agenda

105th Meeting of the Public Health Agency Board

Thursday 20 September 2018 at 1:30pm

Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast, BT2 7BS

standing items

1 1.30	Welcome and apologies		Chair
2 1.30	Declaration of Interests		Chair
3 1.30	Minutes of Previous Meeting held on 11 June 2018		Chair
4 1.30	Matters Arising		Chair
5 1.35	Chair's Business		Chair
6 1.40	Chief Executive's Business		Chief Executive
7 1.50	Finance Report	**PHA/01/09/18**	Mr Cummings

items for approval

8 2.00	Draft Commissioning Plan 2018/19	**PHA/02/09/18**	Dr McCarthy

items for noting

9 2.45	Director of Public Health Annual Report 2017	**PHA/03/09/18**	Dr Mairs
10 3.00	Management Statement / Financial Memorandum	**PHA/04/09/18**	Mr McClean
11 3.10	Review of PHA Procurement Planning Processes	**PHA/05/09/18**	Mr McClean
12 3.20	Programme for Government Report Cards	**PHA/06/09/18**	Mr McClean

closing items

13 3.30	Any Other Business	Chair
14 3.35	Details of next meeting: *Thursday 18 October 2018 at 1:30pm* *Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast*	

HSC Public Health Agency

minutes

104th Meeting of the Public Health Agency Board

Thursday 16 August 2018 at 1.30pm

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

Present

Mr Andrew Dougal	-	Chair
Mrs Valerie Watts	-	Interim Chief Executive
Mr Edmond McClean	-	Interim Deputy Chief Executive / Director of Operations
Dr Adrian Mairs	-	Acting Director of Public Health
Mrs Mary Hinds	-	Director of Nursing and Allied Health Professionals
Councillor William Ashe	-	Non-Executive Director
Mr John-Patrick Clayton	-	Non-Executive Director
Mr Leslie Drew	-	Non-Executive Director
Ms Deepa Mann-Kler	-	Non-Executive Director
Alderman Paul Porter	-	Non-Executive Director
Professor Nichola Rooney	-	Non-Executive Director
Mr Joseph Stewart	-	Non-Executive Director

In Attendance

Mr Paul Cummings	-	Director of Finance, HSCB
Ms Marie Roulston	-	Director of Social Care and Children, HSCB
Mr Robert Graham	-	Secretariat

Apologies

Mrs Joanne McKissick	-	External Relations Manager, PCC

70/18	**Item 1 – Welcome and Apologies**
70/18.1	The Chair welcomed everyone to the meeting. Apologies were noted from Mrs Joanne McKissick.
71/18	**Item 2 - Declaration of Interests**
71/18.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.
72/18	**Item 3 – Minutes of previous meeting held on 11 June 2018**
72/18.1	The minutes of the previous meeting, held on 11 June 2018, were approved as an accurate record of that meeting, subject to two amendments.

72/18.2 Paragraph 57/18.6 should be updated to remove the words in brackets, "and had not subsequently been screened in NI" and the following added to the end of that sentence, "…if they had not been invited for screening since registering with a Northern Ireland GP. This applies to 6 women." In the next sentence, the words "She advised that" and the number "9" should be removed.

72/18.3 In paragraph 60/18.10 the words "in social prescribing." should be added to the end of the paragraph.

72/18.4 Mr Stewart said that at the previous meeting, the Board had expressed a concern regarding the allocation of Transformation funding and how the PHA Board would have no input into any decisions on how this is allocated, and that this should be formally recorded. Mr McClean said that this discussion had taken place in the workshop part of the meeting. Mr Cummings added that he would cover Transformation funding as part of the Finance Report.

73/18 Item 4 – Matters Arising

73/18.1 There were no matters arising.

74/18 Item 5 – Chair's Business

74/18.1 The Chair presented his Report to the Board and began by giving an overview of the year-end Accountability Review meeting that had taken place. He said that he had asked that media campaigns was placed on the agenda, and that he would return to this under Item 8.

74/18.2 The Chair highlighted his concern about the dearth of trainees for consultants in public health and asked whether consideration had been given to the appointment of non-medical public health consultants. Mrs Hinds said that this is being considered as part of the development of a public health nursing framework. Dr Mairs said that it would be beneficial to develop multi-disciplinary teams, but that the real issue is that there are no local multi-disciplinary training programmes available, but that this is being addressed.

74/18.3 The Chair said that, in his opinion, there needs to be a more proactive communications strategy to deliver positive news stories and highlight the excellent work of the Agency.

74/18.4 The Chair advised that he had attended the latest Board meeting of Public Health England.

74/18.5 Ms Mann-Kler noted that non-executive Directors receive copies of press releases and asked about PHA's communications strategy. Mr McClean explained that within the Health Improvement team, each key area of business will have a communications plan. He explained that every two weeks there is a teleconference between the Department's Head of

Information and his counterparts in HSCB, PHA and the Trusts which looks at current issues and lines to take.

74/18.6 Alderman Porter asked if, in the absence of a Minister, there were delays in key messages coming out, but the Interim Chief Executive did not feel that this was the case and she added that since the appointment of David Gordon at the Department of Health, there is now a more proactive approach to communications.

75/18 Item 6 –Chief Executive's Business

75/18.1 The Interim Chief Executive began her Report with an update on the neurology review. She advised that the first phase has been completed which involved identifying and recalling, for neurological review, all active patients of Dr Michael Watt within a 12 week period up to 25 July 18. She added that the next phase, which is underway, involves seeing a small number of patients who were not seen within the 12 week time period (due to patient choice or because they had previously DNAd); undertaking reviews of those already seen (e.g. following investigations) and seeing previously discharged patients who have been re-referred into the neurology service by their GPs. She finished by saying that consideration is being given to the appropriate actions regarding other patients of Dr Watt who were previously discharged back to the care of their GP.

75/18.2 The Interim Chief Executive wished to put on record her thanks to Dr Adrian Mairs and Dr Miriam McCarthy for their contribution to dealing with this situation.

75/18.3 The Interim Chief Executive updated members on the recent recall incident relating to cervical screening which led to 150 women from 2 GP practices being recalled for cervical screening tests in June 2018 as a precautionary measure, due to concerns about the technique used to take their previous sample. She advised that the majority of these women have now attended for their repeat tests and the outcomes of these are being collated, but those who haven't attended have been individually followed up by the practices.

75/18.4 The Interim Chief Executive said that following a recent IT interface incident, a full investigation into the root causes of a number of screening results not transferring to call/recall system has been completed and mitigating solutions put in place. She advised that all affected patients have been reviewed and confirmed that no patient has come to harm as a result. She added that missing results have been manually inputted and all recall timescales have been reset accordingly and that two patients with a small delay in invitation for screening (less than 6 months) have been advised in writing and invited to attend for their next test.
The Interim Chief Executive said that workshops have been held with the voluntary sector and clinical staff in June 2018 to explore audit processes, information provided to women and disclosure of audit outcomes. Following the workshop, she advised that key principles were agreed and

	are informing the development of a comprehensive audit toolkit for Trusts and a patient information resource. She added that it is anticipated that these will be finalised and made available to Trusts by October, to be incorporated into local Trust protocols.
75/18.5	The Interim Chief Executive said that the Chair had already referenced the PHA's year-end Accountability Review, but she wished to thanks PHA officers for their work as it was due to their efforts and preparation for the ground clearing meeting in advance of the Accountability Review meeting that ensured there were no major issues.
75/18.6	The Interim Chief Executive advised members that since the last Board meeting the Department of Health, through Dr Paddy Woods, have formally commissioned the PHA to take forward the initial preparatory work associated with the implementation of the model for a Regional Improvement and Innovation system for Health and Social Care - HSCQI. She said that this work will build on the existing HSC Safety Forum resources to fully deliver the necessary support for quality improvement across the health and social care system, supported by a new HSCQI Alliance. She explained that the membership of the Alliance includes Chief Executives of HSC Trusts, Board/PHA, Chief professional officers from the DoH, GPs and Service users. She added that funding has been allocated to the PHA and a draft organisational structure developed by the Alliance and that the team are currently in the process of drafting job descriptions and ensuring the appropriate allocation of funding for projects identified in 2018/19. She finished by saying that a fuller paper will be brought to the PHA Board in September.
75/18.7	The Chair asked whether the post of Director of Improvement will be a member of the Agency Management Team. The Interim Chief Executive advised that this was the case.
75/18.8	Mr Clayton asked whether patients in the independent sector had been recalled as part of the neurology review. Dr Mairs confirmed that any patients treated in both the Hillsborough Clinic and Ulster Independent Clinic had been written to.
75/18.9	Professor Rooney returned to the Director of Improvement post and asked whether the decision to bring this into the PHA had been brought to the PHA Board. The Interim Chief Executive explained that the decision not to host the post within the PHA had been taken by the Department of Health, but it had since reversed that decision. Mr McClean said that it will be important in the next period for the PHA Board to get an understanding of its future governance responsibilities.

76/18 **Item 7 – Finance Report (PHA/01/08/18)**

76/18.1 Mr Cummings presented the Finance Report for the first quarter of 2018/19 and said that there was a surplus of £316k within programme expenditure and £177k within management and administration. In terms of the programme budget, he said that this is due to a timing issue and is not a concern, but within the management and administration budget, there are vacant posts and recruitment challenges. However, he added that if the recruitment challenges continue, surplus funds from management and administration will be utilised in the programme budget.

76/18.2 The Chair asked if potentially funding could be used on media campaigns. Mr McClean said that AMT will continue to monitor this. Mr Stewart suggested that the PHA Board would also have an input into any decisions made.

76/18.3 Mr Cummings gave members an overview of the Transformation funding. He advised that PHA had been given £4.2m under the confidence and supply agreement, but that most of this money is currently unallocated. He explained that most of the money will be allocated to HSC Trusts once IPTs (Investment Planning Templates) have been developed and approved. He added that the PHA Board has no remit in this area as the Department of Health is the project lead, and that the funding is ring-fenced, with any unspent funding having to be returned to HM Treasury.

76/18.4 The Chair asked when the funds will be allocated. Mr Cummings said that this would occur once the IPTs are approved. The Chair asked if the projects are PHA projects. Mr Cummings advised that the Lead Director for an initiative may be a PHA Director, but the Department is the project lead. The Interim Chief Executive added that the Permanent Secretary had made it clear that she, and other Directors in both HSCB and PHA, will be held accountable if the funds are not spent. In response to a question from the Chair, Mr Cummings confirmed that the funds are non-recurrent. The Interim Chief Executive said that this is a detailed area of work, as over 1,200 jobs are required to be recruited, and that she is expected to report at TIG (Transformation Implementation Group) meetings of any delays. The Chair asked that, since only six months of the financial year remained, if it would be possible to undertake the programme with a doubled level of activity. The response was negative.

76/18.5 Mr Drew asked about the number of vacant posts. Mr McClean said that it is currently around 10% of the workforce. Mr Drew also asked whether the Board would be kept informed about how any surplus funds may be reallocated. Mr McClean said that an update on this will be brought to the Board in October.

76/18.6 Ms Mann-Kler asked if there would be any future updates on the allocation of the Transformation money. Mr Cummings said that the money is for Trusts to allocate, but it must be done in compliance with the "green book", and it can therefore take up to six months before a

satisfactory business case is completed. He added that he would bring to the next meeting a breakdown of the individual schemes.

76/18.7 Professor Rooney returned to the subject of vacant posts, and asked whether there is a perception that PHA is a place that people want to work. Mr Cummings said that one of the key issues is that there is a skills shortage, and that some posts are hard to fill. Dr Mairs advised that within public health, there are not enough people coming through to fill the vacant posts. Mr McClean added that in some cases, there is the perception that posts in the PHA are at lower grades than equivalent posts in other HSC organisations. The Interim Chief Executive said that there is always work PHA could do to raise its profile as an organisation where people want to come and work.

76/18.8 Mr Clayton asked if there is a contingency plan if funding is not spent or if the Trusts are reluctant to spend. The Interim Chief Executive said that this is an issue that the Department is addressing.

76/18.9 Mr Stewart complimented officers on their work in scaling down the funding into projects of a meaningful size.

76/18.10 The Board noted the Finance Report.

77/18 Item 8 – Public Health Social Marketing Campaigns – Evidence of Effectiveness (PHA/02/08/18)

77/18.1 The Chair said that following the Accountability Review meeting, he was hopeful PHA would have received the go-ahead to run some campaign using surplus funds, but this was now looking unlikely. The Chair said that if, by the end of September, it is apparent that there will be surplus Transformation funding, PHA should ask the Department for the use of this so as not to rely on slippage.

77/18.2 Alderman Porter asked about the evaluation and whether it was undertaken by an unbiased source. Mr McClean said that it was, and he added that PHA measures success if a campaign reaches those people for whom it was designed to reach. Professor Rooney felt that the way the data were presented was not impressive. The Chair said that there should be reference to NICE (National Institute for Health and Clinical Excellence), because if it commends a campaign then this has greater impact.

77/18.3 Ms Mann-Kler said that while the paper was a good starting point, it should have been brought to the PHA Board before being submitted to the Department and could have been improved. She felt that there could have been more on the financial situation and the impact of this on campaigns. The Chair explained that he had asked, through the Director of Public Health, that a public health medical trainee undertake this work so that it could be shared with the Department in advance of the Accountability Review meeting, and that it was only completed the day

before the meeting. Ms Mann-Kler felt that a stronger case could have been made and it would have been useful to have personal testimonials. Councillor Ashe suggested that perhaps PHA should measure the impact of not running campaigns.

77/18.4 Mr Clayton said that all of this Transformation work can take place, but if the public health aspect is not right then there is no point, and he felt that there should be a piece of work about communication. He asked whether health inequalities were looked at when doing campaigns. Mr McClean explained that before any campaign is done, there is extensive research undertaken in terms of who the campaign is trying to reach, and what is the most effective way of reaching those people.

77/18.5 Alderman Porter said that PHA needed to be realistic and should only attempt to undertake one campaign at a time. Mr Cummings said that under the current financial climate, the scenario is unlikely to change so if PHA wishes to undertake a campaign it should do so from within its own financial allocation. Mr Drew said that going forward, if PHA can find the funding, it is fundamental that it demonstrates that every £1 invested results in £x being saved.

77/18.6 Ms Mann-Kler asked what has been agreed. The Chair asked whether it was worthwhile enhancing and re-submitting the report. Mr Drew said that the report contained a lot of information, but it was hard to substantive the savings. Mr McClean said that areas for potential campaigns have been submitted to the Department. He agreed to share this list with Board members.

78/18 Item 9 – Annual Report for the Northern Ireland Diabetic Eye Screening Programme 2016/17 (PHA/03/08/18)

78/18.1 Dr Mairs introduced Dr Stephen Bergin, Assistant Director of Screening, who was presenting this Report. Dr Mairs explained that diabetic eye screening is open to anyone over the age of 12 and that the programme has expanded considerably since 2008 with the number of people eligible to attend almost doubling.

78/18.2 Dr Bergin began his overview of the report by explaining that the object of screening is to obtain an early diagnosis, and that screening programmes are dictated by the UK National Screening Committee. He said that in Northern Ireland there are 8 programmes and PHA is responsible for these programmes. He added that over the coming months he would be returning to the Board with reports of other screening programmes.

78/18.3 Dr Bergin advised that Report is for 2016/17. He explained that diabetes is becoming a major health issue that 6% of the population has diabetes, but many are not aware. He said that it is a significant disease and can affect the eyes with its effects being either slow or rapid and catastrophic. He advised that this programme is run by PHA in conjunction with the Belfast Trust, and then when an individual is invited to attend, the test

takes 15 minutes and that 2 photographs are taken with a specialised camera. Following the test, he outlined the three possible results – the individual may have no issues; there may be evidence of damage and a return follow up will be arranged; or a referral to hospital may be required and this can be fast tracked if necessary.

78/18.4 Dr Bergin said that, of those eligible for screening, the attendance for Northern Ireland as a whole was 69.2%, but he would like this to be higher. In terms of going forward, he said the biggest issue for PHA was looking at the uptake among the different socio-economic groups.

78/18.5 Mr Drew noted that one of the hindrances in the Report is the absence of suitable accommodation to undertake the tests and he asked about the use of wellbeing centres. Dr Bergin said that this is a critical issue which PHA is trying to address. He said that various options are being scoped and will be put into a public consultation document. Dr Mairs said that there is a need to provide the programme in a different way.

78/18.6 Alderman Porter noted that PHA is relying on a partnership approach and asked what it can do to improve the uptake. Dr Bergin said that GPs are under pressure in the availability of their accommodation, and that is why there is a need to look at a different model. Dr Mairs added that PHA is not in control in terms of getting access to rooms, but relies on collective working and good will.

78/18.7 Ms Mann-Kler said that diabetes is a public health issue, and that it is a significant issue to merit a public health campaign. Dr Bergin agreed that diabetes can affect every part of the body, and he said that there is a regional network looking at this.

78/18.8 The Board **APPROVED** the Diabetic Eye Screening Report.

79/18 Item 10 – Annual Quality Report (PHA/04/08/18)

79/18.1 Mrs Hinds introduced Ms Grainne Cushley, Project Lead, Safety Quality and Patient Experience to the Board and asked her to present the Report to members.

79/18.2 Ms Cushley advised that this is the fifth Annual Quality Report produced jointly by HSCB and PHA and that the development of the Report is overseen by the Quality Safety Experience group. She said that the Report is currently at the design stage and that it is hoped to bring the final Report to the next Board meeting.

79/18.3 Ms Cushley said that the five sections within the Report following the five strategic goals of Quality 2020, namely Transforming the Culture, Strengthening the Workforce, Measuring Improvements, Raising the Standards and Integrating the Care. Within each section, she said that there are links to where additional information can be found.

79/18.4 Ms Cushley drew members' attention to the infographic which gives a summary of some of the key findings within each section. She explained that the choice of colour for each section has been specifically to tie in with that theme.

79/18.5 Ms Cushley said that following approval by both the HSCB and PHA boards, it is anticipated that the Report will be launched on World Quality Day in November. In the lead up to the publication, she advised that each of the infographics will appear on social media and that feedback will be sought from the public to help inform the structure of next year's report.

79/18.6 The Chair asked if the Dementia Together initiative had ended. Mrs Hinds explained that although the implementation of the Strategy had reached its natural end, some additional funding has been sought from Transformation monies to continue some of the elements.

79/18.7 Ms Mann-Kler commended the work in producing the infographics, but she asked what follow up there will be to Quality 2020. Mrs Hinds said that the Department of Health does not have any specific plans, but these will link in with the work of HSCQI.

79/18.8 Mr Drew said that there is a lot of information in the Report and it comes across very well. He said that it is the type of Report that should be available in GP surgeries as a way of helping to increase the profile of PHA.

79/18.9 Mr Clayton said that the Report contained a lot of useful information and asked if there were any perspectives on workforce issues. Mrs Hinds advised that there are workforce issues, e.g. staff numbers and also morale. She cited the example of Project Retain which is focused on nursing in older people's services. In terms of this year, she added that there is a Commissioning Plan Direction which sets out the priorities for the year.

79/18.10 Mrs Hinds commended the work of Ms Cushley in producing this Report.

79/18.11 The Board **APPROVED** the Annual Quality Report.

80/18 Item 11 – ALB Self-Assessment Tool (PHA/05/08/18)

80/18.1 The Chair presented the ALB Self-Assessment tool and began by apologising for the slight delay in forwarding this paper. He said that in previous years there had been an opportunity for Non-Executives to comment on this in advance, but this had not happened on this occasion, although he had reviewed it. Mr Cummings said that in HSCB, the Governance Committee would normally complete this before it is brought to the Board.

80/18.2 Mr Drew felt that there needed to some degree of involvement from an external facilitator to help pull this document together. The Chair agreed

that for the completion of next year's questionnaire he would like more people to be involved. Mr Cummings said that the document is a checklist and he asked where the Board sees it weaknesses.

80/18.3 Mr Drew expressed concern that there had not been the opportunity for members to review this in advance. Mr Stewart said this exercise could be a useful exercise in terms of self-assessment, or a box-ticking exercise, and it was his view that a number of members should come together to complete it in advance of it being brought to the Board. The Chair thought it would be helpful to have an external facilitator, but the Interim Chief Executive did not feel that this was necessary.

80/18.4 Ms Mann-Kler agreed that it would be beneficial to have facilitated input, as it would also be useful to see how far the Board has progressed since the Board Effectiveness exercise was undertaken in March 2017, given that PHA now has a full Board membership. The Interim Chief Executive said that she is not against having a facilitated session, but explained that there are difficulties in securing external facilitation due to restrictions on the use of consultants.

80/18.5 It was agreed that there would be an early workshop to look at the self-assessment tool and Board effectiveness and it could be facilitated by an associate of the Leadership Centre.

80/18.6 The Board **APPROVED** the self-assessment tool.

81/18 Item 12 – PHA Procurement Plan (PHA/06/08/18)

81/18.1 Mr McClean explained that this paper was an update in advance of a further paper being brought to the Board which outlines the challenges PHA is currently facing with regard to procurement. He said that PHA is now reaching a stage where the re-procurement has to take place of some of the contracts which were procured in the last few years.

81/18.2 Mr McClean advised that approximately 190 contracts have been evaluated this year, and then there are the Transformation initiatives; however every effort will be made to ensure the procurement process is undertaken as efficiently as possible. With regard to Transformation funding, he noted that some of these exercises will take longer than 4/6 weeks as PHA could be open to challenge on its processes.

81/18.3 Alderman Porter asked how organisations can protect themselves and if contracts are time limited. Mr McClean said that all contracts are clear in terms of time, but he added that if contracts are moved then TUPE regulations may apply and he cited the example of the Lifeline contract.

81/18.4 The Board noted the update on the PHA Procurement Plan.

82/18	**Item 13 – Any Other Business**
82/18.1	There was no other business.
83/18	**Item 14 – Details of Next Meeting**
	Thursday 20 September 2018 at 1.30pm *Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast* Signed by Chair: Date:

Public Health Agency

Finance Report

2018-19

Month 4 - July 2018

PHA Financial Report - Executive Summary

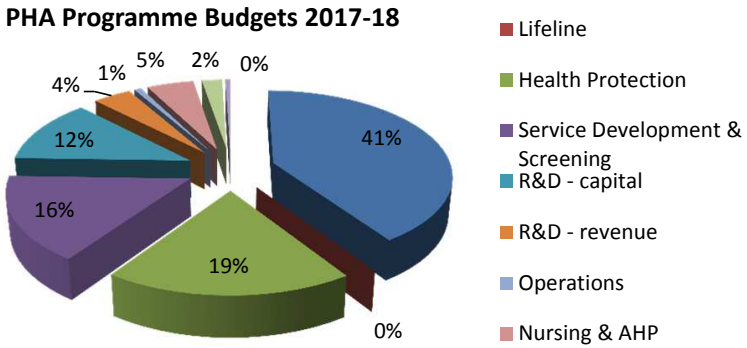
Year to Date Financial Position (page 2)

At the end of month 4 PHA is underspent against its profiled budget by approximately £0.7m. This underspend is primarily within Programme budgets across the Agency, and also includes some underspends on Administration budgets, as shown in more detail on page 5.

Whilst this position is not unusual for this stage of the year due to the difficulty of accurately profiling expenditure, budget managers are being encouraged to closely review their positions to ensure the PHA meets its breakeven obligations at year-end.

Programme Budgets (pages 3&4)

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

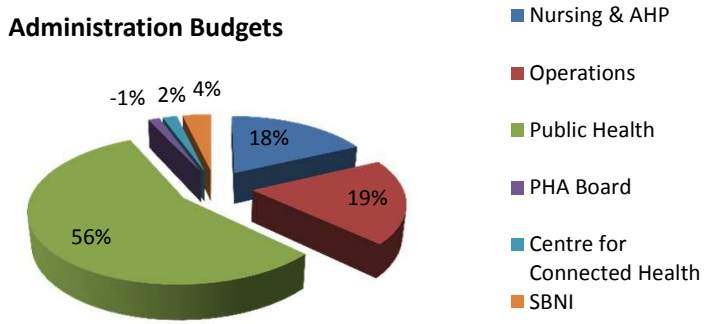


Administration Budgets (page 5)

Approximately half of the Administration budget relates to the Directorate of Public Health, as shown in the chart below.

A significant number of vacant posts remain within PHA, and this is creating slippage on the Administration budget.

Management is proactively working to fill vacant posts and to ensure business needs continue to be met.



Full Year Forecast Position & Risks (page 2)

PHA is currently forecasting a breakeven position for the full year. Slippage is expected to arise from Administration budgets in particular, however management expect this to be used to fund a range of in-year pressures and initiatives.

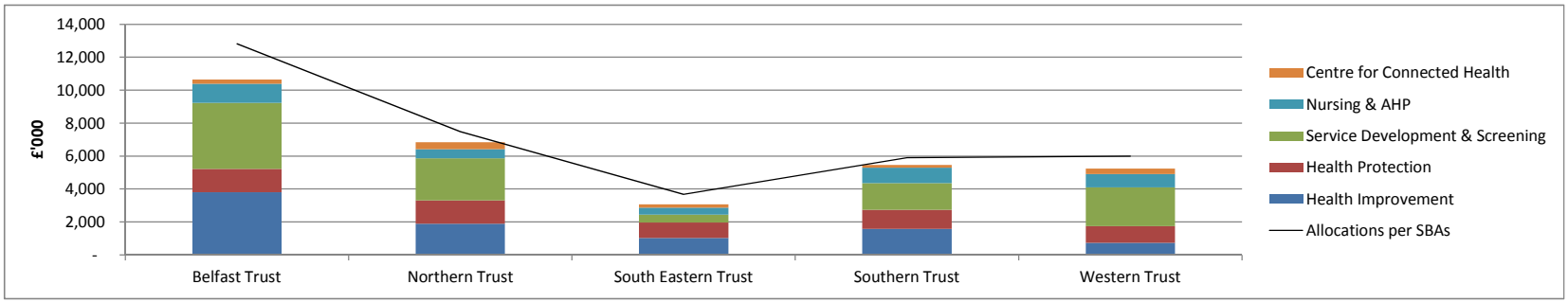
Public Health Agency
2018-19 Summary Position - July 2018

		Annual Budget					Year to Date				
		Programme		Ringfenced Funds	Mgt & Admin	Total	Programme		Ringfenced Funds	Mgt & Admin	Total
		Trust	PHA Direct	Trust & Direct			Trust	PHA Direct	Trust & Direct		
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources											
Departmental Revenue Allocation		31,335	44,169	7,874	18,819	**102,197**	9,475	7,952	1,038	6,170	**24,634**
Revenue Income from Other Sources		-	218	-	560	**778**	-	175	-	193	**368**
Total Available Resources		31,335	44,387	7,874	19,379	**102,975**	9,475	8,127	1,038	6,363	**25,003**
Expenditure	*Page*										
Trusts	*3*	31,335	-	515	-	**31,850**	10,456	-	515	-	**10,971**
PHA Direct Programme *	*4*	-	44,906	7,359	-	**52,265**	-	6,741	523	-	**7,264**
PHA Administration	*5*	-	-	-	18,860	**18,860**	-	-		6,051	**6,051**
Total Proposed Budgets		31,335	44,906	7,874	18,860	**102,975**	10,456	6,741	1,038	6,051	**24,285**
Surplus/(Deficit) - Revenue		(0)	(519)	0	519	(0)	(981)	1,386	(0)	312	**717**
Cumulative variance (%)							***-10.36%***	***17.06%***	***0.00%***	***4.91%***	***2.87%***

The year to date financial position for the PHA shows an underspend against profiled budget of approximately £0.7m, mainly due to spend behind profile on PHA Direct Programme budgets (see page 4), and also a year to date underspend on Admininstration budgets (see page 5). It is currently anticipated that the PHA will achieve breakeven for the full year with underspends on Administration budgets being used to support a range of Programme priorities.

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

Programme Expenditure with Trusts



Core Funds Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	3,805	1,898	1,030	1,587	725	**9,046**	2,247	3,015	(769)
Health Protection	1,424	1,416	940	1,158	1,019	**5,957**	1,986	1,986	0
Service Development & Screening	4,004	2,554	477	1,613	2,349	**10,997**	3,612	3,666	(54)
Nursing & AHP	1,150	554	420	944	819	**3,887**	1,148	1,296	(148)
Centre for Connected Health	264	420	204	164	325	**1,377**	459	470	(11)
Other	24	13	11	12	11	**72**	24	24	0
Total current RRLs	**10,670**	**6,855**	**3,083**	**5,478**	**5,248**	**31,335**	**9,475**	**10,456**	**(981)**
Cumulative variance (%)									***-10.36%***

The above table shows the current Trust allocations split by budget area.

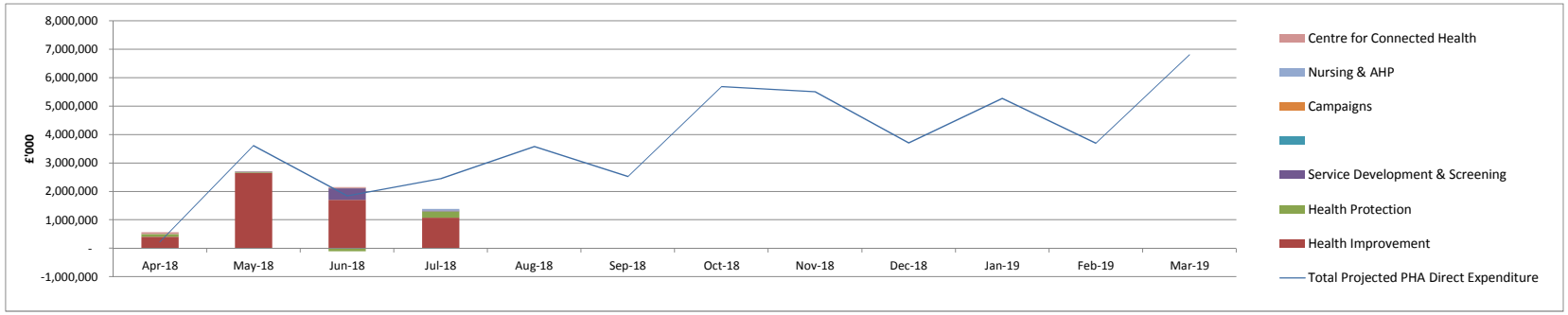
The year to date position shows an overspend against profile, but this is a timing issue only as funds initially held within non-Trust budgets have been issued to Trusts. (Budgets are realigned between Trust and PHA Direct periodically during the year, and this has not been done in the current month.) The Programme position across both Trust and PHA Direct budgets is a £0.4m underspend, mainly due to expenditure behind profile in Health Protection (see page 4). It is expected that these budgets will break even at the end of the year. A breakeven position is also anticipated for the full year.

The Other line relates to general allocations to Trusts for items such as the Apprenticeship Levy and Inflation.

Ringfenced Funds	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / £'000
C&S Transformation & EITP Funds	**103**	**103**	**103**	**103**	**103**	**515**	**515**	**515**	0
									0.00%

Confidence & Supply Transformation funds and the Early Intervention Transformation Programme are ringfenced by DoH and must be reported separately from Core Funds.

PHA Direct Programme Expenditure



Core Funds	Apr-18 £'000	May-18 £'000	Jun-18 £'000	Jul-18 £'000	Aug-18 £'000	Sep-18 £'000	Oct-18 £'000	Nov-18 £'000	Dec-18 £'000	Jan-19 £'000	Feb-19 £'000	Mar-19 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000	
Projected Expenditure																	
Health Improvement	88	3,053	1,155	2,225	2,898	1,064	2,589	2,322	987	3,022	2,759	4,308	**26,468**	6,520	5,854	666	*10.2%*
Health Protection	56	347	93	78	446	888	2,960	1,818	1,023	1,001	709	1,149	**10,568**	574	244	331	*57.6%*
Service Development & Screening	18	140	524	74	54	508	69	88	429	54	121	812	**2,891**	756	586	170	*22.5%*
Research & Development - revenue	-	-	-	-	-	-	-	1,200	1,200	1,100	-	-	**3,500**	-	2	(2)	*0.0%*
Campaigns	9	9	9	9	9	9	9	9	9	9	9	93	**195**	37	1	36	*-100.0%*
Nursing & AHP	17	17	20	24	130	17	17	34	20	50	57	19	**421**	78	69	9	*11.7%*
Centre for Connected Health	40	40	40	40	40	40	40	40	40	40	40	40	**484**	161	92	69	*42.9%*
Other	-	-	-	-	-	-	-	-	-	-	-	379	**379**	0	(107)	107	*100.0%*
Total Projected PHA Direct Expenditure	**227**	**3,607**	**1,842**	**2,450**	**3,577**	**2,526**	**5,684**	**5,511**	**3,708**	**5,276**	**3,695**	**6,801**	**44,906**	**8,127**	**6,741**	**1,386**	
Cumulative variance (%)																***17.06%***	
Actual Expenditure	**570**	**2,784**	**2,007**	**1,380**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**6,741**				
Variance	**(343)**	**824**	**(165)**	**1,071**									**1,386**				

The budgets and profiles are shown after adjusting for retractions and new allocations from DoH.

Expenditure is £1.4m behind profile for the year to date, however some of this funding has been allocated to Trusts and is shown on page 3. (Budgets are realigned between Trust and PHA Direct periodically during the year, and this has not been done in the current month.) Programme spend as a whole (Trust and PHA Direct) is £0.4m behind profile at month 4, mainly due to delays on payments within Health Protection. Budget managers will continue to review variances closely throughout the remainder of the year to ensure PHA meets its breakeven obligations.

Ringfenced Funds	Apr-18 £'000	May-18 £'000	Jun-18 £'000	Jul-18 £'000	Aug-18 £'000	Sep-18 £'000	Oct-18 £'000	Nov-18 £'000	Dec-18 £'000	Jan-19 £'000	Feb-19 £'000	Mar-19 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000	
C&S Transformation & EITP Funds	**-**	**3**	**19**	**501**	**280**	**90**	**235**	**251**	**86**	**152**	**217**	**5,524**	**7,359**	**523**	**523**	**-**	
																0.00%	
Actual Expenditure	**-**	**170**	**55**	**299**									**523**				
Variance	**-**	**(167)**	**(35)**	**202**									**-**				

Confidence & Supply Transformation funds and the Early Intervention Transformation Programme are ringfenced by DoH and must be reported separately from Core Funds. Some of this funding will transfer to Trusts when the appropriate business cases are approved.

PHA Administration
2018-19 Directorate Budgets

	Nursing & AHP £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Annual Budget							
Salaries	3,409	2,542	10,826	173	319	484	**17,754**
Goods & Services	177	1,264	349	35	54	246	**2,125**
Savings target				(500)			**(500)**
Total Budget	**3,586**	**3,806**	**11,175**	**(292)**	**373**	**730**	**19,379**
Budget profiled to date							
Salaries	1,091	847	3,613	58	106	161	**5,876**
Goods & Services	55	390	105	(155)	27	65	**487**
Total	**1,147**	**1,237**	**3,717**	**(97)**	**134**	**226**	**6,363**
Actual expenditure to date							
Salaries	1,068	804	3,393	38	111	102	**5,514**
Goods & Services	62	323	108	4	6	33	**537**
Total	**1,130**	**1,127**	**3,501**	**42**	**117**	**134**	**6,051**
Surplus/(Deficit) to date							
Salaries	24	43	220	20	(5)	60	**362**
Goods & Services	(7)	67	(3)	(159)	21	32	**(50)**
Surplus/(Deficit)	**17**	**110**	**217**	**(139)**	**16**	**91**	**312**
Cumulative variance (%)	*1.45%*	*8.89%*	*5.83%*	*142.93%*	*12.12%*	*0.00%*	***4.91%***

A savings target of £0.5m was applied to the PHA's Administration budget in 2018-19. This is currently held centrally within PHA Board, and will be managed across the Agency through scrutiny and other measures.

The year to date salaries position is showing a £0.3m surplus which has been generated by a number of vacancies during the year. A surplus of approximately £0.5m is currently forecast for the full year, and Senior Management will develop a plan over the coming months to ensure this surplus is used to fund key Programme priorities and enable the PHA to meet its breakeven obligation for the financial year.

July 2018

Public Health Agency
2018-19 Capital Position

	Annual Budget				Year to Date			
	Programme				Programme			
	Trust	PHA Direct	Mgt & Admin	Total	Trust	PHA Direct	Mgt & Admin	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources								
Capital Grant Allocation & Income	7,107	3,516	-	**10,623**	2,369	1,123	-	**3,492**
Expenditure								
Capital Expenditure - Trusts	7,107			**7,107**	2,369			**2,369**
Capital Expenditure - PHA Direct		3,516		**3,516**		380		**380**
	7,107	3,516	-	**10,623**	2,369	380	-	**2,749**
Surplus/(Deficit) - Capital	-	-	-	-	-	744	-	**744**
Cumulative variance (%)					*0.00%*	*66.21%*	*0.00%*	***21.29%***

PHA has received a Capital budget of £10.6m in 2018-19, most of which relates to Research & Development projects in Trusts and other organisations. A £0.7m surplus is shown for the year to date. This is a timing issue only, and a breakeven position is anticipated for the full year.

PHA Prompt Payment

Prompt Payment Statistics

	July 2018 Value	July 2018 Volume	Cumulative position as at 31 July 2018 Value	Cumulative position as at 31 July 2018 Volume
Total bills paid (relating to Prompt Payment target)	£3,705,711	450	£12,525,721	1,850
Total bills paid on time (within 30 days or under other agreed terms)	£3,694,515	422	£12,375,258	1,750
Percentage of bills paid on time	**99.7%**	**93.8%**	**98.8%**	**94.6%**

Prompt Payment performance for the year to date shows that on value the PHA is achieving its 30 day target of 95.0%, although on volume performance is slightly below target at 93.8%. PHA is making good progress on ensuring invoices are processed promptly, and efforts to maintain this good performance will continue for the remainder of the year.

The 10 day prompt payment performance remained strong at 91.7% by value for the year to date, which significantly exceeds the 10 day DoH target for 2018-19 of 60%.

HSC Public Health Agency

board paper

Draft Commissioning Plan 2018/19

date 20 September 2018 **item** 8 **reference** PHA/02/09/18

presented by Dr Miriam McCarthy, Director of Commissioning, HSCB

action required For approval

Summary
Members are asked to approve the attached draft Commissioning Plan 2018/19 (Appendix 1) for submission to the Department of Health.

The Commissioning Plan has been produced collaboratively by the HSCB/PHA, led by a multi-disciplinary editorial group. The Plan seeks to respond to the key four aims outlined within the draft Commissioning Plan Direction 2018 (Appendix 2), namely:

- To improve the health of the population
- To improve the quality and experience of health and social care
- Ensure the sustainability of health and social care services provided
- Support and empower staff delivering health and social care services

The Plan also identifies the key priority areas to be commissioned regionally and locally. However, it should be noted that the Plan does not seek to highlight all of the work being taken forward by HSCB/PHA in 2018/19. Rather, the Plan focusses on a number of key strategic and service priorities which are likely to yield the greatest benefit in terms of patient outcomes and experience of health and social care services at both a regional and local level.

The Commissioning Plan has been produced within a challenging commissioning and financial context. Trusts have already been provided with indicative allocations – from these allocations Trusts will be asked to respond appropriately to the changing patient and client needs and to the specific service pressures identified within the Plan.

Trust responses to the Commissioning Plan (in the form of Trust Delivery Plans) will demonstrate how they propose to address these needs and pressures while living within available financial resources. TDPs will be subject to HSCB Board consideration at a future meeting.

Should members approve the attached draft Plan, the finalised document will be submitted to the Department no later than week beginning 24 September 2018.

Financial implications

The Commissioning Plan has been drafted on the basis of the assumed financial allocations for 2018/19 received from DoH. Other priorities listed should have funding streams already identified or have no additional financial impact during 2018/19.

Equality Impact Assessment

Consistent with statutory obligations Board and Agency staff have undertaken a detailed assessment of the draft Commissioning Plan to identify any potential equality issues arising from the recommendations within the draft Plan. An equality screening report has been draft which outlines the cumulative impact of the Plan on the population of N.Ireland.

The screening document also specifies mitigating action to be taken to avoid any potential negative impact on the nine equality groups. It also specifies where a more in depth EQIA is likely to be required to be completed in advance of implementation. A copy of the screening document is attached at Appendix 3.

It is the view of the HSCB and PHA that there no disproportionate impact on any Section 75 group as a result of this Plan.

Recommendation

Members are asked to **APPROVE** the draft Commissioning Plan as a response to the Commissioning Plan Direction 2018/19, to be forwarded following consideration by the PHA Board to the Department of Health.

Attached separately:

(i) Draft Commissioning Plan 2018/19
(ii) Commissioning Plan Direction 2018 (DOH)
(iii) Equality, Human Rights & Good Relations Screening of Draft Commissioning Plan 2018/19

HSC Public Health Agency

board paper

Director of Public Health Annual Report 2017

date	20 September 2018	**item**	9	**reference**	PHA/03/09/18

presented by Dr Adrian Mairs, Acting Director of Public Health

action required For noting

Summary

The Director of Public Health is required to produce an annual report. The draft report for 2017/18 is attached for information.

The theme this year is early intervention. For the purposes of the report, early intervention does not simply refer to 'early years' intervention – it can be intervention at an early age or intervention at an early stage, for example in a disease process.

The Overview at the beginning provides information on, and examples of, early intervention across the life course. The remaining sections provide more information on specifics areas of work within the different divisions within the Public Health Directorate:

- Health Improvement;
- Health Protection;
- Screening and Service Development; and
- Research and Development.

Equality Impact Assessment

Not applicable.

Recommendation

The Board is asked to **NOTE** the Director of Public Health Report 2017.

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09/18

Director of Public Health Annual Report 2017

Director of Public Health
Annual Report
2017

Public Health Agency

Obesity
HPV
Early Intervention Transformation Programme
Lifestyle intervention
Meningococcal disease
Physical activity
Choose to Live Better
INCREDIBLE YEARS
Welcome Here
Breastfeeding
Home safety check scheme
Family Nurse
Partnership
If I were Jack
Making Life Better
Antimicrobial resistance
#STILLME
Early Intervention
Support Service
Home
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families
Cessation
Smoking
Roots of Empathy
Dementia Together NI
Antenatal care
Mental health
and wellbeing
AAA screening
Sector
Voluntary
Youth Engagement
Service
Thrombectomy
Bowel cancer screening
Type 2
diabetes
Stroke
Mindset
Adolescent
Outbreak
control
Diabetic eye
screening
First Aid
Mental Health
Want2Stop
Early intervention
Human
papillomavirus
vaccine
Baby
Friendly
Initiative
education
and sexuality
Relationships
Relationships and Future
Fatherhood Programme
Thrombolysis
Suicide prevention
Smokebusters
#NotSorryMums
Weigh to a Healthy Pregnancy
Give it a Go!
Newborn Blood spot Screening Programme
Thrombolysis
Cervical cancer
Adverse childhood experience

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Foreword

Foreword

Dr Adrian Mairs

Public health is defined as *'the art and science of preventing disease, prolonging life and promoting health through the organised efforts of society'.*[1] Early intervention to prevent disease, prolong life and promote health is a fundamental cornerstone of effective public health practice.

In the early 20th century Thomas Edison, inventor of the light bulb, is reported to have predicted the need for greater focus on prevention and early intervention in health. He is quoted as suggesting that *'the doctor of the future will give no medication, but will interest his patients in the care of the human frame, diet and in the cause and prevention of disease'.*[2] Inherently, logic implies that the earlier action is taken to prevent or resolve a problem the better the outcome.

In more recent decades, governments and policy makers across the globe have increasingly recognised the need to intervene early, both in the life course and early in the stage of disease, to effectively improve the public's health and wellbeing. For example, in the UK in 2010 the publication of the *Fair society, healthy lives* report on reducing health inequalities, shone a spotlight on the significance of development in the early years of life.[3]

In Northern Ireland, the principles of prevention and early intervention are firmly embedded in the Executive's draft Programme for Government and *Making Life Better*, the strategic framework for public health.[4, 5] These focus on a collaborative cross governmental approach to early intervention and recognise *'the importance of what happens in the early years of life for future experience of*

health and well-being and other life outcomes, such as educational attainment'.[3] Two key themes of *Making Life Better*, 'giving every child the best start' and 'equipped throughout life' take account of needs across the life course, with emphasis given to children and young people, and to supporting individuals' transitions into and through adulthood and older age.[5]

Furthermore the Programme for Government, the *Systems, not structures* review of health and social care in Northern Ireland, and the *Health and wellbeing 2026: delivering together* strategy all recommend early intervention in healthcare outlining that health *'services must be designed and delivered in ways that support people to manage their own care... and enable early intervention to prevent and delay illness.'* [4, 6, 7]

The Public Health Agency (PHA) works in partnership with regional and local government, health and social care professionals, communities and the public to deliver on these important strategic objectives, 'through the organised efforts of society'. This, the ninth annual report of the Director of Public Health, provides a brief snapshot of such work undertaken in 2017. A wide range of projects and ongoing research is described. These include programmes to give children the best start in life, such as the Breastfeeding Welcome Here and Smokebusters schemes, population interventions to detect and protect from ill health at an early stage, such as the human papillomavirus vaccination and newborn blood spot screening programmes, and the development of safe high quality healthcare services to allow early diagnosis and treatment, including effective stroke services.

Dr Adrian Mairs
Acting Director of Public Health

Further information

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Overview

Overview

Early intervention

Early intervention in early years

Pre-pregnancy and pregnancy

Post-pregnancy

Early intervention for young people and teenagers

Early intervention in the adult population

Early intervention for older people

Early intervention in disease prevention: screening and vaccination programmes

Overview

Early intervention

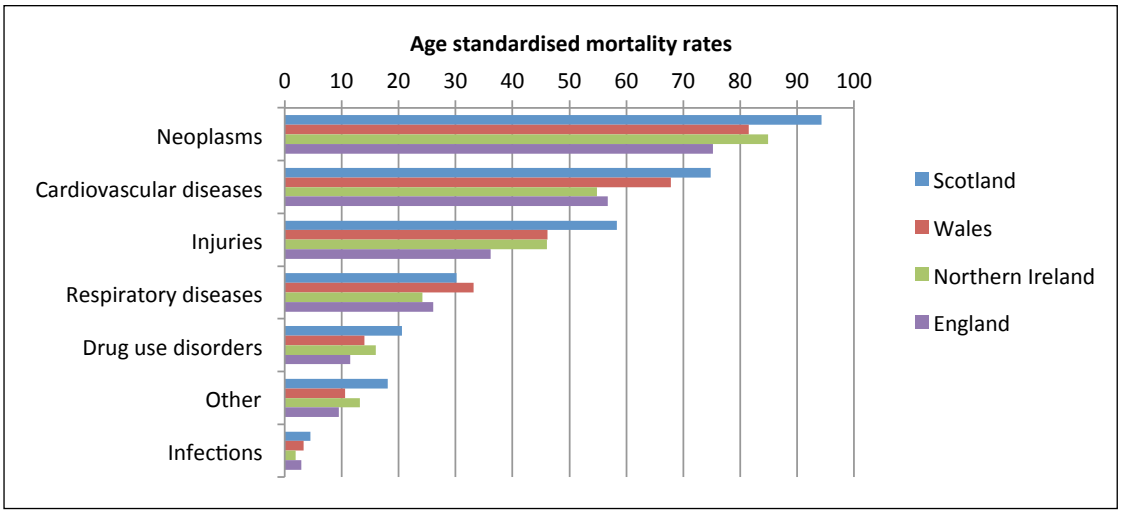
Waiting for problems related to health and social care to occur, treating those problems when they become apparent, and then hoping for a successful outcome is not a satisfactory strategy. The benefits of early intervention are numerous and the traditional model of treating problems as they arise is now too costly to our health service and detrimental to the health and social wellbeing of our population. It is vital that Health and Social Care (HSC) recognises this issue and responds in a proactive manner by embedding early intervention programmes into our public health agenda.

Early intervention is by no means a modern undertaking – one of the earliest examples dates back to the 1800s when English physician John Snow removed the handle from the Broad Street water pump and stopped a cholera outbreak in its tracks. A more recent example of a high-profile early intervention campaign was the 'back to sleep' campaign of the early 1990s when parents were urged to change the sleeping position of babies, which resulted in dramatic decreases in the number of sudden infant death syndrome (SIDS) cases.[8]

For the purposes of this report, early intervention does not simply refer to 'early years' intervention – it can be intervention at an early age or intervention at an early stage, for example in a disease process. Evidence highlights the economic benefits of early intervention, which can reduce or prevent the need for a range of costly and complex remedial interventions. Indeed, the Allen Report recognises that too much reliance is placed on late intervention, which tends to be more costly and sometimes less effective.[9]

In 2016, approximately 24% of all deaths in the UK (141,101 deaths out of 597,206) were from causes considered avoidable through good quality healthcare, earlier diagnosis and wider public health interventions (Figure 1). This included 4,002 people in Northern Ireland who died of illnesses that could either have been prevented in the first place (84%) or that could have been treated successfully if detected early enough.[10]

Figure 1: Avoidable mortality rates by broad cause group UK, 2016.[10]



Note: Age-standardised mortality rates are expressed per 100,000 population and standardised to the 2013 European Standard Population. Age-standardised mortality rates are used to allow comparison between populations which may contain different proportions of people of different ages.

Evidence demonstrates that preventative approaches are cost-saving in both the short and long term and that investing at an early stage is likely to lead to cost-effective health outcomes, contributing to wider sustainability, with economic, social and environmental benefits.[11] The PHA has acknowledged the importance of early intervention and as such the agency's Corporate Plan 2017–2021, which sets out the strategic direction for the PHA for the next four years, specifies that early intervention and prevention will continue to be core to its agenda.[12] The remainder of this report highlights a selection of the early intervention approaches being undertaken by the PHA.

Early intervention in early years

It is widely recognised that intervening early in the lives of children and their families can pay dividends in preventing longer term problems which, left untreated, can escalate in severity. By supporting families and generating positive intergenerational interactions, later onset difficulties can be avoided and substantial public spending savings can be made.[13] The PHA is responsible for a number of programmes aimed at early intervention in the early infant years.

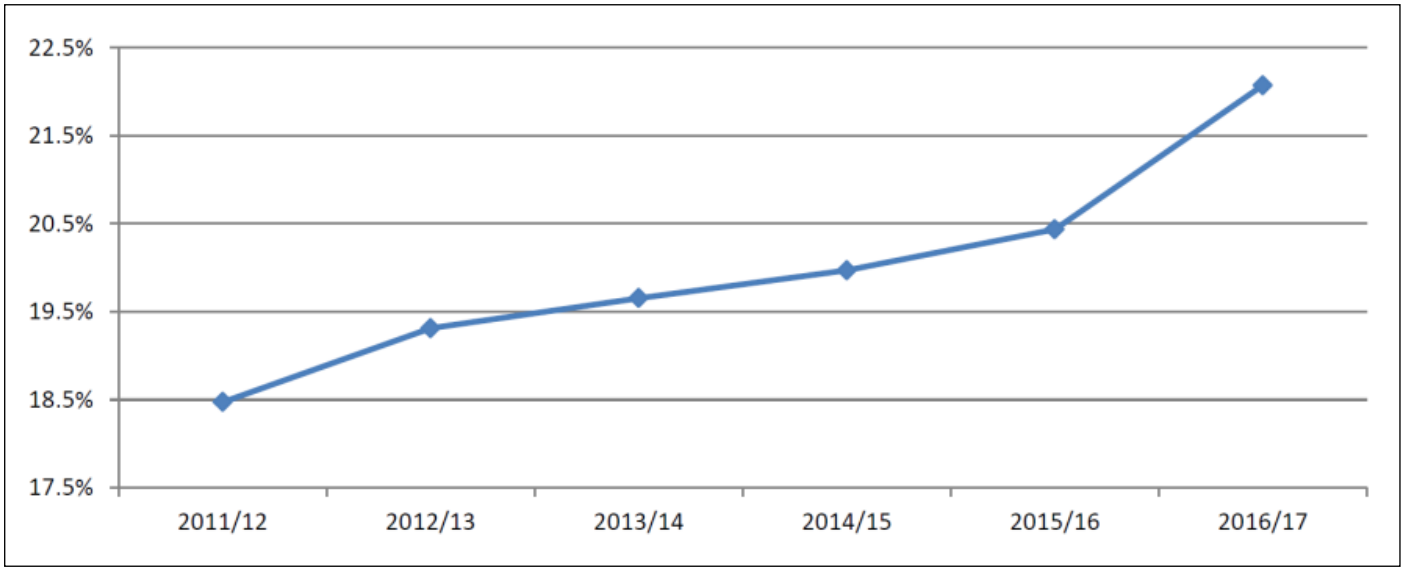
Early Intervention
Transformation Programme

As part of the Delivering Social Change and Atlantic Philanthropies Signature Programme, jointly funded over three years by the Department of Health, Department of Education, Department of Justice, Department for Communities, Department for the Economy, the Delivering Social Change fund and The Atlantic Philanthropies, the Early Intervention Transformation Programme (EITP) in Northern Ireland aims to help improve outcomes for children and young people by embedding early intervention approaches. The programme, which seeks to transform services for children and families in order to deliver a long-term legacy of improvement, has been informed by existing policies such as the Bamford Action Plan (2012-2015), *Breastfeeding – a great start* (2013-2023) and *Healthy child, healthy future* (2010) amongst others.[14-16] A small EITP research fund has also been allocated in order to complement the measurement of project outcomes being undertaken through the implementation of outcomes based accountability within the programme. Further information about these projects can be found in the Research and Development division section of this report.

Pre-pregnancy and pregnancy

Intervening early in the life of a child, even before they are born, can have positive long-term benefits. The PHA advises that all women should aim to be in good health before they become pregnant by making positive lifestyle choices about food, exercise and reducing or stopping alcohol. The Weigh to a Healthy Pregnancy project was developed to address maternal obesity as part of the wider public health obesity prevention agenda in Northern Ireland. Over 22% of mothers giving birth in Northern Ireland during 2016/17 were measured as obese at the time of booking appointment. This proportion has increased year-on-year since 2011/12 (Figure 2).[17] Maternal obesity carries a number of risks to the mother and child, and there is also the economic cost – Morgan et al demonstrated a strong association between healthcare usage cost and BMI, with mean total costs 23% higher among overweight and 37% higher among obese women compared with women with normal weight.[18]

Figure 2: Percentage of mothers classed as obese (I, II and III), Northern Ireland, 2011/12 – 2016/17.[17]

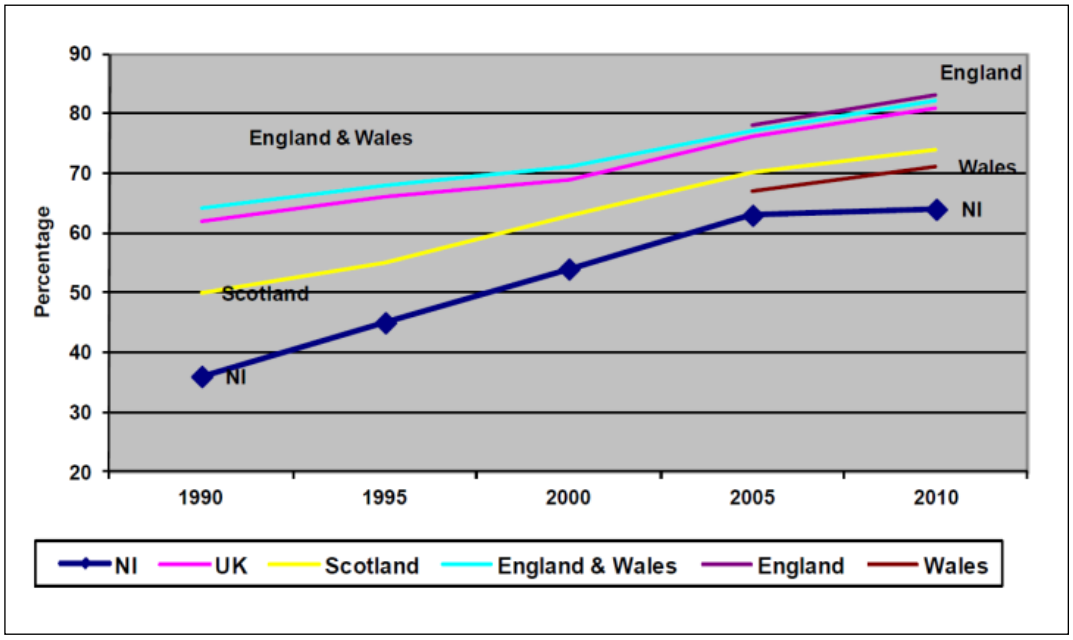


Post-pregnancy

Early intervention and support for families is at the heart of many of our health and social care strategies. It is central to the 'Delivering Together' approach to the transformation of our health and social care system.[7] Breastfeeding is a prime early intervention with benefits for both mother and baby. Improving breastfeeding rates links directly to the Programme for Government outcomes that 'We give our children and young people the best start in life' and 'We enjoy long, healthy, active lives'.[4]

Results from the Infant Feeding Survey (IFS) 2010 show that the breastfeeding initiation rate in Northern Ireland at that time was 64%, similar to the rate five years previously.[19] Despite the breastfeeding initiation rate almost doubling in the last 20 years, the rate in Northern Ireland has consistently remained the lowest in the UK (Figure 3).[19]

Figure 3: Breastfeeding initiation rates in the UK.[19]



Breastfeeding – a great start: A strategy for Northern Ireland (2013-23) was introduced in 2013 with the aim of improving the health and wellbeing of mothers and babies in Northern Ireland through breastfeeding.[15] The PHA led on the implementation of the strategy's actions including the 'Breastfeeding Welcome Here' scheme and the #NotSorryMums campaign. In terms of economic benefits it is suggested that if 45% of women exclusively breastfed for four months, and if 75% of babies in neonatal units were breastfed at discharge, every year there could be an estimated total saving of £17 million as a result of fewer hospital admissions and GP consultations from four acute infant diseases.[20]

The social circumstances of a mother can adversely affect the outcome of pregnancy both for them and their baby, and what happens during pregnancy and in the first years of a baby's life has a major influence on his or her subsequent behaviour, education, employment, health and other life chances.[21] From international research on child development, the PHA identified and subsequently introduced the Family Nurse Partnership (FNP) programme in Northern Ireland. The aim of the programme is to improve the health and wellbeing of our most disadvantaged families and children, and to prevent social exclusion. By December 2017 in total some 785 young women had been enrolled into FNP in Northern Ireland.

Family Nurse Partnership

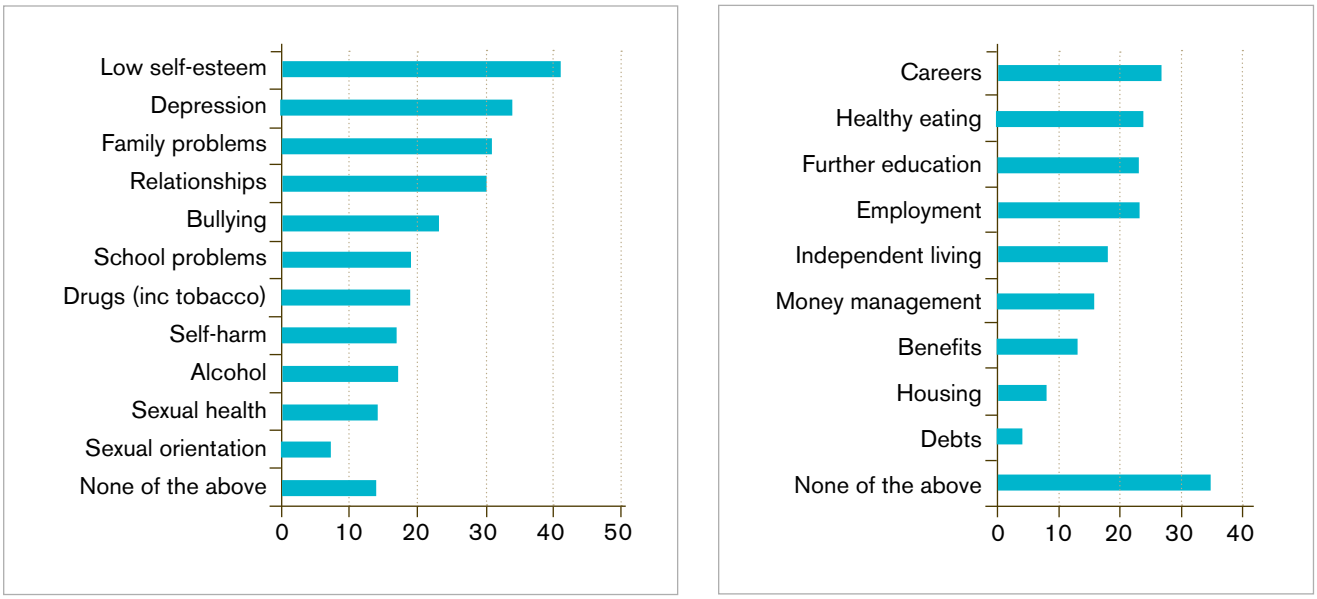
Early intervention for young people and teenagers

Evidence-informed prevention and early intervention programmes have been shown to produce positive impacts throughout childhood and into young adulthood. Allen identifies the need to use evidence-based interventions throughout the first 18 years of life to intervene early before problems escalate and become more expensive to deal with, and difficult or impossible to rectify.[9]

Intervening early can improve outcomes for children, young people and their families and it can be seen as a means of tackling the intergenerational cycle of disadvantage, social deprivation and lack of opportunity. We all want to ensure that all of our children and young people grow up in a society that provides the support they need to achieve their potential, and securing a strategic approach to early child development and family support is a key priority for the PHA. As such the PHA and its partners have implemented schemes which include the Youth Engagement Service (YES) and the Relationship and Sexuality Education (RSE) programme.

YES (formerly known as One Stop Shops) was established to support the health and social wellbeing of young people aged 11-25 years in a youth-friendly and holistic way. YES makes a significant contribution to prevention and early intervention in what can be costly conditions or circumstances if only addressed at later, progressively worse stages.

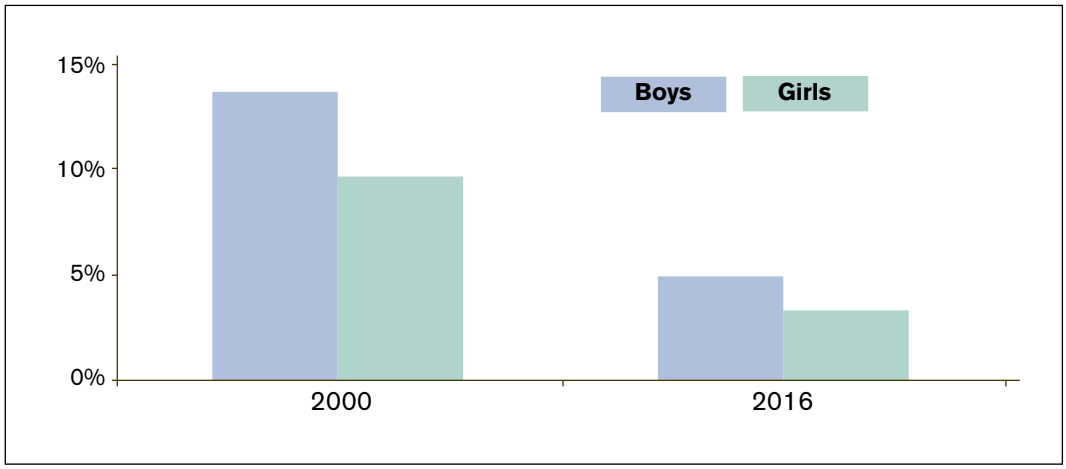
Figure 4: Percentage of young people attending YES who received help with any of the following.[22]



Underage sexual activity is a concern in Northern Ireland and although fewer of our young people report having had sexual intercourse compared with the rest of UK, a recent school-based survey of Year 11 and 12 pupils found 4% have had sexual intercourse, and of those pupils over half (58%) were aged 14–15 when they first had intercourse (Figure 5).[23] The UK has the highest teenage birth and abortion rates in Western Europe and although the rate of teenage pregnancies has reduced in Northern Ireland (from 1,334 babies born to teenage mothers in 2009 to 791 in 2016), early intervention approaches have the potential to reduce these numbers even further.[24, 25]

The PHA commissioned the delivery of the RSE programme in community settings and schools across Northern Ireland. The scheme aims to improve the health and wellbeing of young people aged 11-25 years by enabling them to make healthier choices and to contribute to the reduction in the numbers of young people having underage sex, incidence of sexually transmitted diseases (STIs) among young people and the number of teenage pregnancies.

Figure 5: Proportion of young people in Years 11 and 12 reporting having had sexual experience, including sexual intercourse.[23]

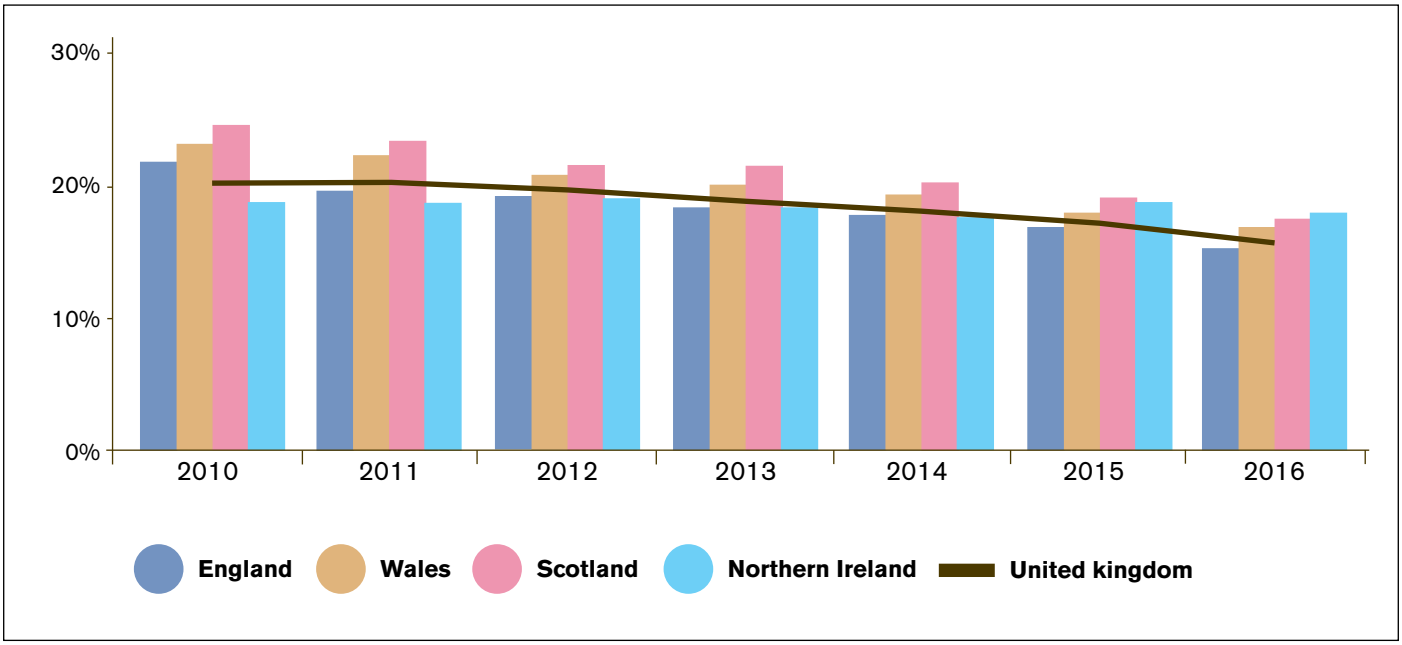


Early intervention in the adult population

Early intervention does not simply apply to the younger generation, it is also about preventing problems from developing in adults. The PHA has a number of early intervention approaches aimed at improving the health and wellbeing of our adult population.

In Northern Ireland smoking is the single greatest cause of preventable illness and premature death, with approximately one in six deaths every year attributable to smoking.[26] In 2016, the proportion of current smokers in the UK was 15.8%, which equates to around 7.6 million in the population, a statistically significant decline of more than 4 percentage points since 2010; Northern Ireland had the highest proportion of current smokers (18.1%, around 243,000 people) (Figure 6).[27] It has been estimated that the cost of treating smoking-related illness in Northern Ireland hospitals alone is around £164m a year.[26]

Figure 6: Smoking prevalence throughout the UK.[27]



If we can intervene and reduce the prevalence of smoking, there are wide-ranging benefits such as improved health and wellbeing, improvement in general fitness, and protecting non-smokers by not exposing them to second-hand smoke.

In 2012, the Department of Health (DoH) published the *Ten-year tobacco control strategy for Northern Ireland*, the overall aim of which is to create a tobacco-free society.[26] The Health survey Northern Ireland (2016/17) demonstrated that 62% of smokers surveyed wanted to stop smoking and 75% had tried to stop.[28]

The PHA has implemented prevention and smoking cessation programmes which include specialist quality-assured stop smoking services as recommended by the National Institute for Health and Clinical Excellence and the 'Want2Stop' website (www.want2stop.info) which includes a wealth of resources for those who wish to quit smoking.[29,30]

Of those surveyed in 2016/17 for the Health survey Northern Ireland, 36% were overweight and 27% were obese.[28] The levels of overweight and obesity have steadily increased over the last decade with more than three in five adults in Northern Ireland now overweight or obese. Early intervention in obesity is crucial to tackle the problem before physical activity becomes severely limited by morbid obesity and conditions such as coronary heart disease, severe chronic obstructive pulmonary disease (COPD), severe osteoarthritis or other such diseases that prevent physical exertion.

The PHA has developed a multifaceted implementation programme addressing the issue of overweight and obesity. This has included public information, nutritional standards in schools and other public providers, education programmes for children and adults, professional training and development, and support for changes to the workplace and other environments. These initiatives have included the Choose to Live Better website (www.choosetolivebetter.com) and the Give it a Go! initiative.

Early intervention for older people

One of the major public health challenges facing our society is how we help older people to live well independently. We live in an ageing population – it is estimated that there were 36,500 people aged 85 and over living in Northern Ireland in June 2016, an increase of 1,000 people (2.8%) since mid-2015. In the decade since mid-2006, the number of people aged 85 and over has increased by 34.8%, almost six times faster than the population aged under 85 (6.4%). The population aged 65 and over is projected to increase by 65.1% to 491,700 people from mid-2016 to mid-2041, with the result that almost one in four people (24.5%) will be in this age category. The population aged 85 and over is projected to increase by 127.2% to reach 82,800 people over the same period, which will see their share of the population doubling from 2.0% to 4.1% (Figure 7).[31] Data also demonstrate that the prevalence of limiting long-term illnesses increases with age, with 53% of males and 64% of females aged 75 and over in Northern Ireland affected (Figure 8).[32]

Figure 7: Estimated and projected population aged 85 and over alongside the number of births, years ending mid-1999, mid-2021, and mid-2033.[31]

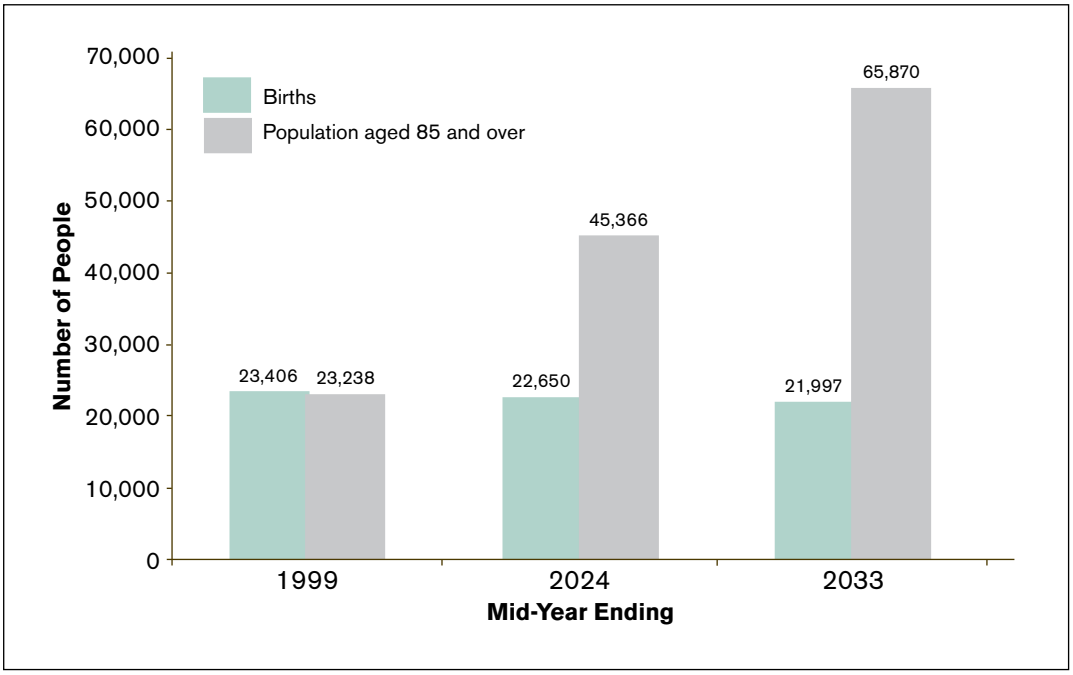
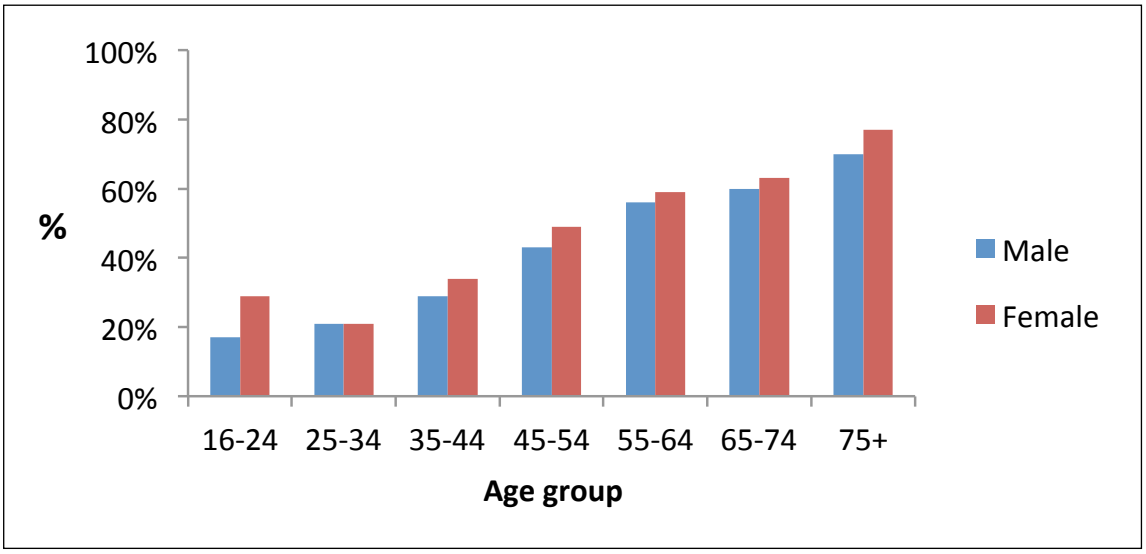


Figure 8: Percentage of people who report having a limiting long-term illness by age and gender.[32]



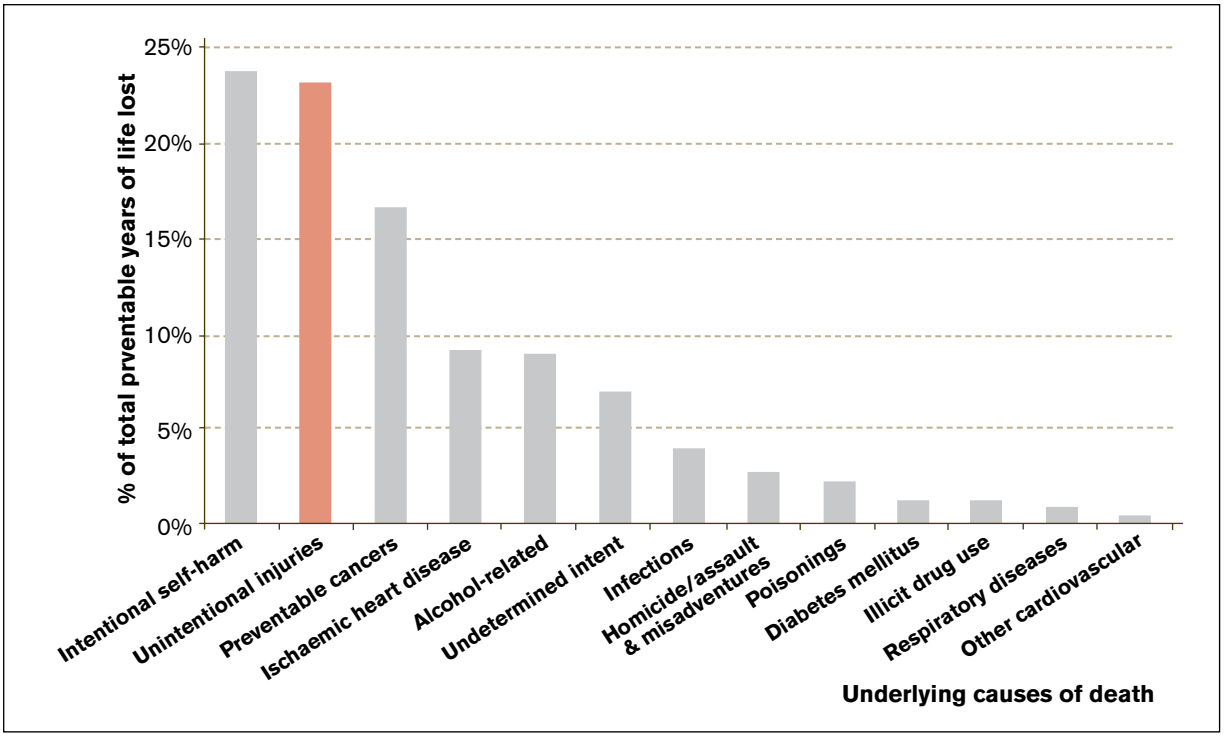
An ageing population is a significant achievement, reflecting advances in healthcare and quality of life, but a key challenge will be to enable older people to remain in good health for as long as possible. It is therefore crucial that our public health agenda addresses the issue of the ageing population, embracing the skills and abilities of older people as a positive resource for the future. There are a number of schemes and campaigns implemented by the PHA and partner organisations aimed at improving the lives of older people through early intervention approaches.

Accidents are the main cause of premature, preventable death for most of a person's life. The human cost of premature deaths can be expressed as preventable years of life lost (PrYLLs); in Northern Ireland unintentional injuries in general (not just from accidents in the home) account for almost a quarter of PrYLLs (Figure 9).[33] The risk of falling increases with age and falls account for 71% of all fatal accidents in those over the age of 65.[34] Between 2001 and 2011 there were 480 deaths (288 male; 192 female) due to falls, equating to just under half (47%) of all unintentional injury and deaths at home.

Data collected through home safety checks of people over 65 and vulnerable adults between April 2012 and March 2014 show that 25% had a home accident in the 12 months before their check and that 94% of these accidents were falls.

In an effort to make people's homes safer and to reduce the numbers of accidental home injuries, the PHA, in partnership with Belfast City Council, Belfast Health and Social Care Trust and Bryson Energy, offers free home safety checks to the over-65s to provide advice and support on how to make their homes safer. The Regional In-Patient Falls Group has also been established to provide multidisciplinary advice and support across HSC in preventing harm to patients who fall while in hospital.

Figure 9: Preventable Years of Life Lost (PrYLLs) in Northern Ireland in 2011 for people up to the age of 60.[33]



Source: RoSPA/Northern Ireland Statistics and Research Agency

It is estimated that by 2050, 135 million people worldwide will have dementia. In 2010 the global cost of dementia care was estimated at $604bn (£396bn; €548bn) and it was projected that this would increase to $1tr by 2030.[35] There is increasing evidence to show that dementia may be preventable and this has led to an international focus on earlier diagnosis and intervention.[36-38] If intervention takes place before cognitive function and mental capacity are affected, it gives people and their families the chance to plan ahead and make important decisions regarding their health behaviours and care arrangements.

In 2014, the Dementia Together NI project was launched by the Executive Office to transform the commissioning, design and delivery of dementia services for people in Northern Ireland and to improve the quality of care and support for people living with dementia. The Health and Social Care Board (HSCB) and the PHA were tasked with jointly taking forward this work.

The HSCB and the PHA introduced the '#STILLME' campaign which was initiated to raise awareness of the signs of dementia, and to reduce stigma and fear about the condition. It is hoped that early diagnosis and support can enable people to plan for the future and to make their own decisions about their care.

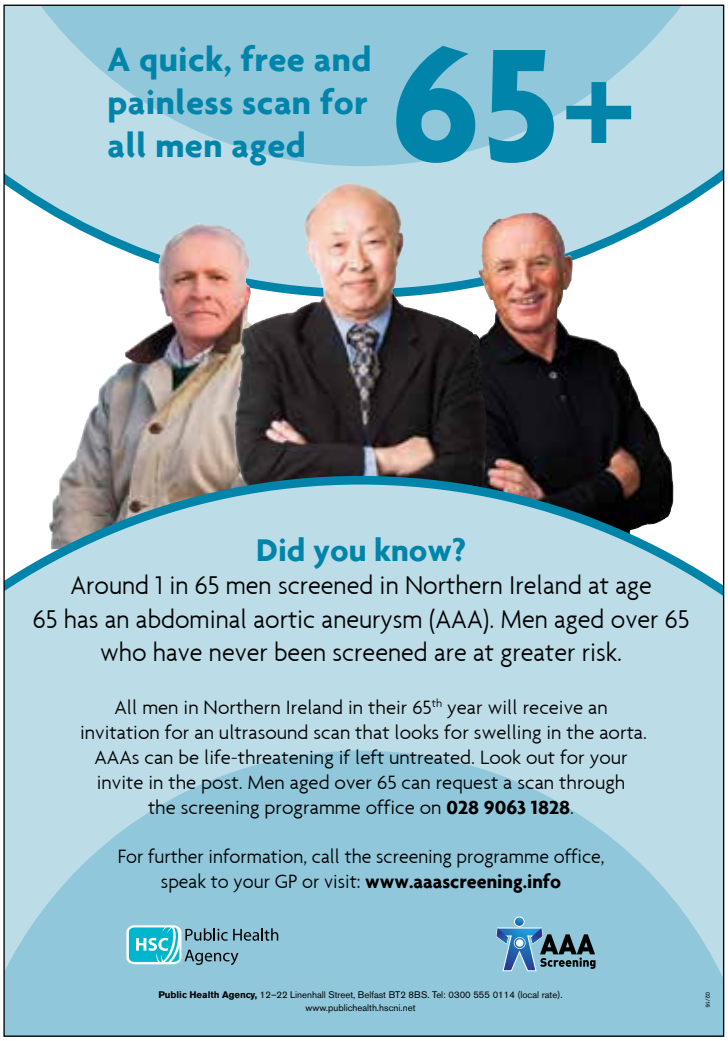
Early intervention in disease prevention: screening and vaccination programmes

The PHA is responsible for a number of screening and vaccination programmes. Screening is important because early detection of disease often produces better outcomes for patients as at this stage treatment may be more effective, avoiding significant ill health and in some cases premature death. Likewise, vaccination against specific diseases is vital, and over the years vaccines have prevented countless cases of disease and have saved millions of lives.

Northern Ireland **Diabetic Eye Screening** Programme

Early diagnosis through screening can lead to improved outcomes for a number of health conditions, and for older people living in Northern Ireland there are a range of screening programmes available including: abdominal aortic aneurysm (AAA) screening offered to all men aged 65 years and over; diabetic eye screening which is currently offered every year to patients aged 12 years and over; and bowel cancer screening which is offered to women and men aged 60-74 years.

One example of how successful early intervention can be is our childhood vaccination programme. After clean water, vaccination is the most effective public health intervention in the world for saving lives and promoting good health. The WHO has stated that "overwhelming evidence demonstrates the benefits of immunisation as one of the most successful and cost-effective health interventions known".[39]



In Northern Ireland we have a comprehensive vaccination programme in place right through the life-course, from the pertussis vaccine in pregnancy providing protection to the newborn, to the shingles vaccine for 70-79 year olds.

Ehreth estimates that around 6 million deaths are prevented worldwide every year because of vaccines.[40] The vaccines not only protect against the diseases themselves but they also provide protection against various complications associated with them.[40]

Early intervention to prevent disease through the childhood vaccination programme undoubtedly requires resources and funding, however, the long-term benefits and cost-savings through a reduction in mortality and morbidity are unquestionable. Globally, the direct savings from vaccines were estimated by Ehreth in 2003 to be of the order of tens of billions of US dollars.[40]

Public health programmes in Northern Ireland are based on scientific and economic evidence where it exists, or on innovative practice if evidence is limited.

Our public health programmes aim to:

- Protect health
- Improve health and reduce inequalities
- Improve health through high quality services
- Invest in high quality research and development

The next sections provide examples of early intervention schemes and programmes of work that have been undertaken or funded by the PHA. Many of the projects presented were carried out in collaboration with other government departments, public and private sector bodies, community and voluntary organisations and members of the public.

Further information

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Health improvement

Introduction

Supporting breastfeeding in Northern Ireland

Supporting early intervention in the early years

Early intervention to prevent accidental injuries to children in the home

Mental health and suicide prevention training for young people

Early intervention to prevent children starting to smoke

Introduction

Introduction

The following articles represent a number of examples of ongoing dynamic health improvement work. They give clear insights into the contributions being made supporting the PHA's role in improving the health and social wellbeing of our population and reducing health inequalities through strong partnerships with individuals, communities and other key public, private and voluntary organisations. Most importantly they support the achievement of improved outcomes in health and wellbeing.

Supporting breastfeeding in Northern Ireland

Public health challenge

Breastfeeding – a great start. A strategy for Northern Ireland 2013-2023 is the framework to improve breastfeeding outcomes in Northern Ireland.[15] The PHA leads the Breastfeeding Strategy and works with key stakeholders to improve outcomes across a wide range of settings, including health and social care, education, workplace and in the community.

Recent research has provided further evidence on the positive effects of breastfeeding on the health of both women and children.[41] These include protection against childhood infections and orthodontic problems, increases in intelligence and probable reductions in overweight and diabetes. Sudden infant death and certain types of leukaemia are also less likely among children who have been breastfed. Breastfeeding mothers benefit from reduced risk of breast and ovarian cancer and a likely reduction in the risk of type 2 diabetes.[41]

The World Health Organization recommends exclusive breastfeeding for the first six months with continued breastfeeding into the second year of life and beyond. In Northern Ireland we have the lowest breastfeeding rates in the UK and Ireland. In 2015/16, 45% of infants were breastfeeding at discharge from hospital, but this decreased to 28% at 6 weeks and declined further to 8% at 12 months.[42] Those least likely to breastfeed include young mothers and those living in areas of significant deprivation.[42]

Actions

The PHA is leading actions to improve breastfeeding through the multi-agency Breast Feeding Strategy Implementation Steering Group. These include:

- support for UNICEF UK Baby Friendly Initiative (BFI) standards across maternity, health visiting, neonatal, Sure Start and university settings;
- promotion of the PHA 'Breastfeeding Welcome Here' scheme;
- investment in mother to mother peer support training;
- enhancement of the human milk bank;
- support for breastfeeding in neonatal units;
- training of health professionals;
- provision of information for parents;
- capacity building in voluntary breastfeeding support;
- raising public awareness;
- developing research.

Baby Shannon McCarthy with mum Emma helps celebrate the MAC Belfast becoming the 500th member of the PHA's Breastfeeding Welcome Here scheme, with Mary Black, Assistant Director for Health and Social Wellbeing Improvement at the PHA, and Lyndsey-Anne Murphy and Julie Stewart from the MAC.

Outcomes

- All maternity units in Northern Ireland have now reached BFI recognised best practice standards.
- The midwifery training programme at Queen's University Belfast achieved BFI accreditation in July 2017.
- In 2017 the PHA provided UNICEF BFI training for 150 health professionals, including midwives, neonatal nurses, health visitors and Sure Start workers.
- The PHA's 'Breastfeeding Welcome Here' scheme grew to over 500 members in 2017 and our website now includes a map to signpost families to members and support.

Next steps

- A review of the Breastfeeding Strategy commenced at the end of 2017.
- A major public information campaign on breastfeeding will launch in 2018.
- The PHA's social media has been strengthened to share mothers' breastfeeding stories and raise awareness, and we are exploring how we can best use social media to further support breastfeeding.
- The 'Breastfeeding Welcome Here' scheme creates supportive environments for breastfeeding. We will continue to grow this initiative across all premises open to the public and community facilities.
- Further research is being developed to inform how best to promote and support breastfeeding in Northern Ireland.

Key facts

- Breastfeeding can significantly improve the health and wellbeing of both mother and baby.
- By 6 weeks of age 72% of all babies born in Northern Ireland are formula fed.
- Improving breastfeeding outcomes involves evidence-based approaches to information and support within the health service setting.
- To be able to breastfeed, women also need support from partners, family, peers, health professionals, employers and the wider community.

Further information

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Supporting early intervention in the early years

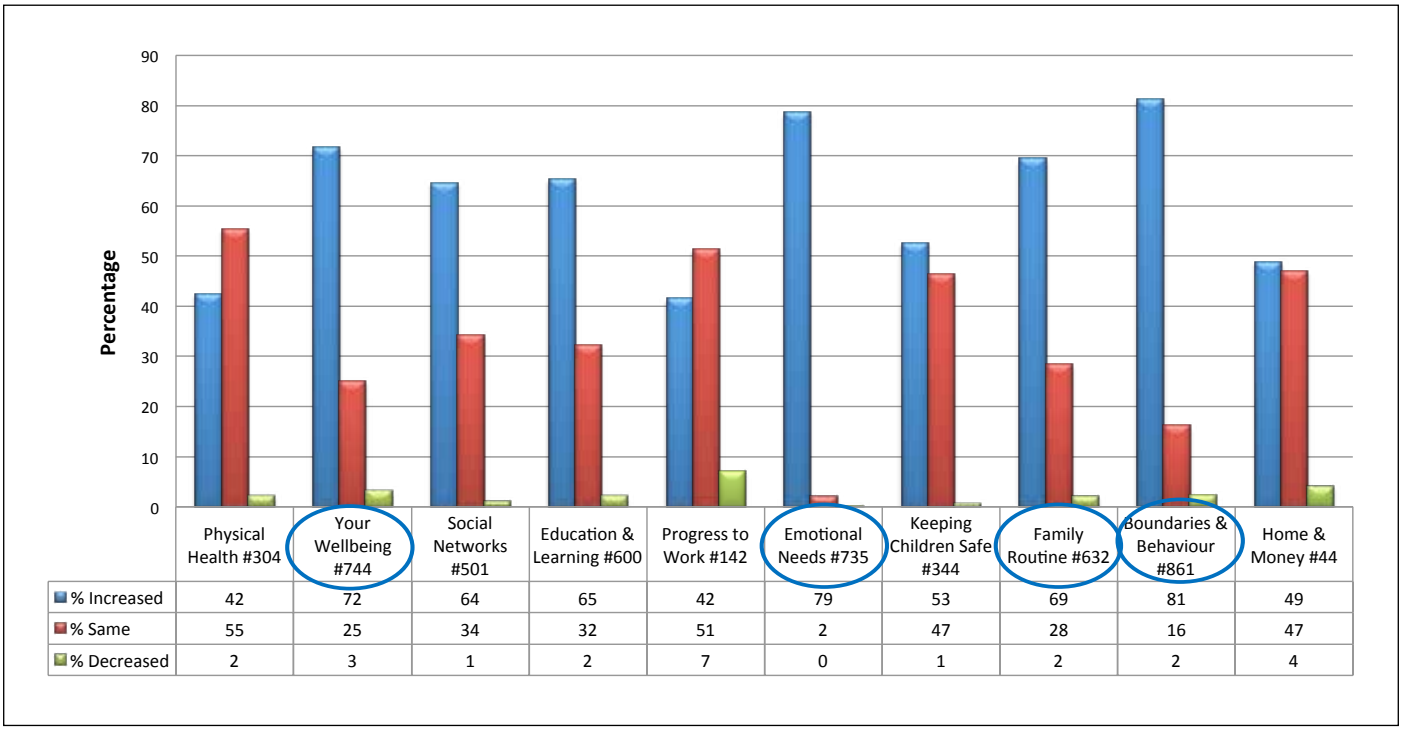
Public health challenge

The profound impact of adverse childhood experience (ACE) is now clear. For example, the likelihood of an adult developing cardiovascular disease increases with each ACE experienced in early years (abuse, neglect and witnessing traumatic events like domestic abuse), with those experiencing seven ACEs or more three times more likely to suffer cardiovascular disease than peers without such experiences.[43] Impacts are also seen in relation to drug and alcohol misuse, mental health, crime and educational performance.

Children who experience maltreatment and grow up without positive and stable relationships, such as children who end up in care, are at greater risk of mental health problems and other poor outcomes throughout their lives.[44] As of March 2016, some 2,890 children were looked after in Northern Ireland.

Early intervention with families and children to prevent problems emerging and positively address the consequences of adversity is therefore of critical importance.

Figure 10: Overall Family Star Plus (cumulative from April 2016-March 2018, n=944 families).



	Physical Health #304	Your Wellbeing #744	Social Networks #501	Education & Learning #600	Progress to Work #142	Emotional Needs #735	Keeping Children Safe #344	Family Routine #632	Boundaries & Behaviour #861	Home & Money #44
% Increased	42	72	64	65	42	79	53	69	81	49
% Same	55	25	34	32	51	2	47	28	16	47
% Decreased	2	3	1	2	7	0	1	2	2	4

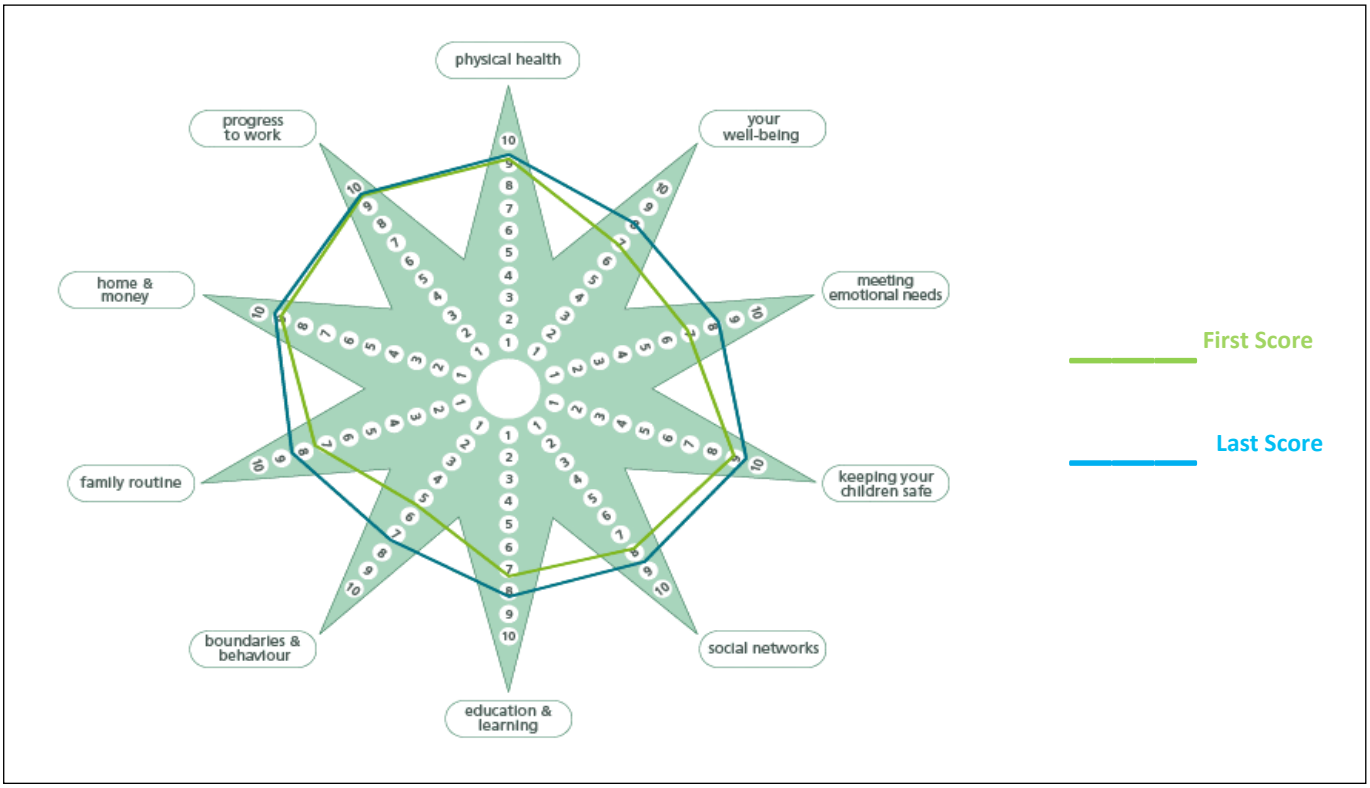
Note: The Family Star Plus focuses on ten core areas that have been found to be critical in enabling children and young people to thrive. Interventions would generally be focused on a maximum of three areas, boundaries and behaviour; emotional needs; family routine and your wellbeing are the most common areas for interventions. Improvement is shown when there is an increase in the area; the chart shows the progress made by families in each of the core areas.

Actions

The PHA, through the Child Development Programme Board, actively supported or initiated a number of key evidence-based programmes including the following:

- The Early Intervention Support Service (EISS) has been developed by the PHA under workstream 2 of the Department of Health led inter-departmental Early Intervention Transformation Programme (EITP). The EISS aims to support and empower families with emerging vulnerabilities by intervening early with evidence-informed services before difficulties become intractable.
- The Incredible Years Coordination Programme has increased the number and capacity of organisations delivering the family support programme, which has achieved high quality and fidelity standards.
- An Infant Mental Health (IMH) Action Plan has been developed and implemented. The IMH Implementation Group has supported workforce training to enable staff within HSC and Early Years settings to improve assessment and intervention with families with infants, when problems emerge.
- A number of high quality parenting support programmes have been developed and resourced, to increase the availability and access by parents to support and guidance.
- Coordinated action to improve levels of breastfeeding has been implemented.
- A total of 118 Roots of Empathy programmes, which support social and emotional learning, have been delivered to 2,950 primary school children.
- Regular and relevant research and evaluation has been carried out for the various interventions.

Figure 11: Family Star Plus (data from April 2016-March 2018, n=944 families).



Note: The data on the Family Star Plus shows the average first and last scores for 944 families: a "big" increase or decrease is defined as more than one point up or down the scale (1 is the lowest score and 10 the highest score).

Impacts

- 1,712 families were supported through the Early Intervention Support Service between August 2015 and March 2018.
- Families supported through EISS report an 81% increased improvement in boundaries and behaviour, 79% improvement in meeting emotional needs and 69% improvement in family routine.
- The PHA design, commissioning and implementation of EISS has contributed to the transformation theme by effectively establishing a coherent regional service.
- Children receiving the Roots of Empathy programme showed a reduction in difficult behaviour and an increase in pro-social behaviour.
- 92% of parents undertaking the Odyssey Parenting Programme (202 out of 220) improved their skills in resolving problems and 26% of young people (78 out of 300) reported their levels of emotional distress had improved.
- 110 Early Years and HSC staff have completed Infant Mental Health Training, including 25 staff who have undertaken a 2 year Infant Mental Health Diploma

Next steps

The Child Development Programme Board will continue to drive action across a range of areas to improve outcomes for children and families.

Key facts

- What happens to children in their earliest years is key to outcomes in adult life.
- Ensuring that children have good parenting and positive early life experiences are key factors enabling the achievement of potential in later life and optimising health and wellbeing outcomes.
- The first three years of a child's life are particularly important due to the social and emotional learning and related brain development that takes place.
- Recovery from the effects of adversity in childhood is possible through support for the parent/carer child relationship.

Further information

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Early intervention to prevent accidental injuries to children in the home

Public health challenge

In a typical week in Northern Ireland two people will die due to a home accident.[34] In addition, there are approximately 17,000 admissions to hospital each year as a result of unintentional injuries.[45] One of the most vulnerable groups are the under fives, who depend on others for their safety. Preventing injuries in this age group involves creating safer environments and products, as well as positively influencing those caring for children.

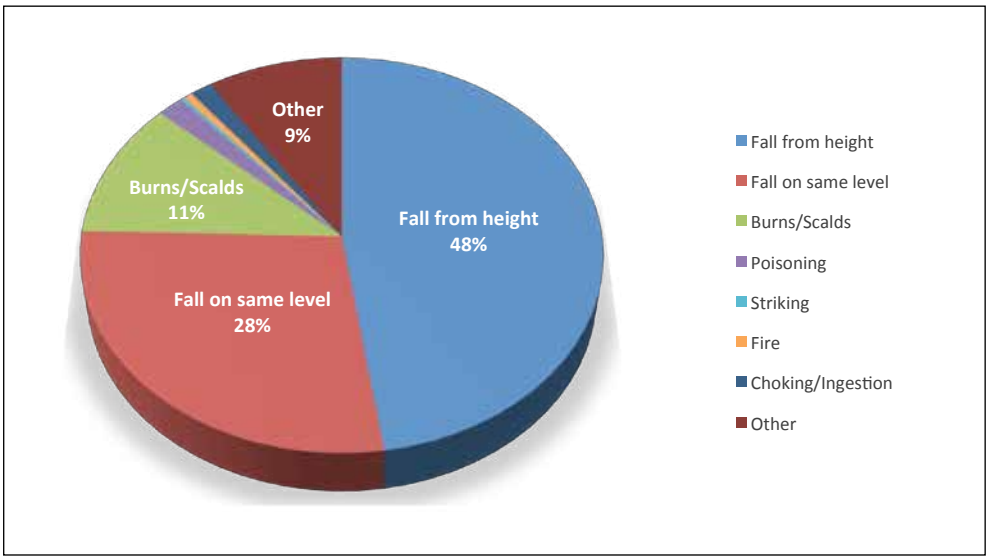
Actions

A Home Accident Prevention Strategy Implementation Group (HAPSIG) consisting of 24 key statutory and voluntary sector partners is working to deliver the Home Accident Prevention Strategy 2015-2025.[34] The strategy's vision is that the Northern Ireland population has the best chance of living safely at home and where the risk of unintentional injury is negligible.

An action plan and three regional sub groups support implementation of the plan. Key actions include:

- the development of two social media campaigns highlighting the dangers associated with blind cord safety (www.nidirect.gov.uk/articles/blind-cord-safety) and burns and scalds (www.nidirect.gov.uk/keeping-children-safe-burns-scalds);
- production of an annual calendar of events supported by partners, including all 11 local councils;
- a successful public information stand at the Balmoral Show on home accident prevention, focusing on blind cord safety;
- a 'Take Action Today' campaign highlighting the dangers of poisonings in the home;
- delivery and monitoring of a regional home safety check scheme.

Figure 12: Types of accidents recorded among the under fives in the Home Safety Check Scheme database, 2016-17 (based on 3,256 home safety checks).[46]



Impacts

- 3,256 home safety checks were delivered to households with under fives in 2016-17.
- Over 28,000 items of equipment were issued to vulnerable families in 2016-17.
- Data collected from home safety checks will inform future actions of all partners.
- The 'Blind Cord Safety' social media campaign has reached 731,487 people, had 235,000 views and been shared 5,100 times via the PHA's Facebook page. It was shared on the Australian national news Facebook page where it has been viewed 4,700,000 times. The campaign was shortlisted for the UK Chartered Institute of Environmental Health Excellence Awards.
- The burns and scalds social media campaign 'Scarred for Life' has reached 107,260 people, had 42,000 views and been shared 399 times.

Next steps

All partners will continue to prioritise home accident prevention and improve the sharing of information and resources across agencies. A further social media campaign is planned for autumn 2018.

Key facts

- Accidents are the main cause of preventable premature death for most of a person's life.[34]
- Falls account for the majority of non-fatal accidents in babies and children under five years.[34]
- Statistics from the home safety check scheme in 2016-17 found that in the under fives:
  - 5% had an accident in the 12 months before their check
  - 76% of accidents were falls
  - 21% visited their GP
  - 59% went to hospital
  - 48% of accidents were falls from a height and the majority occurred in the porch/ hall/stairs area
  - 7% of homes which required stairgates did not have them
  - 66% of homes did not keep blind cords out of reach in the living area
  - 60% of homes did not keep blind cords out of reach in the bedroom
  - 59% of homes did not keep blind cords out of reach in other areas of the home.[46]

Further information

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Mental health and suicide prevention training for young people

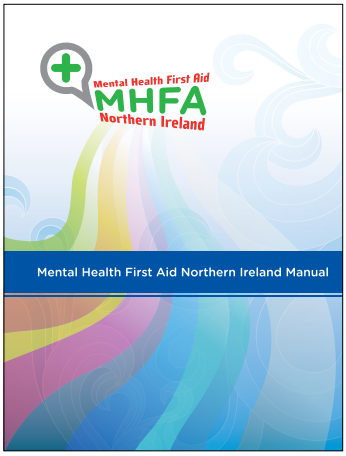
Public health challenge

The PHA continues to implement a multi-agency approach to suicide prevention, working closely with government departments, statutory, community and voluntary organisations, to promote emotional health and wellbeing and reduce the risk of suicide. An important part of this work has been to implement and grow evidence-based training programmes which meet the needs of young people. This training is a recognised intervention to prevent suicide and enables young people to:

- become more aware of their emotional wellbeing and take small steps to improve their mental health;
- learn about mental illnesses and develop appropriate skills to engage with a person experiencing mental illness or having thoughts of suicide, keeping them safe and signposting to appropriate services.

Actions

The PHA commissions a range of training programmes addressing mental and emotional health and wellbeing, and suicide prevention, which are delivered across Northern Ireland. These programmes range from raising awareness about mental health through to crisis intervention.



Mental health training

The aim of mental health training is to enhance protective factors and mitigate risk factors at both individual and community level by focusing on:

- de-stigmatising mental health;
- strengthening young people through opportunities for participation, personal development and problem solving which enhance control and prevent isolation;
- community empowerment and interventions to improve physical and social environments, and strengthen social networks.

An example of this training is the programme Mindset Adolescent, a mental health awareness course which is delivered to young people aged 14–17 and aims to:

- raise awareness and increase understanding of mental and emotional health and wellbeing;
- raise awareness of the signs and symptoms of mental illness;
- promote self-help/resilience techniques and how to maintain a safe level of positive mental and emotional health and wellbeing;
- provide information and resources on local and regional mental health support organisations.

Another example is Mental Health First Aid (MHFA). This is a two day programme which takes participants through a five step approach to become a trained first aider in mental health. MHFA was introduced to Northern Ireland in 2006 and approximately 12,000 people have now achieved their Mental Health First Aider certificate.

Other training courses include programmes using art to encourage positive mental health, which have been provided to schools and youth groups.

Outcomes

In 2017/18

- 4,838 young people participated in mental and emotional wellbeing programmes, which enable them to be more aware of their mental health and take small steps to live emotionally healthy lives.
- 188 teaching and non-teaching staff completed and achieved their Mental Health First Aider certificate. This enables them, within a school or university environment, to confidently approach, support and signpost young people to appropriate help and services.
- 285 teaching and non-teaching staff completed training in suicide awareness and/or suicide intervention training.

Next steps

- A PHA training framework will be developed. This framework will provide information on training opportunities addressing mental and emotional health and wellbeing, and suicide prevention, available throughout Northern Ireland and allow individuals and/or organisations to make informed choices on the most appropriate training.
- We will continue to promote mental and emotional health and wellbeing, and suicide prevention training to young people.
- We will continue to work with the education sector to encourage positive mental and emotional health and wellbeing in pupils and teachers, including conducting a review of current practice in all schools and developing an agreed framework and programmes with the Department of Education.

Key facts

- Mental health problems affect about 1 in 10 children and young people. These include depression, anxiety and conduct disorder and are often a direct response to what is happening in their lives.[47]
- Good mental health allows children and young people to develop the resilience to cope with what life throws at them and grow into well-rounded, healthy adults.[47]

Further information

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Early intervention to prevent children starting to smoke

Public health challenge

Smoking is the single greatest cause of preventable illness and premature death in Northern Ireland, killing about 2,400 people each year.[48] The hospital cost of treating smoking related illnesses in Northern Ireland is estimated to be about £164m each year.[5]

Tobacco control is a key priority of the PHA in addressing the causes and associated inequalities of preventable ill health and meeting the targets of the *Ten-year tobacco control strategy for Northern Ireland*.[26] The overall aim is to create a tobacco-free society in Northern Ireland with three main objectives:

1. Fewer people starting to smoke
2. More smokers quitting
3. Protecting people from tobacco smoke.

The Tobacco Strategy Implementation Steering Group drives a wide range of actions to meet these objectives, including reducing uptake of smoking in children and young people.

Actions

A primary school education and awareness raising programme called 'Smokebusters' is funded by the PHA and offered to all primary school children in Years 6 and 7. Originally developed as a community based smoking prevention initiative for young people, the programme has been refined to be delivered within the school setting in Northern Ireland, as opposed to being delivered in a community setting. The programme, first implemented in 1988, is freely available to all primary schools within Northern Ireland and teachers are able to enrol Year 6 and 7 classes in the Smokebusters programme.

The programme can be delivered either by Cancer Focus or teachers, and explores:

- the tobacco industry's tactics to recruit young smokers;
- the chemicals in a cigarette, the dangers of second-hand smoke and the effects of smoking on the body; and
- how to say 'no' to cigarettes.

Each year group receives information in age appropriate format which uses a character called 'Smoky Sam' to highlight the dangers of smoking. The aims of the programme are:

- to provide a means of conveying information to children about the harmful consequences of smoking;
- to encourage children to reject the smoking habit by increasing their defences against pressure to experiment with cigarettes;
- to promote 'fun' ways of involving children in activities to promote a smoke-free environment in their schools, homes and communities.

The political element of smoking legislation is also covered and children are encouraged to write to MLAs to seek their support in enacting protective legislation.

Impacts

- In 2016/17 the programme was delivered to 602 primary schools across Northern Ireland, representing a 72% uptake with over 35,000 Year 6 and 7 pupils participating. There is a particular emphasis on schools serving disadvantaged areas.
- Resources for teachers have been developed to support the programme, including a PowerPoint presentation, activity worksheets, sample letters of encouragement for ex-smokers and a series of DVDs produced by local schools which show the pressures children typically experience relating to smoking and strategies to deal with these.

An evaluation of the programme in early 2018 by the PHA Health Intelligence Unit showed that:

- teachers are keen to deliver tobacco education and support the Smokebusters programme;
- the vast majority of teachers (81%) feel the dangers of tobacco use are an essential topic to teach;
- children who participated in the programme report more self-efficacy to refuse cigarettes, less experimentation and lower future intention to smoke compared to those who did not participate.[49]

Next steps

A review highlighted a number of measures which will enhance the programme and make it more interesting for children. We plan to use the Cancer Focus website to highlight the Smokebusters brand, making it easier to enrol and download materials. Continued success in reducing smoking levels in Northern Ireland (which have fallen to 20% in 2016/17) have been due to effective smoking prevention programmes alongside other measures including cessation services.[28] These efforts should be redoubled to realise the goal of a smoke-free society.

Key facts[50]

- Around 320,000 adults aged 16 and over still smoke in Northern Ireland.
- Smoking prevalence among 11-16 year olds has declined over the last seven years from 8.7 % in 2007 to 5% in 2013.
- Cigarette smoking is recognised as a major cause of health inequalities in lower socioeconomic groups and is estimated to account for around 50% of the health inequalities gap.
- Smokers in Northern Ireland spend on average 15% of their income on their habit.
- Pregnant women who smoke are more likely to have a miscarriage, ectopic pregnancy or stillbirth, and are more likely to have a baby with low birth weight.

Further information

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Health protection

Introduction

HPV vaccination programmes

Engaging children and young people on antimicrobial resistance

Management of an outbreak of Meningococcal B disease

Introduction

Introduction

The PHA Health Protection Service has a lead role in protecting the population from threats to health, such as infectious disease outbreaks and major incidents. We carry out this role through a range of core functions including surveillance and monitoring, operational support and advice, education, training and research. The service is delivered by a multi-disciplinary team of doctors, nurses, emergency planners, and scientific, surveillance and administrative staff.

Early intervention is fundamental to protecting the public's health. This is demonstrated in the Health Protection Service through strategic preventative work, for example public awareness campaigns and vaccination programmes, as well as through the acute response, where the aim is to detect and respond rapidly to public health threats when they occur. This year's DPH report includes three articles that demonstrate the breadth of strategic and acute health protection work undertaken by the PHA and exemplify how early intervention protects the health of the population of Northern Ireland.

Vaccination is one of the most effective public health interventions in the world for saving lives and promoting good health. The PHA provides regional oversight and support to the delivery of childhood and adult vaccination programmes, and also coordinates the surveillance and control of vaccine preventable diseases. The current human papillomavirus (HPV) vaccination programme is given as an example of how early intervention through vaccination can prevent serious diseases such as cervical cancer.

Antimicrobial resistance (AMR) is currently a major threat to global public health, and an article is included which describes partnership working to intervene early to tackle this threat by educating children and young people about AMR and how to reduce the risk of spreading infections and protect antimicrobials.

Finally, the PHA response to a cluster of meningococcal disease in a secondary school is described, which illustrates how notification of infectious diseases led to rapid detection of a cluster and enabled early intervention and control measures to prevent further spread.

HPV vaccination programmes

Public health challenge

The human papillomavirus (HPV) is a virus that can infect the skin and ano-genital tracts. There are many different HPV types, the majority of which don't cause human disease. However, there are two high risk types (types 16 and 18) that can be sexually transmitted and are linked to cancers of the female and male ano-genital tract. HPV viruses (types 6 and 11) can also cause genital warts in men and women.

Around 90 women in Northern Ireland are diagnosed with cervical cancer each year, with 22 women dying from the condition annually. The HPV vaccine was introduced in 2008 for girls in Year 9 and 10 and protects against the two types of HPV that cause over 70% of cervical cancers. In 2012 the vaccine used was changed to one which also provides protection against genital warts.

Since the introduction of the girls' programme, evidence has emerged suggesting that other cancers are also linked to HPV infection, including anal, oropharyngeal and penile cancers, with men who have sex with men (MSM) at disproportionately higher risk. The girls' programme has been shown to also provide indirect protection to heterosexual boys when there is high vaccine coverage in girls. However, MSM, who are a group at high risk of HPV infection and associated disease, received very little indirect health benefit. As a result, in 2016 the HPV vaccine was introduced for MSM up to and including 45 years of age attending genitourinary medicine (GUM) clinics. The aim of the programme was to provide direct protection against HPV infection, HPV associated cancers and genital warts to the MSM population up to the age of 45 years.

Figure 13: HPV vaccination uptake rates, Year 9 and 10 girls completing full course, 2009-17, Northern Ireland.[51]

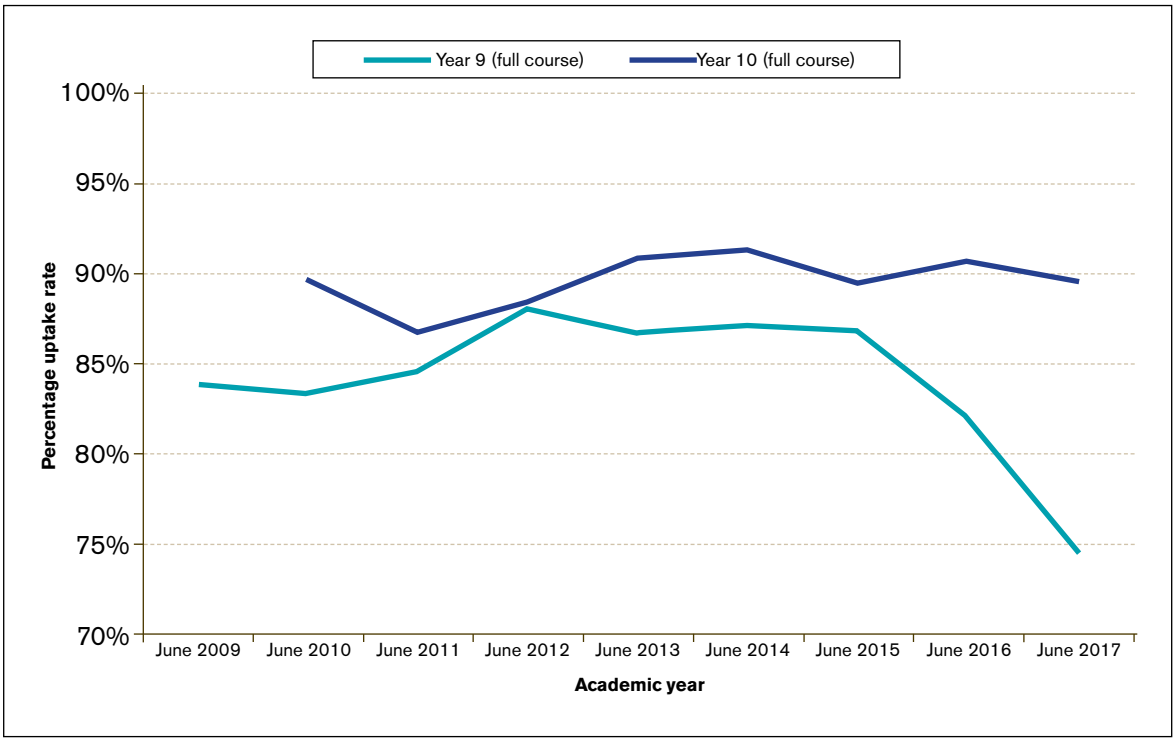
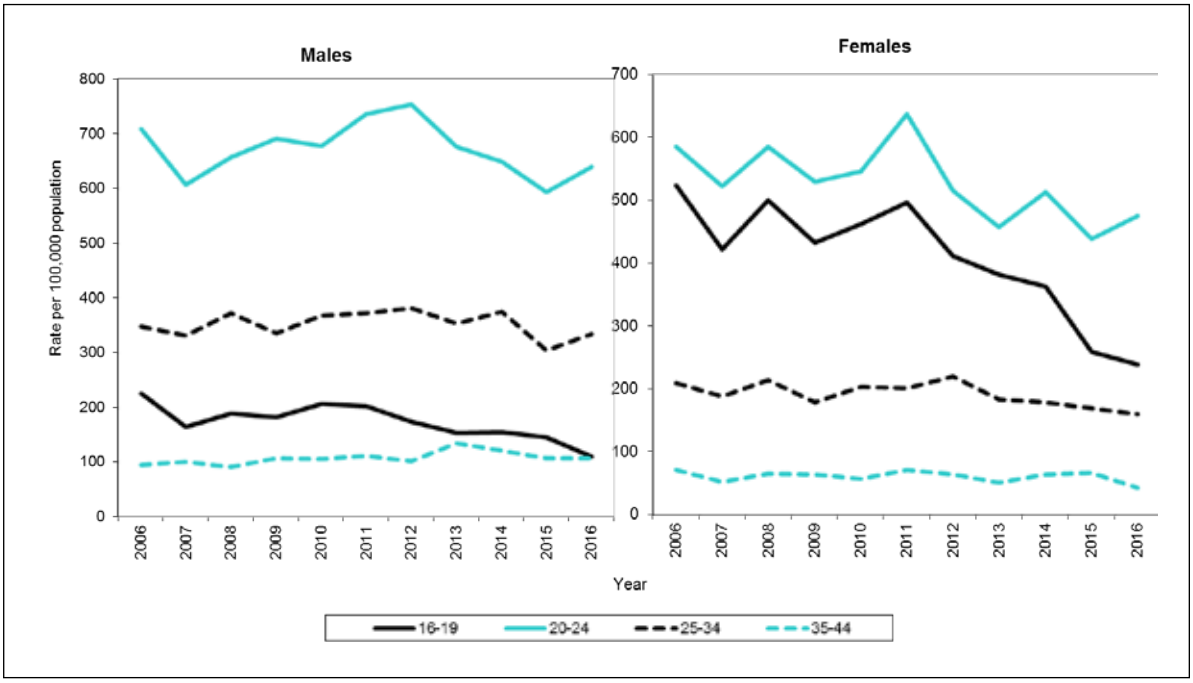


Figure 14: Rates of diagnosis of genital warts (first episode) in Northern Ireland, by age and gender, 2006–2016.[52]



Actions

School health provides the HPV vaccine to girls in Year 9 and 10 at school with catch up available in general practice for those who miss out in school.

GUM health professionals offer the full course of HPV vaccine (3 doses) to all MSM up to and including the age of 45 years attending the clinic regardless of risk, sexual behaviour or disease status. Administration of doses is aligned with recommended GUM appointments in order to reduce introducing additional visits for vaccination only.

Outcomes

The uptake of a completed course by the end of Year 9 has fallen somewhat since a peak in 2012, but due to further clinics being offered in Year 10, nearly 90% of girls had completed the course by the end of Year 10 in June 2017. Disappointingly there was a continued decrease in uptake of the HPV vaccine in Year 9 for the academic year 2016-17 (Figure 13).[51]

Due to routine cervical screening tests being carried out from the age of 25 years, it is still too early to show a decrease in the number of cervical cancer cases. However early indications from Australia and Scotland show decreases in precancerous lesions.

Cases of genital warts in young people, particularly young girls, are also falling, showing early effects of the vaccine programme (Figure 14).[52]

The HPV vaccine programme for MSM has been operational since October 2016. The programme has been welcomed by health professionals and voluntary organisations, and has been well received by patients.

Figures provided by GUM clinics for the first year of the programme (1 October 2016 to 30 September 2017) show that just over 2,000 MSM up to and including 45 years of age attended GUM clinics in Northern Ireland. Of these individuals, 72% received the first dose, 43% received dose 1 and dose 2, and 17% had completed the three dose schedule.[53] The vaccine schedule should ideally be given within one year, although a two year period is clinically acceptable. It is therefore too early to expect higher uptake completion after this first year.

It is also too early to see decreases in incidence of genital warts and other HPV-related disease in the MSM population specifically due to this programme.

Next steps

The PHA is investigating the reason for the decrease in uptake of the HPV vaccine in Year 9 girls. These girls are offered the chance to be immunised in Year 10 and PHA are working with communications colleagues and school health to improve the uptake for the current 2017-18 campaign.

The PHA is continuing to monitor the HPV MSM programme at least until the programme has been offered for two years, after which vaccine coverage will be recalculated. We have shared the uptake information and received feedback from GUM professionals and plan to present the information to a wider group of GUM health professionals. Sharing the information provides an opportunity to work with GUM staff to improve the coding of vaccine administration at clinics to ensure more accurate coverage information.

Key facts

- Around 90 women in Northern Ireland are diagnosed with cervical cancer each year, with 22 women dying from the condition annually.
- HPV vaccine protects against the two types of HPV that cause over 70% of cervical cancers. HPV is offered to girls in Year 9 and 10 through a school-based programme and provides the best protection against the disease.
- Men who have sex with men (MSM) bear a significantly increased burden of HPV infection and related cancers compared to heterosexual men. The incidence of anal cancer is also highest in HIV positive MSM.
- HPV vaccine is offered to all eligible MSM attending GUM and/or HIV clinics across Northern Ireland.
- 90% of genital warts are due to HPV types 6 and 11, which the HPV vaccine protects against.

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Engaging children and young people on antimicrobial resistance

Public health challenge

Antimicrobials are essential medicines for treating bacterial infections in both humans and animals, but are losing their effectiveness at an increasing rate due to the development of antimicrobial resistance (AMR). The consequences of AMR include increased treatment failure for common infections and decreased treatment options where antimicrobials are vital, such as after major surgery and during chemotherapy. AMR was recognised by Northern Ireland's Chief Medical Officer (CMO) in his annual report as one of the greatest dangers to human health and to medicines worldwide.[54]

Overuse of antibiotics is a major factor in the rise of drug-resistant infections, and Northern Ireland has the highest consumption of antibiotics per head of population in the United Kingdom. Engagement with the public is vital to raise awareness and change behaviour with regard to antibiotic use.

Actions

As part of the PHA's strategy to work with the public to increase awareness of the risks of AMR, the PHA and the Centre from Excellence for Public Health Northern Ireland have partnered with the STEM Ambassador Hub, which promotes Science, Technology, Engineering and Maths education and is based at W5, to educate children and young people about infections and antibiotic use. By engaging with children and young people, we can help to develop a new generation who understand prevention and help us tackle the global AMR challenge. Two of the main activities have been the launch of 'e-Bug' resource and the delivery of interactive events.

e-Bug resources

Public Health England's 'e-Bug' resources have been launched in Northern Ireland. These include multiple teaching sessions on antimicrobial resistance delivered to a range of schools – primary, post-primary and special educational needs. In partnership with the Department of Education and CCEA, the e-Bug resources are being mapped against the Northern Ireland curriculum for all key stages. Training events on e-Bug are being delivered for all teachers in Northern Ireland with the support of the national e-Bug team.

'Become an Antibiotic Guardian' event

This interactive event took place on European Antibiotic Awareness Day 2017 at the W5 interactive science discovery centre, and was aimed at children and their families. Activities included:

- Visual and interactive demonstrations showing children what different microbes are and how antimicrobial resistance develops.
- An interactive game to help older children decide do they need an antibiotic or not.
- Engagement with parents and younger children to discuss antibiotics and when they are needed.
- 'Design your own Microbe' colouring in activities.
- The use of iPads and tablets for children to play antimicrobial resistance games.
- Various antimicrobial resistance videos and cartoons on display throughout event.

Impacts

Feedback from the W5 event was extremely positive – 89% of those who completed evaluation forms would attend this event again and 89% felt that the information provided had given them a better understanding of when antibiotics are necessary. Overall 91% reported they knew more about antibiotic resistance after attending the event. A video showing the highlights of the event released on social media has reached 4,635 people (as of 9 March 2018). The e-Bug resources have been well received and both activities have been nominated for entry to the Antibiotic Guardian Awards 2018.

'Become an Antibiotic Guardian' event at W5, held on European Antibiotic Awareness Day 2017.

Next steps

With the success of the e-Bug material evident, the PHA will continue to work with Public Health England (which developed e-Bug) to support its implementation in Northern Ireland and train teachers in how to deliver the material. The aim is that this resource will be available for teachers to use to help teach children about microbes and the appropriate use of antibiotics. We will continue to make the most of opportunities such as World Antibiotic Awareness Week and European Antibiotic Awareness Day to promote important AMR messages and hold events which engage the public and lead to changes in behaviour that can help to tackle the development of AMR.

For further information on e-Bug, visit http://www.e-bug.eu/

Key facts

- Antimicrobial resistance is a serious threat to public health.
- Overuse of antibiotics is a major driver of resistance.
- PHA has worked with partners to educate children and young people around the risks of AMR and to promote appropriate use of antibiotics.

Further information

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Management of an outbreak of Meningococcal B disease

Public health challenge

During the peak of Storm Ophelia in October 2017, the PHA Health Protection Service investigated and managed a cluster of Meningococcal Group B disease in secondary school aged children attending the same high school. Meningococcal bacteria can cause meningitis (inflammation of the lining of the brain) and septicaemia (blood poisoning). Both diseases are very serious and, especially if not diagnosed early, can be fatal. The majority of cases of meningococcal disease are not associated with further cases, however clusters and outbreaks can occur. In educational settings, once a second case has occurred, the risk of a third case may be as high as 30-50% with the risk being highest in the week after the second case.[55] In these circumstances, early detection and intervention is key to preventing spread. Meningococcal disease is a notifiable disease which means that when a doctor suspects that a patient is suffering from a notifiable disease, he or she is legally required to inform the Director of Public Health. The prime purpose of the notifications system is to trigger investigation, detect possible outbreaks and initiate contact tracing.

Actions

In October 2017, the PHA Duty Room was notified of two probable cases of meningococcal disease in individuals in the same class of a local high school. Microbiological results subsequently confirmed both cases as indistinguishable serotype B meningococcus. Chemoprophylaxis (antibiotics to eradicate carriage of meningococcal bacteria) was arranged for the household contacts of both cases, in order to prevent onward spread and written information on signs and symptoms was provided.

An Outbreak Control Team (OCT) was convened to assess risk of spread within the wider school group and implement control measures. Letters were sent to out of hours GP and emergency departments to notify them of the cluster and in conjunction with the school headmaster, communication was made with the wider school group. A risk assessment was carried out and 37 pupils and 17 teachers were identified as being at higher risk of meningococcal transmission based on the extent of their contact with the cases.

There were no other extracurricular or social links identified between the cases. Arrangements were made to offer chemoprophylaxis and two doses of Bexsero (Men B) vaccine one month apart to these contacts.

It can be logistically challenging to administer chemoprophylaxis and information to a risk group, and Storm Ophelia made this more complicated. As the school was closed, communication with parents of pupils was carried out by the headmaster through the school texting service. Arrangements were initially made with Trust school nursing teams and pharmacy to attend the school. However, due to adverse weather conditions, the school remained closed. As an alternative, the next day PHA nursing and medical staff spoke to parents of pupils and the teachers by telephone and GP colleagues administered chemoprophylaxis.

Impacts

Within one week of declaring the cluster, the PHA with the assistance of primary care, identified, phoned and administered chemoprophylaxis and the first dose of Men B vaccine to all contacts. This occurred despite additional challenges associated with school closures due to Storm Ophelia. There have been no further cases of meningococcal disease linked to the cluster.

Next steps

PHA will continue to promote vaccine programmes that reduce the risk of meningococcal disease and will follow up cases notified to take the necessary actions to reduce onward spread.

Key facts

- Meningococcal bacteria can cause meningitis (inflammation of the lining of the brain) and septicaemia (blood poisoning).
- In October 2017, the PHA Health Protection Duty Room was notified of two probable cases of meningococcal group B disease in individuals in the same class of a local high school.
- An outbreak control team was convened to manage the cluster, chaired by PHA.
- PHA, with the assistance of primary care, identified, phoned and administered chemoprophylaxis and Men B vaccine to all close contacts identified to prevent onward spread.
- Primary care played a key role in delivering the response during an unusual weather situation which resulted in school closures.
- PHA will continue to promote vaccine programmes that reduce the risk of meningococcal disease.

Further information

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Screening and service development

Introduction

The Newborn Blood spot Screening Programme

Primary prevention of type 2 diabetes

Early intervention and stroke

Introduction

Introduction

Safe, effective, high quality health care services are critical to ensuring early intervention and management of illness and disease. The PHA provides professional expertise on service evaluation and review, assessment of the health and wellbeing needs of the population, and evidence-based practice. The PHA also plays a key role in supporting the development, implementation and evaluation of regional service frameworks.

Population screening programmes provide an important opportunity for early detection of disease, which can allow early intervention and improved outcomes for patients. Screening is not suitable for every condition, however, and organised screening programmes are only established on the recommendation of the UK National Screening Committee according to the best available evidence. Any condition being considered as a screening programme must meet a number of stringent criteria before it is recommended by the Committee.

In Northern Ireland the PHA has responsibility for commissioning, coordinating and quality assuring eight population screening programmes. These programmes cover the entire population, from birth through to older age. They include screening for infectious diseases in pregnancy, newborn blood spot and newborn hearing screening, diabetic eye screening, cervical cancer screening, breast screening, bowel cancer screening and abdominal aortic aneurysm screening.

The Newborn Blood spot Screening Programme

Public health challenge

The Newborn Blood spot Screening Programme (NBSP) aims to identify babies who may have one of a range of rare but serious inherited conditions so that early intervention can improve their health. It is an important public health screening programme which supports 'giving every child the best start in life', a key objective of the Department of Health's *Making Life Better* strategy.[5]

Newborn blood spot screening is a complex programme, involving a wide range of services, from highly specialised laboratories through to individual staff in the community and in hospitals, working closely together.

As part of the programme, in the first week after birth, all babies in Northern Ireland are offered screening for a range of inherited conditions including phenylketonuria (PKU), congenital hypothyroidism (CHT), cystic fibrosis (CF), medium chain acyl coA dehydrogenase deficiency (MCADD) and sickle cell disorders (SCD). This is often referred to as the 'heel prick' test. The purpose of screening is to identify babies more likely to have these conditions. Screening is not 100% accurate.

If the screening test is positive, a baby will be offered further tests or investigations to confirm the diagnosis. Where one of these conditions is confirmed as present, effective interventions are available to prevent subsequent illness and/or disability arising. Most babies screened will not have any of these conditions but, for the small number who do, the benefits of screening are substantial. The programme makes a major contribution to the prevention of disability and death in our community, through early diagnosis and effective early interventions.

Actions

Current actions for the NBSP in Northern Ireland include the following:

- Ensuring that robust and regionally consistent 'failsafe' practices are in place, to enhance programme quality and safety (the purpose of a failsafe is to identify babies with outstanding blood spot results).
- A drive to improve the rate of Health and Care Number (HCN) completion, by the health professional conducting the screening test. Every person who is born or resident in Northern Ireland should be assigned a unique HCN. This number can be used to link health and social care records and provides an important safety and quality mechanism for identifying and matching baby records in the NBSP. This has resulted in a progressive reduction in the proportion of test samples without a HCN from 11.5% in January 2016 to 2.4% in October 2017.[56]

Outcomes

The PHA and partner organisations are responsible for ensuring that the population has access to safe, effective, high quality and equitable screening programmes. As part of this function for newborn blood spot screening, the Northern Ireland programme participates in a national (UK) system of quality assurance and performance management.

The most recently published national and regional reports show that the NBSP in Northern Ireland is of high quality and is performing well against national standards.[57] Key findings show that during 2016-17 the Northern Ireland programme:

- achieved more than 99.9% of 'born in and resident' babies having a conclusive result recorded on the Child Health information System for all conditions, at the end of the reporting period;
- was the best performing UK region in relation to timely receipt of samples in the newborn screening laboratory, with 99.5% of samples received within 4 working days of collection.

The primary outcome and benefit of the NBSP is early detection of and appropriate intervention to treat conditions that would otherwise cause serious and permanent harm to babies. In 2016-17 in Northern Ireland over 24,000 babies were screened as part of the programme and in total 32 children were diagnosed as having one of the conditions.

Next steps

In line with recommendations from the UK National Screening Committee, the Department of Health has advised that screening of additional selected Inherited Metabolic Disorders is added to the NBSP in Northern Ireland. Plans are underway to facilitate this. The following four additional conditions will form part of the expanded programme:

- Glutaric aciduria type 1 (GA1)
- Isovaleric acidaemia (IVA)
- Maple syrup urine disease (MSUD)
- Homocystinuria (pyridoxine unresponsive) (HCU)

Key facts

- The NBSP plays an important role in early intervention and improved health outcomes for babies.
- Latest figures (2016-17) show that the coverage (ie percentage of babies with a conclusive result for PKU recorded on the Child Health information System by 17 days of age) is 98.9% in Northern Ireland.[57]
- Future plans include testing for an additional four Inherited Metabolic Diseases.

Further information

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Primary prevention of type 2 diabetes

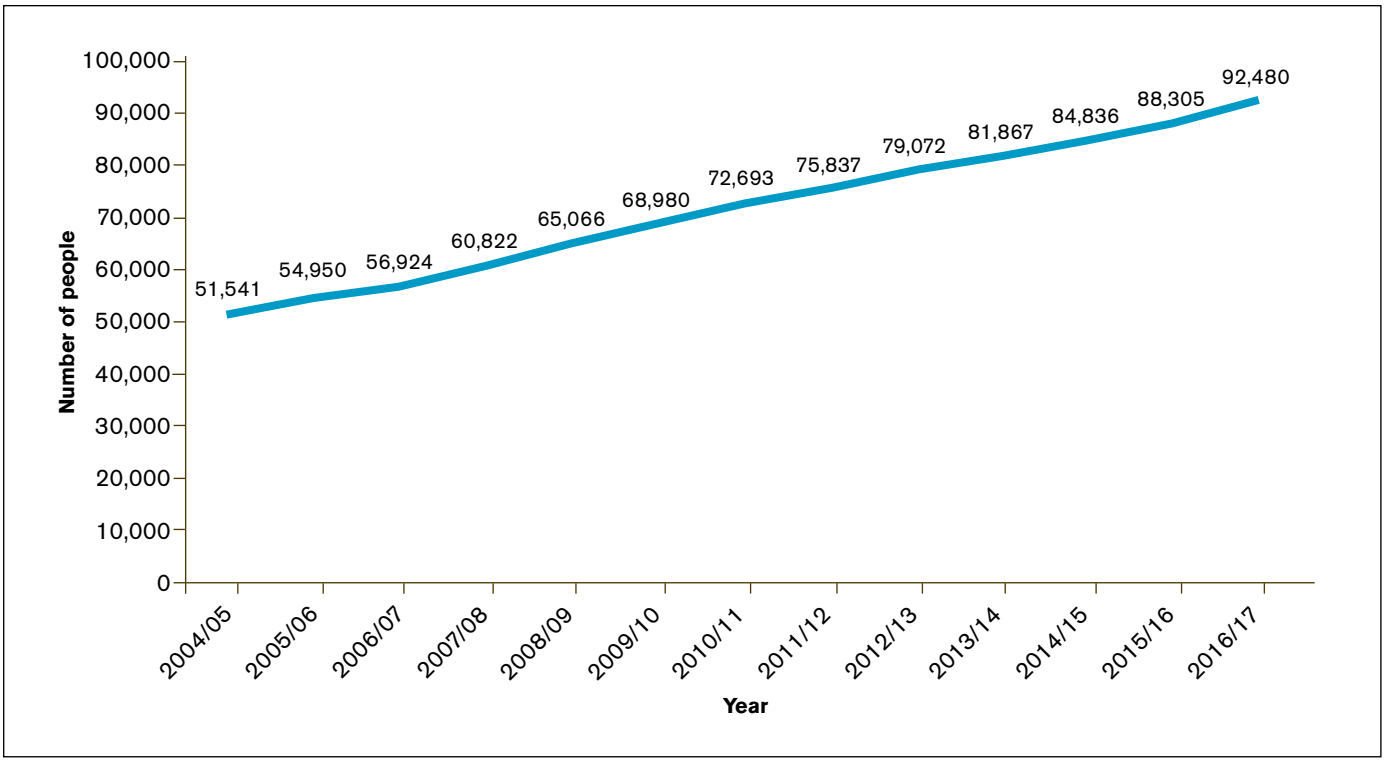
Public health challenge

Diabetes is a metabolic condition in which the body does not produce sufficient insulin to regulate blood sugar levels or where the insulin produced is unable to work effectively. There are two main types of diabetes:

- Type 1 diabetes is an auto-immune condition in which the cells that produce insulin are destroyed so lifelong treatment with insulin is required.
- Type 2 diabetes occurs when the body either stops producing enough insulin for its needs or becomes resistant to the effect of insulin produced. The condition is progressive requiring lifestyle management (diet and exercise) at all stages. Over time most people with type 2 diabetes will require oral medication and or insulin. Type 2 accounts for 90% of all cases of diabetes.

Type 2 diabetes mellitus (T2DM) is one of the most common long-term health conditions in Northern Ireland, associated with significant morbidity, mortality and healthcare costs. The number of people living with diabetes continues to increase as shown in Figure 15. The Health and Social Care Board estimates that by 2027 there will be a further 45,000 cases of type 2 patients across Northern Ireland. It is known that the risk of developing T2DM is strongly linked to modifiable health behaviours, in particular diet and weight.[58]

Figure 15: The number of people (aged 17 years and over) registered as having diabetes by GP practices in Northern Ireland from 2004-2017.[59]



Actions

'Pre-diabetes' is an umbrella term for impaired fasting glycaemia (IFG) and impaired glucose tolerance (IGT), conditions which are not diagnosed as T2DM but are also not considered to represent normal sugar regulation. The condition, however, increases the risk of developing diabetes. Evidence has shown that modest changes in diet and physical activity levels can reduce incidence of T2DM by more than 50% for individuals with pre-diabetes.[60] This offers an important opportunity for early intervention to reduce the number of people developing T2DM.

Support has been sought from the Department of Health's Transformation Implementation Group (TIG) for a proposal to develop a regional programme for the identification and management of individuals at high risk of developing T2DM in Northern Ireland. This group has a high risk score and fasting plasma glucose of 5.5–6.9 mmol/l or HbA1c of 42–47 mmol/mol [6.0–6.4%]. The programme will aim to prevent or delay the onset of T2DM in the identified group.

Next steps

There will be two main components to the programme – the identification of high risk individuals, through primary care, and the development and delivery of a lifestyle intervention programme to which high risk individuals will be offered referral. The programme will reflect the National Institute for Health and Care Excellence guidelines on the prevention of T2DM in people at high risk.[61]

Eating healthily and being more active can reduce your risk of developing type 2 diabetes.

Key facts

- The prevalence of T2DM is increasing with estimates that by 2027 there will be a further 45,000 cases of Type 2 patients across Northern Ireland.
- The risk of developing T2DM is strongly linked to modifiable health behaviours, in particular diet and weight.
- A lifestyle intervention programme will be offered to individuals at high risk of developing type 2 diabetes.

Further information

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Early intervention and stroke

Public health challenge

A stroke is caused by an interruption in the blood supply to the brain either by a blockage (ischaemic stroke) or a bleed (haemorrhagic strokes). The majority of strokes are ischaemic strokes.

Every year in Northern Ireland there are approximately 2,700 emergency hospital admissions due to stroke. Death rates from stroke have declined by around 50% in the past 20 years. While strokes are more common in older age groups, one in 10 strokes happen in people aged under 55.[62]

There has been a rapid expansion in the last 10 years in research evidence for preventing and treating strokes. This provides services with an opportunity to lessen the impact of stroke on our population particularly in view of the expected increase in the number of elderly people in the next few years.

Actions

Prevention and early intervention

Addressing lifestyle factors such as stopping smoking, healthy eating, maintaining a healthy body weight and taking regular exercise are all important in preventing stroke.

People at a higher risk of stroke include those with high blood pressure, irregular heartbeat such as atrial fibrillation, heart disease and diabetes. If an individual has any of these risk factors it is important that they are treated effectively to reduce their risk of stroke.

Another high risk group for stroke are patients who have suffered a transient ischaemic attack (TIA) or 'mini stroke'. The symptoms of TIA are the same as a stroke, but with a TIA these symptoms usually resolve within 30 minutes and always within 24 hours unlike a stroke where symptoms persist. TIA patients are at a much higher risk of experiencing a stroke in the following days and weeks. If TIAs are treated quickly (within 24 hours) the risk of a stroke occurring can be greatly reduced.

Treatment and early intervention

The PHA-led FAST public awareness media campaign has raised awareness in the general population of the symptoms of stroke. The campaign outlines for the public what to do if they think someone is having a stroke and to seek help immediately by dialling 999. Promoting earlier intervention aims to improve outcomes.

Thrombolysis

Following medical assessment at hospital, if an ischaemic stroke is confirmed, the patient will be assessed for thrombolysis, a treatment which dissolves blood clots in the brain. Up to 20% of ischaemic stroke patients are suitable for this treatment and the sooner it is given after a stroke the more likely it is to be effective. Thrombolysis can be provided up to four and a half hours after the first symptoms of stroke.

Thrombectomy

Thrombectomy is a procedure which can remove a large clot from the brain following an ischaemic stroke. People with this type of stroke often have the most severe disabilities after a stroke and the most limited recovery. This procedure involves the insertion of a small tube into the blood vessel combined with a special type of brain scan to remove the blood clot. Thrombectomy can be delivered up to six hours or more after the onset of the stroke and in some cases even up to 24 hours. This treatment is highly effective in reducing disability and can more than double the chances of a good recovery in suitable patients.

The PHA played a key role in developing a thrombectomy service in Northern Ireland. It is provided by interventional neuroradiologists in the Belfast HSC Trust and is operational on weekdays from 9am to 5pm. The PHA continues to support the Trust with plans to gradually expand its availability in the next few years, starting in 2018 with expansion of the service to 8am to 8pm on weekdays.

Outcomes

Thrombolysis

Thrombolysis may benefit up to 20% of ischaemic strokes. For every 100 patients that are treated with thrombolysis within three hours of stroke onset 32 people achieve a better recovery. This number reduces to 16 people when treatment is given between three and four and a half hours of stroke onset.

Pictured at the launch of the public conversation on Reshaping Stroke Services in Northern Ireland are (from left) Fedelma Carter and Neil Johnston NI Chest, Heart and Stroke; Dr Brid Farrell, Public Health Agency; Dr Enda Kerr, Stroke Physician, Western and Belfast Health and Social Care Trusts; Nicola Moran, Chair NIMAST and Barry MacAulay, Stroke Association.

Thrombectomy

Thrombectomy may benefit up to 5% of ischaemic strokes. For every 100 people who receive thrombectomy, 20 more survivors will be independent and 38 will be less disabled after stroke.[62]

Next steps

The PHA is working in partnership with the HSCB, those who provide stroke services, and the public on an extensive project to reshape stroke services in Northern Ireland. The first phase of this work involved a pre-consultation exercise in summer 2017 which allowed the public a chance to have their say on this important issue.

Key facts

- Each year in Northern Ireland there are approximately 2,700 emergency hospital admissions due to stroke.
- The FAST media campaign increases public awareness of the signs and symptoms of stroke and how to access help quickly.
- In ischaemic strokes early intervention by timely thrombolysis and thrombectomy, if indicated, can reduce death and disability.

Further information

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Research and development

Introduction

Evaluating the Early Intervention Support Service

Using the voluntary sector to provide services to children and families with complex needs: benefits and risks

Improving relationships and sexual health in schools and prisons

The APPLE Project

Introduction

Introduction

The HSC Research and Development (R&D) division of the PHA aims to fund research that can secure lasting improvements in the health and wellbeing of the entire Northern Ireland population.

In partnership with The Atlantic Philanthropies, the HSC R&D division funded a number of research projects during 2017 under the Early Intervention Transformation Programme (EITP) workstreams 1, 2 and 3. The projects are aimed at informing the process of continuous improvement of EITP workstreams, informing the development of any subsequent EITP interventions, and informing future strategy for EITP for children and young people and their families in Northern Ireland. The following section provides an overview of the three funded EITP research projects as well as the 'If I were Jack' trial, a project set out to develop an evidence-based relationship and sexual health education (RSE) for young people in schools and men in prisons.

Evaluating the Early Intervention Support Service

Public health challenge

Early intervention can be a key mechanism in helping to improve outcomes for children, young people and families: intervening early and equipping families with the skills they need (and helping to build resilience) can help prevent emerging problems. The Early Intervention Support Service (EISS) was established as part of the EITP in 2015. It was formed under the umbrella of the Northern Ireland Executive/Atlantic Philanthropies 'Delivering Social Change Signature Programme', and is jointly funded by the Delivering Social Change fund, five government departments and The Atlantic Philanthropies.

Early Intervention
Transformation Programme

To address the lack of inter-agency collaboration within services in Northern Ireland, EITP uses a collaborative preventative model which uses partnership working to work towards three central goals: equipping parents with the skills needed to give their children the best start in life; supporting families outside of the statutory system when problems first emerge; and positively addressing the impact of adversity on children by intervening both earlier and more effectively to reduce the risk of poor outcomes later in life. The aim therefore of EITP is to improve outcomes for children and young people in Northern Ireland through establishing a range of early intervention, and importantly, collaborative approaches.

EISS is a short-term, home-based intervention, delivered to families with a child between the ages of 0-18 and with no contact with statutory services. EISS aims to support families before or when problems arise, and before there is a need for statutory involvement, ie Tier 2 families. There are five services currently operating in each of the Health and Social Care Trust areas, which deliver a range of practical and therapeutic support to families. Each EISS was aligned closely with Family Support Hubs and existing services in the pilot area, and aimed to provide a range of practical and therapeutic support to families; however, duplication of existing services was to be avoided.

Pictured at the EISS local stakeholder event in Belfast on 19 October 2017 are the Belfast EISS team, members of the Public Health Agency and the QUB research team.

Actions

To provide an evidence base and to evaluate the effectiveness of EISS in supporting families, a research team from Queen's University Belfast designed and undertook a mixed methods evaluation in 2017. Each EISS asked parents referred to their service for consent to participate in the evaluation. The researchers:

- carried out pre/post-test measures with 80 families in contact with EISS;
- conducted a process evaluation involving interviews with managers, stakeholders, practitioners and families in contact with EISS;
- submitted a draft report to funders at the end of March 2018 (summary and recommendations are pending).[63]

Outcomes

The draft report indicated that there were statistically significant differences in two of the outcomes measured with small effect sizes; an increase in parenting confidence around 'empathy' (Sig=0.014, d=0.67) and 'play' (Sig=0.039, d=0.56) with children. While these differences are by no means generic enough to comment on with certainty, the results are certainly encouraging and a step in the right direction.

The output from the process evaluation was extremely positive and helpful in interpreting the results:

- The nature of the short-term intervention (12 weeks) only feasibly allowed for small changes to be observed. However, short-term small changes have the potential to lead to longer term positive outcomes.
- The home visiting aspect was particularly beneficial for families for practical reasons, as was the non-judgemental approach of the key worker. This could have led to greater parental engagement with the service.
- Based on the evidence base for early intervention, the lack of adherence to fidelity to the intervention may have impacted on the effectiveness of the evaluation and the target population (0-18) was possibly too wide.

Key facts

- Families and children who experience multiple deprivation are at higher risk of developmental problems. Northern Ireland is the most deprived area of the United Kingdom, with 37% of the population living in an area that is within the 20% most deprived across the UK.[64]
- Early intervention now is a central concept worldwide across a wide range of family support research and service developments, and is critical in helping to improve outcomes for families, children and young people.
- However, consensus on 'what works' in early intervention approaches is still contested.

Next steps

The research team have submitted the final draft of the report to the funders and are awaiting feedback. It is expected the evaluation will go some way to providing justification, an evidence base and empirical support in deciding whether to continue EISS and/or a roll-out to more areas throughout Northern Ireland.

Further information

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Using the voluntary sector to provide services to children and families with complex needs: benefits and risks

Public health challenge

The voluntary sector is often involved in providing services and supports to families and children with complex needs due to its particular expertise and ability to engage service users. The services provided by the voluntary sector usually complement existing statutory social work services rather than duplicate or compete with them. However, in times of contracting State welfare services and neoliberal policies emphasising using the free market to provide more economical services, the voluntary sector is increasingly being commissioned by the State to provide services to families and children with complex needs. Despite the role of the voluntary sector in providing these services, there has been a lack of robust research examining if the commissioning of the voluntary sector affects family outcomes and how this compares to the use of statutory social work services. Dr Michelle Butler, Dr Aisling McLaughlin, Dr David Hayes and Dr Andrew Percy of Queen's University Belfast sought to address this gap in our knowledge by conducting two rapid reviews of the international literature on the commissioning, governance and delivery of services by the voluntary sector, if these services affect outcomes and how these services compare to statutory social work services.

Actions

Two rapid reviews of all English language papers, from 2000 onwards, using the terms 'voluntary sector,' 'social work services,' 'complex needs' and 'children and families' were conducted. The first review focused on the commissioning of voluntary sector services while the second focused on family outcomes. How voluntary sector services compare to statutory social work services was explored in both reviews. All papers were screened and excluded if they did not discuss voluntary and social work service provision to families and children with complex needs or were not relevant to the research questions (see Figure 16). See Figure 17 for the variety of complex needs referred to in the literature.

Figure 16: Screening of papers.

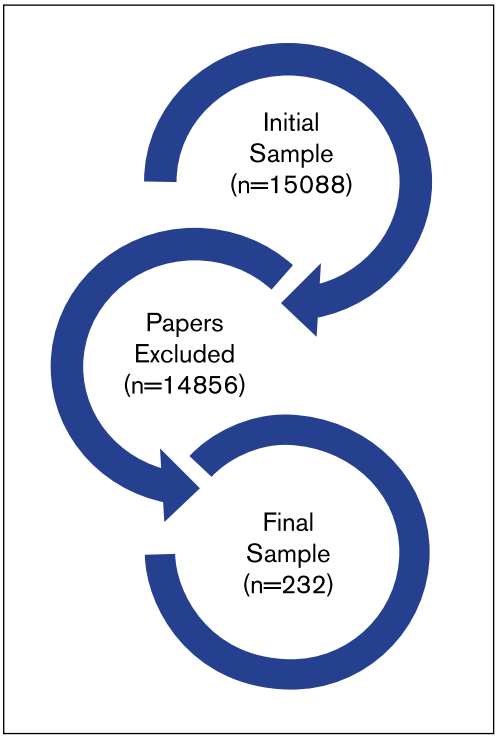
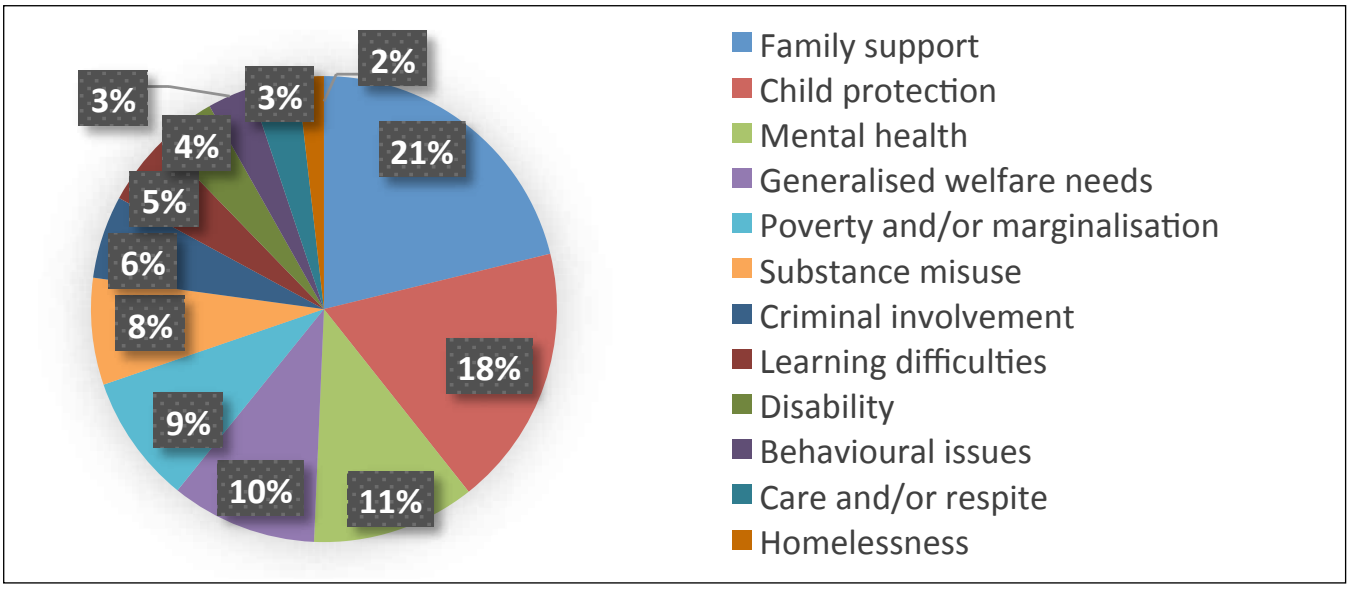


Figure 17: Range of complex needs referred to.



Outcomes

A key benefit of the voluntary sector is its flexibility and ability to engage hard to reach groups. However, no consistent differences in outcomes were found between the voluntary sector and statutory social work services. Instead, individual organisational culture, staff practices and the commissioning process shaped outcomes. A commissioning process which under-costed services and adopted a short-term, fragmented approach to service delivery hindered effective interagency collaboration and the development of trusting relationships, which were key to improving outcomes for children and families with complex needs. In addition, a competitive tendering commissioning process did not result in a more cost-effective, efficient service compared to a non-competitive process due to limited alternative providers, disruption to service users and shortcomings in the governance of service contracts.

Key facts

- No consistent differences between the voluntary sector and statutory social work services were found as individual organisational culture, staff practices and the commissioning process were more important in shaping outcomes and users' experiences of service provision.
- A competitive tendering commissioning process does not always result in a more cost-effective, efficient service and can complicate interagency collaboration and hinder outcomes for children and families with complex needs.
- Regardless of whether services are delivered by the voluntary sector, statutory social work services or a combination thereof, effective interagency collaboration and the development of trusting relationships were key to improving outcomes for those with complex needs.

Next steps

The next stage of the project will examine the extent to which these findings are applicable to the Northern Ireland context.

Further information

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Improving relationships and sexual health in schools and prisons

Public health challenge

The right to high quality relationships and sexual health education (RSE) is enshrined in the United Nations Rights of the Child and, in Northern Ireland, in the *Sexual health promotion strategy and action plan, 2008-13* extended to 2015 with an addendum.[65,66]

Rising to these challenges, a group of researchers based at Queen's University Belfast, working in partnership with the PHA and a wide range of stakeholders, set out to develop evidence-based RSE for young people in schools and men in prisons.

Actions

Our work in Schools: We developed 'If I were Jack'. This is a schools-based RSE intervention which especially emphasises the role of teenage men in preventing teenage pregnancy and promoting positive relationships and sexual health. It is delivered to both males and females aged 14-16 (https://www.qub.ac.uk/sites/if-i-were-jack/).

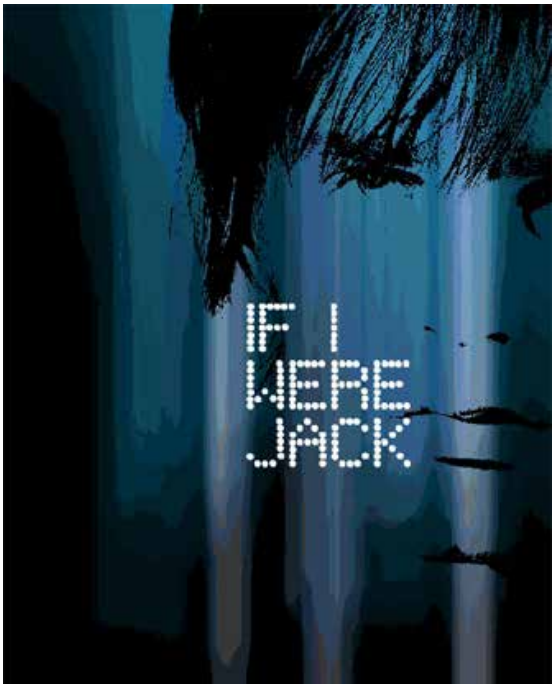
Our work in Prisons: Dr Michelle Templeton delivered 'If I were Jack' with young men in Hydebank Wood College (HWC) together with Barnardo's NI and used this opportunity to better assess their RSE needs (https://goo.gl/bHfMkx).

Dr Carmel Kelly led our team to develop nurse-led asymptomatic screening of sexually transmitted infections (STIs) within prison healthcare, and together with Dr Templeton, used a participatory approach with the young men in HWC to co-produce a sexual health promotion video.

We are now developing a bespoke RSE programme for young incarcerated men. The objective of the Relationships and Future Fatherhood programme is to help men have healthy respectful relationships. It will cover sexual and mental health, the characteristics of forming healthy relationships, and hopes and intentions for future parenthood.

Impacts

A cluster randomised controlled trial (cRCT) of 'If I were Jack' among 831 pupils in eight post-primary schools in Northern Ireland demonstrated that this RSE programme is acceptable to schools, pupils, teachers and parents (including in faith based schools), can be feasibly implemented and is cost-effective (under £14 per pupil). The trial was funded by the National Institute for Health Research (NIHR) and HSC R&D.



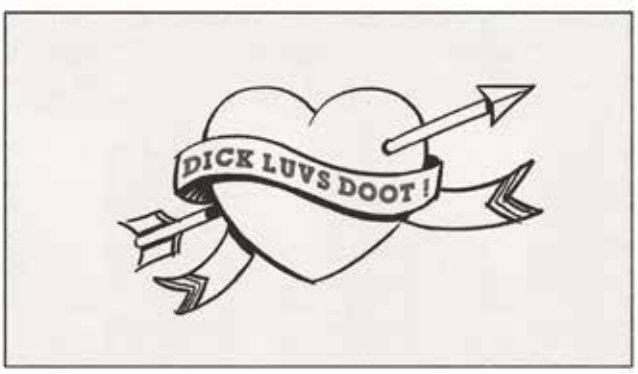
'If I were Jack' is a unique relationship and sexuality education intervention which was developed collaboratively with scientific experts, government bodies, pupils and teachers over several years in the UK, Ireland and Australia. https://www.qub.ac.uk/sites/if-i-were-jack/

Launch of *Improving sexual health of men in NI prisons* at Hydebank Wood College (March 2018) Included from L-R Catherine Baxter, Jaqueline Magennis (Nurses at HBW), Dr Michael Mc Bride (Chief Medical Officer), Professor Maria Lohan (School of Nursing and Midwifery QUB), Dr Carmel Kelly (Clinical Nurse Lead for sexual health SET, QUB), Dr Michelle Templeton (Research Fellow QUB), Professor Donna Fitzsimons (Head of School), Rachel Gibbs (Assistant Director Prison Health SET), Tracey Heasley (Clinical Nurse Lead for prison healthcare SET), Governors Richard Taylor and Austin Treacy (NIPS) and William Halligan (Nurse – Maghaberry prison).
https://daro.qub.ac.uk/improving-sexual-health-of-northern-ireland-prisoners

We are underway with a UK-wide cRCT providing evidence of if, and how, 'If I were Jack' might reduce unprotected sex, and promote respectful relationships (funded by NIHR and supported by HSC R&D).

'If I were Jack' is being rolled out to schools in the Republic of Ireland through the Department of Education and Science.

Nurse-led sexual health services have been established in each of the prisons, delivered by the South Eastern Health and Social Care Trust (SET). 'Dick Luvs Doot', the health promotion video made with men in prison, for men in prison, is available on YouTube at https://goo.gl/iZf4qJ Both these projects were funded by the Burdett Trust.



Next steps

Working with our partners and stakeholders we will:

- further enhance nurse-led sexual health services in prison healthcare;
- develop a Relationships and Future Fatherhood Programme for young incarcerated men (in Scotland and Northern Ireland) based on the strongest international evidence and young men's views;
- complete our UK-wide trial of 'If I were Jack';
- deliver a systematic review of the evidence on engaging men in sexual and reproductive health globally for the World Health Organization.

Key facts

- The UK has the highest rates of teenage pregnancy in Western Europe.
- The children of a parent who has been imprisoned are three times more likely to be involved in offending.
- The key to young male offenders' rehabilitation, alongside enhancing education and employability, is to develop their relationships and parenting skills by helping them understand the importance of fatherhood and the difference 'good fathering' can make to their future children.

Further information

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The APPLE Project

Public health challenge

Current evidence suggests that all facets of child development (physical, intellectual and emotional) are influenced significantly by the foundations laid in early childhood. This begins during pregnancy, continuing through the early years and is reflected in children's readiness for school and subsequent educational outcomes. In Northern Ireland significant changes following the introduction of policies including *Families Matter* and *Healthy child, healthy future* have paved the way for the transformation of services which integrate health and education in the early years.[67,16] The implementation of new initiatives under EITP requires evaluation to ensure services are evidence-based and impact on the desired outcomes. Antenatal care and education are generally recognised as the mechanisms through which improved maternal and infant outcomes are achieved both in the short and long term. Changes to universal services are currently being rolled out by Health and Social Care Trusts here and include the introduction of:

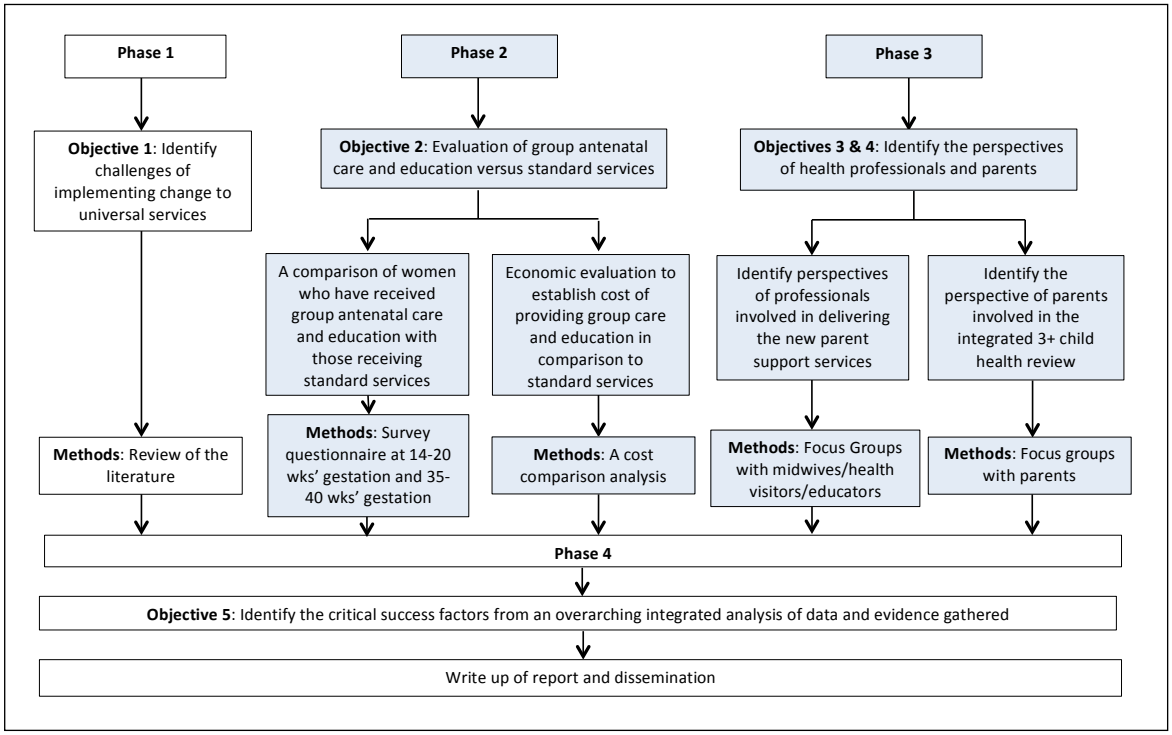
- group based antenatal care and education to first time mothers with uncomplicated pregnancies and their partners;
- a named health visitor to pre-school education settings;
- an integrated 3+ years child health review within pre-school education settings.

Actions

The APPLE (A Parent and Professional Learning Evaluation) Project is evaluating the changes to the provision of antenatal care by comparing outcomes for women who are receiving *group* antenatal care and education with women who are receiving *routine* antenatal care and education services. The APPLE Project will also seek to gain a better understanding of the process of introducing changes to universal services by discussing the implementation of changes and the delivery of group based antenatal care and education with health care professionals, and by asking parents about their experiences of the 3+ child health review.

Members of the APPLE Project Team L-R Ms Aideen Gildea, Dr Jenny McNeill, Dr Fiona Lynn, Dr Lorna Lawther all QUB. Missing members: Prof Fiona Alderdice, NPEU/QUB, Dr Sharon Millen, QUB.

Figure 18: Flow diagram for the APPLE Project.



Outcomes

The APPLE Project is focused on evaluating ongoing initiatives within EITP and therefore seeks to meet the overarching aims of The Atlantic Philanthropies in Northern Ireland through supporting the healthy development of children by giving them the best start in life, striving not only to improve outcomes in the short term but also those in the long term. As a consequence, the findings of this evaluation will directly impact on both the provision of health and education services in Northern Ireland with the ultimate aim of identifying best practice leading to optimal outcomes for parents and children.

Next Steps

The APPLE Project is currently ongoing and results are not yet available. Preliminary work with health professionals involved across all health and social care trusts in Northern Ireland has been undertaken in preparation for the collection of data. Results of the project will be used to inform the direction of future antenatal and early years' service provision.

Key facts

- The introduction and evaluation of group antenatal care and education is novel to Northern Ireland.
- Group antenatal care and education has been shown to positively impact on social and clinical outcomes.
- Preliminary feedback from service users suggests pregnant women and their partners are responding positively to the changes to care provision.

Further information

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Created by the PHA's Health Intelligence Unit. Page numbers refer to the PDF of core tables, which is available to download from the PHA website at www.publichealth.hscni.net

Further information

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HSC Public Health Agency

board paper

Management Statement / Financial Memorandum

date 20 September 2018 **item** 10 **reference** PHA/04/09/18

presented by Mr Edmond McClean, Deputy Chief Executive

action required For noting

Summary

The Management Statement and Financial Memorandums (MS/FMs) is central to the accountability process and sets the framework for the relationship between the Department of Health and the Public Health Agency. In line with Governance processes, MS/FMs should be updated at least every 5 years. The MS/FM for the PHA was last fully revised and updated in 2013.

This MS/FM has been updated to reflect the updated template developed by the Department of Finance, Governance Unit and Finance Directorate. Any changes made have been minor.

It should be noted that the Memorandum of Understanding between the PHA and the Safeguarding Board for Northern Ireland is currently being reviewed and once updated, this will be added to the MS/FM.

Equality Impact Assessment

Not applicable.

Recommendation

The PHA board is asked to **NOTE** the Management Statement / Financial Memorandum.

MANAGEMENT STATEMENT (Tab A) and FINANCIAL MEMORANDUM (Tab B)

Between DoH and PHA

August 2018

MANAGEMENT STATEMENT

1. INTRODUCTION

1.1 This document

1.1.1 This *Management Statement* and *Financial Memorandum* (MS/FM) has been drawn up by the Department of Health (DoH) in consultation with the Public Health Agency (PHA), Linenhall Street, Belfast. The document is based on a model prepared by the Department of Finance (DoF).

1.1.2 The terms and conditions set out in the combined M*anagement Statement* and *Financial Memorandum* may be supplemented by guidelines or directions issued by the sponsor Department/Minister in respect of the exercise of any individual functions, powers and duties of the PHA.

1.1.3 A copy of the MS/FM for the PHA should be given to all newly appointed Board Members, senior PHA executive staff and Departmental sponsor staff on appointment. Additionally the MS/FM should be tabled for the information of Board Members at least annually at a full meeting of the Board. Amendments made to the MS/FM should also be brought to the attention of the full Board on a timely basis.

1.1.4 Subject to the legislation noted below, this *Management Statement* sets out the broad framework within which the PHA will operate, in particular:

- the PHA's overall aims, objectives and targets in support of the sponsor Department's wider strategic aims, the NICS Outcomes Delivery plan and the outcomes and targets contained in the current draft Programme for Government (PfG).
- the rules and guidelines relevant to the exercise of the PHA's functions, duties and powers;
- the conditions under which any public funds are paid to the PHA; and
- how the PHA is to be held to account for its performance.

1.1.5 The associated *Financial Memorandum* sets out in greater detail certain aspects of the financial provisions which the PHA shall observe. However, the *Management Statement* and *Financial Memorandum* do not convey any legal powers or responsibilities.

1.1.6 The document shall be periodically reviewed by the sponsor Department in accordance with the timetable referred to in Section 7 below.

1.1.7 The PHA, the sponsor Department, or the Minister, may propose amendments to this document at any time. Any such proposals by the PHA shall be considered in the light of evolving Departmental policy aims, operational factors and the track record of the PHA itself. The guiding principle shall be that the extent of flexibility and freedom given to the PHA shall reflect both the quality of its internal controls to achieve performance and its operational needs. The sponsor Department shall determine what changes, if any, are to be incorporated in the document. Legislative provisions shall take precedence over any part of the document. Significant variations to the document shall be cleared with DoF Supply after consultation with the PHA, as appropriate. (The definition of "significant" will be determined by the sponsor Department in consultation with DoF).

1.1.8 The *MS/FM* is approved, signed and dated by the sponsor Department and the PHA's Chief Executive.

1.1.9 Any question regarding the interpretation of the document shall be resolved by the sponsor Department after consultation with the PHA and, as necessary, with DoF Supply.

1.1.10 Copies of this document and any subsequent substantive amendments shall be placed in the Library of the Assembly. (Copies shall also be made available to members of the public on the PHA's website).

1.2 The founding legislation, functions, duties and powers of the PHA

1.2.1 The PHA is established under section 12 (1) of the Health and Social Care (Reform) Act (Northern Ireland) 2009 (hereafter referred to as the Act). The PHA does not carry out its functions on behalf of the Crown.

1.2.2 The PHA is established for the purposes specified in section 13 of the Act. The PHA's general powers etc. are listed in Schedule 2 to the Act.

1.3 Classification

1.3.1 For policy/administrative purposes the PHA is classified as a Health and Social Care body (akin to an executive non-Departmental public body) and for national accounts purposes is classified to the central government sector).

1.3.3 References to the PHA include, where they exist, all its subsidiaries and joint ventures that are classified to the public sector for national accounts purposes. If such a subsidiary or joint venture is created, there shall be a document setting out the arrangements between it and the PHA.

2. AIMS, OBJECTIVES AND TARGETS

2.1 The approved overall aim for the PHA is to improve the health and social well-being of the population and the quality of care provided, and to protect the population from communicable disease or emergencies or other threats to public health. As well as the provision or securing of services related to those functions, the PHA will commission or undertake programmes of research, health awareness and promotion etc. This aim will be delivered through three core functions of the PHA:

- securing the provision of and developing and providing programmes and initiatives designed to secure the improvement of the health and social well-being of and reduce health inequalities between people in Northern Ireland,

- protecting the community (or any part of the community) against communicable disease and other dangers to health and social well-being including dangers arising on environmental or public health grounds or arising out of emergencies; and

- providing professional input to the commissioning of health and social care services which meet established quality standards and which support innovation.

2.2 The PHA also has a general responsibility for promoting improved partnership working with local government and other public sector organisations to bring about real improvements in public health and social well-being on the ground and anticipating the new opportunities offered by community planning.

2.3 Objectives and key targets - The Department determines the PHA's performance framework in light of the Department's wider strategic aims, the NICS Outcomes Delivery Plan, and current draft PfG objectives and targets.

2.4 The key targets, standards and actions to be delivered by the PHA are set out in its Annual Business Plan supported by the 3 year strategic plan. These are defined by the Department within Commissioning Directions and approved by the Minister. The Department also determines, by direction, the format and broad content of the Commissioning Plan, which is to be drawn up by the HSCB in accordance with section 8 of the Act, i.e. in consultation with the PHA, having due regards for any advice or information provided by the Agency, and published only with its approval. The Commissioning Plan explains how the PHA will meet each of the targets, standards and actions for which it is deemed by the Department to have sole or lead responsibility. The document will also set out the PHA's contribution to the commissioning process through its professional medical expertise.

3. RESPONSIBILITIES AND ACCOUNTABILITY

3.1 The Minister

3.1.1 The Minister is accountable to the Assembly for the activities and performance of the PHA. Their responsibilities include:

- approving the PHA's strategic objectives and the policy and performance framework within which the PHA will operate (as set out in this *Management Statement* and *Financial Memorandum* and associated documents);
- keeping the Assembly informed about the PHA's performance; as part of the HSC system;
- carrying out responsibilities specified in the founding legislation including appointments to the board (including its Chairman) and laying of the annual report and accounts before the Assembly; and
- approving the remuneration scheme for Non-Executive board members and setting the annual pay settlement each year under these arrangements.

3.2 The Accounting Officer of the sponsor Department

3.2.1 The Permanent Secretary, as the sponsor Department's principal Accounting Officer (the 'Departmental Accounting Officer'), is responsible for the overall organisation, management and staffing of the sponsor Department and for ensuring that there is a high standard of financial management in the Department as a whole. The Departmental Accounting Officer is accountable to the Assembly for the issue of any grant-in-aid to the PHA. The Departmental Accounting Officer designates the Chief Executive of the PHA as the PHA's Accounting Officer, and may withdraw the Accounting Officer designation if he/she believes that the incumbent is no longer suitable for the role.

3.2.2 In particular, the Departmental Accounting Officer of the sponsor Department shall ensure that:

- the PHA's strategic aim(s) and objectives support the sponsor Department's wider strategic aims, the NICS Outcomes Delivery Plan and current draft PfG objectives and targets;
- the financial and other management controls applied by the sponsor Department to the PHA are appropriate and sufficient to safeguard public funds and for ensuring that the PHA's compliance with those controls is effectively monitored ("public funds" include not only any funds granted to the PHA by the Assembly but also any other funds falling within the stewardship of the PHA);

- the internal controls applied by the PHA conform to the requirements of regularity, propriety and good financial management; and
- any grant-in-aid to the PHA is within the ambit and the amount of the Request for Resources and that Assembly authority has been sought and given.

3.2.3 The responsibilities of a Departmental Accounting Officer are set out in more detail in Chapter 3 of Managing Public Money Northern Ireland (MPMNI).

3.2.4 The Departmental Accounting Officer (DAO) is also responsible for ensuring that arrangements are in place to:

- continuously monitor the PHA's activities to measure progress against approved targets, standards and actions, and to assess compliance with safety and quality, governance, risk management and other relevant requirements placed on the organisation;
- address significant problems in the PHA, making such interventions as he/she judges necessary to address such problems;
- periodically carry out an assessment of the risks both to the Department's and the PHA's objectives and activities;
- inform the PHA of relevant Government policy in a timely manner; and
- bring concerns about the activities of the PHA to the full PHA Board, requiring explanations and assurances that appropriate action has been taken.

3.3 The sponsoring team in the Department

3.3.1 Within the sponsoring Department, **Health Development Policy Branch (HDPB)** is the sponsoring team for the PHA. The Branch, in consultation as necessary with the relevant Departmental Accounting Officer, is the primary source of advice to the Minister on the discharge of his/her responsibilities in respect of the PHA, and the primary point of contact for the PHA in dealing with the sponsor Department. The sponsoring team shall carry out its duties under the management of a senior officer, who shall have primary responsibility within the team for overseeing the activities of the PHA.

3.3.2 The Executive Board Member (EBM) sponsor from the Department is the Chief Medical Officer, Dr Michael McBride. The EBM Sponsor has primary responsibility for overseeing sponsorship of the PHA. In particular the EBM supports the Permanent Secretary in ensuring sponsorship is applied systematically; provides an assurance that a proportionate approach to assurance and accountability is in place; manages the PHA's business planning process; and ensures that significant governance, risk management or internal control issues are escalates within the Department. The EBM Sponsor also undertakes end-year appraisals for PHA Chairs and participates in ground-clearing and accountability meetings as required.

3.3.3 The sponsoring team shall advise the Minister on:

- an appropriate framework of objectives and targets for the PHA in the light of the Department's wider strategic aims, the NICS Outcomes Delivery Plan and current draft PfG objectives and targets;
- an appropriate budget for the PHA in the light of the Department's overall public expenditure priorities; and
- how well the PHA is achieving its strategic objectives and whether it is delivering value for money.

3.4 The PHA's Board

3.4.1 The Board Members are appointed by the Minister, following an open competition in accordance with the Code of Practice issued by the Commissioner for Public Appointments for Northern Ireland. The established departmental practice is that initial appointments are usually for a four year period. Re-appointment for a second term of

appointment can be considered. In the absence of a Government Minister the Permanent Secretary of the Department of Health can appoint Board Members. The PHA Board is made up of a Non-Executive Chair, the Chief Executive, seven Non-Executive Directors, and three Executive Directors. Executive Directors are employees of the PHA.

3.4.2 The Board must ensure that effective arrangements are in place to provide assurance on risk management, governance and internal control. The Board must set up an Audit Committee, which complies with the requirements of The Code of Conduct and Code of Accountability originally issued in November 1994, updated and reissued in July 2012. Circular HSS(PDD) 08/94 also set out detailed guidance on the establishment of audit committees. And any subsequent relevant guidance, is chaired by an independent non-executive, and comprising solely independent members, to provide independent advice on the effectiveness of the internal control and risk management systems.

3.4.3 The Board has corporate responsibility for ensuring that the PHA fulfils the aims and objectives set by DoH and approved by the Minister, and for promoting the efficient, economic and effective use of staff and other resources by the PHA. To this end, and in pursuit of its wider corporate responsibilities, the Board shall:

- establish the overall strategic direction of the PHA within the policy and resources framework determined by the sponsor Minister and Department;
- constructively challenge the PHA's executive team in their planning, target setting and delivery of performance;
- ensure that the sponsor Department is kept informed of any changes which are likely to impact on the strategic direction of the PHA or on the attainability of its targets, and determine the steps needed to deal with such changes;
- ensure that any statutory or administrative requirements for the use of public funds are complied with; that the Board operates within the limits of its statutory authority and any delegated authority agreed with the sponsor Department, and in accordance with any other conditions relating to the use of public funds; and that, in reaching decisions, the Board takes into account all relevant guidance issued by DoF and the sponsor Department;
- ensure that the Board receives and reviews regular financial information concerning the management of the PHA; is informed in a timely manner about any concerns about the activities of the PHA; and provides positive assurance to the sponsor Department that appropriate action has been taken on such concerns;
- demonstrate high standards of corporate governance at all times, including using the independent audit committee, (see paragraph 4.7) to help the Board to address the key financial and other risks facing the PHA; and
- appoint with the Minister's approval, or with the sponsor Department's approval, a Chief Executive to the PHA and, in consultation with the sponsor Department, set performance objectives and remuneration terms linked to these objectives for the Chief Executive, which give due weight to the proper management and use of public monies.

3.4.4 Individual Board Members shall act in accordance with their wider responsibilities as Members of the Board – namely to:

- comply at all times with the Code of Practice (see paragraph 3.4.2) that is adopted by the PHA and with the rules and guidance relating to the use of public funds and to conflicts of interest. The Code of Conduct draws attention to the requirement for public service values to be at the heart of Health and Social Care (HSC) in Northern Ireland. High standards of corporate and personal conduct are essential. Moreover, as the HSC is publically funded, it is accountable to the Northern Ireland Assembly for the services provided and for the effective and economical use of

taxpayers' money. It also sets out measures to deal with possible conflicts of interest of board members;

- not misuse information gained in the course of their public service for personal gain or for political profit, nor seek to use the opportunity of public service to promote their private interests or those of connected persons or organisations; and to declare publicly and to the board any private interests that may be perceived to conflict with their public duties;
- comply with the Board's rules on the acceptance of gifts and hospitality, and of business appointments; and
- act in good faith and in the best interests of the PHA.

3.4.5 The Code of Practice on Openness in the HPSS sets out the requirements for public access to information and for the conduct of board meetings. The Agency is required to ensure appropriate compliance with the Freedom of Information Act (2000).

3.4.6 The sponsor Department shall have access to all Board meeting (and Governance and Audit Committee) papers and minutes.

3.5 The Chairman of the PHA

3.5.1 The Chairman is appointed as set out in paragraph 3.4.1.

3.5.2 The Chairman is accountable to the Minister of the sponsor Department. The Chairman shall ensure that the PHA's policies and actions support the wider strategic policies of the Minister; and that the PHA's affairs are conducted with probity. The Chairman shares with other Board members the corporate responsibilities set out in paragraph 3.4.2, and in particular for ensuring that the PHA fulfils the aims and objectives set by the sponsor Department and approved by the Minister.

3.5.3 The Chairman has a particular leadership responsibility on the following matters:

- formulating the Board's strategy;
- ensuring that the Board, in reaching decisions, takes proper account of guidance provided by the Minister or the sponsor Department;
- promoting the efficient, economic and effective use of staff and other resources;
- encouraging and delivering high standards of regularity and propriety;
- representing the views of the Board to the general public; and
- ensuring that the Board meets at regular intervals throughout the year and that the minutes of meetings accurately record the decisions taken and, where appropriate, the views of individual Board Members. Meetings must be open to the public, the public should be advised of meetings thought the press and the minutes must be placed on the PHA website after formal approval.

3.5.4 The Chairman shall also:

- ensure that all members of the Board, when taking up office, are fully briefed on the terms of their appointment and on their duties, rights and responsibilities, and receive appropriate induction training, including on the financial management and reporting requirements of public sector bodies and on any differences which may exist between private and public sector practice;
- advise the Department of the needs of the PHA when Board vacancies arise, with a view to ensuring a proper balance of professional and financial expertise; and
- assess the performance of individual Board Members. Board Members will be subject to ongoing performance appraisal, with a formal assessment being completed by the Chair of the Board at the end of each year. Members will be made aware that they are being appraised, the standards against which they will be appraised, and will have an opportunity to contribute to and view their report.

The Chair of the Board will also be appraised on an annual basis by the Departmental Accounting Officer.

- Ensure the completion of the Board Governance Self Assessment Tool on an annual basis. Assurance will be provided through the mid-year assurance statement, that the tool is being completed, actions are being addressed and that any exception issues will be raised with the Department.

3.5.5 The Chairman shall also ensure that a Code of Practice for Board Members is in place, based on the Codes of conduct for board members of public bodies (FD (DFP) 04/14 refers. The Code shall commit the Chairman and other Board Members to the Nolan "seven principles of public life", and shall include a requirement for a comprehensive and publicly available register of Board Members' interests.

3.5.6 Communications between the Board, the Minister and the Department shall normally be through the Chairman. The Chairman shall ensure that the other Board Members are kept informed of such communications on a timely basis.

3.6 The Chief Executive's role as Accounting Officer

3.6.1 The Chief Executive of the PHA is designated as the PHA's Accounting Officer by the Departmental Accounting Officer of the sponsor Department.

3.6.2 The Chief Executive, as the PHA's Accounting Officer, is personally responsible for safeguarding the public funds for which he/she has charge; for ensuring propriety and regularity in the handling of those public funds; and for the day-to-day operations and management of the PHA. In addition, he/she should ensure that the PHA as a whole is run on the basis of the standards (in terms of governance, decision-making and financial management) set out in Box 3.1 to MPMNI. In addition, the Chief Executive must, within three months of appointment, attend the training course 'An Introduction to Public Accountability for Accounting Officers'.

3.6.3 As Accounting Officer, the Chief Executive shall exercise the following responsibilities in particular:

on planning and monitoring -

- establish, with approval of the sponsor Department, the PHA's corporate and business plans in support of the Department's wider strategic aims, the NICS Outcomes Delivery plan and current draft PfG objectives and targets;
- inform the sponsor Department of the PHA's progress in helping to achieve the Department's policy objectives and in demonstrating how resources are being used to achieve those objectives;
- ensure that timely forecasts and monitoring information on performance and finance are provided to the sponsor Department; that the sponsor Department is notified promptly if overspends or underspends are likely and that corrective action is taken.
- that any significant problems, whether financial or otherwise, and whether detected by internal audit or by other means, are notified to the sponsor Department in a timely fashion;

on PHA's corporate host responsibilities to the Safeguarding Board for Northern Ireland (the SBNI) -

- Ensure the PHA discharges and accounts for its corporate host obligations to the SBNI in accordance with the Memorandum of Understanding. The PHA acts as corporate host to the Safeguarding Board for Northern Ireland (the SBNI). It discharges functions primarily relating to the regulations made under section 1(5)(c)2 of the 2011 SBNI Act.

- The PHA is accountable to the Department for the discharge of its corporate host obligations to the SBNI but is not accountable for how the SBNI discharges its statutory objective, functions and duties.
- A copy of the Memorandum of Understanding between the Department, the PHA and the SBNI is attached at Appendix 2.

on advising the Board -

- advise the Board on the discharge of its responsibilities as set out in this document, in the founding legislation and in any other relevant instructions and guidance that may be issued from time to time by DoF or the sponsor Department;
- advise the Board on the PHA's performance compared with its aims and objectives;
- ensure that financial considerations are taken fully into account by the Board at all stages in reaching and executing its decisions, and that standard financial appraisal techniques are followed appropriately;
- take action in line with Section 3.8 of MPMNI if the Board, or its Chairman, is contemplating a course of action involving a transaction which the Chief Executive considers would infringe the requirements of propriety or regularity, or does not represent prudent or economical administration, efficiency or effectiveness;

on managing risk and resources -

- ensure that a system of risk management is maintained to inform decisions on financial and operational planning and to assist in achieving objectives and targets;
- ensure that an effective system of programme and project management and contract management is maintained;
- ensure compliance with the Northern Ireland Public Procurement Policy;
- ensure that all public funds made available to the PHA are used for the purpose intended by the Assembly, and that such monies, together with the PHA's assets, equipment and staff, are used economically, efficiently and effectively;
- ensure that adequate internal management and financial controls are maintained by the PHA, including effective measures against fraud and theft;
- maintain a comprehensive system of internal delegated authorities that are notified to all staff, together with a system for regularly reviewing compliance with these delegations;
- ensure that effective personnel management policies are maintained;

on accounting for the PHA's activities -

- sign the accounts and be responsible for ensuring that proper records are kept relating to the accounts and that the accounts are properly prepared and presented in accordance with any directions issued by the Minister, the sponsor Department, or DoF;
- sign a Statement of Accounting Officer's responsibilities, for inclusion in the annual report and accounts;
- sign a Governance Statement regarding the PHA's system of internal control, for inclusion in the annual report and accounts, that details significant internal control divergences;
- sign a mid-year assurance statement on the condition of the PHA's system of internal control;
- ensure that effective procedures for handling complaints about the PHA are established and made widely known within the PHA;
- act in accordance with the terms of this document and with the instructions and relevant guidance in *MPMNI* and other instructions and guidance issued from time to time by the sponsor Department and DoF - in particular, Chapter 3 of MPMNI and the Treasury document *Regularity and Propriety and Value for Money* (a copy

of which the Chief Executive shall receive on appointment). Section IX of the *Financial Memorandum* refers to other key guidance;

- give evidence, normally with the Accounting Officer of the sponsor Department, if summoned before the Public Accounts Committee on the use and stewardship of public funds by the PHA;
- ensure that an Equality Scheme is in place, reviewed and equality impact assessed as required by the Equality Commission and TEO;
- ensure that Lifetime Opportunities is taken into account; and
- ensure that the requirements of the Data Protection Act 2018 and the Freedom of Information Act 2000 are complied with.
- ensuring that a business continuity plan is developed and maintained;
- ensuring that effective procedures for handling adverse incidents are established and made widely known within the PHA;
- Copies of adverse inspection reports are shared with the Department
- Ensuring an acceptance and provision of Gifts and Hospitality Policy is in place that set out the principles and requirements under which gifts and hospitality can be received and in turn when such offers can be made**.**
- Ensuring that the requirements of relevant statutes, court rulings, and Departmental directions are fully complied with.

3.7 The Chief Executive's role as Consolidation Officer

3.7.1 For the purposes of Whole of Government Accounts, the Chief Executive of the PHA is normally appointed by DoF as the PHA's Consolidation Officer.

3.7.2 As the PHA's Consolidation Officer, the Chief Executive shall be personally responsible for preparing the consolidation information, which sets out the financial results and position of the PHA; for arranging for its audit; and for sending the information and the audit report to the Principal Consolidation Officer nominated by DoF.

3.7.3 As Consolidation Officer, the Chief Executive shall comply with the requirements of the PHA Consolidation Officer Letter of Appointment as issued by DoF and shall, in particular:

- ensure that the PHA has in place and maintains sets of accounting records that will provide the necessary information for the consolidation process; and
- prepare the consolidation information (including the relevant accounting and disclosure requirements and all relevant consolidation adjustments) in accordance with the consolidation instructions and directions issued by DoF on the form, manner and timetable for the delivery of such information.

3.8 Delegation of duties

3.8.1 The Chief Executive may delegate the day-to-day administration of his/her Accounting Officer and Consolidation Officer responsibilities to other employees in the PHA. However, he/she shall not assign absolutely to any other person any of the responsibilities set out in this document.

3.9 The Chief Executive's role as Principal Officer for Ombudsman cases

3.9.1 The Chief Executive of the PHA is the Principal Officer for handling cases involving the Northern Ireland Commissioner for Complaints. As Principal Officer, he/she shall inform the Permanent Secretary of the sponsor Department of any complaints about the PHA accepted by the Ombudsman for investigation, and about the PHA's proposed response to any subsequent recommendations from the Ombudsman.

3.10 Consulting customers

3.10.1The PHA will work in partnership with its stakeholders and customers to deliver the services/programmes, for which it has responsibility, to agreed standards. It will consult

regularly to develop a clear understanding of citizens' needs and expectations of its services, and to seek feedback from both stakeholders and customers and will work to deliver a modern, accessible service. It will follow the guidance of the Health and Social Care (Reform) Act (Northern-Ireland) 2009 (points 19 and 20) as appropriate. http://www.legislation.gov.uk/nia/2009/1/pdfs/nia_20090001_en.pdf

PLANNING, BUDGETING AND CONTROL

4.1 The corporate plan

4.1.1 Consistent with the timetable for the NI Executive's Budget process reviews, the PHA shall submit to the sponsor Department a draft of the PHA's corporate plan [normally] covering the three years ahead. The PHA shall have agreed with the sponsor Department the issues to be addressed in the plan and the timetable for its preparation.

4.1.2 DoF reserves the right to ask to see and agree the PHA's corporate plan.

4.1.3 The plan shall reflect the PHA's statutory duties and, within those duties, the priorities set from time to time by the Minister. In particular, the plan shall demonstrate how the PHA contributes to the achievement of the Department's strategic aims, the NICS Outcomes Delivery Plan and current draft PfG objectives and targets.

4.1.4 The corporate plan shall set out:

- the PHA's key objectives and associated key performance targets for the forward years, and its strategy for achieving those objectives;
- a review of the PHA's performance in the preceding financial years and an estimate of performance in the current year;
- alternative scenarios to take account of factors which may significantly affect the execution of the plan, but which cannot be accurately forecast;
- a forecast of expenditure and income, taking account of guidance on resource assumptions and policies provided by the sponsor Department at the beginning of the planning round. These forecasts should represent the PHA's best estimate of all its available income not just any grant or grant-in-aid; and
- other matters as agreed between the sponsor Department and the PHA – for example - statement of purpose of organisation as per legislation, strategic aims, performance in preceding corporate plan period, governance and accountability arrangements, links with the NICS Outcomes Delivery Plan, draft PfG and wider ministerial/Departmental priorities.

4.1.5 The main elements of the plan, including the key performance targets, shall be agreed between the sponsor Department and the PHA in light of the sponsor Department's decisions on policy and resources taken in the context of the Executive's wider policy and spending priorities and decisions.

4.2 The business plan

4.2.1 Each year of the corporate plan, amplified as necessary, shall inform the basis of the business plan for the relevant forthcoming year. The business plan shall include key targets and milestones for the year immediately ahead and shall be linked to budgeting information so that resources allocated to achieve specific objectives can readily be identified by the sponsor Department.

4.2.2 The business plan should include reference to SMART objectives that:

- support the delivery of the NICS Outcomes Delivery Plan and the current draft PfG Commitments;
- support the delivery of Departmental policy and strategy

- deliver on the functions etc. specified in the PHAs founding legislation setting out the purposes for which the PHA was created and the functions/services it is to deliver
- address known areas of underperformance, the findings of inquiries etc. and respond to particular events, serious adverse incidents and near misses.
- References to staff – training, development etc.

4.2.3 **DoF reserves the right to ask to see and agree the PHA's annual business plan.**

4.2.4 Corporate and business plans will be formally approved by the Permanent Secretary.

4.3 Publication of plans

4.3.1 The corporate and business plans shall be published and made available on the Internet.

4.4 Reporting performance to the sponsor Department

4.4.1 The PHA shall operate management information and accounting systems which enable it to review in a timely and effective manner its financial and non-financial performance against the budgets and targets set out in its agreed corporate and business plans.

4.4.2 The PHA shall take the initiative in informing the sponsor Department of changes in external conditions, which make the achievement of objectives more or less difficult, or which may require a change to the budget or objectives as set out in the corporate or business plans.

4.4.3 The PHA's performance in helping to deliver Departmental policies, including the achievement of key objectives, shall be reported to the Department on a regular basis. Performance will be formally reviewed twice yearly by the Permanent Secretary and other officials of the sponsor Department. The Minister shall meet the Board as appropriate to discuss the PHA's performance, its current and future activities, and any policy developments relevant to those activities.

4.4.4 The Department may, at its discretion, request evidence of progress against key objectives at any time. Senior Departmental officials will hold two Ground Clearing Sponsor Review Meeting(s) (SRM) with the PHA, and one non-Ground Clearing SRM per year. The purpose of these meetings is to discuss the PHA's overall performance, its current and future activities, any policy developments relevant to those activities safety and quality, financial performance and corporate control/risk management performance, and other issues as prescribed by the Department.

4.4.5 Issues identified at the Ground Clearing meeting which cannot be resolved at the meeting or through other avenues will be escalated for discussion to the Accounting Officer Accountability meeting with the Chair and Chief Executive of the PHA.

4.4.6 The PHA's performance against key targets shall be reported in the PHA's annual report and accounts (see Section 5.1 below).

4.5 **Budgeting procedures**

4.5.1 The PHA's budgeting procedures are set out in the *Financial Memorandum*.

4.6 Internal audit

4.6.1 The PHA shall establish and maintain arrangements for internal audit in accordance with the PSIAS (Public Sector Internal Audit Standards).

4.6.2 The Department should outline the arrangements that they have determined as appropriate for the PHA taking account of DAO (DFP) 01/10 Internal Audit Arrangements between Departments and Arm's Length Bodies.) This will include specifying the Department's requirements in terms of

- having input to PHA planned internal audit coverage;
- arrangements for the receipt of audit reports, assignment reports, the Head of Internal Audit's annual report and opinion etc;
- arrangements for the completion of Internal and External Assessments of the PHA internal audit function against PSIAS including advising that the sponsor Department reserves a right of access to carry out its own independent reviews of internal audit in the PHA;
- the right of access to all documents prepared by the PHA's internal auditor, including where the service is contracted out. Where the PHA's audit service is contracted out the PHA should stipulate this requirement when tendering for the services.

4.6.3 The PHA shall consult the sponsor Department to ensure that the latter is satisfied with the competence and qualifications of the Head of Internal Audit and that the requirements for approving the appointment are in accordance with PSIAS and relevant DoF guidance.

4.6.4 The sponsor Department will review the PHA's terms of reference for internal audit service provision. The PHA shall notify the sponsor Department of any subsequent changes to internal audit's terms of reference. The Sponsor branch will have an annual meeting with the PHA's internal audit to discuss the PHA's audit plan and strategy.

4.7 Audit Committee

4.7.1 The PHA shall set up an independent audit committee as a committee of its Board, in accordance with current Cabinet Office Guidance and in line with the Audit and Risk Assurance Committee Handbook.

4.7.2 The audit committee's meeting agendas, minutes and papers shall be forwarded as soon as possible to the sponsoring team.

4.7.3 The Audit Committee should complete the National Audit Office Checklist on an annual basis. Assurance on completion of the checklist will be provided through the mid-year assurance statement any exception issues should be reported to the Department.

4.7.4 The sponsor Department will review the PHA's audit committee terms of reference. The PHA shall notify the sponsor Department of any subsequent changes to the audit committee's terms of reference. The sponsor Department will attend at least one PHA audit committee meeting per year as an observer, and will not participate in any Audit Committee discussion.

4.8 Fraud

4.8.1 The PHA shall report immediately to the Counter Fraud and Probity Services (CFPS) within the BSO all frauds (proven or suspected), including attempted fraud. CFPS shall then report the frauds immediately to DoF and the C&AG. In addition the PHA shall forward to CFPS the annual fraud return, commissioned by DoF, on fraud and theft suffered by the PHA

4.8.2 All HSC bodies are required to have an Anti-Fraud Policy and Fraud Response Plan in place. This should be reviewed at least every 5 years and sent to CFPS for review. The PHA shall notify the sponsor Department of any subsequent changes to the policy or response plan.

4.9 Additional Departmental access to the PHA

4.9.1 In addition to the right of access referred to in paragraph 4.6.2 above, the sponsor Department shall have a right of access to all the PHA's records and personnel for purposes such as for example sponsorship audits and operational investigations. (See also paragraphs 3.4.4 and 4.7.2 access to Board and Audit Committee minutes).

5. EXTERNAL ACCOUNTABILITY

5.1 The annual report and accounts

5.1.1 After the end of each financial year the PHA shall publish as a single document an annual report of its activities together with its audited annual accounts. The report shall also cover the activities of any corporate bodies under the control of the PHA. A draft of the report shall be submitted to the sponsor Department in line with the timescale set by the Department before the proposed publication date although it is expected that the Department and the PHA will have had extensive pre-publication discussion on the content of the report prior to formal submission to the Department.

5.1.2 The report and accounts shall comply with the most recent version of the Government Financial Reporting Manual (FReM) issued by DoF. (*NOTE: This guidance is updated every year*). The accounts shall be prepared in accordance with any relevant statutes and the specific Accounts Direction issued by the sponsor Department.

5.1.3 The report and accounts shall outline the PHA's main activities and performance during the previous financial year and set out in summary form the PHA's forward plans. Information on performance against key financial targets shall be included in the notes to the accounts, and shall therefore be within the scope of the audit.

5.1.4 The report and accounts shall be laid before the Assembly and made available, in accordance with the guidance on the procedures for presenting and laying the combined annual report and accounts as prescribed in the relevant FD letter issued by DoF.

5.1.5 Due to the potential accounting and budgetary implications, any changes to accounting policies or significant estimation techniques underpinning the preparation of annual accounts, requires the prior written approval of the sponsor.

5.2 External audit

5.2.1 The Comptroller and Auditor General (C&AG) audits the PHA's annual accounts and passes the accounts to the sponsor Department who shall lay them before the Assembly. For the purpose of audit the C&AG has a statutory right of access to relevant documents as provided for in Articles 3 and 4 of the Audit and Accountability (Northern Ireland) Order 2003.

5.2.2 The C&AG will liaise with the PHA on the arrangements for completing the audit of the PHA's accounts. This will either be undertaken by staff of the NIAO or a private sector firm appointed by the C&AG to undertake the audit on his behalf. The final decision on how such audits will be undertaken rests with the C&AG, who retains overall responsibility for the audit.

5.2.3 The C&AG has agreed to share with sponsor Departments relevant information identified during the audit process including the report to those charged with governance at the end of the audit. This shall apply, in particular, to issues which impact on the Department's responsibilities in relation to financial systems within the PHA. The C&AG will also consider, where asked, providing Departments and other relevant bodies with reports which Departments may request at the commencement of the audit and which are compatible with the independent auditor's role.

5.3 VFM examinations

5.3.1 The C&AG may carry out examinations into the economy, efficiency and effectiveness with which the PHA has used its resources in discharging its functions. For the purpose of these examinations the C&AG has statutory access to documents as provided for under Articles 3 and 4 of the Audit and Accountability (Northern Ireland) Order 2003.

Where making payment of a grant, or drawing up a contract, the PHA should ensure that it includes a clause which makes the grant or contract conditional upon the recipient or contractor providing access to the C&AG in relation to documents relevant to the transaction. Where subcontractors are likely to be involved, it should also be made clear that the requirements extend to them.

6. STAFF MANAGEMENT

6.1 General

6.1.1 The decision to fill vacant or new senior positions in PHAs (at Director or Assistant Director level) is subject to approval by the Department, except where there are exceptional circumstances which have been agreed by the Department in advance.

6.1.2 Approvals for any change to the remuneration of Senior Executives must be obtained from the Department. This position will be kept under review by the Department.

6.1.3 Within the arrangements approved by the Minister and DoF the PHA shall have responsibility for the recruitment, retention and motivation of its staff. To this end the PHA shall ensure that:

- its rules for the recruitment and management of staff create an inclusive culture in which diversity is fully valued; where appointment and advancement is based on merit; and where there is no discrimination on grounds of gender, marital status, domestic circumstances, sexual orientation, race, colour, ethnic or national origin, religion, disability, community background or age;
- the level and structure of its staffing, including grading and numbers of staff, are appropriate to its functions and the requirements of efficiency, effectiveness and economy;
- the performance of its staff at all levels is satisfactorily appraised and the PHA's performance measurement systems are reviewed from time to time;
- its staff are encouraged to acquire the appropriate professional, management and other expertise necessary to achieve the PHA's objectives;
- proper consultation with staff takes place on key issues affecting them;
- adequate grievance and disciplinary procedures are in place;
- whistle blowing procedures consistent with the Public Interest (Northern Ireland) Order 2003 are in place; and

6.1.4 A code of conduct for staff is in place based on Annex 5A of Public Bodies: A Guide for Northern Ireland Departments (available at www.afmdni.gov.uk).

7. REVIEWING

7.1 The PHA shall be reviewed periodically, in accordance with the business needs of the sponsor Department and the PHA. Reference should be made to Chapter 9 of the Public Bodies: a Guide for Northern Ireland Departments.

7.2 The next review of the PHA will take place at a time determined by the Department.

SIGNED ON BEHALF OF THE DEPARTMENT OF HEALTH

RICHARD PENGELLY
PERMANENT SECRETARY

DATE: 11 September 2018

SIGNED ON BEHALF OF THE PUBLIC HEALTH AGENCY

VALERIE WATTS
CHIEF EXECUTIVE (INTERIM)

DATE:

Documentary requirements **Appendix 1**

1.1 Documentation to be sent to the Sponsor Branch for information

Monthly (or as the occasion arises)

- Board meeting papers (including draft minutes) for each meeting as and when issued to Board members
- Audit Committee papers (including draft minutes) for each meeting as and when issued to Committee members
- Monthly financial monitoring returns to Finance Directorate in the Department
- Last MS noted – Assurance Committee papers (including draft minutes) for each meeting as and when issued to Committee members

Annually

- Register of Board members' interests.
- The annual report, with the draft submitted to the Department two weeks before the publications date (separate timetable for the annual accounts, Governance Statement etc. set by Finance Directorate).
- The Assurance Framework (annually)

Once and then when revised

- Code of Conduct for Board members
- Code of Practice for staff
- Audit Committee Terms of Reference
- Audit Strategy
- Assurance / Governance Committee Terms of Reference
- Complaints procedure
- Anti-Fraud Policy
- Fraud Response Plan
- Whistle-blowing procedures
- Grievance and Disciplinary procedures
- Equality scheme
- Publication scheme
- Consultation Scheme
- Business Continuity Plan

1.2 Documentation to be sent to the Sponsor Branch for consideration / comment / approval

Quarterly

- Report on quarterly assessment of progress being made in the delivery of the Commissioning Plan's aims and objectives.

Bi-annual

- Corporate Risk Register every six months

Annually

- Annual Governance Statement
- Mid-year Assurance Statement (by end-October)
- Annual Internal Audit work-plan
- Internal Audit Progress Report
- Annual Fraud return
- Corporate Plan (including the Business Plan) must be produced and approved by the Department.
- An annual Commissioning Plan established by the HSCB but approved by the PHA
- The Head of Internal Audit's end-of-year and mid-year opinion on risk management, control and governance

As specified

- Corporate Plan for approval

Once

- Adverse inspection reports by external bodies (e.g. RQIA, MHRA), as specified in directions
- Internal Audit reports with less than satisfactory assurance
- Reports to Those Charged with Governance

Appendix 2

Currently being reviewed – July 2018

MEMORANDUM OF UNDERSTANDING

BETWEEN

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

PUBLIC HEALTH AGENCY

AND

SAFEGUARDING BOARD FOR NI

11 September 2012

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INTRODUCTION

1. This Memorandum of Understanding (MoU) is a tri-lateral agreement between the Department of Health, Social Services and Public Safety (the Department), Regional Agency for Public Health and Social Well-being (hereafter referred to as the Public Health Agency (PHA)) and the Safeguarding Board for Northern Ireland (SBNI). The SBNI was established under the Safeguarding Board (NI) Act 2011 as an unincorporated statutory body. It is sponsored by the Department.

2. The SBNI is a multi-disciplinary interagency body and its objective is to coordinate and ensure the effectiveness of what is done by its members to safeguard and promote the welfare of children in Northern Ireland. The SBNI will have a range of functions which it must undertake including:

i. developing policies and procedures for safeguarding and promoting the welfare of children in Northern Ireland;
ii. promoting an awareness of the need to safeguard and promote the welfare of children;
iii. keeping under review the effectiveness of what is done by members to safeguard and promote the welfare of children;
iv. undertaking case management reviews without discretion in such circumstances as may be prescribed;
v. reviewing such information as may be prescribed in relation to deaths of children in NI;
vi. advising the Regional Health and Social Care Board and Local Commissioning Groups in relation to safeguarding and promoting the welfare of children:
i) as soon as reasonably practicable after receipt of a request for advice; and
ii) on such other occasions as the Safeguarding Board thinks appropriate.
vii. promote communication between the Board and children and young persons; and
viii. making arrangements for consultation and discussion in relation to safeguarding and promoting the welfare of children

3. The PHA was established under section 12(1) of the Health and Social Care (Reform) Act (Northern Ireland) 2009 and is an Arms Length Body (ALB) of the Department of Health, Social Services and Public Safety (DHSSPS). It delivers a range of health functions including:

    1. health and social wellbeing improvement;

        - health protection;
        - public health support to commissioning and policy development; and
        - HSC research and development.

4. Chapter 7 of Managing Public Money Northern Ireland (MPMNI)**1** considers the working partnerships that public sector organisations may establish in order to deliver their objectives more effectively than they could acting alone.

5. It is also acknowledged in MPMNI that "*there are many different kinds of partnership. Each involves some tension between autonomy and accountability with scope for conflict if the terms of engagement are not resolved openly at the outset. Each partnership requires its own customised terms to work effectively. One size does not fit all'* This MoU describes the nature of the relationship between the Department, the PHA and the SBNI.
6. The PHA will act as corporate host to the SBNI discharging functions primarily relating to regulations made under section 1(5)(c)**2** of the 2011 SBNI Act. The relationship between

[1] Managing Public Money Northern Ireland sets out the main principles for dealing with resources used by public sector organisations in Northern Ireland (NI). http://www.ceforum.org/upload2/MPMNI_July08

the PHA and Department and the framework within which PHA operates as an ALB of the Department is specified in the Management Statement and Financial Memorandum (MSFM) in place between these bodies. The MSFM makes reference to the PHA's corporate host responsibilities to the SBNI, acknowledging that the PHA is accountable to the Department for the discharge of its corporate host obligations to SBNI but is not accountable for how the SBNI discharges its statutory objective, functions and duties.

7. This MoU does not affect existing statutory functions nor amend any other policies or agreements relating to the activities of the PHA or SBNI. It is not a legally binding document nor a contract between partners, nor is it intended to cover every aspect of the relationship between the three organisations. Each signatory agrees to work together within the framework outlined in this MoU.

8. It is acknowledged that the SBNI and its objective and functions of safeguarding and promoting the welfare of children in Northern Ireland are entirely separate from that of the PHA. However, in light of its small size, it has been agreed that the PHA, will support the SBNI by securing HR, financial and other support services for the Board. The PHA does not have its own in-house HR, IT, Equality and Finance functions and these are secured by it from BSO and HSCB through a Service Level Agreement. The arrangement of PHA acting as corporate host for SBNI will allow it to take advantage of the relationship PHA has with BSO and HSCB and therefore minimise the administrative apparatus necessary to support the SBNI.

PURPOSE

9. This MoU specifies the roles, responsibilities and obligations of the Department, PHA and the SBNI necessary to facilitate the arrangement whereby the PHA acts as host to the SBNI. As the corporate host, PHA will either provide or secure the necessary corporate governance structures, accommodation, financial management, IT, HR, Legal and Equality services, necessary to meet the staffing, accommodation and expenses needs of the SBNI. This will enable the SBNI to effectively function within the resources made available to it by the Department.

10. Within the SBNI financial allocation, provision will be made to cover the costs of the above services. PHA, as corporate host, will be consulted in advance of any proposed change to SBNI requirements and the SBNI will secure from the Department such approvals and additional resources as may be necessary to implement these requirements.

11. This MoU will be subject to review after one year and three years thereafter. In the early stages of the operation of the MOU, there may be initial issues requiring resolution. Any issues arising at any stage from the operation of the MoU, will be brought to the Department's attention by the SBNI or PHA, as soon as practicable.

ASSURANCE AND ACCOUNTABILITY ARRANGEMENTS

12. The PHA's responsibilities in respect of the SBNI governance functions are defined in the PHA's Management Statement and Financial Memorandum which clearly states that the PHA is accountable to the Department for the discharge of its corporate host obligations to SBNI but is **not** accountable for how the SBNI discharges its statutory objective, functions and duties. As an unincorporated statutory body, the SBNI will **not** have a separate MSFM. However, a copy of this MoU will be appended to the MSFM of the PHA

[2] Section 1(5) of the Safeguarding Board (NI) Act 2011 states "Regulations may make provision as to – (c) the staff, premises, and expenses of the Safeguarding Board (including provision as to which person or body provides the staff, premises or expenses)

and these arrangements should be reflected in any future update to the Department's Framework Document.

13. The Department must exercise oversight of the SBNI on an ongoing basis throughout the year. SBNI must provide regular performance reports and documentation demonstrating progress against Departmental priorities and assurance as to the ongoing effectiveness of their systems on internal control.

14. This will include twice yearly Department Accounting Officer sponsored assurance and accountability meetings between the Department and the SBNI Chair which will be timed and conducted in line with the arrangements for the equivalent meetings with DHSSPS sponsored Arms Length Bodies (ALBs).

15. PHA officers will not attend the SBNI twice yearly Department Accounting Officer sponsored assurance and accountability meetings. The SBNI Chair and Director of Operations may be asked by the Department to attend PHA twice yearly Department Accounting Officer sponsored assurance and accountability meetings if there are particular issues relating to corporate host functions which require discussion.

16. On an ongoing basis and at Department Accounting Officer sponsored accountability meetings, the Department will ask the PHA and the SBNI to account for risk management arrangements as they relate to the SBNI. The PHA will account for risks relating to its corporate host functions; the SBNI will account for any risks associated with its statutory objective, functions and duties directly to the Department.

17. If requested, the SBNI Chair and/or Director of Operations will attend meetings of the PHA Governance and Audit Committee in relation to corporate and resource governance matters. Matters relating to quality and performance against SBNI objectives will be handled through the Department's sponsorship arrangements with the SBNI and will be subject to the usual governance and assurance arrangements within the Department.

Assurance Framework

18. The SBNI is required to establish its own Internal Assurance Framework which should be broadly based on the arrangements set out in the DHSSPS Framework: A Practical Guide for Boards of DHSSPS Arms Length Bodies document (March 2009). The Framework will be reviewed every two years and should be shared in draft form with the PHA Governance and Audit Committee on an annual basis for their comment and approval for those elements relating to the corporate host functions.

Declaration of Assurance to Department

19. At the end of each year and mid-year the SBNI will provide Declarations of Assurance. A template for the Declaration of Assurance to the Department is attached at **Annex 1**. Twice yearly, a Declaration of Assurance will be provided to:
    - the PHA in relation to those matters which relate to the PHA's corporate host function, which will inform the PHA mid-year assurance statement and Statement of Internal Control **(**SIC); and
    - the Department in relation to performance against the SBNI's statutory objective, functions and duties and any risks associated with them.

Risk Register

20. The SBNI will put in place its own Risk Register. An updated risk register will be submitted by the SBNI to the Department, and for consideration, to the PHA Governance and Audit committee every six months, in respect of those areas relevant to the PHA as corporate host.

Business Continuity Plan

21. The SBNI will put in place its own Business Continuity arrangements, which will be developed and tested as part of PHA Business continuity planning.

Controls Assurance Standards

22. The relevance of specific Controls Assurance Standards (CAS) should be agreed between PHA, SBNI and the Department. The SBNI will comply with specified criteria within the relevant CAS.

Internal Audit

23. SBNI will be included within the PHA annual Internal Audit work plan. In keeping with established PHA procedures, SBNI audit reports will be brought to the PHA Governance and Audit Committee, for consideration of those areas where the SBNI provides assurance to the PHA. The SBNI shall provide a written declaration to the PHA that it has submitted final audit reports to the Department including management responses to any weaknesses found. The Department may wish to have separate audit arrangements for those areas for which the SBNI provides assurance directly to the Department.

Information Management

24. The SBNI will designate suitable members of its staff as Data Guardian, Senior Information Risk Owner (SIRO), and Information Asset Officer (IAO) who will be responsible for ensuring that information risk is managed appropriately and for providing assurances to the SBNI Chair.

25. The SBNI will be responsible for handling its own Freedom of Information requests.

Complaints Handling

26. The SBNI will put in place adequate arrangements for the handling of complaints against it relating to the discharge of its statutory objective, functions and duties. The PHA will not be liable in any way for the handling of such complaints against the SBNI. However, the PHA will work in partnership with the SBNI on complaints that are relevant to corporate hosting matters.

27. The Chair of the SBNI will inform the Permanent Secretary of the Department of any complaints about the SBNI accepted by the Ombudsman for investigation, and about the SBNI's proposed response to any subsequent recommendations from the Ombudsman.

28. The Chair of the SBNI will inform the Chief Executive of the PHA of any matters affecting employees of the PHA acting as officers of the SBNI.

Alerts

29. The SBNI must alert the Department in a timely manner of any action or risk which would adversely impact on the delivery of the SBNI's functions or reputation or that of the Department. The SBNI must alert the PHA in a timely manner of any action or risk which would adversely impact on the PHA. The PHA must alert the Chair of the SBNI and the Department in a timely manner of any material action or risk which would adversely impact on the SBNI. The PHA must alert the Department in a timely manner of any action or risk arising from these hosting arrangements which would adversely impact on the delivery of the PHA functions or reputation or that of the Department.

FINANCIAL MANAGEMENT

30. As an unincorporated statutory body, the SBNI is unable to hold its own funds. The PHA will receive an agreed financial allocation, including funding for Salaries and Wages, Goods and Services, SBNI accommodation costs and legal services, representing the full running costs of the SBNI.

31. Responsibility for the proper management of public funds allocated to SBNI falls to the CEO of the PHA, who will hold accounting officer responsibilities in respect of the SBNI's stewardship of public funds as set out in MPMNI. Normally accountability also extends to how an organisation performs against objectives. However, this will be a matter for the Chair of the SBNI who will account directly to the Department's Accounting Officer in relation to the delivery of the SBNI statutory objective, functions and duties. This will be set out in the revised Accounting officer letter to the CEO of the PHA.

32. On behalf of the SBNI and in line with his/her responsibilities, the Chief Executive of PHA, as Accounting Officer, will be expected to ensure effective financial arrangements are in place and effective financial services are secured from HSCB/BSO for the proper management of the SBNI budget.

33. Details of the SBNI's expenditure will be included within the PHA Annual Accounts.

34. The PHA will not use funds allocated for the SBNI for any other purpose. Any request for additional resources by SBNI or in respect of SBNI must be referred to the sponsor branch in the Department. The PHA Accounting Officer should be advised of all requests and approvals of additional resources and expenditure, as he/she will be held accountable for this expenditure.

35. It is the responsibility of the SBNI to ensure that it complies with PHA Standing Orders (where they relate to corporate host functions including finance), Standing Financial Instructions and all other financial policies and procedures of the PHA.

36. SBNI assurance on these matters, including the arrangements for ensuring the financial stability (including financial risks) of the SBNI, for ensuring value for money and that resources allocated by the Minister/Department are deployed fully in achievement of agreed outcomes will be provided by the SBNI to the PHA in its Declarations of Assurance.

PERFORMANCE AGAINST OBJECTIVES

37. The SBNI will be required to submit to the Department a draft 3-year strategic plan. The plan will reflect the SBNI priorities, strategic aims and objectives. It will set out how the SBNI will deliver on its statutory objective, functions and statutory duties. The plan will be subject to Departmental approval and will be supported by an annual Business Plan.

38. The Business Plan will include key actions, supported by performance targets and indicators, to be undertaken in the year ahead and will include budget information.

39. PHA, as corporate host for the SBNI, has no responsibility for the development of the SBNI Strategic and Business Plans, their review or approval. However as a core member of the SBNI, the PHA will contribute fully to the development of the SBNI's Strategic and Business Plans.

40. Prior to the approval of the SBNI Strategic and Business Plans the Department will consult the Chief Executive of the PHA in respect of any financial issues relevant to his/her role as PHA Accounting Officer.

LEGAL SERVICES

41. The Departmental Solicitors Office will provide legal services for matters relating to the SBNI's statutory objective, functions and duties. PHA will secure legal services from the Directorate of Legal Services for those matters for which PHA has responsibility in its SBNI corporate hosting role.

ASSETS AND ESTATE MANAGEMENT

42. The PHA will provide agreed office accommodation for SBNI staff. The proportionate costs of this accommodation will be met by SBNI. The PHA will provide standard office equipment. Costs of equipment, telephone line rental and telephone calls will be borne by SBNI. Access to PHA switchboard services will be provided free of charge.

43. The SBNI is accommodated within the premises of the PHA. The SBNI will comply with Departmental requirements placed on the PHA in relation to its usage of PHA leased premises. The SBNI will comply with specified criteria, set out in the Buildings, Land, Plant and Non Medical Equipment Controls Assurance Standard, as agreed with the PHA.

HUMAN RESOURCES

44. With the exception of the Chair and lay persons, who are publicly appointed by the Department, the employer of SBNI staff is the Public Health Agency. The Department has determined that all SBNI posts will be subject to the approval of the Department. The level and structure of SBNI staffing agreed with the Department should not be utilised elsewhere in PHA without formal agreement with the Department. Where the SBNI require additional support from PHA staff it will agree and make such financial provision as may be necessary for this.

45. The PHA will have responsibility for securing HSC payment arrangements for SBNI staff salaries and related costs. Staff costs and any associated processing costs will be borne by the SBNI.

Management of SBNI Staff

46. SBNI staff, as employees of the PHA, will be subject to the same policies and procedures as other PHA staff. The SBNI and its staff must comply with the HR policies and procedures set down by PHA including those relating to complaints, grievances, discipline and whistle blowing The Chair of the SBNI will advise the PHA Chief Executive or his/her nominated officer, of any issues emerging in relation to SBNI staff and their adherence to PHA policies and procedures. Individual incidents/breaches of these policies and procedures will be managed by the SBNI in the first instance, in keeping with normal HSC good practice, PHA guidance and escalation arrangements.

Staff Appraisal

47. Annual appraisal of SBNI staff will be conducted by the SBNI, against SBNI business and personal staff objectives and in line with the HSC Performance Appraisal processes operated by the PHA. The Chief Executive of the PHA will countersign the SBNI Chair's annual appraisal of the Director of Operations. Appraisal of the performance of the Chair and lay members will be conducted in line with established Public Appointment's arrangements.

Staff Training and Development

48. The SBNI is responsible for securing the provision of training and development of its staff in relation to SBNI functions and for making funds available for this purpose as approved by the Department. The SBNI will work with PHA to negotiate and resource shared training and development provision.

Recruitment of Staff

49. The PHA will secure the timely recruitment of agreed SBNI staff posts through the BSO HR service and the costs of recruitment will be borne by the SBNI.

PRESENTATIONAL ISSUES

Communication and Liaison Arrangements

50. Good communication is essential for effective working. PHA and SBNI agree to keep each other promptly and regularly informed about any work being undertaken or issues arising which may impact on the other, or in which the other organisation has an interest. Both parties must keep the Department informed about any matter which is likely to be of interest to the Department or the Minister.

51. Regular meetings will be held between the Chief Executive of the PHA and the Chair of the SBNI. Any disagreements which may arise between the PHA and the SBNI will normally be resolved amicably at the working level. If this is not possible, senior management at either organisation should seek to settle any issue. Failure to resolve disputes at this level should be referred to the Department.

Media Handling and Support

52. Day to day support for the SBNI in relation to media handling/communications will be provided by PHA. There may be occasions where conflicts of interest arise, when it is more appropriate for the SBNI to go directly to the Department for support.

Web site

53. The SBNI will commission the development of a website from the PHA. The development, ongoing maintenance and support costs will be borne by SBNI.

OTHER MATTERS

Indemnity

54. The SBNI Chair and the members of the Safeguarding Board (SBNI) will be indemnified by the Department while they are engaged in SBNI business, provided they have acted honestly and in good faith, and have not acted recklessly. This means that the Department will indemnify the Chair and the members of the SBNI in relation to any legal costs and damages which may be awarded against him or the other members of the SBNI, in connection with the conduct of SBNI business.

Conflicts of Interest

55. If any conflicts of interest should arise for the Chief Executive of the PHA in his role as Accounting Officer for the PHA and the SBNI, the matter should be referred to the Department for resolution.

AGREEMENT AND REVIEW OF THE MEMORANDUM OF UNDERSTANDING

56. This Memorandum will be reviewed after one year and three years thereafter. It will also be amended if necessary, following any relevant changes to the policies, procedures and structures of the parties concerned.

Agreement to this Memorandum of Understanding is given by signature of the following:

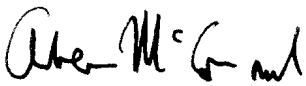
On behalf of PHA

…….. **Mr Eddie Rooney**
Chief Executive

On behalf of SBNI

…… **Mr Hugh Connor**
SBNI Chair

Endorsement on behalf of the Department of Health, Social Services and Public Safety



…… **Mr Andrew McCormick**
Permanent Secretary

This Memorandum of Understanding will be effective from 17 September 2012 and subject to review by 17 September 2013.

Annex 1

TEMPLATE - SBNI Declaration of Assurance to the Department

This statement concerns the condition of the system of internal control in the Safeguarding Board NI as at DD/ MMM /YYYY

The purpose of this assurance statement is to attest to the effectiveness of the system of internal control. In accordance with Departmental guidance, I do this under the following headings.

1. **Governance**

   A system of governance which encompasses effective corporate control arrangements is in operation e.g. corporate and business planning arrangements; risk management and internal controls; and monitoring and assurance thereon.

   A Declaration of assurance (see attached) has been provided to the PHA to inform their mid-year assurance statement or SIC.

2. **Significant Internal Control Problems** –

   [Insert details of significant internal control problems not otherwise covered e.g. description of the issue that has arisen and its (potential) impact on services, service-users, stakeholders etc, and a summary of the action taken or proposed to address the issue]

3. **Assurance Framework**

   I can confirm that an Assurance Framework, which operates to maintain, and help provide reasonable assurance of the effectiveness of controls, has been approved and is reviewed by the SBNI. Minutes of board meetings are available to further attest to this.

4. **Risk Register**

   I confirm that the Corporate Risk Register has been regularly reviewed by organisation and that risk management systems/processes are in place throughout the organisation. As part of the system of risk management, the Register is presented to the Department, and for consideration, to the PHA *Governance Audit* Committee, every six months – most recently on *[dd.mm.yy]*.

5. **Performance against Departmental Objectives**

   I confirm satisfactory progress towards the achievement of the objectives and targets set by the Department [*with the following exceptions:-*]

6. **External and Internal Audit reports (if relevant)**

   I confirm implementation of the accepted recommendations made by internal or external audit**,** with the following exception:

Signed
SBNI Chair

FINANCIAL MEMORANDUM

BETWEEN

THE DEPARTMENT OF HEALTH

AND

THE PUBLIC HEALTH AGENCY

Agreement of Terms

This Financial Memorandum sets out the strategic control framework within which the Public Health Agency (PHA) is required to operate, including the conditions under which Government funds are provided as detailed in Managing Public Money Northern Ireland (MPMNI). It aims to achieve prudent and effective management of resources by the PHA, combined with a reasonable degree of day-to-day freedom for the PHA to manage its operations.

The Memorandum has been drawn up by the Department of Health (DoH), in consultation with the PHA, which agrees to conduct its finances within the conditions contained therein. The contents of the Memorandum have been approved by the Department of Finance (DoF). It will remain in force and binding on the PHA until such time as it is reviewed and/or revised by the Department of Health.

SIGNED ON BEHALF OF THE DEPARTMENT OF HEALTH

SIGNED ON BEHALF OF THE PHA

PERMANENT SECRETARY
DATE: 11 September 2018

CHIEF EXECUTIVE
DATE:

1. INTRODUCTION

1.1. This Financial Memorandum sets out certain aspects of the financial framework within which the PHA is required to operate.

1.2. The terms and conditions set out in the combined Management Statement and Financial Memorandum (MSFM) may be supplemented by guidelines or directions issued by the Department/ Minister in respect of the exercise of any individual functions, powers or duties of the PHA.

1.3. The PHA should follow the standards, rules, guidance and advice in MPMNI and satisfy the conditions and requirements set out in the combined MSFM document, together with such other conditions as the Department/Minister may from time to time impose.

2. INCOME AND EXPENDITURE- GENERAL

2.1. **The Departmental Expenditure Limit (DEL)**

2.1.1. The PHA's current and capital expenditure form part of the Department's Resource DEL and Capital DEL respectively.

2.2. **Expenditure not proposed in the budget / Delegated Limits**

2.2.1. The PHA must not enter into any commitments or incur expenditure above pre-defined limits as set out in the delegated arrangements or which incur expenditure which is not provided for in the annual budget as approved by the Department. This reflects the general principles set out in MPMNI relating to the authority for expenditure, regularity, propriety and value for money which applies to all public expenditure.

2.2.2. The PHA shall not, without prior Departmental approval, enter into any undertaking to incur any expenditure outside its remit or which may be likely to bring either the PHA or the Department into disrepute.

2.3. **Novel, Contentious or Repercussive Proposals**

2.3.1. The PHA must obtain the approval of the Department of Health and the Department of Finance for any transactions which set precedents, are novel, potentially contentious or could cause repercussions elsewhere in the public sector. DoH and DoF approval must be obtained even where such transactions are within the PHA's delegated limits which appear to offer value for money. Examples include:

a. incurring expenditure for any purpose which is or might be considered novel or contentious, or which has or could have significant future cost implications, including staff benefits;
b. making any significant changes in the operation of funding of initiatives or particular schemes previously approved by the Department;
c. unusual financing transactions, especially those with lasting commitments; and
d. making any change of policy or practice which has wider financial implications (e.g. because it might prove repercussive among other public sector bodies) or which might significantly affect the future level of the resources required. The Department will advise on what constitutes 'significant' in this context.

2.3.2. The PHA must identify any factors that might set precedents or make expenditure novel, contentious or repercussive to the Department when submitting such proposals

for approval, whether capital, IT, Direct Award Contracts (DAC), consultancy, gifting etc. and irrespective of any existing delegations.

2.4. **Procurement**

2.4.1. The PHA's procurement policies shall reflect the public procurement policy adopted by the Northern Ireland Executive in May 2002 (refreshed May 2009); Procurement Guidance Notes and any other guidelines or guidance issued by DoH, Central Procurement Directorate (CPD) and the Procurement Board. The PHA shall also ensure that it complies with any relevant UK and EU or other international procurement rules.

2.4.2. In particular, the PHA shall reflect in its policies DoH and DoF Guidance on procurement which addresses the appropriate market testing and evidence retention that should take place for all levels of purchase, irrespective of value, as small expenditures may not require CoPE involvement, but nonetheless require a form of market testing.

2.4.3. Periodically and wherever practicable, the PHA's procurement policies shall be benchmarked against best practice elsewhere.

2.4.4. The PHA's procurement activity should be carried out by means of a Service Level Agreement (SLA) with a recognised and approved Centre of Procurement Expertise (CoPE). The relevant CoPEs are: the Business Services Organisation – Procurement and Logistics Service (BSO PaLS) for Goods and Services and Central Procurement Directorate – Health Projects (CPD HP) for Construction Works/Services. If another CoPE or equivalent is to be used for a specific project, this should be consented to in advance by either BSO PaLS or CPD HP depending on the subject matter.

2.4.5. The Accounting Officer may decide on the level of internal delegation required for approval of purchases subject to delegated limits set by DoH or DoF guidance, and subject to any additional SLA requirements regarding, or formal guidance on, lowest acceptable delegations given by the relevant CoPE.

2.4.6. Delegations for the approval of purchases should be formally recorded within the organisation's scheme of delegation.

2.5. **Competition**

2.5.1. Competition promotes economy, efficiency and effectiveness in public expenditure. Works, goods and services should be acquired through public competition unless there are convincing reasons to the contrary, and where appropriate should comply with EU and domestic advertising rules and policy. The form of competition chosen should be appropriate to the value and complexity of the goods or services to be acquired.

2.5.2. Contracts shall be placed on a competitive basis and tenders accepted from suppliers who provide best value for money overall.

2.5.3. Where a contract is awarded to an economic operator (i.e. supplier, contractor) without competition, this is referred to as a Direct Award Contract (DAC). In light of their exceptional nature, all DACs should be dealt with in accordance with the advice requirements and delegations set out in DoH and DoF guidance and in accordance with the SLA or any formal general guidance on direct awards given by the relevant CoPE (in addition to complying with any other applicable delegations not arising as a result of DAC status e.g. capital or IT delegations).

2.5.4. The PHA shall send to the Department on a bi-annual basis (or on such other basis as shall be required by DoH) a report of contracts above the current de minimis limit for procurement expenditure in which competitive tendering was not employed.

2.6. **Best Value for money**

2.6.1. Procurement of work, supplies and services by the PHA shall be based on best value for money. This is defined as the most advantageous combination of costs, quality and sustainability to meet customer and PHA requirements. In this context, cost means consideration of the whole life cost; quality means meeting a specification which is fit for purpose and sufficient to meet the customer's requirements; and sustainability means economic, social and environmental benefits. It is not about minimising up front prices. Whether in conventional procurement, market testing, private finance or some other form of public private partnership, finding value for money involves an appropriate allocation of risk.

2.6.2. In accordance with MPMNI/Northern Ireland Guide to Expenditure Appraisal and Evaluation (NIGEAE), where appropriate, a full options appraisal should be carried out before procurement decisions are taken.

Expenditure and Payments

2.7. **Timeliness in paying bills**

2.7.1. The PHA shall collect receipts and pay all matured and properly authorised invoices in accordance with applicable terms, MPMNI and any guidance issued by the Department/ DoF.

2.8. **Payments in advance**

2.8.1. The PHA should control its commitments and expenditure to provide value for money. Payments made in advance of the delivery of a service are not value for money and should only be made in exceptional circumstances and require the approval of DoF. There are occasions where advance payments are acceptable and examples are listed in MPMNI.

2.9. **Deferred payments**

2.9.1. Any proposal for deferred payments is considered novel and contentious and must receive DoF approval.

2.10. **Risk Management**

2.10.1. The PHA shall ensure that it has systems in place for identifying and managing risk and that the risks it faces are dealt with in an appropriate manner, in accordance with relevant aspects of best practice in corporate governance, and shall develop a risk management strategy, in accordance with the Treasury guidance *The Management of Risk: Principles and Concepts (the Orange Book) and MPMNI*.

2.10.2. The PHA shall take proportionate and appropriate steps to assess the financial and economic standing of any organisation or other body with which it intends to enter into a contract or which it intends to give grant or grant-in-aid.

2.11. **Fraud**

2.11.1. The PHA shall adopt and implement policies and practices to safeguard itself against fraud, and ensure it has adequate controls to detect and deter fraud in accordance with MPMNI and Departmental and DoF guidance which includes DoF's *Managing the Risk of Fraud*. In line with this the PHA should develop a fraud policy statement and fraud response plan. This should be updated every 5 years and sent to Counter Fraud

and Probity Services at BSO for review. The PHA shall notify the Department of any subsequent changes to the policy or response plan.

2.11.2. The PHA should identify, and assess how it might be vulnerable to fraud (including bribery), and evaluate the possible impact and likelihood of each fraud risk. Fraud should be always considered as a risk in the risk register.

2.11.3. All cases of attempted, suspected or proven fraud shall be reported to the BSO who shall report it to DoF and the Comptroller and Auditor General (C&AG) (see section 4.8 in the Management Statement) as soon as they are discovered, irrespective of the amount involved.

2.12. **Wider markets**

2.12.1. In line with MPMNI the PHA shall seek to maximise receipts and seek out and implement wider market opportunities, provided that this is consistent with (a) the PHA's main functions and core objectives and (b) its corporate plan as agreed with the Department. All such proposals must be supported by a business case and subject to Departmental approval and DoF approval, where appropriate.

2.12.2. The PHA must ensure that services are priced fairly and competition law and the rules on state aid are considered. The PHA must not however acquire assets just for the purpose of engaging in, or extending, commercial activity. If the wider markets activity demands further investment to keep it viable, the PHA must ensure the activity is reappraised.

2.13. **State Aid**

2.13.1. Any funding favouring a particular company or sector or seen to distort competition could be subject to the EU rules and, in certain circumstances, require notification to the European Commission. Article 107(1) of the EU Treaty prohibits in principle any form of preferential government assistance – state aid - to commercial undertakings. The purpose is to prevent distortion of competition within the EU. When designing policies, the PHA should consider early whether state aids rules apply and seek advice from the Department.

2.14. **Fees and Charges**

2.14.1. Fees or charges for any services supplied by the PHA, including services provided between HSC bodies shall be determined in accordance with MPMNI and should be based on a full cost recovery basis. Where it is decided to charge less than full costs, this will require Ministerial and DoF approval and there should be an agreed plan to achieve full cost recovery within a reasonable period. If the subsidy is intended to last the decision should be documented and periodically reviewed**.**

2.14.2. All fees and charges should be disclosed in the annual accounts in line with MPMNI / FReM.

2.15. **Commercial services**

2.15.1. Charges for commercial services should be set at a commercial rate in line with market practice and reflect fair competition with private sector providers. The requirements of competition law and State Aid must be considered. Decisions to set rates at below market practice must have Ministerial and DoF approval**.**

2.16. **Shared services**

2.16.1. Active engagement should be undertaken with the BSO to continue improving, enhancing and extracting value from existing and new services with consideration to consolidating services through shared service provisioning.

2.16.2. The PHA should always use BSO in the first instance where it can provide the relevant service. Where it is not possible to avail of BSO services then Enterprise Shared Services (ESS) should be always be considered as a viable alternative and must appraised in the business case.

2.16.3. All charges should be at cost in accordance with fees and charges guidance in MPMNI.

THE PHA's INCOME

3.1. Grant-in-Aid

3.1.1. Grant-in-aid (GIA) will be paid to the PHA in regular instalments as agreed on the basis of a written application from the PHA showing evidence of need. The application shall certify that the conditions applying to the use of GIA have been observed to date and that further GIA is now required for purposes appropriate to the PHA's functions. The forecast GIA provided by the PHA and included in the Department's spring supplementary estimates cannot be exceeded.

3.1.2. Where GIA is drawn by a service provider party on behalf of the PHA, the PHA should seek assurances throughout the period about monies drawn on their behalf.

3.1.3. The PHA should have regard to the general guidance and principles enshrined in MPMNI that it should seek GIA according to need. GIA should not be drawn down in advance of need.

3.1.4. Cash balances during the year shall be held at the minimum consistent with the efficient operation of the functions of the PHA. GIA not drawn down by the end of the year shall lapse. However, where draw-down of GIA is delayed to avoid excess cash balances at year-end, the Department will make available in the next financial year (subject to approval by the Assembly of the relevant Estimates provision) any such GIA required to meet any liabilities at year end, such as creditors.

3.2. Fines and Taxes as Receipts

3.2.1. Most fines and taxes (including levies and some licences) do not provide additional DEL spending power and should be surrendered to the Department.

3.3. Receipts from sale of goods or services

3.3.1. Receipts from the sale of goods and services (including certain licences), rent of land and dividends normally provide additional spending power. If the PHA wishes to retain a receipt or utilise an increase in the level of receipts, it must gain the prior approval of the Department.

3.3.2. If there is any doubt about the correct classification of a receipt, the PHA shall consult the Department, which may consult DoF as necessary.

3.4. Interest earned

3.4.1. Interest earned on cash balances cannot necessarily be retained by the PHA without Departmental approval. Depending on the budgeting treatment of this receipt, and its impact on the PHA's cash requirement, it may lead to commensurate reduction of GIA or be required to be surrendered to the NI Consolidated Fund via the Department.

3.5. Unforecast changes in in-year income

3.5.1. If the negative DEL income realised or expected to be realised in-year is <u>less</u> than estimated, the PHA shall, unless otherwise agreed with the Department, ensure a

corresponding reduction in its gross expenditure so that the authorised provision is not exceeded. (NOTE: For example, if the PHA is allocated £100 resource DEL provision by the Department and expects to receive £10 of negative DEL income, it may plan to spend a total of £110. If income (on an accruals basis) turns out to be only £5, the PHA will need to reduce its expenditure to £105 to avoid breaching its budget. If the PHA still spends £110, the Department will need to find £5 of savings from elsewhere within its total DEL to offset this overspend).

3.5.2. If the negative DEL income realised, or expected to be realised, in the year is more than estimated, the PHA may apply to the Department to retain the excess income for specified additional expenditure within the current financial year without an offsetting reduction to GIA. The Department shall consider such applications, taking account of competing demands for resources, and will consult with DoF in relation to any significant amounts. If an application is refused, any GIA shall be commensurately reduced or the excess receipts shall be required to be surrendered to the NI Consolidated Fund via the Department.

3.6. Build-up and draw-down of deposits

3.6.1. The PHA shall comply with the rules that any DEL expenditure financed by the draw-down of deposits counts within DEL. The PHA shall maintain and manage cash balances as working balances only. These shall be held at a minimum level throughout the year. Any interest earned on overnight deposits must be returned to the Department.

3.7. Proceeds from Disposal of Assets

3.7.1. Disposals of land and buildings are dealt with in Section 6 below.

3.8. Gifts and Bequests received

3.8.1. The PHA is free to retain any gifts, bequests or similar donations subject to paragraph 3.8.2. These shall be capitalised at fair value on receipt and must be notified to the Department.

3.8.2. Before accepting a gift, bequest or similar donation, the PHA shall consider if there are any costs associated in doing so or any conflicts of interest arising. The PHA shall not accept a gift, bequest or similar donation if there are conditions attached to its acceptance that would be inconsistent with the PHA's function.

3.8.3. The PHA must keep a register detailing gifts they have received, their estimated value and what happened to them (whether they were retained, disposed of, etc). The PHA should liaise with Department as to whether the gifts received need to be noted in annual report and accounts.

3.8.4. Donations, sponsorship or contributions, e.g. from developers should also be treated as gifts and should be treated in line with guidance in Managing Public Money NI on Gifts and accounted for in accordance with FReM requirements.

3.9. Other Receipts

3.9.1. The PHA should ensure that effective control is maintained, and records kept, of receipts from other sources (e.g. provision of fire certificates, reports etc).

3.10. Borrowing

3.10.1. Normally the PHA is not permitted to borrow funds. However if doing so, under exceptional circumstances, the PHA must observe the principles in MPMNI, seeking the approval of the Department and, where appropriate DoF, to ensure it has the

necessary authority and budget cover for borrowing or the expenditure to be financed for such borrowing.

4. EXPENDITURE ON STAFF

4.1 Staff Costs

4.1.1. Subject to its delegated limits of authority, the PHA will ensure that the creation of any new/additional posts does not incur future commitments which will exceed its ability to pay for them.

4.2 Pay and Conditions of Service

4.2.1. Employees of the PHA, whether on permanent or temporary contract, will be subject to levels of remuneration, and terms and conditions of service (including Superannuation) as agreed by the Department and DoF. Current terms and conditions for employees of the PHA are set out in the NHS Terms and conditions of Service Handbook**.**

4.2.2. Annual pay increases of the PHA staff must be in accordance with the annual Finance Director (FD) letter on Pay Remit Approval Process and Guidance issued by DoF. All proposed pay awards must be approved by the PHA Remuneration Committee and Board prior to submission to the Department for approval. All proposed pay awards must have prior approval of the Department and DoF Minister before implementation.

4.2.3. Payments shall be made to Board members in respect of travelling expenses, fees or other allowances in accordance with the relevant (Payment of Allowances to Members) Determination and Direction (Northern Ireland), which the Department may from time to time amend. The PHA shall ensure that a comprehensive set of guidelines on all expenditure on travel and subsistence is in place.

4.2.4. Recruitment exercises to fill vacant or new senior positions in the PHA should proceed only where there are exceptional circumstances which have been agreed by the Permanent Secretary of the Department in advance. This position will be kept under review by the Department.

4.2.5. Any change to the remuneration of Senior Executives must have prior approval of the Permanent Secretary of the Department and the DoF Minister.

4.3. Pension Costs

4.3.1. The PHA's staff shall be eligible to join the Health and Social Care (HSC) Pension Scheme.

4.3.2. Staff may opt out of the HSC Pension Scheme provided by the PHA. However, the employer's contribution to any personal pension arrangement, including a stakeholder pension, shall be limited to the national insurance rebate level.

4.3.3. Any proposal by the PHA to move from the existing pension arrangements, or to pay any redundancy, or compensation for loss of office, requires the approval of the Department and DoF. Proposals on severance payments must comply with MPMNI and any related DoF/ Departmental guidance.

5. NON-STAFF EXPENDITURE

5.1. Economic Appraisal

5.1.1. The PHA is required to apply the principles of economic appraisal, with appropriate and proportionate effort, to all decisions and proposals concerning spending or saving public money, including European Union (EU) funds, and any other decisions or proposals that involve changes in the use of public resources. For example, appraisal must be applied irrespective of whether the relevant public expenditure or resources:

- involve capital or current spending, or both;
- are large or small;
- are above or below delegated limits.

5.1.2. All business cases must be approved internally in line with the scheme of delegation. Those Business cases above the delegated limits must be submitted for Departmental approval prior to any expenditure being committed. Business cases submitted to the Department for approval must be approved by the PHA's Board and signed off by its Accounting Officer.

5.1.3. All business cases for external consultancy, including those below delegated limits, must be submitted to the Department in advance of any expenditure. All business cases for Direct Award Contracts should be advised on by the CoPE and appropriately approved in advance of expenditure.

5.1.4. Delegations do not remove the need for appraisal or evaluation. All expenditure, including that below delegation limits, must be appraised and evaluated with effort that is proportionate to the resources involved, with due regard to the specific nature of the case. NIGEAE provides more detailed guidance on the application of appropriate and proportionate effort.

5.1.5. Business cases and appraisals should be prepared in accordance with the following guidance, using the pro forma templates or full business case as required:

- The Northern Ireland Guide to Expenditure Appraisal and Evaluation (NIGEAE);
- The HM Treasury Guide, The Green Book: Appraisal and Evaluation in Central Government;
- Departmental circulars;
- Business cases below delegated limits will be subject to an annual test drilling exercise by the Department and DoF.

5.2. Capital Expenditure

5.2.1. Subject to being above an agreed capitalisation threshold, all expenditure on the acquisition or creation of fixed assets shall be capitalised on an accruals basis in accordance with relevant accounting standards.

5.2.2. Proposals for large scale capital projects or acquisitions will normally be considered within the PHA's corporate and business planning process. Applications for approval within the corporate/business plan by the Department, and DoF if necessary, shall be supported by formal notification that the proposed project or purchase has been examined and duly authorised by the Board. Regular reports on the progress of projects shall be submitted to the Department in accordance with current instructions.

5.2.3. Approval of the corporate/business plan does not obviate the PHA's responsibility to abide by the economic appraisal process.

5.3. Capital Projects

5.3.1. The Accounting Officer or appropriate officer as notified to the Department may authorise capital or IT expenditure on discreet capital projects of up to the agreed

delegated limits. Capital or IT projects over this amount require the approval of the Department and where necessary DoF.

5.3.2. The principles of appraisal, evaluation and management apply equally to proposals supported by information communication technology (ICT) as to all other areas of public expenditure The appraisal of Information Technology (IT) projects should include the staffing and other resource implications.

5.3.3. Any novel and/or potentially contentious projects, regardless of the amount of expenditure, require the approvals of the Department and DoF.

5.3.4. Transfers of assets between government departments should generally be at full current market value; assets transferred under a transfer of functions order to implement a machinery of government change are generally made at no charge.

5.4. Transfer of Funds within Budgets

5.4.1. Unless financial provision is subject to specific Department or DoF controls (e.g. where provision is ring-fenced for specific purposes such as contractually committed projects) or delegated limits, transfers between budgets within the total capital budget, or between budgets within the total revenue budget, do not need Departmental approval. The one exception to this is that, due to HM Treasury controls, any movement into, or out, of depreciation and impairments within the resource budget will require Departmental and DoF approval. [*NOTE: Under resource budgeting rules, transfers from capital to resource budgets are not allowed*.]

5.4.2. Virement of funding from capital to resource budgets shall not be permitted without prior approval from the Department, DoF and the Executive.

5.5. Lending, Guarantees, Indemnities; Contingent Liabilities; Letters of Comfort

5.5.1. The PHA shall not, without the prior written consent of the Department (and, where necessary, DoF), lend money, charge any asset or security, give any guarantees or indemnities or letters of comfort, or incur any other contingent liability (as defined in Managing Public Money Northern Ireland), whether or not in a legally binding form.

5.6. Grants or loans by the PHA

5.6.1. Unless covered by a delegated authority, all proposals to make a loan to a third party, whether one-off or under a scheme, together with the terms and conditions under which such a loan is made, shall be subject to prior approval by the Department and, where necessary, DoF. If loans are to be made under a continuing scheme, statutory authority is likely to be required.

5.6.2. The terms and conditions of such grants or loans shall include the requirement on the recipient organisation to prepare accounts and to ensure that its books and records in relation to the grant or loan are readily available for inspection by the PHA, the Department and the Comptroller and Auditor General.

5.7. Gifts Made

5.7.1. Departmental / DoF approval is needed for all gifts above delegated limits. Those exceeding £250,000 (or subsequent updated limits) also require Estimate cover and to be notified to the Assembly. Gifts include transfers of assets or leases at below market value. Public money must not be used to provide for gifts to members of staff. This shall also apply to members of the Board. Gifts by management to staff are subject to the requirements of DAO (DoF) 05/03.

5.7.2. Gifts should be noted in the annual report and accounts in line with MPMNI and the latest FReM requirements.

5.8. Write-offs, Losses and Other Special Payments

5.8.1. Proposals for write offs losses or other special payments including ex gratia and compensation payments outside the delegated limits must have the prior approval of the Department and where necessary DoF. Furthermore it is important to consult with the Department if payments are made, irrespective of delegations, which:

- involve important questions of principle;
- raise doubts about the effectiveness of existing systems;
- contain lessons which might be of wider interest;
- might create a precedent for other departments; or
- arise because of obscure or ambiguous instructions issued centrally.

5.8.2. Losses shall not be written off until all reasonable attempts to make a recovery have been made and have proved unsuccessful and there is no feasible alternative.

5.8.3. The PHA should always pursue recovery of overpayments, irrespective of how they came to be made.

5.8.4. Special payments should only be authorised after careful appraisal of the facts and when satisfied that the best course has been identified.

5.8.5. The PHA should ensure that full, justification is provided together with the necessary legal advice where appropriate and lessons learned clearly identified.

5.8.6. Details of all losses and special payments should be recorded in a Losses and Special Payments Register, which will be available to auditors. The Register should be kept up-to-date and should show evidence of the approval by the appropriate officer as notified to the Department, for amounts below the delegated limit, and the Department, where appropriate.

5.8.7. Losses and special payments should be reported in the annual accounts in accordance with MPMNI and the latest FReM requirements.

5.9. Remedy

5.9.1. The PHA should operate a clear accessible complaints process which should respond promptly and consistently and consider whether a remedy is appropriate in line with MPMNI.

5.10. Leasing

5.10.1. Prior Departmental and DoF approval is required for all property and finance leases as delegated authority has been removed. The PHA must have DEL provision for finance leases and other transactions that are, in substance, a form of borrowing.

5.10.2. Before acquiring a new lease or continuing with an existing lease term, the PHA must, at expiry or break option dates, submit a proportionate business case at least 12 months before either the lease expiry date or landlord /tenant notice date whichever is earlier. The PHA must ensure that the lease demonstrates value for money and that this is appropriately demonstrated in the business case through analysis of options including leasing of alternative property assets and purchase.

5.10.3. Business cases must be submitted for Departmental approval in the first instance. The Department will then seek approval from DoF before expenditure is committed.

5.11. Public Private Partnerships

5.11.1. The PHA should seek opportunities to enter into public/private partnerships where this would be more affordable and offer better value for money than conventional procurement.

5.11.2. All such proposals require Departmental / DoF approval. The PHA must consult with the Department when considering any proposal to enter into such arrangements. Procurement by private finance is only considered suitable for capital projects of £50million and above, because less capital intensive projects seldom justify the relatively high procurement and management costs involved. For instance, PFI solutions are not usually considered appropriate for Information Communication Technology (ICT) projects. Private finance should only be used after the rigorous scrutiny of all alternative procurement options, where:

- the use of private finance offers better value for money for the public sector compared with other forms of procurement; and
- the public sector partner is able to predict the nature and level of its long term service requirements with a reasonable degree of certainty.

5.11.3. The PHA should ensure adherence to DoF guidance on value for money assessments of alternative procurement options.

5.11.4. The PHA should consult with the Department over the accounting and budgeting treatment for any private finance initiative. Where judgement over the level of control is difficult, the Department will consult DoF (who may need to consult with the Office of National Statistics over national accounts treatment).

5.12. Subsidiary Companies and Joint Ventures

5.12.1. The PHA shall not establish subsidiary companies or joint ventures without the express approval of the Department and DoF. In judging such proposals, the Department will have regard to its own wider strategic aims, objectives and those of the Government.

5.12.2. For public expenditure accounts purposes, any subsidiary company or joint venture controlled or owned by the PHA shall be consolidated with it in accordance with guidance in the FReM, subject to any particular treatment required by the FReM. Where the judgement over the level of control is difficult, the Department will consult DoF (who may need to consult with the Office of National Statistics over national accounts treatment). Unless specifically agreed with the Department and DoF, such subsidiary companies or joint ventures shall be subject to the controls and requirements set out in this MSFM and to the further provisions set out in supporting documentation.

5.13. Financial Investments

5.13.1. The PHA shall not make any financial investment without the prior written approval of the sponsor Department and, where appropriate, DoF, nor should it build up cash balances or net assets in excess of what is required for operational purposes. Funds held in bank accounts or as financial investments may be a factor for consideration when grant-in-aid is determined. Equity shares in ventures which further the objectives of the PHA shall equally be subject to Departmental and DoF approval unless covered by a specific delegation.

5.14. Unconventional Financing

5.14.1. The PHA shall not enter into any unconventional financing arrangement without the approval of the Department and DoF. If the PHA is using a new or non-standard technique, it should ensure that it has the competence to manage, control and track its

use and any resulting financial exposures, which may vary with time. In particular, the PHA should consult the Department before using derivatives for the first time. The PHA must evaluate any such financing techniques carefully, especially to assess value for money and any proposal must be assessed in line with MPMNI chapter on funding.

5.15. Commercial Insurance

5.15.1. The PHA shall not take out any insurance without the prior approval of the Department and DoF, other than third party insurance required by the Road Traffic (NI) Order 1981 (as amended) and any other insurance which is a statutory obligation or which is permitted in Managing Public Money Northern Ireland. Decisions on whether to buy insurance should be based on objective cost-benefit analysis, using guidance in the *Northern Ireland Guide to Expenditure Appraisal and Evaluation* (NIGEAE) (supported by additional DoF guidance).

5.15.2. In the case of a major loss or third-party claim, the Department shall liaise with the PHA about the circumstances in which an appropriate addition to budget out of the Department's funds and/or adjustment to the PHA's targets shall be considered. The Department will liaise with DoF Supply where required in such cases.

5.16 Employers Liability

5.16.1 The PHA is listed in exemption Regulations made by the Department of Enterprise, Trade and Investment (now the Department for the Economy), under the Employer's Liability (Compulsory Insurance) (Amendment) Regulations (Northern Ireland) 2009, and therefore is not required to insure against liability for personal injury suffered by its employees.

5.17. Payment/Credit Cards

5.17.1. The PHA, in consultation with the Department, shall ensure that procedures on the issue of payment cards (including credit cards) are in place. No payment/credit cards should be issued without the prior written approval of the PHA's Accounting Officer.

5.18. Hospitality

5.18.1. The PHA shall ensure that a comprehensive set of guidelines on the provision of hospitality is in place. Reference should be made to Departmental guidance.

5.19. Use of consultants

5.19.1. The PHA must notify the Department of any occasion when it intends to use consultants, for what purpose, and submit consultancy business case in advance of any expenditure being committed. Prior Departmental/ DoF approval must be sought in line with current delegated limits. The PHA shall also comply with current Departmental and DoF guidance on the Use of Consultants.

5.19.2. The PHA will provide the Department with a quarterly statement on the status of all consultancies completed and/or started in each financial year.

5.19.3. Care should be taken to avoid actual, potential, or perceived conflicts of interest when employing consultants.

6. MANAGEMENT AND DISPOSAL OF ASSETS

6.1. Asset Management Strategy

6.1.1. Each public sector organisation is expected to develop and operate an asset management strategy underpinned by a reliable and up to date asset register which should be reviewed annually by the PHA's Accounting Officer as part of the corporate planning process.

6.1.2. The PHA must ensure effective use, maintenance, acquisition and disposal of the public sector assets under its control.

6.1.3. The PHA shall keep an up to date asset register of all the capital assets it owns and uses.

6.2. Asset transfer between public bodies

6.2.1. Public sector organisations may transfer property among themselves without placing the asset on the open market, provided they do so at market prices and in appropriate circumstances and this is accounted for in compliance with MPMNI and FReM.

6.3. Machinery of Government changes

6.3.1. Some assets transfer due to machinery of government changes. The relevant legislation (Transfer Order) should prescribe the terms of any such transfer.

6.3.2. The PHA should maintain information asset registers as part of their asset management strategy.

6.4. Register of Assets

6.4.1. The PHA shall maintain an accurate and up to date register of fixed assets.

6.5. Disposal of Assets

6.5.1. The PHA shall dispose of those assets that are surplus to its requirements in compliance with current policy. Assets should be sold for best price, as advised by Land & Property Services. Assets shall be sold by auction or competitive tender as advised by Land & Property Services (unless otherwise agreed by the Department) and in accordance with the principles of MPMNI provided that the PHA is satisfied that the articles are spent, redundant or surplus to requirements.

6.5.2. Other than at a public auction, no article shall pass into the possession of any member of staff of the PHA or member of the Board without approval of the Department.

6.5.3. All receipts derived from the sale of assets (including grant financed assets, see below) must be declared to the Department, which will consult with DoF on the appropriate treatment.

6.6. Recovery of Grant – Financed Assets

6.6.1. Where the PHA has financed expenditure on capital assets by third parties, the PHA shall set conditions and make appropriate arrangements to ensure that assets are not disposed of without the PHA's prior consent.

6.6.2. The PHA shall ensure that any grants to third parties for the acquisition of assets should normally include a clawback condition under which they can recoup the proceeds if the recipient of the grant later sells the asset.

6.6.3. The PHA shall ensure that, if the assets created by grants made by the Board cease to be used by the recipient of the grant for the intended purpose, a proper proportion of the value of the asset shall be repaid to the PHA for surrender to the Department. The amount recoverable shall be calculated by reference to the best possible value of the asset and in proportion to the NI Consolidated Fund's original investment(s) in the asset.

7. BUDGETING PROCEDURES

7.1. Setting the Annual Budget

7.1.1. Each year, in the light of decisions by the Department on the PHA's updated draft corporate plan, the Department will send to the PHA:

- a formal statement of the annual budgetary provision allocated by the Department in the light of competing priorities across the Department and of any forecast income approved by the Department; and
- a statement of any planned change in policies affecting the PHA.

7.1.2. The PHA approved annual business plan will take account both of its approved funding provision and any forecast receipts, and will include a budget of estimated payments and receipts together with a profile of expected expenditure and of draw-down of any Departmental funding and/or other income over the year. These elements will form part of the approved business plan for the year in question (Section 4.2 of the Management Statement).

7.1.3. Any Grant-in-Aid provided by the Department for the year in question will be voted in the Department's Estimate and will be subject to Assembly control.

7.2. General Conditions for the Authority to Spend

7.2.1. Once the PHA's budget has been approved by the Department (and subject to any restrictions imposed by Statute/the Minister/this MSFM or any other circulars, directives, and best practice guidance that may issue from, or by way of, the Department), the PHA shall have authority to incur expenditure approved in the budget without further reference to the Department, on the following conditions:

- The PHA shall comply with the delegations issued by the Department in HSC(F) 52-2016 (Appendix 1) or subsequent revisions). These delegations shall not be altered without the prior agreement of the Department and DoF;
- The PHA shall comply with the conditions set out in paragraph 2.3 above regarding novel, contentious or repercussive proposals;
- Inclusion of any planned and approved expenditure in the PHA's budget shall not remove the need to seek formal Departmental (and, where necessary, DoF) approval where such proposed expenditure is above the delegated limits, or is for new schemes not previously agreed;
- The PHA shall provide the Department with such information about its operations, performance, individual projects or other expenditure as the Department may reasonably require (see paragraph 7.3 below); and
- The PHA shall comply with NI Procurement Policy and carry out procurement via a recognised and approved CoPE.

7.3. Providing Monitoring Information to the Department

7.3.1. The PHA shall provide the Department with information on a regular basis which will enable the satisfactory monitoring by the Department of:

- The PHA's cash management;
- its draw-down of any grant-in-aid;
- the expenditure for that month;
- forecast outturn by resource headings; and
- other data required for the DoF Outturn and Forecast Outturn Return.

Other information requirements are listed at **Appendix 2**.

8. BANKING

8.1. Banking Arrangements

8.1.1. The PHA's Accounting Officer is responsible for ensuring that the PHA's banking arrangements are in accordance with the requirements of Chapter 5 of *MPMNI*. In particular, the Accounting Officer shall ensure that the arrangements safeguard public funds and that their implementation ensures efficiency, economy and effectiveness. This responsibility remains even with the current banking pool arrangements. Accounting Officers are responsible for the credit risk to which public funds are exposed when held in commercial banks. It is important that they manage this risk actively, so that it is kept to a minimum. This means using the most efficient and cost effective money transmission methods and securing the best terms possible from banks. The PHA should seek the advice of the Department before opening new bank accounts.

8.1.2. The PHA's Accounting Officer shall therefore ensure that:

- these arrangements are suitably structured and represent value-for-money, and are reviewed at least every two years, with a comprehensive review, usually leading to competitive tendering, at least every three to five years;
- sufficient information about banking arrangements is supplied to the Department's Accounting Officer to enable the latter to satisfy his/her own responsibilities;
- The PHA's banking arrangements shall be kept separate and distinct from those of any other person or organisation; and
- adequate records are maintained of payments and receipts and adequate facilities are available for the secure storage of cash.

9. COMPLIANCE WITH INSTRUCTIONS AND GUIDANCE

9.1. Relevant Documents

9.1.1. The PHA shall comply with the following general guidance documents:

- This document (both the *Financial Memorandum* and the *Management Statement*);
- *Managing Public Money Northern Ireland* (*MPMNI*);
- *Public Bodies - a Guide for NI Departments* issued by DoF;
- *Government Internal Audit Standards*, issued by DoF;
- *Managing the Risk of Fraud* issued by DoF;
- *The Government Financial Reporting Manual (FReM)* (Treasury document) issued by DoF;
- Relevant DoF Dear Accounting Officer and Finance Director letters;
- Relevant Dear Consolidation Officer and Dear Consolidation Manager letters issued by DoF;
- *Regularity, Propriety and Value for Money*, issued by Treasury;
- The Consolidation Officer Letter of Appointment, issued by DoF;
- *PFI - Working Together in Financing our Future: Policy Framework for Public Private Partnerships in Northern Ireland"* available at: http://webarchive.proni.gov.uk/20141007005953/http://www.ofmdfmni.gov.uk/maindoc.pdf .
- Other relevant instructions and guidance issued by the central Departments (DoF/The Executive Office (TEO)) including Procurement Board and CPD guidance;
- Specific instructions and guidance issued by the Department;
- Recommendations made by the Public Accounts Committee, or by other Assembly/Parliamentary authority, which have been accepted by the Government and which are relevant to the PHA.

10. REVIEW OF FINANCIAL MEMORANDUM

10.1. This Financial Memorandum will normally be formally reviewed every five years, or following a review of the PHA's functions as provided for in the Management Statement.

10.2. The Department of Finance will be consulted on any significant variation proposed to the Management Statement and Financial Memorandum.

APPENDIX 1

HSC(F) 52-2016 Revised HSC & NIFRS Delegated Limits and requirements for Departmental / DoF approval

1. DoF has updated some of the delegated limits per (DAO (DPF) 06/12) providing guidance on the revised arrangements for Departmental delegations, following the restructuring of the new nine Departments, and the associated requirements for DoF approval. The revised DAO can be found at: https://www.finance-ni.gov.uk/sites/default/files/publications/dfp/daodfp0612_revised%20280716_0. pdf . The principles of DAO (DFP) 06/12 still remain and reminds organisations of the guidance contained in MPMNI relating to the authority for expenditure, regularity, propriety and value for money and the requirement to ensure that the principles of appraisals are applied when expending resources. The relevant extracts are included at **Annex A**.

2. This circular sets out the delegations between DoH and Health and Social Care bodies and NIFRS and conveys delegated authority to commit and incur expenditure subject to the restrictions set out at T**able A** below and per **Annex B and Annex C.**

3. The main changes to delegated limits are:
   - Capital Projects
     - DoH delegated limit excluding hospital schemes has increased from £1m to £2m
     - Trusts delegated limit, excluding hospital schemes, has increased from £500k to £1.5m
     - New delegated limit introduced for PHA lead Research and development of £1.5m
     - Trusts delegated limit for hospital schemes has also increased from £500k to £1.5m
   - Gifts has increased from £100 to £250 for all bodies;
   - Ex-Gratia Financial Remedy Payments (i.e.those made to complainants through an organisation's internal complaints procedures/processes increased from £250 to £500;
   - Overpayments - Foregoing the recoupment of overpayments of pay, pensions and allowances ; Pensions from £500 to £1,000;
   - Clinical negligence – delegated limit increased from £500k to £1m;
   - Delegated limit for all leases for Office / warehouse / storage accommodation is nil for all bodies;
   - DoH Delegated limit for EU Peace IV and In VA Programmes has increased from £2m to £5m. Delegated limits for all bodies remains NIL.

4. The table below summarises the main financial delegated limits where the Department has given delegated authority to HSC and NIFRS to spend within those limits. This must be read in conjunction with **Annex B** and **Annex C which contains a full list of delegations for which HSC bodies and NIFRS have NO delegated authority other than those listed below.**

5. All proposed expenditure which is set to exceed the HSC/NIFRS delegated limit must receive the appropriate prior approval before commitment to spend.

TABLE A

Area of Delegation	**HSC/NIFRS Delegated Limit**	**DoH Delegated Limit**
Use of External Consultants	HSC Bodies - £10,000 NIFRS - £10,000	£75,000
Capital Expenditure (excluding hospital schemes)	HSC Board &Trusts - £1,500,000 BSO £250,000	£2,000,000
	PHA - £50,000	
	PHA R&D - £1,500,000	
	NIBTS - £200,000	
	Other HSC Bodies - £10,000	
	NIFRS - £250,000	
Hospital Schemes – New Build, Extension, Refurbishment and Equipment involving capital expenditure	HSC Board &Trusts - £1,500,000 BSO - £250,000 PHA - £50,000 NIBTS - £200,000 Other HSC Bodies - £10,000	£5,000,000
IT Projects	HSC Board; Trusts; BSO; PHA; £250,000	£1,000,000
	NIBTS - £200,000	
	NIMDTA - £20,000	
	Other HSC Bodies - £10,000 NIFRS - £250,000	
Gifts	£250	£250
Losses – write off of cash losses and cash equivalents, bookkeeping losses, exchange rate fluctuations, fruitless payments and constructive losses, property in stores or in use due to any deliberate act	HSC Bodies £10,000 NIFRS - £1,000	n/a*
Losses -. The write off of losses relating to pay, allowances, superannuation benefits, social security benefits, grants, subsidies and the failure to make adequate charges for use of public property or services and loans - as per guidance in MPMNI	All HSC Bodies and NIFRS - Nil**	Nil**
Losses - Waived of Abandoned claims	HSC Bodies £10,000 NIFRS - £1,000	£100,000
Special payments / Ex-Gratia Payments	All HSC Bodies - £10,000 NIFRS - £1,000	£100,000
Overpayments - Foregoing the recoupment of overpayments of pay,	All HSC Bodies and NIFRS - £1,000 (pay & allowances)	£20,000

Area of Delegation	HSC/NIFRS Delegated Limit	DoH Delegated Limit
pensions and allowances	£1,000 (pensions)	
Overpayments - Foregoing the recoupment of overpayments of grants	All HSC Bodies and NIFRS - Nil**	Nil**
Special severance payments	All HSC Bodies and NIFRS - Nil**	Nil**
Ex-Gratia Financial Remedy Payments (i.e..those made to complainants through an organisation's internal complaints procedures/processes)	All HSC Bodies and NIFRS - £500	£500
Ex-Gratia Payments to be made as a result of a recommendation from the NI Public Services Ombudsman	All HSC Bodies - £10,000 NIFRS - £1,000	£50,000
Compensation payments for Clinical Negligence (to include interim payments if overall settlement is expected to exceed delegated limits) To include agreement of Periodic Payment Orders (PPOs)	HSC Bodies £1.000,000 NIFRS n/a	£2,000,000
Compensation payments following legal advice (This would include all personal injury and public liability claims)	HSC Bodies - £25,000 NIFRS - £1,000	£100,000
Compensation payments without legal advice	All HSC Bodies and NIFRS - Nil	£10,000
Extra-Statutory and Extra-Regulatory payments	All HSC Bodies and NIFRS - Nil	£100,000
Confidentiality Agreements	Nil	Nil
Grants: Revenue Capital	All HSC Bodies and NIFRS £500k per annum £200k in total	£500k per annum £200k in total
Leases for office accommodation/ warehousing / storage	All HSC Bodies and NIFRS Nil	Nil
Pay remits	All HSC Bodies and NIFRS Nil	Nil
Revenue Business cases	NIFRS - £250,000 All other HSC Bodies – fully delegated	Nil

* DoH has full delegated authority

** Prior DoH and DoF approval required in all cases

6. It is mandatory for HSC bodies and NIFRS to obtain prior Departmental approval for expenditure above those limits outlined above and per Annex B & C attached. Failure to obtain the required DoF approvals will result in regularity and propriety issues. Any expenditure which falls outside a Department's delegated authority and which has not been approved by DoF is deemed irregular and could result in qualified accounts and investigation by PAC.

7. Where expenditure proposals exceed the Department's delegated limits, DoF Supply will act as the approving authority.

8. All expenditure which is novel, contentious, repercussive or which could set a potentially expensive precedent, irrespective of size, even if it appears to offer value for money taken in isolation **must** have Departmental and DoF approval before expenditure is committed.

Further Guidance

9. For further details on these categories of expenditure, including approvals procedures, HSC Bodies and NIFRS should refer to Managing Public Money Northern Ireland[3] and NIGEAE[4], as well as current Departmental finance guidance on:
   - The use of professional services (including consultants)
   - Losses and special payments
   - Claims handling (including clinical negligence and personal injury litigation)
   - Fraud
   - Capital

Process for approval of expenditure

10. Any payments / expenditure that require Departmental approval must be submitted through Financial Policy and Accountability Unit, who will act as a single point of contact through whom all liaison with DoF on significant financial matters, including approvals, should be conducted. This is to ensure that appropriate Departmental approvals have been obtained and that regularity, propriety and VFM have been adhered to.

11. It has been agreed that the Infrastructure Investment Director will be the contact point for all such submissions concerning capital.

Should you have any queries please contact the following.

Charles Barnett 02890 522254
Sharon Allen (Capital) 02890 523169

Action Required

12. HSC Bodies and NIFRS to note the requirements to obtain prior Departmental approval before committing expenditure outside the delegations conveyed by this letter. This circular should therefore be circulated as appropriate throughout your organisation, and schemes of delegation revised and updated accordingly.

Yours sincerely

PAULA SHEARER
Financial Policy, Accountability and Counter Fraud Unit

[3] https://www.finance-ni.gov.uk/articles/managing-public-money-ni-mpmni
[4] https://www.finance-ni.gov.uk/topics/finance/northern-ireland-guide-expenditure-appraisal-and-evaluation-nigeae

Annex A

Extract from revised DAO (DFP) 06/2012

Expenditure Appraisal and Evaluation

1. FD(DFP) 20/09 draws departments' attention to the Northern Ireland Guide to
    a. Expenditure Appraisal and Evaluation (NIGEAE), which contains DoF's core guidance on the appraisal, evaluation, approval and management of policies, programmes and projects. The principles of appraisal should be applied, with proportionate effort, to every proposal for spending or saving public money, or proportionate changes in the use of public sector resources. For example, appraisal must be applied irrespective of whether the relevant public expenditure or resources:
    b. involve capital or current spending, or both;
    c. are large or small;
    d. are above or below delegated limits.

2. Appraisal is a systematic process for examining alternative uses of resources. It is designed to assist in defining problems and finding the solutions which offer the best value for money. It is a way of thinking expenditure proposals through, right from the emergence of the need for a project through its implementation, to post-project evaluation. It is the established vehicle for planning and approving projects and other expenditures. Good appraisal leads to better decisions and use of resources. It facilitates good project management and project evaluation. Appraisal is not optional; it is an essential part of good financial management, which is vital to decision-making and crucial to accountability. But it must also be proportionate.

3. It is important to begin applying appraisal early in the gestation of any proposal which has expenditure or resource implications. The justification for incurring any expenditure at all should be considered. Appraisal should be applied from the emergence of a need right through to the recommendation of the most cost-effective course of action. It should not be regarded merely as the means to refine the details of a predetermined option.

4. It should be noted that delegations do not remove the need for appraisal or evaluation. All expenditure, including that below delegation limits, must be appraised and evaluated with effort that is proportionate to the resources involved, with due regard to the specific nature of the case. NIGEAE provides more detailed guidance on the application of appropriate and proportionate effort.

Implementation of delegated authority

5. This DAO restates a number of working arrangements which are intended to facilitate the efficient implementation of delegated authority and the achievement of accountability and value for money. They are part of the internal controls of a department and should facilitate an Accounting Officer in signing the Governance Statement.

Management Arrangements

6. Departments should nominate a senior official, preferably the Departmental Finance Director, to assist in the discharge of all aspects of the delegation arrangements within the department. This official should act as a single point of contact through whom all liaison with DoF on significant financial matters, including approvals, should be conducted, unless alternative arrangements are agreed with DoF. Departments should inform DoF of the name and job title of this point of contact and notify DoF of any subsequent change.

7. Expenditure above delegated limits generally requires specific DoF approval. The normal procedure for seeking DoF approval is to submit a suitable business case to the appropriate DoF Supply Division in accordance with the guidance in NIGEAE.

8. All cases presented to DoF for approval must confirm that the department is content with the regularity, propriety and value for money of the project and the project has the necessary approvals within the departmental Accounting Officer's delegated arrangements. Where it is clear to DoF that a case has been submitted without proper departmental approval procedures being followed, the case will be returned without consideration.

9. It should be noted that where DoF approval is required, expenditure should not be committed until DoF approval has been granted. Where DoF's approval has not been sought, DoF will not generally grant retrospective approval where the relevant expenditure has already been committed or the works have commenced.

10. The practice of consulting DoF informally during the course of development of a project is strongly encouraged, particularly where the project is deemed to be complicated, novel or contentious. However, such informed consultation does not remove the need for a department to formally submit the project for DoF approval if that is required. DoF will not confirm its formal view of any proposal unless the department has provided confirmation of its Accounting Officer's view (under the responsibility of the Accounting Officer) on the regularity, propriety and value for money of the relevant proposed expenditure.

Appraisals and Post Project Evaluations

11. All departments should ensure that their operating procedures and guidance on conducting economic appraisals comply with NIGEAE, are recorded in a Finance Manual, that this Manual is kept updated regularly, and that those who are involved in the economic appraisal process have access to it.

12. The Departmental Finance Director should ensure that commensurate Post Project Evaluations (PPEs) are completed in accordance with the principles set out in NIGEAE that lessons learnt are shared within the department (and, where appropriate, with other departments). A copy of the PPE should be forwarded to DoF Supply if it formed a condition of the approval. Departmental Finance Manuals should ensure that appropriate procedures are established for PPEs.

Review of Processes

13. Each department should carry out an annual review (independent of the spending areas) of the processes in relation to the appraisal of cases and PPEs that fall within its delegated limits, to ensure that the proper processes are being followed and the delegation limits set out in this DAO adhered to. If a department has evidence-based confidence in its internal controls, it may decide to implement a cycle of reviews, taking a different part of the department each year.

Review of Economic Appraisals/PPEs

14. In addition to the annual review of processes described at (viii) above, departments should conduct ad hoc 'test drilling' of economic appraisals and PPEs that fall (a) within their delegated limits and (b) within the delegated limits given to their sponsored bodies, to ensure that the appropriate appraisal standards have been applied in accordance with NIGEAE guidance and that decisions have been taken on a proper basis. The review should be undertaken independent of the spending area. A department may undertake a cycle of reviews concentrating on the higher risk areas. A report of the findings of the examination of individual cases should be provided by departments to the Departmental Accounting Officer and to DoF Supply on an annual basis, by 30 June each year. This

should provide further assurance to the Departmental Accounting Officer in signing off the Annual Governance Statement.

15. Departments should submit to DoF Supply a list of all appraisals above the level agreed with their Supply Officer. Supply may request a sample of those cases for review, to confirm the effectiveness of departments' control systems (in line with the criteria in MPMNI A.2.3.8). Any necessary corrective action identified should be implemented within an agreed timescale.

Annex B

AREAS REQUIRING DoF APPROVAL FOR ALL DEPARTMENTS

	Details	Reference
Where DoF approval (in writing) is required:		
Use of Resources		
1	Public statements which might imply a willingness on the part of the Executive to commit resources or incur expenditure beyond agreed levels	MPMNI Box A.2.3.A
2	Guarantees, indemnities or general statements/ letters of comfort which could create a contingent liability	MPMNI Box A.2.3.A
3	All expenditure which is novel, contentious, repercussive or which could set a potentially expensive precedent, irrespective of size, even if it appears to offer value for money taken in isolation	MPMNI Box A.2.3.A Box 2.3
4	Expenditure that could create pressures which could lead to a breach of: 1. Departmental Expenditure Limits (DELs); 2. resource limits or capital limits; or 3. Estimates provision.	MPMNI Box A.2.3.B
5	Expenditure that would entail contractual commitments to significant levels of spending in future years for which plans have not been set	MPMNI Box A.2.3.B
6	Legislation with financial implications as per guidance in MPMNI	MPMNI A.2.2.1
7	New services under the sole authority of the Budget Act	MPMNI A.2.5.15
8	Loans – on borrowing from the Northern Ireland Consolidated Fund for Contingencies	MPMNI A.2.5.9 MPMNI A.2.5.11
Accounting Officers		
9	Appointment of the permanent head of each central government department to be its Accounting Officer	MPMNI 3.2.1
10	Appointment of an Accounting Officer for a Trading Fund (TF)	Financial Provisions NI Order 1993 and MPMNI 3.2.2
Internal Management		
11	Gifts – Giving any individual gift in excess of £250. **Refer to Table A for HSC and NIFRS Delegation**	MPMNI A.4.12.3
12	Insurance – Decision to purchase commercial insurance.	MPMNI 4.4.1 – 4.4.2

	Details	Reference
13	Losses – The write off of losses relating to pay, allowances, superannuation benefits, social security benefits, grants, subsidies and the failure to make adequate charges for use of public property or services and loans - as per guidance in MPMNI - **Refer to Table A for HSC and NIFRS Delegation**	MPMNI Annex A.4
14	Losses - Waived or Abandoned claims above £100,000 and Special payments e.g. ex gratia over £100,000. To include the foregoing the recoupment of overpayments of pay, pensions and allowances over £20,000 and the recoupment of overpayments of grants. **Refer to Table A for HSC and NIFRS Delegation**	MPMNI A.4.10.2 & Box A.4.10.A MPMNI A.4.11
15	Payments – Advance payments excluding those allowed under the guidance in MPMNI	MPMNI A.4.6.5
16	Payments – Deferred payments excluding those allowed under the guidance in MPMNI	MPMNI A.4.6.9
17	Payments - Special severance payments - **Refer to Table A for HSC and NIFRS Delegation**	MPMNI A.4.13.9
18	Payments – Financial Remedy Payments over £500 (ie payments made to complainants through an organisations internal complaints procedures/processes) and payments over £50,000 to be made as a result of a recommendation from the Northern Ireland Public Services Ombudsman	MPMNI A.4.14.8
Funding		
19	Banking – Proposals to open an account outside the pool or any proposed changes to Banking Pool arrangements	MPMNI 5.8.2 MPMNI A.5.7.3 MPMNI Box A.5.7.B
20	Banking – Requests for indemnities that commercial banks may seek to replace their normal arrangements	MPMNI Box A.5.7B
21	Borrowing from the Private Sector for all Arms Length Bodies (ALBs)	MPMNI 5.7.1
22	Borrowing on terms more costly than those usually available to government	MPMNI A.5.6.11
23	Borrowing – foreign borrowing	MPMNI A.5.6.12
24	Foreign Currency - Any proposals to negotiate contracts in foreign currencies other than the euro, yen or US dollar	MPMNI A.5.7.13
25	Income - Use of income and cash by departments to meet expenditure needs if there is no specific legislation	MPMNI A.5.3.1 MPMNI A.5.3.5
26	Income & Receipts - Increases to the amount that can be treated as an accruing resource	MPMNI A.5.3.8 MPMNI A.5.3.9

	Details	Reference
	during a financial year in order to finance a comparable increase in expenditure as per in-year monitoring/budgeting guidance	
27	Liabilities – Departments seeking statutory authority to accept liabilities	MPMNI A.5.5.5
28	Liabilities – Assuming statutory liabilities including the liabilities of any sponsored bodies in excess of £1 million for any single transaction	MPMNI A.5.5.14
29	Liabilities – Reporting non-statutory, where required, to the Assembly	MPMNI A.5.5.23
30	Liabilities – Reporting a contingent liability in confidence by writing to the Chair of the PAC	MPMNI A.5.5.28
31	Liabilities – Departments should consult DoF about reporting a liability during recess and outside Assembly sessions during a dissolution	MPMNI A.5.5.30 MPMNI A.5.5.34
32	Loans – proposals to make voted loans and premature repayment	MPMNI 5.6.1 MPMNI A.5.6.2
Fees, Charges and Levies		
33	Charges - Primary legislation to empower charging	MPMNI 6.2.1
34	Charges - Restructuring charges using the Fees and Charges (NI) Order 1988 No. 929 (N.I.8) in line with guidance in MPMNI	MPMNI Box 6.2
35	Charges - Public sector supplier moving away from full cost charging	MPMNI A.6.4.8
36	Interdepartmental Transactions – where the transaction may require legislative procedures or where DoF agreement is required under statute	MPMNI A.6.6.3
Working with Others		
37	Agency framework documents and the methods of financing an agency	MPMNI 7.4.2 & Box 7.2
38	All Management Statements and Financial Memorandums (MSFM) or other relationship documents	MPMNI 7.7.6
39	The establishment or termination of an NDPB	Public Bodies: A Guide for NI Departments
40	The establishment and operation of a Trading Fund including sources of capital	Financial Provisions NI Order 1993 and MPMNI A.6.6.3, MPMNI 7.5.2, 7.5.4 & Box 7.3
41	Provision of funding by way of an Endowment Fund	A.5.1.10
42	Grants to Councils under the Local Government (Finance) Act (NI) 2011	Local Government (Finance) Act (NI) 2011
Other Delegations		
43	Wider market projects where the full annual cost or aggregated annual income from such	MPMNI A.7.6.6

	Details	Reference
	services exceeds, or is expected to exceed thresholds agreed by DoF	
44	Assets - Transfer or disposal of assets at less than market value.	
45	Assets – to appropriate any sums realised as a result of selling an asset above the deminimis level in the DoF Budget/In-year Monitoring Guidance	
46	Assets – to allow an organisation to retain receipts arising from the sale of assets funded by grant or grant-in-aid above the deminimis level in the DoF Budget/In-year Monitoring Guidance	
47	Compensation payments without legal advice - Individual compensation claims settled out of court over £10,000. - **Refer to Table A for HSC and NIFRS Delegation**	
48	Compensation payments following legal advice - Individual compensation claims settled out of court over £100,000 where the legal advice is that the department will not win the case if contested in court. - **Refer to Table A for HSC and NIFRS Delegation**	
49	Consultants – Expenditure on external consultancy projects over £75,000 Expenditure on external consultancy assignments co-funded by the Strategic Investment Board over £150k – **Refer to Table A for HSC and NIFRS Delegation**	FD(DOF)07/12 Minute to Principal Finance Officers dated 19 April 2004
50	Estimates – form and content of Main and Supplementary Estimates.	Supply Estimates in Northern Ireland – A Guidance Manual
51	Virement	Supply Estimates in Northern Ireland – A Guidance Manual
52	Fraud – any departure from immediate reporting (not including National Fraud Initiative (NFI) for which separate arrangements have been agreed	FD(DFP) 02/13
53	IT projects over £1 million **Refer to Table A for HSC and NIFRS Delegation**	CONSIDER AGAINST AGILE
54	Capital Projects - All other expenditure on Capital Projects involving over £2million of Central Government expenditure unless other delegations specifically allow - **Refer to Table A for HSC and NIFRS Delegation**	
55	Projects - All PFI + 3PD projects at key stages as stipulated in NIGEAE	NI Guide to Expenditure Appraisal and Evaluation MPMNI A.7.5.4 FD(DFP) 20/09 FD(DFP) 17/11

	Details	Reference
56	Receipts – repayment of CFERs from the Northern Ireland Consolidated Fund	
57	Redundancy – All staff redundancy schemes not covered by existing regulations or which are more generous than existing NICS scheme.	
58	EU - All expenditure over £5 million under the EU Programmes for which the Special EU Programmes Body is responsible rather than with a threshold of £2 million.	Letter to Finance Directors & EUSG Members 2 March 2011
59	Pay Remits - **Refer to Table A for HSC and NIFRS Delegation**	FD Letter - Pay Remit Approval Process and Guidance
60	All leases for Office Accommodation (including supporting storage or warehousing) – both new and existing extension or renewal beyond break points. Excluding offices outside Northern Ireland - **Refer to Table A for HSC and NIFRS Delegation**	Letter to Accounting Officers 28 July 2014

Annex C

Specific DEPARTMENT OF HEALTH delegations

Ref Number	Details	Reference
Where DoF approval (in writing) is required:		
1	Hospital Schemes – Ne Build, Extension, Refurbishment and Equipment involving capital expenditure over £5 – **Refer to Table A for HSC and NIRFS Delegation.**	
2	Third Party Development schemes for health and social care / service provision.	
3	All grants/awards to the Voluntary and Community Sector: Revenue Grants £500,000 per annum, Capital Grants £200,000 – **refer to Table A for HSC and NIRFS Delegation**	
4	Medical/Clinical Negligence settlements over £2m – **refer to Table A for HSC and NIRFS Delegation**	
5		
6		

Ref number	Details	**Reference**
Where DoF approval (in writing) is required:		
5	Staff redundancy schemes.	
6	Provisions concerning appointment of officers.	Fire Services (NI) Order 1984
7	Doctors Qualifications.	HPSS Order 1972 Article 107(6)
8	Doctors Rights/Working Conditions.	HPSS Order 1972 Article 107(6)
9	Requirement to maintain list of Doctors/Dentists by Boards / Departments.	HPSS Order 1972 Article 107(6)
10	Terms of Service for Medical Professionals.	HPSS Order 1972 Article 107(6)
11	Prescription Charges.	HPSS Order 1972 Article 98 (2) Schedule 15
12	Optical Charges.	HPSS Order 1972 Article 98 (2) Schedule 15
13	Dental Charges.	HPSS Order 1972 Article 98 (2) Schedule 15

APPENDIX 2

Core Departmental Information Requirements

1. *INFORMATION TO BE PROVIDED ROUTINELY DURING THE FINANCIAL YEAR*
   - 1.1 Minutes of Board and all Committee meetings (to be forwarded to the Department as soon as possible following each meeting)
   - 1.2 Internal audit reports where substantive assurance not achieved (immediately following report)
   - 1.3 Inspection/review reports (immediately following receipt of report by the PHA)
   - 1.4 Monthly financial monitoring returns (to enable the Department to exercise both Estimate and budgetary control)

2. *OTHER INFORMATION TO BE PROVIDED*
   - 2.1 Corporate/Business Plan (to be forwarded to the Department, in draft form, prior to sign-off by the PHA in February/March)
   - 2.2 Internal audit work plan for the forthcoming year (to be forwarded in February/March)
   - 2.3 Internal audit report for the previous year (to be forwarded in May/June)
   - 2.4 Business Continuity plan (to be updated at least annually, and forwarded to the Department thereafter)
   - 2.5 Risk register (to be updated at, least annually, and forwarded to the Department in March/April)
   - 2.6 Assurance Framework (to be updated, at least annually, and forwarded to the Department in March/April)
   - 2.7 Mid-year Assurance Statement, end of year Governance Statement (to be forwarded to the Department in October/November and May/June respectively)

HSC Public Health Agency

board paper

Review of PHA Procurement Planning Processes

date 20 September 2018 **item** 11 **reference** PHA/05/09/18

presented by Mr Edmond McClean, Deputy Chief Executive

action required For noting

Introduction

The update on the PHA social care procurement plan presented at the August board meeting, set out that, to date, the PHA has completed the procurement process on 75 contracts with an annual value of £11.5m. 190 rolling contracts with a value of circa £8.7m remain to be fully reviewed and procured, where required. 125 of these contracts (with a value of circa £5.8m) are currently being reviewed under the processes approved by the PHA board for the Protect Life 2 and Use of Place procurements. It was also noted that the PHA will also need to begin planning for the re-tendering of services, where contracts previously procured are due to expire in the next 12 to 18 months.

The paper also identified that implementation of the social care procurement plan has been slower than expected. This paper summarises some of the key issues, and sets out the proposed approach to review and address this, with the overarching aim of ensuring that PHA has robust processes in place to enable it to ensure that available skills and capacity are used to maximum effect in delivering key outcomes in line with PHA priorities.

Context

With the introduction of the new procurement regulations in 2015 the focus of attention has been on the technical procurement requirements. However it has become increasingly clear that the pre-procurement planning phase is equally, if not more, important. This includes:

- Assessing population needs;
- Reviewing existing service provision;
- Agreeing service priorities and models;
- Establishing funding priorities;
- Understanding the market;
- Developing business cases;
- PPI

- Equality and Rural Screening.

It is recognised that the pre-procurement planning stages are not unique to procurement, but are fundamental when reviewing and or developing any programme or service, whether or not it will, in part or in totality, be taken forward through procurement.

Issues

Progress with awarding new tenders has been slower than anticipated for a number of reasons, including the following:

- Strategic plans for service areas have not always been sufficiently developed or updated to allow tenders to progress in the timescales anticipated;
- In instances there may be limited market intelligence to help inform and shape specifications and agree costing models;
- There are limited resources and associated gaps in skills and knowledge to undertake the planning stages and then manage procurement from specification development through to contract award;
- Delays in the finalisation of key regional strategies, particularly the new Suicide Prevention Strategy – Protect Life 2 by DoH.

Proposed Approach to Address Issues

It is proposed that a time-limited working group be established to review how the PHA ensures that its procurement plan reflects the PHA strategic priorities, in line with the PHA Corporate Plan, and to make recommendations on changes required to ensure that pre-procurement planning is initiated and completed in a timely manner, and any other changes that would improve how future procurements are managed more effectively.

The working group would include representation from:

- AMT member
- A PHA board non-executive
- AD Health Improvement
- A Head of Health Improvement
- AD Planning and Operational Services
- PHA Planning and procurement lead

The remit of the working group will be to:

- Review existing pre-procurement planning and procurement processes, identifying opportunities to streamline this work as well as enabling fit for purpose contexts to inform and progress key service and population objectives ;
- Identify the knowledge and skills required, and how any existing gaps can be addressed;
- Assess options for how PHA can work across Directorates and Functions to ensure future procurements are progressed and managed as efficiently and effectively as possible.
- Enable the development and maintenance of an agreed and prioritised procurement plan, in line with the strategic objectives of the PHA, that can be delivered within appropriate timescales;
- Agree the right scale and mix of staff with the knowledge and skills required to plan, implement and manage procurements.

It is expected that the working group will engage with relevant stakeholders. It is also proposed that a workshop will be held with all board members to explore the possible solutions to address these issues, in early 2019.

Equality Impact Assessment

Not applicable.

Recommendation

The PHA board is asked to **NOTE** this process, and to nominate a Non-Executive Director to participate in the working group.

HSC Public Health Agency

board paper

Programme for Government Report Cards

date 20 September 2018 **item** 12 **reference** PHA/06/09/18

presented by Mr Edmond McClean, Deputy Chief Executive

action required For noting

Summary

The Outcomes Delivery Plan 2018/19 is an implementation document for PfG for the year 2018/19 and contains a small sample of the actions held across the long term PfG delivery plans. This plan is monitored by the Outcome Owners (nominated permanent secretaries) and TEO who have requested completed, public facing report cards for the sample actions in September 18 and March 19 (unless an Assembly is in place and procedures may change). Each Outcome Owner is responsible for compiling both a statement of assurance to NICS Board in August that reporting will occur in September (completed) and relevant report cards for publication by TEO.

The following actions are those that PHA are responsible for reporting on through the Population Health Directorate of DoH and have been included in the Outcomes Delivery Plan for 2018/19 under outcomes 3, 4 and 12. The Outcome Owner for Outcomes 3 and 12 is Derek Baker (Education) and for Outcome 4, the Outcome Owner is Richard Pengelly.

Action	Outcome	Owner
Development of a "Healthy Places" programme	3	Mary Black
Increase participation on the Family Nurse Partnership	3, 12	Deirdre Webb
Increase percentage of patients with confirmed ischaemic stroke who receive thrombolysis treatment, where clinically appropriate	4	Brid Farrell
Provide targeted support for pregnant women identified as being at risk of delivering low birth weight babies through increased foetal monitoring and	12	Denise Boulter

support for reducing smoking, overweight and obesity in pregnancy		
Increase the scale and spread of the Self – Harm Intervention Programme	3,4	Mary Black
Expand smoke-free public places	3	Mary Black

Please note there may be other areas PHA are asked to contribute to but will not be responsible ror reporting e.g. age friendly

The following 5 report cards and 1 update have been completed and designed based on guidance from both DoH and TEO. They also reflect the responses provided to the earlier statement of assurance with regard to their progress.

TEO have asked for report cards to be submitted and ready for publication before 30 September (final submission date has not yet been confirmed) and DoH have asked for the attached 6 areas of work to be submitted within the first week of September.

While TEO have called this mid-year reporting, it is important to note that mid-year reporting data and information for 2018/19 is not available within these timescales. The report cards contain the most recent and quality assured data available for each area of work and will continue to develop as information becomes available. The aim now is to continue developing these report cards and to begin development of those required for the longer-term delivery plans.

Equality Impact Assessment

Not applicable.

Recommendation

The PHA board is asked to **NOTE** the Programme for Government report cards.

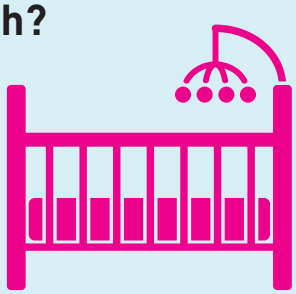
Birth Weight

Report Card

Action

Provide targeted support for pregnant women identified as being at risk of delivering low birth weight babies through increased foetal monitoring and support for reducing smoking, overweight and obesity in pregnancy.

How much?



Number of babies born below 10th centile

May 2017–March 2018

1,959

1st Quarter 2018

485

Number of babies identified as below 10th centile

May 2017–March 2018

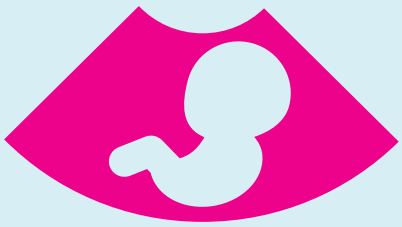
979

1st Quarter 2018

261

- **Number of women referred for appropriate care (Data Development)**
- **Number scheduled appointments attended (Data Development)**

How well?



% babies born below 10th centile detected in antenatal period

May 2017–March 2018

50%

1st Quarter 2018

54%

- **% women booked by 12 weeks (Data Development)**
- **% referred on to appropriate care (with further breakdowns as appropriate) (Data Development)**
- **% scheduled appointments attended (Data Development)**

Anyone better off?

No. & % stillbirths in babies detected as being below 10th centile (Data Development)

No. & % babies referred on to appropriate care during the antenatal period being born at healthy weight (Data Development)

Birth Weight

Additional info

References

Saving Babies Lives https://www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf NHS

NIMATs (Northern Ireland Maternity System) – The regional maternity information system

Increase participation on the Family Nurse Partnership

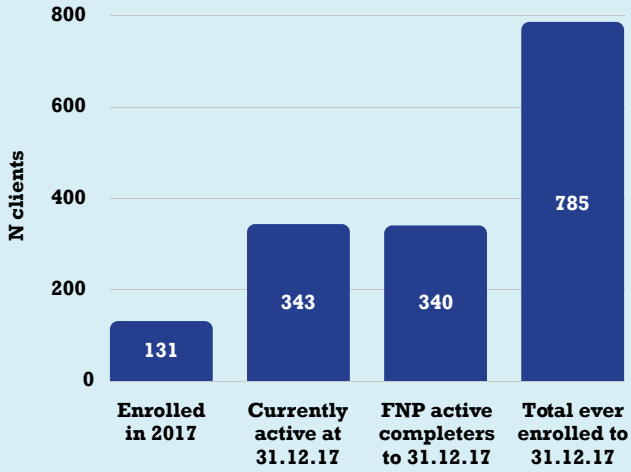
Report Card

How much?

A total of 131 clients were enrolled in the year 2017.

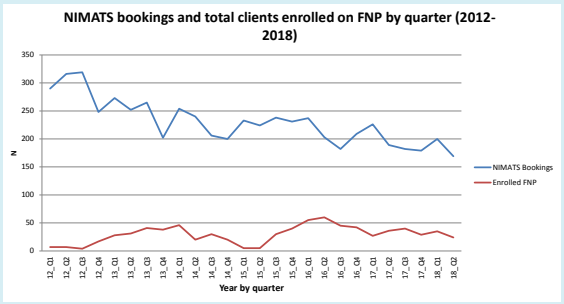
On 31.12.2017 of the 785 clients who were ever enrolled there were 343 current clients and 340 active clients had completed the programme.

Client profile



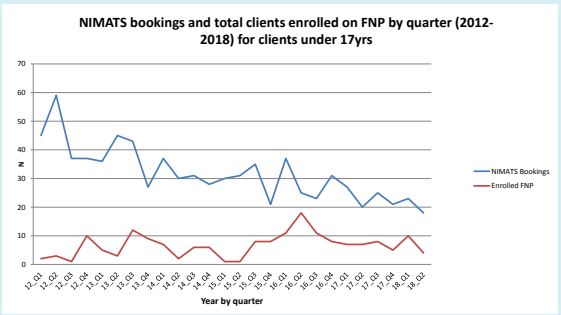
How well?

NIMATS bookings* and total clients enrolled on FNP by quarter (2012-2018)



*First time mothers under 20

NIMATS bookings* and total clients enrolled on FNP by quarter (2012-2018) for clients under 17yrs



*First time mothers under 20

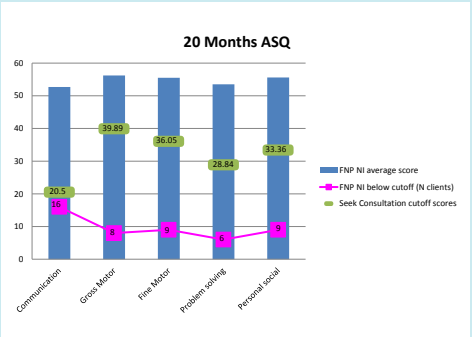
Latest attrition rates

Total attrition by stage for stage completers	Performance %(N)	Goal
Attrition - Pregnancy	1.4% (8)	10%
Attrition - Infancy	7.3% (29)	20%
Attrition - Toddlerhood	6.6% (22)	10%

*FNP Annual Report 2017(data to 31/12/2016).

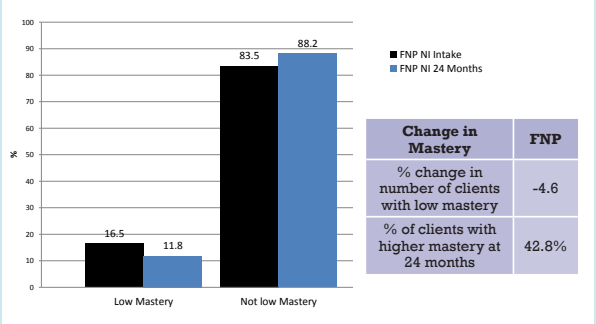
Anyone better off?

Ages and Stages Questionnaire*



*FNP Annual Report 2017 (data to 31/12/2016).

Mastery at intake and 24 months



Change in Mastery	FNP
% change in number of clients with low mastery	-4.6
% of clients with higher mastery at 24 months	42.8%

*FNP Annual Report 2017 (data to 31/12/2016).

Low birth weight (<2.5KG) NIMATS 2017

	N Births*	N <2.5KG	%
Non FNP	762	50	6.6
FNP	147	10	6.8
Total	909	60	6.6

*Births to first time NI resident mothers <=20 years (NIMATS) in 2017.

Attempted breastfeeding NIMATS 2017

Under 20		20 and under	
FNP	**Non FNP**	**FNP**	**Non FNP**
43% (N=55/128)	39.7% (N=184/463)	43.2% (N=63/146)	41.7% (N=316/758)

*Births to first time NI resident mothers <=20 years (NIMATS) in 2017.

Increase participation on the Family Nurse Partnership

Additional info

Notes

How well?
The younger clients under 17 years have been prioritised for programme places

Any better off?
Child Development at 20 months are within normal limits
Young mother mastery levels are higher at the end of the programme
Lower Numbers of babies with lower birth weight
Improvement in Breastfeeding Rates for Mothers on the Programme

Definitions

Mastery
Sense of mastery is a form of perceived personal control, a sense of control over the events in one's life. Low levels of sense of mastery have been linked to mental and general ill-health. A high level of sense of mastery is associated with positive mental health. Sense of mastery acts as a mediator between stress factors and various health outcomes.

Ages and Stages Questionnaire
The ASQ and ASQ: SE are validated population level developmental screening tools that actively involve and encourage parents to be observant of their child's development. http://api.ning.com/files/OBvpVpF2atOOElvrrsMNPfFwwE8P0f*0O0VWzHEuQ7lkoDi-vsAVNBMqDBx2nXz4bml7SNkX2Gbsl3W97hcx8e3WEzjlNDn5/UseofAgesandStagesguidanceMarch2017.pdf
Ages & Stages questionnaires Each ASQ questionnaire contains 30 items divided into five areas of development. The items in each area are arranged from easy to more difficult. The 30 items that pertain to specific areas of development are followed by a section of overall questions that ask about general parental concerns. The five developmental areas covered in each ASQ questionnaire are communication, gross motor, fine motor, problem solving, personal-social.

Developing a Healthy Places Programme Update

Report Card

The Department of Health and the Public Health Agency, together with other Government Departments have been shaping a Healthy Places model of development. It became increasingly clear that a number of Departments were advocating a place based approach to reducing inequalities and improving outcomes, on issues such as offending and reoffending, health and wellbeing, having a more equal society, self-efficacy, community development and rural development. This issue was brought to the All Departmental Officials Group (ADOG) which provides the strategic governance structure for Making Life Better and it was subsequently agreed that a sub group would be established to consider how placed based approaches might be brought together in a more coherent way across Government Departments in order to address the wider determinants of health and improve multiple social outcomes.

The subgroup has now met on a regular basis with a number of papers having been produced to drive the development of the programme. Firstly, a concept paper was produced and a number of possible communities have been identified based on evidence of need and knowledge of practice. Government Departments have now populated a template which provides an overview of the needs and possibilities in a short list of five possible areas for a demonstration project. A briefing paper was prepared and presented to the All Departmental Officials Group on 7th August 2018 where there was broad agreement on the way forward. A paper has also been prepared for consideration by the Top Management Group of Government Departments.

In addition, meetings have been held with the Chief Executive of Causeway Coast and Glens, David Jack, the lead representative for health and wellbeing within the local Government organisation, SOLACE. It has been the view of the planning group that local Government are essential to the development of this work. As a result of this engagement, a paper will be presented to SOLACE members in preparation for their meeting on 5th September 2018 with a view to a presentation to SOLACE at their meeting on 5th October 2018. It is intended to gain their views and ultimate agreement to the selection of the three demonstration areas in order to allow the developmental process to progress at a local level.

In parallel with this strategic development, an application was submitted and secured HSC Transformation funding to facilitate programme development. A Job Description has been drafted for a project lead officer, with recruitment scheduled for September 2018. In addition, consideration has been given to the indicators and measures that might be used to evaluate the programme. It will be essential that this programme also links to the Outcomes Framework developed as part of the HSC Transformation Community Development work stream, which links action at local level through to the higher level outcomes of the Programme for Government Delivery Plan.

Developing a Healthier Places Programme: Community Planning Update

Report Card

PHA and HSC are represented across each of the eleven councils and in the relevant tiers of community planning structures as appropriate. Working with councils and through involvement in the community planning development process, all community plans have included a focus on health and wellbeing, as either an outcome or a theme; the creation of a health and wellbeing subgroup to progress implementation; and agreement of about a range of population health indicators.

Reflected in each community plan, the following four areas of focus have allowed for a consistent regional approach to improving health and wellbeing while also allowing local flexibility in how these areas are progressed and improved:

- Improvements to the early years of life
- Increased opportunities for physical activity
- Improved mental health and wellbeing
- Older people will maintain healthy, active lives; and promotion of age friendly communities

The HSC Family has adopted a coordinated approach to community planning, working together through the PHA-led HSC Community Planning Forum, to align, identify key issues and further develop consistent approaches across the region. A particular focus has been advanced to address potential challenges and securing immediate as well as longer-term cumulative benefits of joint working and collaboration.

In addition, work is underway to explore the potential of a number of regional joint working opportunities on work such as 'Take 5' (mental and emotional health and wellbeing), community development, workplace health, active travel, Breastfeeding Welcome Here Schemes and the food offering in the public sector.

Performance measures and indicators are being developed as action plans are agreed within each community planning structure. The pace and structure of actions will be determined through the community planning process and in the spirit of partnership and collaboration embodied by Making Life Better and Community Planning.

Performance management templates will be further developed in line with and at the pace of the action plans and community planning timescales.

Self – Harm Intervention Programme

Report Card

Action

Increase the scale and spread of the Self – Harm Intervention Programme.

How much?

During 2017-18 the HSC Trusts referred

3,017

people to SHIP who required support regarding self harming behaviour.

During 2017-18,

236

families/carers agreed to support from SHIP.

SHIP
Self-harm Intervention Programme

During 2017-18:

8,773

sessions of support were delivered to adults who self harm

1,328

sessions of support were delivered to young people under 18 years who self harm

434

sessions of support were delivered to families and carers

Clients are offered on average 5 sessions of psychological support depending on their needs.

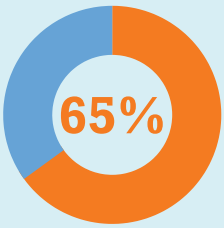
Context

The Self Harm Intervention Programme (SHIP) was established in late 2015 and has been growing steadily since. The service is accessible right across Northern Ireland for people aged 11 years and over who self harm. Referrals are made to SHIP by HSC Trust mental health services through a formal referral pathway. SHIP also provides support to families and carers of people who self harm to help them cope with the issue.

The SHIP service is assertive in proactively making contact with the people who have been referred and offering them an appointment within a week and also engaging their families or carers where appropriate.

How well?

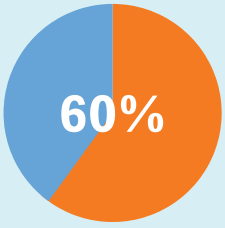
People who self harm can sometimes find it difficult to engage with services for a variety of reasons including stigma. Engagement levels are good for both males and females with approximately 65% of people referred taking up the service.



Anyone better off?

Clients using the service are asked to complete feedback forms. The feedback from the service is extremely positive with the vast majority of clients reporting that the service has helped them 'a lot' to cope with their problems. Clients also report that they better understand the reasons why they self harm.

Changes in psychological wellbeing are monitored using CORE outcome measures. Annual data is not yet available for reporting but based on a single quarter there was good evidence of improvement with 60% of clients that completed pre and post questionnaires demonstrating a 'reliable improvement' in scores.



09/18

Smoke-free public places

Report Card

Action

Expand smoke-free public places

How much?

440

primary and special schools in NI have adopted 'Smoke-Free Schools Gates' approach

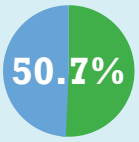
880 Smoke-Free Schools Gates

signs erected on primary school property to date

5

Health & Social Care Trusts have adopted Smoke-Free Grounds policy and signage across all sites

How well?



of primary and special schools have adopted 'Smoke-Free Schools Gates' approach

- **% of primary schools satisfied with initiative (data development)**
- **% reduction in littering caused by cigarette waste near school gates (data development)**
- **% of patients/staff and visitors who support Smoke-Free Trust sites (data development)**
- **% reduction in littering on HSC sites caused by cigarette waste (data development)**

Anyone better off?

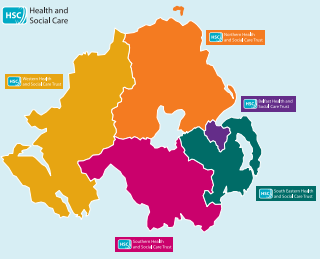
440

primary schools benefitting from smoke free school gates, protecting parents & carers, siblings, pupils and staff from exposure to second hand smoke

Initial findings from HSCT surveys indicate widespread support for the scheme, with a small number of policy breaches (data currently being collated) – data development

Anecdotally, the numbers of parents and adults smoking near school gates has reduced

X sites across 5 Trusts benefiting from reduced levels of smoking on site thereby reducing exposure to second hand smoke (data development)



Next steps

- ✓ A further 207 primary schools have indicated that they also want to join the scheme in 2018/19
- ✓ Analysis of the 5 Health & Social Care Trusts surveys of patients/staff and visitors to gauge support for Smoke-Free Trust sites

Stroke

Report Card

Action

Increase percentage of patients with confirmed ischaemic stroke who receive thrombolysis treatment, where clinically appropriate

Context

In Northern Ireland (NI), the number of people admitted to hospital with an acute stroke ranges from 2600 to 2800 each year. An audit in 2016 showed that many people who experience a transient ischaemic attack (TIA or mini stroke) do not promptly, i.e. within 24 hours, seek or receive medical attention to reduce the risk of suffering an acute stroke. The F.A.S.T. campaign has been one way in which we have raised awareness about the importance of TIAs as a stroke warning sign.It is important the people are aware of stroke symptoms so that they can alert emergency services and get to hospital quickly. Evidence shows that people getting quickly to and receiving care in dedicated stroke units are more likely to be alive, independent and living at home one year after their stroke. More patients than ever are now receiving timely thrombolysis, but more could benefit. By ensuring people who have an acute stroke receive prompt assessment and treatment, we can reduce the levels of disability in survivors of stroke and reduce the number of deaths that result from stroke.

How much?

2,741 people admitted with acute stroke in 17/18 PMSI Data

In 17/18, **242** more people admitted to a stroke units

355 patients with ischaemic stroke received thrombolysis treatment SSNAP

In 17/18, **26** more people received thrombolysis than in 16/17

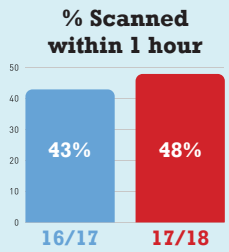
68 patients received mechanical thrombectomy during the hours of operation of the service in BHSCT SSNAP

How well?

16% of people with acute stroke receive thrombolysis (PFG indicator % of Infarct type strokes lysed)

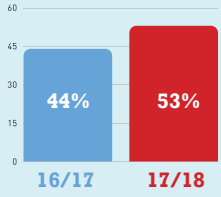
71% of stroke patients receive thrombolysis within 60 mins of hospital arrival. SSNAP

Compared to 16/17 results in 17/18 show that **220 more people** were scanned in the first hour after arrival



Thrombolysis given on average **5 mins** quicker in 17/18 compared to 16/17

323 more people screened for swallow in first 4 hours



60 MIN

7 out of 8 or 88% of assessment sites have a median door to needle time of 60 minutes

Anyone better off?

91% of clinically eligible patients received thrombolysis treatment - 17/18

In 17/18, compared to 16/17:

✓ **165 more people** left hospital independent

Stroke

Additional info

References

NI participates in the National Stroke audit called SSNAP, and information about care provided to every person admitted to hospital with a stroke is recorded in the audit. This allows us to compare the performance of services here N Ireland with other centres and regions in the NHS.

Glossary

Thrombectomy	surgical removal of a thrombus from a blood vessel.
Thrombolysis	the dissolution of a blood clot, especially as induced artificially by infusion of an enzyme into the blood.