting arrangements in line with good practice and other DHSSPS requirements, including reviewing the PHA Assurance Framework and the effectiveness of PHA systems to review progress on implementation of action plans resulting from inspections, inquiries and audit findings.	Governance arrangements are kept under constant review. The PHA reviewed its Assurance Framework in April 2013. The updated Assurance Framework was presented to AMT (4 June 2013) and GAC on 20 June 2013. The Assurance Framework has been reviewed in September 2013 (presented to AMT and subsequently GAC 3 October 13) and for April 2014 (presented to AMT and subsequently GAC on 10 April 2014)	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
6.10) Continue to assess compliance with relevant controls assurance standards in a timely manner, maintaining substantive compliance and prepare for the introduction of the new Information Governance standard.	Substantive compliance achieved in all standards during 12/13. The PHA has assessed compliance against all relevant CAS for 2013/14. In accordance with Departmental guidance self-assessment indicates that substantial compliance has been achieved for all, internal audit verification of applicable standards is currently awaited. The final report will be submitted to DHSSPS in line with required timescale The PHA has assessed its compliance with the new Information Management Controls Assurance Standard, achieving substantial compliance. Action plans are being developed and will be monitored to ensure gaps in compliance are addressed and compliance levels continue to improve.	G	A	G	G	.

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
6.11) Test and review the PHA Business Continuity Plan	Test of Public Health Agency Business Continuity Plan took place on 02/09/2013 and revised documentation was issued early in 2014 following approval by GAC and PHA Board in December. This was the first joint exercise involving the Health and Social Care Board and Public Health Agency and these organisations and the Business Services Organisation continue to work closely together to ensure plans are robust. Contact details and other Business Continuity information is kept under regular review. The PHA project team continue to meet bi-annually. Staff continue to be reminded of the importance of Business Continuity.	G	G	G	G	
6.12) Review PHA processes for preparation and approval of business cases and develop a business case database.	The PHA process for preparation & approval of business cases were reviewed, with a paper on the outcome presented to PHA Board in June and subsequently forwarded to DHSSPS. A business case database has been established. PHA will continue to ensure its business cases processes are kept updated in line with DHSSPS guidance.	*G*	*G*	*G*	*G*	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
6.13) Continue to maintain and improve where appropriate the quality of information/data being presented to the PHA board	All information/data being presented to the PHA board to support decision making, is firstly presented to and approved by AMT and the Chief Executive, as part of the quality assurance process. The PHA continues to ensure data quality assurance processes are in place across the range of data coming to the board. This includes: • Developmental work and regular review to ensure the comprehensiveness and robustness of PEMS data; • Finance information and reporting has been extensively reviewed, (and in particular during late 2012/13 early 2013/14 in light of problems linked to the implementation of the new finance and HR systems) • Robust procedures are in place within Health Protection and screening services to quality assure data. Board members are provided with Health Intelligence Briefings which include summaries of official statistics across a range of thematic areas, including those relating to ministerial targets. These inform decision making across the PHA. Statistics are also incorporated into the DPH Annual Report, which is brought to the PHA board for noting.	G	G	G	G	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
6.14) Complete the business case for new accommodation, and move staff accordingly. In doing so it will ensure that property costs demonstrate value for money, that any surplus assets are disposed of, and that appropriate skills and expertise are accessed.	Business Case is being updated in line with reviewed costs. Lease negotiations with landlord are being finalised.	G	G	G	A	Timescales for moving staff have been delayed. However work is continuing with Health Estates & Design Team to ensure necessary works are carried out and appropriate facilities management arrangements put in place to facilitate staff move to new accommodation.
6.15) Preparation of a Property Asset Management Plan for submission to the DHSSPS.	Property Asset Management Plan has been produced & submitted to DHSSPS (June 2013)	G	G	G	G	
6.16) Ensure effective finance systems and processes are in place consistent with best practice and agreed Departmental requirements	A range of service improvement projects have been taken forward by the finance team in respect of user requirements in the new financial systems (FPM and Eproc). This is focussing primarily on the quality of financial coding and faster approval and payment of invoices, a paper has been provided to AMT in July 2013. A service improvement project to expedite memo payments has also been implemented as part of normal business. In addition, HSCB Financial Management and PHA Operational Performance staff are currently reviewing the inter-relationships of information provided to and from PHA budget holders A range of improvements have been implemented and will be kept under continuous review	*G*	*G*	*G*	*G*	

Target from Corporate Business Plan	Progress	Achievability				Mitigating actions where performance is Amber / Red
		June	Sept	Dec	Mar	
6.17) Conduct a review of management costs within the PHA, and prepare a report and savings plan to be approved by the PHA board and the Department	PHA regularly reviews its management costs. In particular, as the PHA has developed a business case for new accommodation, the management and admin budgets have been reviewed across the organisation, to realign budgets, and maximise the management and admin budget to meet the accommodation costs. Staffing costs are also kept under regular review.	G	G	G	G	
6.18) Develop and agree a performance framework with appropriate performance indicators reflecting the work of the PHA	Proposed Indicators for the Framework document have been reviewed and finalised by programme leads. Baseline data is currently being compiled for additional indicators identified. Draft Framework document will be submitted to PHA for approval.	G	G	G	G	
6.19) Ensure that the PHA Annual Business Plan for 2014/15 is prepared in line with Departmental requirements, approved by the PHA board and submitted to the Department by the end of January 2014	PHA Annual Business Plan was developed, approved by PHA Board 23rd January 2014 and submitted to DHSSPS 24th January 2014. It was subsequently approved by DHSSPS 26th March 2014.	G	G	G	G	

PHA/05/05/14

Health and Social Wellbeing Improvement Update

May 2014

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	15 May 2014
Title of Paper	Health and Social Wellbeing Improvement Update
Agenda Item	11
Reference	PHA/05/05/14
Summary	
PowerPoint presentation update on key achievements in Health and Social Wellbeing Improvement during 2013/14	
Equality Screening / Equality Impact Assessment	N/A
Recommendation / Resolution	For Noting
Director's Signature	CHarper
Title	Director of Public Health
Date	7 May 2014

PHA Board
Health and Social Wellbeing Improvement Update

Mary Black CBE
Assistant Director Health and
Social Wellbeing Improvement
15th May 2014

Improving Your Health and Wellbeing

Context

- New Public Health Framework
- Local Government Reform
- Poverty and Social Exclusion
- Service Pressures in Trusts
- New challenges e.g. E cigarettes

Improving Your Health and Wellbeing

What We Do

- Influence commissioning of health and social care
- Directly commission health improvement services
- Work in partnership with statutory, community, voluntary and private sectors
- Lead on regional developments and facilitate delivery
- Contribute to research and evidence base

Improving Your Health and Wellbeing

Procurement……..

- Sexual Health
- Mental Health and Wellbeing
- Drugs and Alcohol misuse
- Lifeline Service
- One Stop Shops

Improving Your Health and Wellbeing

Building Blocks for a Healthy Life

Working with others to

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

Improving Your Health and Wellbeing

Give every child and young person the best start in life

- Parenting Support Programmes
- Breastfeeding
- Roots of Empathy
- Infant Mental Health
- Early intervention in areas of social complexity
- Early Years Transformation Programme

Improving Your Health and Wellbeing

Ensure a decent standard of living

Maximising Access in Rural Areas (MARA)

- Over 10,525 first visits and almost 7,000 follow up visits completed
- Levered £1,288,832 energy efficiency
- 3,783 households accessed Home Safety advice and equipment
- Welfare claims £534,526 so far
- 509 referrals to rural transport
- 301 boiler replacements £199,300

Improving Your Health and Wellbeing

Fareshare

Social Return on Investment of

£1: £8

86 tonnes food waste redistributed

360 tonnes of greenhouse gas emissions prevented

203,333
hot meals served

Improving Your Health and Wellbeing

Build Sustainable Communities

Improving Your Health and Wellbeing

Resurgram - Lisburn

- Early Intervention Partnership
- Incredible Years in five Community Primary Schools
- Education initiative underachievement
- Family support fund with Bryson and Big Lottery
- Education Plan

Improving Your Health and Wellbeing

Farm Families Check

Farm Families Check Scheme

- 4831 screened - 51.5% advised to see GP for further investigation, 23.9% referred to MARA project and 531 clients referred to a farm safety course

Improving Your Health and Wellbeing

Kilkooley - Bangor

- Multi-agency partnership Action Plan
- Community Development
- Allotments and horticulture – Healthy Living Centre
- Health Improvement programmes
- Women's centre

Improving Your Health and Wellbeing

Community Allotments

- Green Gym – Dig it and Eat it
- ‘Meanwhile’ use with Groundwork
- Social and therapeutic horticulture
- Allotments with councils, local communities, NR
- Small grants with Conservation NI

Improving Your Health and Wellbeing

Travellers Health Forum

- Employment of Travellers, men’s health
- Travellers Support Work
- Mental health and wellbeing
- Women’s Choir
- Breastfeeding
- Communication

Improving Your Health and Wellbeing

BME

- NI New Entrants Service
- Roma – needs, health liaison workers, nursing support
- Stronger Together Network
- Minority ethnic health and wellbeing
- Website

Improving Your Health and Wellbeing

Older people

- Active Ageing Strategy
- Health and Wellbeing Improvement Programmes
- Models of Engagement
- Community Conversations
- Arts Festival

Improving Your Health and Wellbeing

LGBT Community

- HSC Staff Forum
- E Learning Programme
- Development of materials
- Website
- Pride festivals

Improving Your Health and Wellbeing

Arts and Health

Arts and Health
- RIPE - Older Peoples Festival
- Let's Dance - Strabane Community
- Twilight - Looked After Children
- Arts Ekta - BME engagement

Improving Your Health and Wellbeing

Make Healthy Choices Easier

Improving Your Health and Wellbeing

Suicide Prevention and Mental Health and Wellbeing

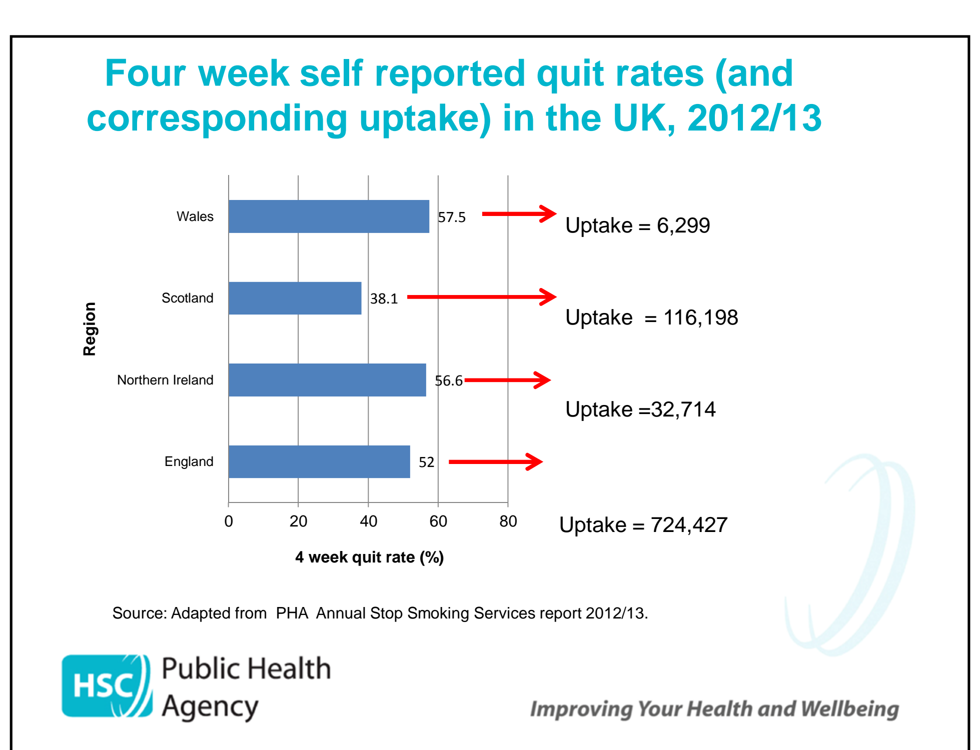
- Training Action Plan
- Standards
- FLOURISH
- Self Harm Registry
- Sudden Death Information
- Student Health

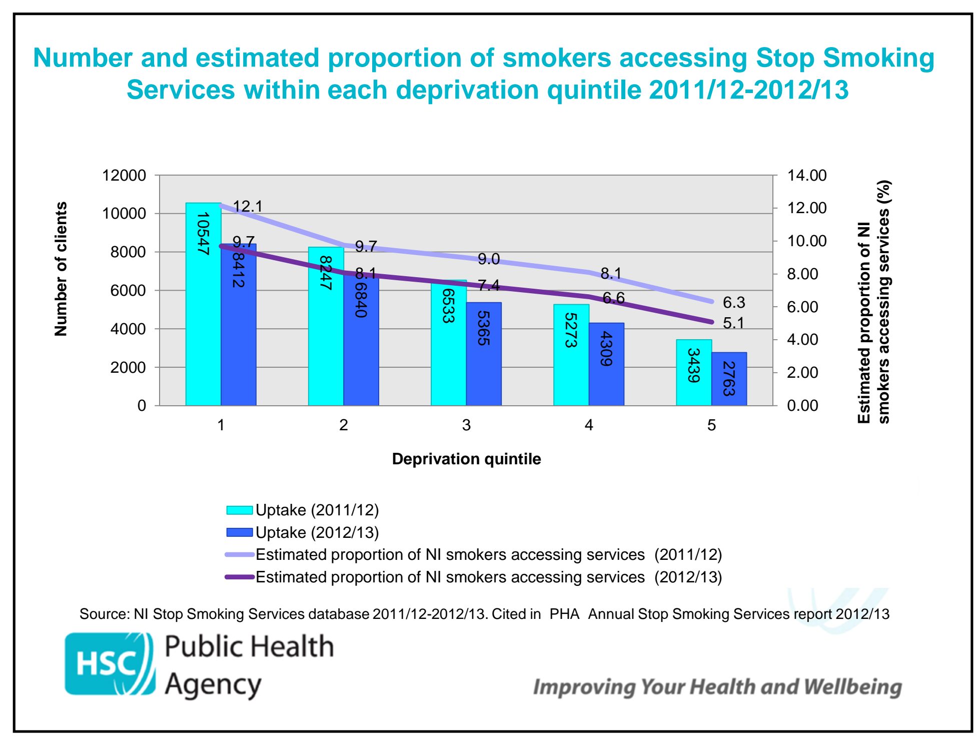
Improving Your Health and Wellbeing

Sporting Organisations

- Sport NI, IFA, GAA, IRFU
- IFA e-learning
- Training for coaches mental health and wellbeing
- Youth player development
- GAA ‘Heads Up’ resource
- Mental health and sport – 55 governing bodies

Improving Your Health and Wellbeing




Number and estimated proportion of smokers accessing Stop Smoking Services within each deprivation quintile 2011/12-2012/13
Number of clients
12000
10000
8000
6000
4000
2000
0
10547
8412
8247
6840
6533
5365
5273
4309
3439
2763
12.1
9.7
9.7
8.1
9.0
7.4
8.1
6.6
6.3
5.1
1
2
3
4
5
Deprivation quintile
14.00
12.00
10.00
8.00
6.00
4.00
2.00
0.00
Estimated proportion of NI smokers accessing services (%)
Uptake (2011/12)
Uptake (2012/13)
Estimated proportion of NI smokers accessing services (2011/12)
Estimated proportion of NI smokers accessing services (2012/13)
Source: NI Stop Smoking Services database 2011/12-2012/13. Cited in PHA Annual Stop Smoking Services report 2012/13
HSC Public Health Agency
Improving Your Health and Wellbeing

Standardised Packs - Progress
SMOKING CLOGS THE ARTERIES AND CAUSES HEART ATTACKS AND STROKES
WARNING
Brand
Variant
20
20 CIGARETTES
BRAND VARIANT
HSC Public Health Agency
Improving Your Health and Wellbeing

Interactive Services

Online chat

SMS text

Improving Your Health and Wellbeing

Size of the problem in NI

Health Survey Northern Ireland 2010/11

	Men	Women	All adults
% overweight	44	30	36
% obese	23	23	23

3 in every 5 adults in NI carry excess weight

Improving Your Health and Wellbeing

Childhood obesity – year 1

	2008-09
Overweight	17.2%
Obese	5.3%
Overweight or obese	22.5%

Source: Child Health System

Improving Your Health and Wellbeing

Childhood obesity – year 8/9

	2008-09
Overweight	20.2%
Obese	7.1%
Overweight or obese	27.3%

Source: BMI measurements at year 8/9

Improving Your Health and Wellbeing

Obesity Prevention

- Weigh to Health
- Physical Activity Referral Scheme
- Food Labelling
- Food in Schools
- Healthy Breaks
- Active Travel
- Cook It!
- Workplace

Improving Your Health and Wellbeing

Active Belfast

"People in Belfast will be more active and healthier."

Impro

Focusing on life inequalities

Examples of work

Active Belfast Grant Scheme

- > £200,000 to support local projects
- Covers the areas of play, schools, travel and workplaces
- Includes larger citywide and local community projects

Impro

Active Belfast

Focusing on life inequalities

Examples of work

Physical Activity Referral

- Increased investment by £250,000 per year
- Employment of 13 new staff
- Development of condition specific pathways – link to TYC
- 2,000 clients per year - aim for 4,500

HSC Public Health Agency

Impro

Active Belfast

Focusing on life inequalities

Examples of work

Active Outdoors

- Investment of > £160,000 in outdoor gym sites
- Growing Communities strategy
- Opening of Musgrave Park therapy garden and 4 new community gardens
- Whiterock Hub

Impro

Focusing on life inequalities

Actions to increase youth participation

Post primary school

- Training for youth workers and youth club staff
- Fitness equipment in schools
- Learn to surf programme for children with Autism

Active Belfast

Impro

Focusing on life inequalities

Health Plus Pharmacy

- 100 Pharmacies trained
- Standards and accreditation agreed
- New resources and website
- Link with other programmes e.g. Breastfeeding, Drugs and Alcohol, Mental Health

Improving Your Health and Wellbeing

Public Information Campaign

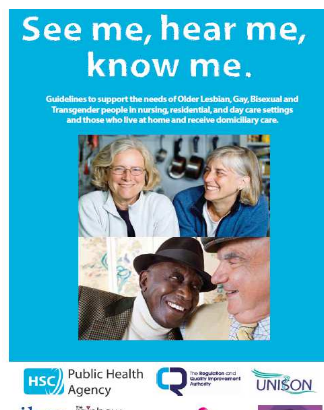
Improving Your Health and Wellbeing

Public Information Campaign

Its Good to Have Someone in Your Corner

Improving Your Health and Wellbeing

Guidelines



Improving Your Health and Wellbeing

Learning and Development

- PHA Inaugural Tobacco Control Conference November 2013
- The Best Start for Every Child - Maternal Nutrition November 2013
- Mental Health and Resilience Conference February 2014

Raising Resilience
Protecting Mental Health at Work

Improving Your Health and Wellbeing

Future Plans and Challenges

- Scale
- Synergy
- Settings
- Social Inclusion

Improving Your Health and Wellbeing

PHA/06/05/14

Child Development Programme Board Update

May 2014

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	15 May 2014
Title of Paper	Child Development Programme Board Update
Agenda Item	12
Reference	PHA/06/05/14

Summary

The Child Development Board was established in June 2010, reflecting the PHA's Corporate Strategy focus on Giving Every Child the Best Start in Life. The remit of the Board is to develop an integrated pathway from conception to 18 years of age which includes proven programmes in early child and youth development. The role of this group has become increasingly important as the PHA has become involved in taking forward new inter-sectoral initiatives on children's health and well-being.
The CDPB has 9 key work strand teams which provide quarterly progress reports to the Board:

1. ***Infant Mental Health Training***. This work stream is on track. PHA is supporting Solihull training for Surestart centres, nursing staff and other professionals.
2. ***Parenting Programmes.*** All programmes in this work strand are on track.
3. ***Breastfeeding.*** A Breastfeeding Action Plan has been developed by the Breastfeeding Strategy Implementation Group.
4. ***Roots of Empathy.*** This work stream is progressing well.
5. ***Social Complexity in Pregnancy.*** The timescale for this project slipped but the team continues to work through the design elements. The intervention has been finalised, including a manual for staff.
6. ***Communications.*** Recent new activity included presentations to the Children & Young People's Strategic Partnership outcomes groups on the parenting programmes being commissioned by PHA. A short summary report was presented to CDPB on the study visit to Finland.
7. ***Research***. This work stream is on track.

CDPB also receives progress reports for information on the following 2 projects. However, the governance sits with the project boards that oversee these programmes:

8. ***Family Nurse Partnership***. Teams exist in 3 Trusts with plans to extend the FNP programme to the other 2 Trusts.

9. ***Healthy Child Healthy Future.*** There are current risks and impact on children resulting from the shortages in the Health Visiting workforce at present.

The Early Intervention Transformation Programme (EITP) is being delivered as part of the Delivering Social Change Programme (DSC) and will be implemented between April 2014 and March 2018. Early Years Intervention Programmes including

Incredible Years, Parenting Your Teen Programme, Strengthening Families Programme and Infant Mental Health training have all been commissioned and are being delivered. CDPB will receive updates on EITP for noting and will also be a source of stakeholder engagement and advise to EITP. An overview of the work of CDPB and the minutes of the last meeting held on 21 March 2014 are attached for further information.	
Equality Screening / Equality Impact Assessment	N/A
Recommendation / Resolution	For Noting
Director's Signature	CHarper
Title	Director of Public Health
Date	23 April 2014

Child Development Project Board-Progress Report-

April 2014

1. **Child Development Project Board**

The Child Development Board (Terms of Reference included as Appendix 1) was established in June 2010, reflecting the PHA's Corporate Strategy focus on Giving Every Child the Best Start in Life. The remit of the Board is to develop an integrated pathway from conception to 18 years of age which includes proven programmes in early child and youth development. The role of this group has become increasingly important as the PHA has become involved in driving forward new inter-sectoral initiatives on children's health and well-being.

The CDPB has 9 key work strand teams which provide quarterly progress reports to the Board:

1. ***Infant Mental Health Training***.
2. ***Parenting Programmes.***
3. ***Breastfeeding.***
4. ***Roots of Empathy.***
5. ***Social Complexity in Pregnancy.***
6. ***Communications***.
7. ***Research***.

CDPB also receives progress reports for information on the following 2 projects. However, the governance sits with the project boards that oversee these programmes:

8. ***Family Nurse Partnership***.

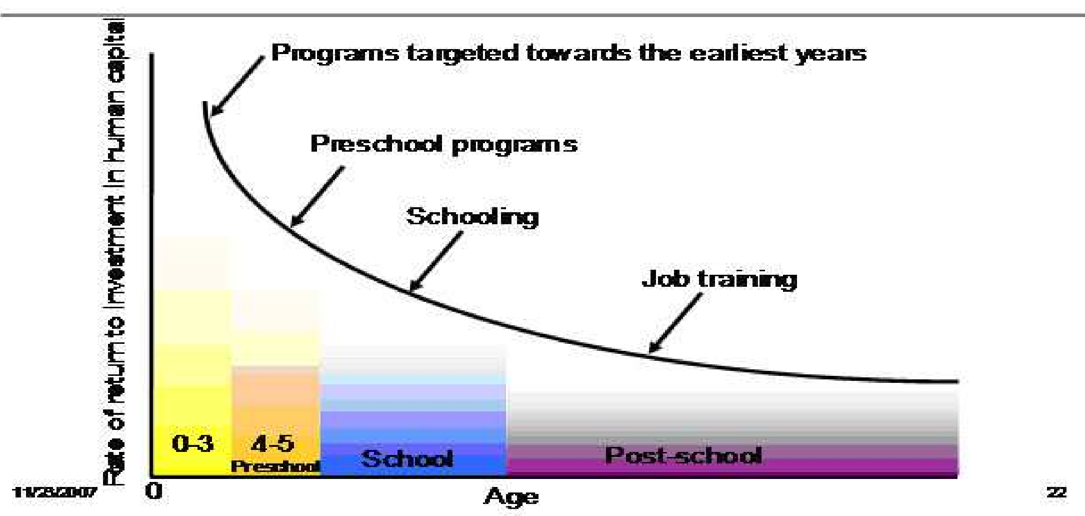
9. ***Healthy Child Healthy Future.***.

The Early Intervention Transformation Programme (EITP) is being delivered as part of the Delivering Social Change Programme (DSC) and will be implemented between April 2014 and March 2018. Early Years Intervention Programmes including Incredible Years, Parenting Your Teen Programme, Strengthening Families Programme and Infant Mental Health training have all been commissioned and are being delivered.

2. **The best start in life**

An increasing body of evidence and research highlights that a child's early years' experience represents a foundation for later health and wellbeing. Policy makers, Government Departments, public sector and community and voluntary sector providers are increasingly considering how evidence based early years interventions can be prioritised at this optimal period of development. Far more is known now than even a few years ago about the extent to which a child's early development, including before birth, lays the foundation for their future life. The Financial Impact of Early Years Interventions in Scotland (2010) report suggests that effective

interventions early in life (pre-birth to 8 years) for children with moderate and severe difficulties such as Looked After Children and those in residential care can result in significant medium term savings to the public sector. In other words, early years is the optimal time for investment as demonstrated in the table below developed by the Economics Nobel Laureate Professor James Heckman.



Early interventions, according to Professor James Heckman of the University of Chicago, "promote schooling, raise the quality of the workforce, enhance the productivity of schools and reduce crime, teenage pregnancy and welfare dependency. They raise earnings and promote social attachment. Focusing solely on earnings gains, returns to dollars invested are as high as 15-17%... a rare public policy initiative that promotes fairness and social justice and at the same time promotes productivity in the economy and in society at large" (Heckman 2006).

Despite considerable public sector investment Northern Ireland continues to experience persistent patterns of inequalities which have not shifted in relative terms although some improvements in health and wellbeing for the overall population have been achieved. The broader consequences of persistent health and social inequalities, increased demand for health and social care services informed by an increasing aging population and financial public sector spending constraints further emphasises the challenges facing Northern Ireland. Less of the same will not help us to move up the league tables in any number of quality of life indicators. The international evidence from economists, psychologists, child development specialists and others suggests that we prioritise investment in services that provide intensive support during pregnancy, the first 5 years of life and later childhood.

The Publication of the Marmot Review (2010) also 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 the proportion of overall expenditure allocated to the early years; emphasised the need

to reduce inequalities in the early development of physical and emotional health and improving cognitive, linguistic and social skills - so building resilience and wellbeing among young children. To do this, Marmot recommends investment in 'high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient.'[4]

3. Public Health Agency

The PHA, primarily through a Child Development Project Board, has initiated and supported a range of programmes addressing the needs of children and young people experiencing inequalities. Membership is drawn from across the PHA, Health and Social Care Board, Health and Social Care Trusts, education, academia and the community and voluntary sector. The Project Board specifically agrees action on effective evidenced based interventions. This includes the introduction of new programmes to Northern Ireland, expansion and development of existing programmes and the application of relevant research and evaluation to those programmes to inform wider learning and development.

4. The PHA Approach

Improving long-term outcomes for the whole population begins with ensuring that every child has the best possible start in life and with a focus on ensuring that children who are the most vulnerable and at risk are especially supported. The PHA is committed to ensuring that the environment is made as supportive as possible and that every family has access to information and support to make healthy choices in life. There is now a wide body of evidence which demonstrates that disadvantage starts before birth and accumulates throughout life. It is clear that it is only through intervening early in a child's life to break both the intergenerational nature of disadvantage and to help establish the right conditions, can a child be given the right opportunity to flourish throughout their life. Securing a strategic approach to early child development and family support therefore, is an important priority for the PHA.

How can this impact on a child throughout the life cycle?

The Adverse Childhood Experiences (ACE) Study[1] is a long term study of the associations between childhood maltreatment and later-life health and wellbeing.

stress

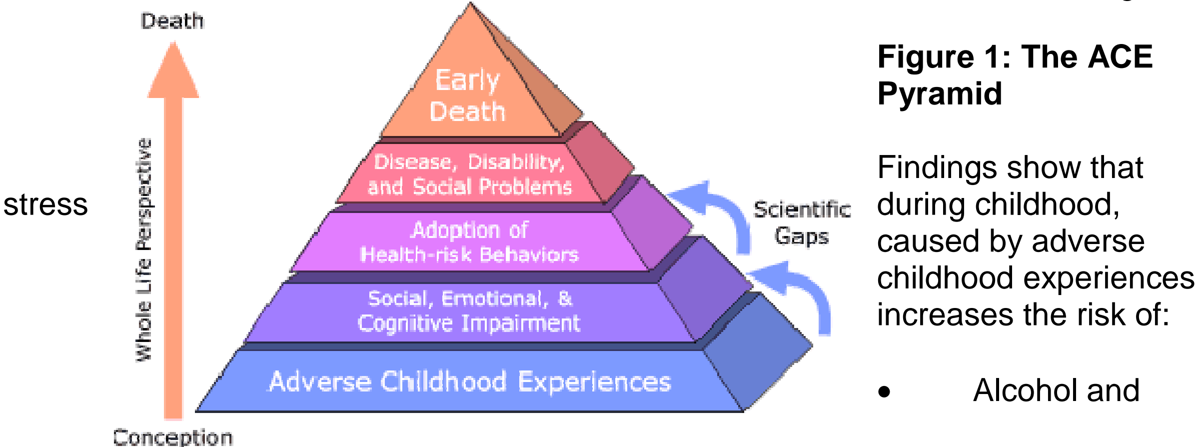


Figure 1: The ACE Pyramid

Findings show that during childhood, caused by adverse childhood experiences, increases the risk of:

- Alcohol and

[1] Anda, R.F. & Felitti, V.J. (ongoing)

drug abuse

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

Other studies have shown negative outcomes for social and emotional development:

- Educational outcomes
- Interaction with peers and relationship building
- Anti-social behaviours and criminal activity
- Ability to thrive in the workplace

Research has found that by the age of 3, those children who would go on to display violent behaviours in later years were already displaying significantly more violence than other children[2]. Quality of parental interaction in these early years plays a vital role in the development of this aggressive behaviour.

5. What types of intervention are currently available?

Interventions are centred around increasing attachment, nurturing behaviour, positive role-modelling and empathy, and can be focused towards the child/primary care giver relationship or at the parenting behaviour alone (pre- and post-natal). Programmes may be universal, i.e. available to all, or targeted to those with a pre-identified risk or concern, and may take place in the home, or in group settings.

The Public Health Agency is committed both to innovation and implementation of work which supports children and young people secure the best start in life. In particular, the Agency has progressed evidence based action which supports early childhood development. In doing so the Agency, through the success of these interventions, plans to secure the achievement of improved outcomes for children and families.

The Public Health Agency is a member of the Children and Young Peoples Partnership at both regional and local levels. These agendas mutually reinforce the need for a focus on outcomes in programmes and processes which build on existing and new practice.

The PHA is currently contributing fully to the implementation of the Delivering Social Change policy, initially through implementing Parenting Programmes through the DSC Signature Programmes. In addition the PHA is fulfilling a key planning and

[2] Tremblay, R. 2006

implementation role in developments relating to the Early Years Transformation Programme.

- Significant progress continues to be made on four of the five parenting support programmes being delivered through the Public Health Agency (PHA). This Signature Programme is intended to provide additional high quality support to new and existing parents living in areas of deprivation through positive parenting programmes. Through the programmes, we expect to guidance, training, support and information to be provided for up to 1,200 families.

- Commissioning of the introduction of the fifth programme, Triple P, has been delayed while its implementation and potential outcomes were given further consideration by the PHA Child Development Project Board. At this stage PHA are considering as an option not to proceed with Triple P programme and to expand/broaden the scale and content delivery of the other four programmes to ensure that the overall number of families indicated by PHA for support would be met. Triple P evaluation has shown mixed results. In addition a requirement of the level 1 Programme is the large scale production of positive parenting images and advertising, using various medium, including posters, leaflets and billboards. This presents a considerable challenge based on the lead in times for procuring media campaigns and limitations on media campaigns.

5.1 Background to Parenting Support Programmes

The Delivering Social Change Parenting Support Programmes (see DSC Parenting Programme powerpoint attachment for information) are as follows:

5.1.1 Incredible Years (IY) aims to reduce behaviour problems and to promote problem solving skills, social competence and emotional regulation. Programmes are aimed at parents or teachers of children aged 0-12. The PHA programme aims to increase the number or organisations who deliver the programme in NI to the highest quality and adherence to programme fidelity standards. A regional support and development programme has been agreed and a schedule of networking, training and product development has been worked up and is being implemented with organisations currently delivering Incredible Years programmes. Consideration is also being given to the development of the emerging Incredible Years programme for babies, a new curriculum programme that has recently become available.

5.1.2 Infant Mental Health Training is based on the compelling evidence of the negative impact of adverse childhood experiences, particularly in infancy. Infant Mental Health Training programmes will develop the capacity of those in contact with vulnerable families and babies to identify and act on risk factors for the infant's mental health including the mental illness of mother and father. A more confident and

trained workforce will support the likelihood of improved health and wellbeing, prevention of mental illness and enhancement of later life outcomes of those at risk. The investment in Infant Mental Health Training has, in addition to providing access of 270 early years and HSC professionals to one of 3 new training programmes, enabled the establishment of a regional Infant Mental Health Plan that will determine the level of investment required beyond the current scale of training resourced under Delivering Social Change.

5.1.3 Triple P is aimed at parents of children aged 2-12 with mild to serious concerns about the child's behaviour, this programme assumes that parenting practices may unintentionally reinforce children's behavioural and emotional problems. The programme aims to identify practices that might encourage negative behaviour, and replace them with strategies to promote good behaviours. Following withdrawal from the programme of the only Triple P provider in NI, a specification had been developed to guide commissioning of Triple P level 1 and 2 Positive Parenting Programmes to NI. One of the significant implications of level 1 Positive Parenting Programme is the large scale production of positive parenting images and advertising, using various medium, including posters, leaflets and billboards. This presents a considerable challenge based on the lead in times for procuring media campaigns and limitations on media campaigns. In addition Triple P evaluation has shown mixed results. Consequently a decision will be made on whether to proceed with Tripe P commissioning and development in NI.

5.1.4 Strengthening Families Programme is designed to reduce risk factors for children in families with a history of parental drug and alcohol abuse. The core aim is to improve the family environment by helping parents to develop discipline techniques and to understand the importance of rewards and positive attitudes in their children. The DSC investment will expand and continue programmes in 3 Trust localities and has facilitated new local service development for 2 years in Belfast and Southern localities from December 2013.

5.1.5 Parenting UR Teen is an 8 week programme developed by Parenting NI and has the key purpose of improving the parent/adolescent relationship and is based on an authoritative parenting style. A 2 Year contract is in place for Programmes being delivered within 2013/15 in Carrick, Dungannon, East Belfast, Belfast City Centre, Lisburn and Omagh. Within 2014/15 Parenting Ur Teen Programmes will also be delivered in Newry, West Belfast, Enniskillen, Magherafelt, Belfast City Centre and Downpatrick.

The **Early Intervention Transformation Programme (EITP)** is being delivered as part of the Delivering Social Change Programme (DSC). It will be implemented between April 2014 and March 2018. The EITP is an integrated cross developmental early intervention programme involving six departments namely Department for Health, Social Services and Public Safety (DHSSPS); Department for Social

Development (DSD); Department of Justice (DOJ); Department of Education (DE); Department of Employment and Learning (DEL) and Office of First and Deputy First Minister (OFMDFM)with significant funding input from Atlantic Philanthropies (AP) the EITP presents a unique opportunity to address the lifelong poor outcomes that some children experience in Northern Ireland (NI). The EITP represents the pulling together of the resources of the Northern Ireland Executive, with support from philanthropy, in order to work together to ensure that all children born within its jurisdiction have the best possible chance of experiencing a healthy and happy life.

As part of the EITP a new flexible Early Intervention Service (EIS) aligned to Family Support Hubs will be developed to support families when problems first emerge, before significant problems become intractable or before statutory services are required. Early Intervention can be defined as "*intervening early and as soon as possible to tackle problems emerging for children, young people and their families or with a population at risk of developing problems. Early intervention may occur at any stage in a person's life*" (C4EO, 2011). This definition includes both interventions early in life (with young children including antenatal interventions) and interventions early in the development of a problem with children or young people of any age and their families. The EIS represents an opportunity for the development of a new model which will develop a core EIS for families aligned to Family Support Hubs in every area of NI. This will be achieved by putting in place a joined up network of early intervention supports and services which build on and link to universal services and are culturally appropriate for NI, the local area and all children, young people and families in that area. Complementary parenting programme development will also be considered to ensure that the EIS and others across NI can facilitate access to a number of core programmes. Specifically an expanded portfolio of parenting programmes, in addition to the signature programmes indicated earlier, will be further developed and implemented from October 2014-June 2018. Currently a procurement process is being undertaken to ensure expert and objective analysis can inform the recommendation of the ideal selected programmes and related balance of the focus on different age groups from 0-18. The current and expanded parenting programme development and ensuring optimum fit to local circumstances within each HSC Trust will be a core focus for the new Health and Social Wellbeing Improvement –Child Development Interventions postholder.

Roots of Empathy Signature Programme

Root of Empathy was originally developed in Canada, and is formally recognised by the World Health Organisation (WHO). ROE was initially piloted in two classrooms in Toronto in 1996 and since then has been extensively rolled out in schools throughout Canada. It is also being delivered in New Zealand and the United States and is currently being delivered in targeted programmes, in the Isle of Man, Scotland, Northern Ireland, and the Republic of Ireland. The PHA, working closely with the 5 Trusts, ELB's and schools, have progressed the development and implementation of the programme across NI.

Emotional and social wellbeing is crucial for children to develop positive relationships and succeed in school and later life. Roots of Empathy is a schools based social and emotional competence promotion programme for primary school children which provides and effective approach to reducing the risk factors that cause violence. Public health guidelines and recommendations were published by the National Institute of Clinical Excellence (NICE) in 2008 to encourage the promotion of social and emotional wellbeing in primary school children. According to the guidelines, child wellbeing is important in its own right and as a determinant of success in school and in supporting physical health and development. It is recommended that schools: create an ethos that supports positive behaviours for learning and building successful relationships; provide an emotionally secure and safe environment that protects against bullying and violence; and which offer teachers and practitioners the support they need in developing children's social and emotional wellbeing. Evidence suggests that well designed school based prevention programmes can improve a variety of social, health and academic outcomes for children and young people. Several reviews reach the general consensus that universal school based programmes positively impact on child outcomes. including attitudes, positive social behaviour, conduct problems, emotional distress and academic performance

The ROE programme comprises of 27 lessons, based around a monthly classroom visit by an infant and parent, who are typically recruited from the local community and are 'adopted' by the class at the start of the school year.

During these visits, children learn about the baby's growth and development, by interacting with and observing the baby. A trained ROE instructor visits the class and teacher three times a month for the pre-family visit, the visit of the parent and infant and a post-family visit. Each ROE lesson promotes learning about the different dimensions of empathy: emotion identification and explanation; perspective-taking; and emotional sensitivity. The parent-infant visit serves as a springboard for discussions about understanding feelings and infant development along with effective parenting practices.

ROE seeks to develop children's social and emotional understanding, promote prosocial and decrease aggressive behaviours, and increase children's knowledge about infant development and effective parenting practices.

Within 2013/14 there are 119 ROE programmes delivered in 117 schools, supporting over 3,300 primary school children. It has attracted significant interest from the education sector and increasing numbers of primary schools have expressed an interest in running the programme. Currently the programme is delivered in almost 1 in every 7 primary schools in NI.

Queen's University Belfast has been provided significant funding through the PHA HSC research and development division to support a long term evaluation of the programme, including an analysis of its cost effectiveness. The evaluation involves randomly selecting schools to receive the programme and comparing their outcomes against schools that do not. Children undertaking the programme in primary 5 and 6 will be followed up until the first year of secondary school in order to determine the longer term effect of ROE. The findings of this research and evaluation will be used from 2014/15 to inform decisions' on the wider and long term development of the programme.

The Public Health Agency will continue to work closely with Roots of Empathy Canada, the 5 Health and Social Care Trusts, Education & Library Boards, schools and Queens University Belfast to develop the programme across Northern Ireland.

Currently each HSC Trust has a named member of staff within Health and Social Wellbeing Improvement who acts as a locality project lead for Roots of Empathy and consequently it is not anticipated that the planned Health and Social Wellbeing Improvement –Child Development Interventions postholder, will assume a role on the ongoing implementation of the programme.

Family Nurse Partnerships

The current service supporting under 19 first time mothers through a 2 year, nurse led support programme, will be expanded from 3 to all 5 Trusts by 2015/16. This represents a considerable commissioning development and investment for vulnerable young parents who require intensive support.

Appendix 1 Membership of Child Development Project Board and Terms of Reference

Dr Carolyn Harper, PHA, Chair
Dr Maura O'Neill WHSCT
Mary Black, PHA
Siobhan Fitzpatrick, Early Years
Joy Poots, CINI
Janet Calvert, PHA
Amanda McLean, PHA
Celine McStravick, NCB NI
Marian Robertson, SEHSCT
Nuala Toner, BHSCT
Susan Gault, NHSCT
David Douglas, SHSCT
Julie McConville, SHSCT
Mary Rafferty, PHA
Una Turbitt, PHA
Dr Brid Farrell, PHA
Maurice Meehan, PHA
Dr Nicola Armstrong, PHA
Dr Janice Bailey, PHA
Ruth Carroll, PHA
Carolyn Mason, RCN
Sheena Funston, WHSCT
Bryan Nelson, BHSCT
Tommy Boyle, BHSCT
Miriam Karp, PHA
Denise Boulter, PHA
Bride Harkin, PHA
Pat Cullen, PHA
Dawn Shaw, Action For Children
Eamon McMahon, BHSCT
Sharon Beattie, SBNI
Fionnuala McAndrew, HSCB
Maurice Leeson, HSCB
Gerry Conway, HSCB
Deirdre Webb, PHA
Professor Paul Connolly, QUB

CDPB Terms of Reference

1. Advise PHA on initiatives, programmes or other actions that should be taken to improve children's health and wellbeing
2. Co-ordinate and integrate PHA initiatives relating to child development to ensure a comprehensive and evidence-based approach
3. Oversee implementation of Family Nurse Partnership
4. Oversee implementation of Roots of Empathy
5. Oversee implementation of other child development-related activity
6. Ensure that key initiatives are evaluated rigorously and/or subject to a robust research programme
7. Ensure engagement with parents and communities in designing and implementing initiatives, recognising that their support is essential
8. Communicate the work of the Project Board, including sharing learning
9. Develop and maintain strategic relationships with key stakeholders, including the Children and Young People's Strategic Partnership

Appendix 2 Previous Minutes of CDPB

CHILD DEVELOPMENT PROJECT BOARD

Friday 21 March 2014 9.30-11.30am
5th floor meeting Room Linenhall Street

MINUTES

Present: Carolyn Harper, PHA
Finola McAlarney, PHA
Maura O'Neill (teleconference), WHSCT
Mary Black, PHA
Siobhan Fitzpatrick, Early Years
Joy Poots, CINI
Janet Calvert, PHA
Amanda McLean, PHA
Celine McStravick, NCB
Marian Robertson, SEHSCT
Nuala Toner, BHSCT
Susan Gault, NHSCT
David Douglas, SHSCT
Mary Rafferty, PHA
Una Turbitt, PHA
Brid Farrell, PHA
Maurice Meehan, PHA
Nicola Armstrong, PHA
Ruth Carroll, PHA
Carolyn Mason, RCN
Sheena Funston, WHSCT
Bryan Nelson, BHSCT

Apologies: Miriam Karp, PHA
Denise Boulter, PHA
Bride Harkin, PHA
Pat Cullen, PHA
Dawn Shaw, Action For Children
Eamon McMahon, BHSCT
Sharon Beattie, SBNI
Maurice Leeson, HSCB
Deirdre Webb, PHA

1. **Minutes of 13 December 2013**
   Under paragraph 4 of the NSPCC report, the minutes will be amended to reflect the fact that the work led by Molly Kane on perinatal mental health is to review current services with the potential to establish a specialist mother and baby unit; the unit option is to be explored.
   Bryan Nelson had also attended the meeting.

2. **Matters Arising**
   Commissioning regular focus groups with mothers who use HSC maternity services members were advised that there are number of focus groups held or planned on an ad hoc basis in relation to development/implementation of strategies to inform the PHA work on breastfeeding and as part of other initiatives. This work also relates to the PPI and patient experience agendas. It was agreed that a systematic approach to getting feedback from women who use maternity services and feeding that into trust and commissioner and multi-agency planning groups, was important and valuable. Dr Harper agreed to speak to Pat Cullen, Director of Nursing and AHPs to consider how best to take this forward in a systematic way and building on existing arrangements.

   Action: Dr Harper to speak to Mrs Cullen as above

   All other actions were completed or are on track.

3. **Work strand progress reports**

   a) **Infant Mental Health Training**
   This workstream remains on track. A regional action plan for infant mental health training has been drafted and revised with input from an expert reference group. The intention is to finalise the plan by May/June to come to the June Project Board meeting and if approved, to PHA management team and Board.

   The Solihull training, infant mental health diploma and video interactive guidance training are progressing well, though IT challenges remain in relation to video interactive guidance training. Recruitment for year two of the three training programmes is underway.

   The workstream has also made contact with Denise Boulter, PHA Midwifery and Janine Lynch, Consultant Psychiatrist in

Belfast Trust in relation to a service model from London that provides support to women who have perinatal mental health problems but are not at the threshold for statutory mental health services. The workstream will liaise with Molly Kane, PHA who is leading on the work to improve perinatal infant mental health, picking up the recommendations from the NSPCC report referenced above and at the December 2013 Project Board meeting.

b) Parenting Programmes

This workstream is taking forward the parenting programmes and other work funded through the Delivering Social Change programme. Incredible Years, infant mental health training, Strengthening Families and Parenting your Teen are all on track.

In relation to the Triple P programme, the results from the Longford based randomised controlled trial of Triple P were expected in January 2014, but are not yet available and the timescale for publication has not been confirmed. In addition, the stakeholder engagement workshops identified some concerns regarding the applicability of the Triple P programme within Northern Ireland. In light of these issues, Project Board accepted the advice of the workstream to put further work on Triple P on hold at this time and seek AMT and DHSSPS approval to vire resources to the other parenting programmes in this workstrand. DHSSPS are aware of the issues and the possibility of virement.

Action: Maurice to update DHSSPS lead and prepare a paper for Agency Management Team to seek approval to vire funds from Triple P to the other parenting programmes.

c) Family Nurse Partnerships

Members noted the update from Deirdre Webb on the existing FNP teams in Western, Southern and Belfast Trusts. Recruitment into the programmes is on track. In addition, in

response to the Commissioning Direction for 2014/15, the Commissioning Plan includes a commitment to extension of the FNP programme into the South Eastern and Northern Trust.

d) Roots of Empathy

The programme is running well in participating schools, currently 119 (1 in 7 primary schools). A further cohort of schools will be recruited from September 2014, and a further 40 instructors will be trained. A seminar is being planned for September/October 2014 to share the experience of the Roots of Empathy programme in Northern Ireland and, assuming results are available; share findings from the Roots of Empathy randomised controlled trial.

e) Social Complexity

The intervention has been finalised including the programme manual to support home visits. An outline research protocol has been drafted with advice from Professors Mike Clarke, Geraldine McDonald and Fiona Alderdice. Discussions are underway with Trusts regarding a pilot site. Objective this for the next period is to finalise the study protocol and pilot site.

f) Breastfeeding

Janet Calvert provided the action plan from the Breastfeeding Strategy Implementation Group. This includes specific actions under the following themes:

- Legislation
- Workplace Support
- HSC and Community Support
- Baby Friendly Settings
- Professional Training and Development
- Public Information
- Monitoring Indicators
- User Involvement
- Research.

Project Board will also receive progress reports against the action plan for information and advice as appropriate. The

Breastfeeding Strategy Implementation Group will oversee implementation of the breastfeeding strategy action plan and report to PHA Management Team and Board.

g) Research

The Roots of Empathy randomised controlled trial is on track. In addition, the Research Design Group has supported the work of the social complexity workstream. The Parenting your Teen programme is exploring the possibility of funding through the enabling scheme of HSC R&D. The Cochrane systematic review has conducted updated searches and it is anticipated that findings may be available for the September Board meeting.

There are no material concerns and the workstream is on track.

h) Communication

Discussions have been held with the CYPSP Outcomes Groups on the parenting programmes. These were very useful and constructive. Further engagement with Outcomes Groups is planned with the Transformation programme.

Celine McStravick from National Children's Bureau presented a short summary report on the study visit to Finland in September 2013. This highlighted some key policy differences between Finland and Northern Ireland, for example, a strong emphasis on universal services and delivering services to a very high standard. Members felt there would be value in also looking at the approaches in other countries and in drawing together a short simple document which would highlight key messages for policy makers, MLAs, other key decision makers in Northern Ireland.

Action: NCB to prepare the summary as outlined above.

i) Health Child Healthy Future

A range of initiatives are underway:

- All Trusts are increasing the number of health visitor students in 2014/15.

- An application has been made to GAIN to audit the quality of health visitor contacts.
- A case load waiting report is being prepared and will compare 2011 and 2013.
- Software for case load analysis is being developed.
- The family assessment document is being reviewed to identify opportunities to release health visitor time for direct patient care.
- The child health system will enable monitoring of health visitor contacts.
- Notably, the analysis of the scale of shortfall in health visitor provision in Northern Ireland has been presented to the Senior Management Team of HSCB and is included in the 2014/15 Service Development proposals. In addition, it has been included on the HSCB corporate risk register and on the corporate risk register of all Trusts.

4. Early Intervention Transformation Programme

Maurice Meehan and Dr Harper updated members on the EITP programme. There are three workstreams:

- Workstream 1 Pat Cullen as lead covering universal health visiting services and antenatal services.
- Workstream 2 Carolyn Harper covering development of a new early intervention service, standard offering of evidence based parenting programmes, and importantly integration of those with existing services within the geographic areas covered by the family support hubs (25 in total).
- Workstream 3 Fionnuala McAndrew Enhanced statutory social services.

  In terms workstream 2, the intention is to work with local Outcomes Groups and key stakeholders to develop a service specification for an early intervention service which would provide support to the families of children who are displaying signs of difficulty which haven't been resolved or cannot be resolved by a single agency, but are not yet at the threshold for statutory social services. There is little provision for these families at this time. The intervention service would provide support to the family at a level and for a duration appropriate to the family's needs. The emphasis will be on local level

responsive and flexible working and will depend heavily on good working relationships with all other providers in the area including the school principals, GPs, PSNI, Early Years Providers etc. A menu of parenting programmes would also be available, if required.

In response to queries from members, Dr Harper agreed to discuss the implementation structures with the workstream 2 steering group and with Directors of Social Services to ensure that the health needs of children are taken into account and met.

Action: Dr Harper to discuss with workstream 2 steering group and Directors of Social Services.

5. Bright Start Strategy and Learning to Learn Strategy

Members noted these recent strategies and expressed concern regarding the direction of travel compared to the messages coming through from the study visit to Finland. It was felt that the summary document referred to above would be helpful to members and others in engaging with policy makers in developing a cross government joined up set of strong policies to support children and improve a range of health and social wellbeing outcomes. Members also felt that there would be value in having PHA input to the childcare strategy management forum.

Action: Maurice Meehan to explore the possibility of PHA input into the childcare strategy management forum.

6. Any Other Business

In response to a query regarding breastfeeding rates by ward, Joy Poots to liaise with Brid Farrell directly.

Child Health System report Brid indicated that the report is now finalised and she will arrange to bring it through to AMT and PHA Board.

Action: Brid to arrange for the Child Health System report to come to Agency Management Team and PHA Board.

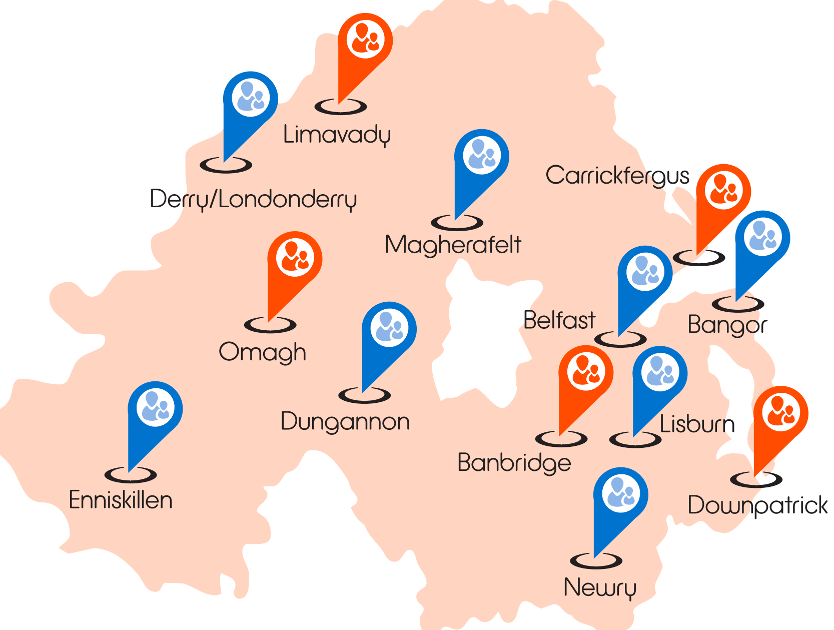
Northern Ireland Health Survey Janet Calvert reported that this included some useful information regarding breastfeeding attitudes. Janet will share the report to Project Board members through Finola.

Action: Janet Calvert to share the Northern Ireland Health Survey Summary with Finola for distribution to members.

Colin Report Card Maurice Meehan shared the report card format used by Colin Partnership to monitor progress in their early intervention work. Members felt that the report card was an excellent and clear way to track outcomes and progress across the various strands in the early intervention programme within Colin. It could also provide a model for monitoring at a more strategic level. NCB to consider this.

Action: NCB to consider adapting the report card for strategic outcomes monitoring.

Positive
Parenting
Programmes



Delivering Social Change across Northern Ireland

Delivering Social Change across Northern Ireland

Limavady

Derry/Londonderry

Magherafelt

Carrickfergus

Omagh

Belfast

Bangor

Dungannon

Lisburn

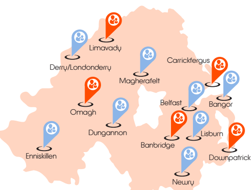
Enniskillen

Banbridge

Downpatrick

Newry

Delivering positive parenting support in Northern Ireland: expanding on what works, ensuring robust implementation and introducing new programmes



Delivering Social Change across Northern Ireland

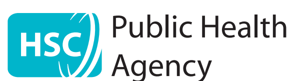
PHA - giving every child the best start in life

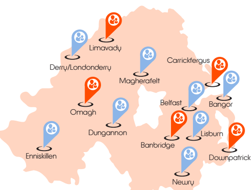
Early Intervention can be defined as ***'intervening early and as soon as possible to tackle problems emerging for children, young people and their families or with a population at risk of developing problems. Early intervention may occur at any stage in a child's life'.*** (C4EO, 2011)

The Delivering Social Change framework was set up by the Northern Ireland Executive to tackle poverty and social exclusion. It aims to deliver a sustained reduction in poverty and associated issues across all ages and to improve children and young people's health, well-being and life opportunities thereby breaking the long term cycle of multi-generational problems.

'We believe the most significant opportunities to improve people's health, well-being and life opportunities exist in the form of early interventions and services, particularly (but not exclusively) designed for children and young people.'
Delivering Social Change, Children and Young Person's Early Action Paper, November 2012

The Public Health Agency have been awarded funding through this Delivering Social Change Framework to develop and deliver a suite of positive parenting programmes.





Delivering Social Change across Northern Ireland

Engagement
Investment
Implementation

Ongoing engagement with the Child Development Project Board, the Children and Young People's Strategic Partnership, and other key stakeholders, has helped to inform this work.

Expenditure:

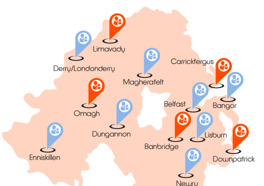
- £2 million

Implementation:

- Infant Mental Health
- Odyssey Parenting UR Teen
- Incredible Years
- Strengthening Families Programme
- Triple P

Numbers employed to date:

- Two full time and eight part time staff
- 10+ sessional workers



Delivering Social Change across Northern Ireland

Intervention across the life course

Programmes include:

Breastfeeding support (0-6 months)

Infant Mental Health (-9 months to 2 years)

Family Nurse Partnership (-9 months to 2 years)

Incredible Years (0-12 years)

Triple P (2-12 years)

Roots of Empathy (5-12 years)

Strengthening Families (10-14 years)

Odyssey: Parenting UR Teen (12-18 years)

-9 months

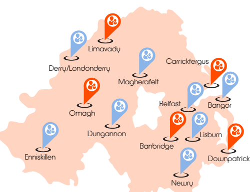
0 years

2 years

5 years

12 years

18 years



Delivering Social Change across Northern Ireland

Infant Mental Health Programme

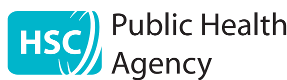
Evidence shows that strong maternal bonding with a child from the antenatal period to third year is a critical factor in enabling a child to reach their maximum potential.

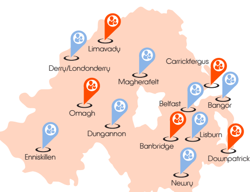
Following an audit of infant mental health training and service delivery in Northern Ireland, a regional infant mental health planning group has been convened, and a programme of infant mental health training is being rolled out for key personnel.

270 Health and Social Care staff, and from early years organisations, will receive infant mental health training from programmes such as

- Solihull
- Video interactive Guidance
- Tavistock M7 and M9 Diploma courses

to improve their assessment and intervention capacity to engage with vulnerable families with risks to the mental health of infants.





Delivering Social Change across Northern Ireland

Odyssey: Parenting UR Teen Programme

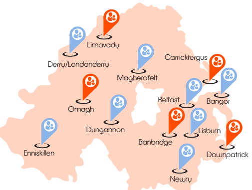
The Parenting Ur Teen Programme is, from April 2013, being offered to families in **six** locations across Northern Ireland each year for **two** years. **336** families will be supported.

The target group are those families experiencing difficulties in behaviour of teenager/pre-teenager children, and particularly to families with social complexity and/or wider disadvantage.

Successful outcomes include:

- an improvement in parenting style and parental mental health;
- improved teenage behaviour in the home;
- improved family functioning

Expansion of the programme to Scotland is a measurement of local success.



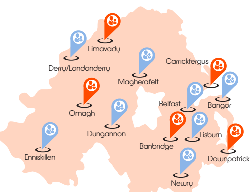
Delivering Social Change across Northern Ireland

Incredible Years Programme is a series of parenting programmes for children aged 0-12 years at risk of conduct disorder. It has been shown to reduce antisocial behaviour, school drop-out, violence, drug abuse and delinquency. It also reduces parental stress and increases effective parenting. All the programmes have been well evaluated globally by independent researchers using Randomised Controlled Trials studies, and have been shown to be highly effective.

The Public Health Agency is working to support the roll out and delivery of Incredible Years across the region on a coordinated basis.

In June 2012 an audit of programme delivery was undertaken across Northern Ireland. **70** Practitioners were involved in the audit process, and a practice seminar was held to inform the way ahead. Contact has been made with Incredible Years headquarters in Seattle, as well as other case study sites, to demonstrate good practice, integration, evaluation and fidelity.

Signature programme support will include training, practice networks, introduction of programme standards and an increase in the numbers of organisations delivering the Incredible Years programme to fidelity in Northern Ireland.

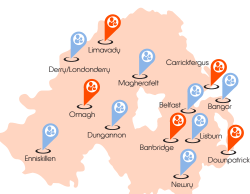


Delivering Social Change across Northern Ireland

Strengthening Families

The Strengthening Families Programme is designed to reduce risk factors for children in families with a history of parental drug and alcohol abuse. The core aim is to improve the family environment by helping parents to develop discipline techniques and to understand the importance of rewards and positive attitudes in their children.

The Delivering Social Change investment will expand and continue programmes in three Trust localities and facilitate local service development for two years in Belfast and Southern localities. In total across Northern Ireland, **48 programmes will be delivered over two years, involving 500 families.**



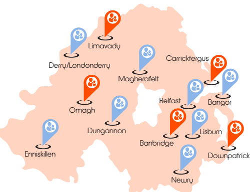
Delivering Social Change across Northern Ireland

Triple P Programme

Triple P is aimed at parents of children aged 2-12, and seeks to identify specific practices that might encourage negative behaviour, and replace them with strategies to promote good behaviours. There are **five** tiers of intervention depending on severity of behavioural difficulties, and each tier can be adapted for different age groups.

NSPCC have recently withdrawn delivery of Triple P in Northern Ireland. In light of this, Public Health Agency are considering evidence and delivery models from elsewhere, including the Republic of Ireland and Scotland, and will make a decision on future delivery. Referrals would be made through Social Work and Gateway teams.

In October 2013, an information seminar was held in Belfast, with over **70** practitioners in attendance. Presentations were made by representatives from Glasgow City Council and the Midlands Parenting Partnership.



Delivering Social Change across Northern Ireland

Key progress has been made, with the Public Health Agency working alongside the Children & Young People's Strategic Partnership, as well as other key stakeholders, to ensure efficient delivery of services.

'High quality parenting support is recognised as an important factor for ensuring that children get the best possible start in life. If we intervene early enough, and effectively enough, we can give children the much needed social and emotional foundation which will enable them to achieve throughout their lives and help to keep them healthy and happy'.
Delivering Social Change, Children and Young Person's Early Action Paper, November 2012

For further information, please contact:

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Public Health Agency
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Further information on Delivering Social Change can be found on the Office of the First and Deputy First Minister website at **www.ofmdfmni.gov.uk**

PHA/07/05/14

ALB Self-Assessment Action Plan

May 2014

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	15 May 2014
Title of Paper	ALB Self-Assessment Action Plan
Agenda Item	14
Reference	PHA/07/05/14

Summary

The PHA completed the ALB Self-Assessment for DHSSPS. The attached draft Action Plan has been prepared to address areas where "red flags" were identified within the questionnaire.

Equality Screening / Equality Impact Assessment	N/A
Recommendation / Resolution	For Noting
Director's Signature	
Title	Chair
Date	7 May 2014

ALB SELF ASSESSMENT QUESTIONNAIRE ACTION PLAN

Reference	Action	Responsible	Deadline	Status
1.1 GP1 RF1	PHA to raise with PAU and Sponsor Branch the need to fill vacancies on the PHA Board as quickly as possible.	Chair / PAU	June 2014	Not yet completed
2.1 GP3 RF2	Upon receipt of the guidance, the PHA will follow DHSSPS advice on independent verification of the self-assessment questionnaire.	DHSSPS	TBA	Not yet completed
2.1 GP4 RF3	PHA will discuss at its Board workshop in 2014, methods of obtaining stakeholder perspectives to assist the completion of next year's questionnaire.	Chair	September 2014	Not yet completed
2.2 GP1 GP4 GP6 RF1 RF2	PHA will review its own development needs as part of the agenda for its annual workshop, ensuring this addresses the findings of the self-assessment and takes account of the following elements: • Understanding relationship between Minister, DHSSPS and PHA • PHA business areas • PHA board effectiveness and governance arrangements	Chair	September 2014	Not yet completed
2.3 GP1	Review and amend PHA Board member induction process	Chair	October 2014	Not yet completed

PHA/08/05/14

Draft Investment Plan

May 2014

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	15 May 2014
Title of Paper	Draft Investment Plan 2014/15
Agenda Item	15
Reference	PHA/08/05/14

Summary

- The draft Investment Plan attached provides Members with an overview of the PHA budget position for 2014/15. It identifies the scale of additional funding that is available to support new developments in 2014/15 and how PHA has achieved efficiency savings of £2.0m to meet identified service pressures and priorities, as required under the Commissioning Plan.
- A more comprehensive Investment Plan document will be presented to the PHA board in June for final approval. This will contain more detailed information in relation to the breakdown of how the core baseline programme budgets will be allocated and a finalised list of all new developments that will be implemented in 2014/15.

Equality Screening / Equality Impact Assessment	N/A
Recommendation / Resolution	For Noting
Director's Signature	[signature]
Title	Director of Operations
Date	8 May 2014

Draft Investment Plan 2014/15

Introduction

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

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

Baseline Allocation 2014/15

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

Table 1: Baseline Budget 2014/15

Budget Area	Budget (£000s)
Opening Allocation	85,568
2014/15 pressures	3,577
Rotovirus Vaccination programme	165
2nd phase Children's Flu programme	1,699
Total	91,009

2.2 The opening allocation excludes additional funding that will be allocated to the PHA during the year by other Government Departments to take forward initiatives such as *Delivering Social Change*, *MARA* and the *Farm Families* project.

Recurrent Funding for New Developments

3.1 In addition to the new funding made available to the PHA in 2014/15, a detailed review of all existing baseline budgets has been undertaken to identify where existing funding commitments have naturally expired at the end of March 2014 as well as identifying opportunities to release and reallocate funds to support new developments and address service pressures of higher importance. As a result an overall investment fund of £3.218m has been identified. This is broken down as follows:

Table 2: Recurrent Funds for New Developments

Area of Funding	Allocated (£000's)	Available for Investment (£000's)
New Development funding 2014/15	1,438	1,438
Pay and Price uplift (2014/15)	2,139	1,235
Funding released from 2013/14 baseline	-	545
Total	3,577	3,218

3.2 In February 2014, the PHA agreed an initial package of new developments to the value of £2.113m and work is under way at the time of writing to finalise proposals in respect of the balance of £1.105m.

In Year funding

4.1 As there will be a planned lead-in time in getting many of the new developments fully operational, in-year funds of £1.432m will be generated and used to support a number of additional priorities during 2014/15.

4.2 In February 2014, the PHA board also approved in-year funding proposals totalling £0.949m. Additional proposals of £0.196m have now been identified linked to the MARA (£0.142m); ARC (£0.044m) and Melanoma (£0.010m) initiatives.

Proposals to the value of a further £0.287m are also currently being considered.

Table 3: Summary of In-year Funding Available

In year Funds	£000s
Total available 2014/15	3,218
In year requirement against £2.113m	(1,510)
Additional Non Recurring pressures approved February 2014	(949)
Additional Non Recurring for consideration	(196)
3 months effect of £1.1m	(276)
Balance of In- year funding remaining for allocation	**287**

Review of Baseline Budgets

5.1 In addition to new funding available to PHA, a review of how all baseline funding is being allocated in 2014/15 has also been undertaken. A total of £248k is being re-cycled to support new developments. A breakdown of the new developments is outlined in appendix 1.

Efficiency Savings 2014/15

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

6.2 Based on the information outlined above in table 2, the PHA has realised efficiencies of circa £1.235m from reviewing the application of pay and price uplifts and releasing £0.545m from the baseline budget.

6.3 In addition, new developments to the value of £0.248m have been funded by re-focusing funding within existing baseline budgets. In total, efficiencies of £2.028m will be achieved.

Monitoring and Review

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

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

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Appendix 1

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

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