HSC Public Health Agency

agenda

Title of Meeting	110th Meeting of the Public Health Agency Board
Date	21 March 2019 at 1.30pm
Venue	Board Room, Gransha Park House, 15 Gransha Park, Clooney Road, Derry / Londonderry BT47 6FN

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 21 February 2019		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/01/03/19**	Mr Cummings

committee updates

8 2.00	Update from Governance and Audit Committee	**PHA/02/03/19**	Mr Drew

items for approval

9 2.10	PHA Business Plan 2019/20	**PHA/03/03/19**	Mr McClean
10 2.25	Review of PHA Standing Orders and Standing Financial instructions	**PHA/04/03/19**	Mr McClean / Mr Cummings
11 2.35	PHA Business Continuity Plan	**PHA/05/03/19**	Mr McClean
12 2.45	Data Protection Impact Assessment Policy and Guidance	**PHA/06/03/19**	Mr McClean

closing items

13 Any other Business
2.55

14 Details of next meeting:

Thursday 18 April 2019 at 1:30pm

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

HSC Public Health Agency

minutes

Title of Meeting	109th Meeting of the Public Health Agency Board
Date	21 February 2019 at 1.30pm
Venue	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
Mrs Mary Hinds	-	Director of Nursing and Allied Health Professionals
Dr Adrian Mairs	-	Acting Director of Public Health
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
Ms Nicola Woods	-	Boardroom Apprentice

1/19 **Item 1 – Welcome and Apologies**

1/19.1 The Chair welcomed everyone to the meeting. Apologies were noted from Mrs Joanne McKissick and Ms Nicola Woods.

2/19 **Item 2 - Declaration of Interests**

2/19.1 The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.

3/19 **Item 3 – Minutes of previous meeting held on 20 December 2018**

3/19.1 The minutes of the previous meeting, held on 20 December 2018, were approved as an accurate record of that meeting.

4/19 **Item 4 – Matters Arising**

4/19.1 There were no matters arising.

5/19 **Item 5 – Chair's Business**

5/19.1 The Chair noted that there has been extensive coverage in various media in recent weeks on the effects of social media in facilitating young people to self-harm or to attempt suicide. He added that the Public Health Agency funds a diverse range of organisations to deliver services to prevent such harm and to support those at risk and their families. He asked how the PHA can ensure that the staff of those service-providing organisations are equipped and empowered to deal with an extremely fast-changing environment, and how the PHA can ensure that there is a consistency of standards and effectiveness in the delivery of such services?

5/19.2 Dr Mairs advised that PHA has been working with colleges to develop a training package and has developed quality standards in collaboration with the community and voluntary sector. The Chair noted that a suicide prevention conference had taken place recently and asked if PHA had been represented. Dr Mairs said that Brendan Bonner had been in attendance. Mr McClean advised that PHA undertakes real time media monitoring, and if there is a sense that there is a cluster of suicides then measures can be taken to get messages out immediately to those who may be vulnerable.

5/19.3 The Chair informed members that work is continuing on the duty of candour workstream following the Hyponatraemia Inquiry. He commended the work being undertaken by PHA staff Claire Fordyce and Martin Quinn in this area.

5/19.4 The Chair gave members an overview of a recent visit from Richard Parish, a non-Executive Director of Public Health England. He said that issues discussed included campaign and rural needs.

6/19 **Item 6 – Chief Executive's Business**

6/19.1 The Interim Chief Executive advised the Board that the Department of Health is leading work with HSC organisations, including PHA, which is at an advanced stage of preparing for the UK's exit from the EU. A number of workstreams have been established to ensure that appropriate business continuity, preventative and contingency measures are in place. She added that in terms of contingency planning there is a focus on medicines supply, the movement of people, and the transfer of

data. Furthermore, she said that in line with well-established civil contingency plans, the system is also ensuring arrangements are in place to respond effectively to any developing issues.

6/19.2 She agreed to keep the Board updated on this issue.

6/19.3 The Interim Chief Executive updated members on the review of neurology patients. She advised that a further 1,044 people had been recalled, namely individuals who had been seen by Consultant Neurologist Dr Michael Watt and discharged to the care of their GP. She explained that this latest review is being concentrated on specific groups of patients taking specific, specialised medicines, and that of the 1044 people invited as part of this phase of the recall, 711 have been seen and 6 have appointments booked. She added that a further 310 either declined an appointment, no longer need to be seen or failed to attend on more than one occasion.

6/19.4 The Interim Chief Executive assured members that core neurology outpatient activity has been maintained throughout the whole recall process and it is expected that patients in this phase of the recall will have been seen by the end of February 2019.

6/19.5 The Interim Chief Executive acknowledged the commitment and dedication of staff in the Belfast Trust for progressing this recall in such a well organised yet patient sensitive manner. She also paid tribute to Dr Miriam McCarthy from HSCB and Dr Adrian Mairs for their leadership and advice in this matter.

6/19.6 The Interim Chief Executive said that work continues on the design and legislative preparations for the closure of the HSCB, albeit at a slower pace in recognition of competing pressures across the HSCB and the Department. She said that the anticipated closure date of the HSCB is now 31 March 2021 and that a letter was issued to all staff by the Permanent Secretary regarding this. She stressed that it is important that there is clarity on the way forward and the transition arrangements and that changes can be made to the way organisations work together without the need for legislation.

6/19.7 The Interim Chief Executive informed the Board that as part of a programme of staff engagement, the Permanent Secretary recently visited Board offices in Linenhall Street and Gransha recently in what were useful and very engaging events.

6/19.8 With regard to the Transformation agenda, the Interim Chief Executive said that monitoring of the projects funded in 2018/19 is continuing with detailing planning underway for 2019/20. She highlighted some of the initiatives that are taking place.

6/19.9 The Interim Chief Executive said she wished to inform the Board that Dr Carolyn Harper has now retired from service. She said that Carolyn

had a distinguished career right from her undergraduate days including being appointed as a consultant in the legacy Northern Health and Social Services Board; and taking up the post of medical director to the lead provider of public health services in the State of California.

6/19.10 The Interim Chief Executive added that in 2007 Carolyn took up post as Deputy Chief Medical Officer for Safety, Quality and Services at the Department of Health & Social Services and amongst other responsibilities, supported the work programme under the Review of Public Administration, including the organisational arrangements for the new Public Health Agency.

6/19.11 The Interim Chief Executive said that in 2009 Carolyn was appointed as its first Director of Public Health and Executive Medical Director of the Health and Social Care Board, and that she showed immense dedication to establishing both these new roles and to the new organisations.

6/19.12 The Interim Chief Executive said that Carolyn was passionately committed to improving the health of the public, addressing health inequalities, giving every child the best possible start in life, and giving a voice to those who were disadvantaged or marginalised.

6/19.13 On behalf of the Board, the Interim Chief Executive wished Carolyn every happiness for her retirement.

6/19.14 The Interim Chief Executive informed members that over the past few months there has been increased political interest in the three crisis de-escalation pilots across Northern Ireland. She advised that pilots in the Western and South Eastern Trust are already up and running, while it is hoped that the pilot in the Belfast Trust will be operational from 1 April. Following requests from some of the main political parties for a briefing, the Interim Chief Executive said that she agreed to facilitate an all-party briefing and this took place on 11 February.

6/19.15 The Interim Chief Executive advised that Janet Calvert, PHA's breastfeeding lead, has been invited to the prestigious Communities and Hospitals Advancing Maternity Practices (CHAMPS) conference in October 2019 in Jackson, Mississippi to present PHA's work in this area following a similar presentation she delivered at the Unicef UK Baby Friendly Initiative Annual Conference in Liverpool. She added that another regional project that PHA is involved in the area of Nursing, Project RETAIN, has attracted international attention with Assistant Director of Nursing, Siobhan McIntyre and Project Lead, Gillian McCorkell being invited to present their work at the International Council of Nurses Congress in Singapore.

6/19.16 The Interim Chief Executive said that Professor David Olds from the University of Colorado is going to be the distinguished speaker at the Family Nurse Partnership conference at Riddell Hall on 12 March, and

that any members interested in attending this event should contact the Director of Nursing's office.

7/19 **Item 7 – Finance Report (PHA/01/02/19)**

7/19.1 Mr Cummings advised that the Finance Report for the period up to 31 December 2018 showed a year to date surplus of £3.8m, however a large part of this is due to the Lifeline service and that will be settled before the year-end. He said that the Agency is striving to achieve a year-end break-even position. He added that there is also a surplus within the management and administration budget.

7/19.2 Mr Cummings said that in terms of budget planning for 2019/20, it is expected that PHA will be facing a 3% reduction in its budget, but this has not yet been confirmed.

7/19.3 Mr Drew asked if there was a prioritisation process for allocating additional funds to programme expenditure. Mr Cummings explained that a key factor is whether a certain initiative can utilise the funds in-year given a reduced lead-in time. Ms Mann-Kler asked about the issues within health protection. Mr Cummings explained that this is principally to do with costs associated with vaccines, and that he would have further information on this at the next meeting.

7/19.4 Mr Clayton asked about confidence and supply monies, and if there will be a further tranche of money this year. He noted that there had been a retraction of £1.7m from PHA's confidence and supply funds. Mr Cummings explained that any underspends in confidence and supply monies are handed back to the Department of Health, and there is no automatic rollover of funds. He said that there is £100m of funding for next year.

7/19.5 Alderman Porter said that it is difficult for PHA to argue against a reduction of 3% in its budget, when it does not spend all of its current budget. Mr Cummings said that the PHA surplus is normally a small surplus.

7/19.6 The Chair asked about R&D spend and whether the budget had been reduced. Mr Cummings explained that while most of the R&D budget is capital, there are also some revenue elements.

7/19.7 The Board noted the Finance Report.

8/19 **Item 8 – Newborn Blood Spot Screening in Northern Ireland Annual Report 2016-2017 (PHA/02/02/19)**

8/19.1 Dr Stephen Bergin joined the meeting to present the reports pertaining to Items 8 and 9. He gave an overview of screening programmes by informing members that PHA is now responsible for the quality assurance of 8 screening programmes which in total involve screening

almost one quarter of the population of Northern Ireland.

8/19.2 Dr Bergin explained that newborn bloodspot screening test, otherwise known as the “heel prick” is an essential test and that 98% of the 23,000 babies born in Northern Ireland in 2016/17 had this undertaken within five days of birth. Out of these, he said that 32 babies were confirmed as having one of the five conditions that are screened for.

8/19.3 Dr Bergin advised that the “avoidable repeat” rate was 4.39% and that this needs to be reduced. He explained that this is where a sample taken has not met the required standard for analysis, and a repeat sample is requested.

8/19.4 Dr Bergin said that going forward the programme is going to be expanded to take in testing for four additional inherited metabolic diseases.

8/19.5 Mr Drew said that the report was very encouraging, but he asked whether the further development of the programme will result in more staff needed to be recruited in order to process the results more quickly. Dr Mairs advised that part of the business case pertaining to this programme relates to additional staff. He noted that the number of babies with positive tests is quite small, but they do require to be followed up.

8/19.6 Alderman Porter asked whether in any cases where a concern was highlighted at birth, if these were reviewed again two to three years later. Dr Bergin said although this would be outwith the remit of the screening programme, it is important that there is a link with a care pathway and that paediatricians know their role in this area.

8/19.7 Councillor Ashe asked why it took up to 6/8 weeks for families to be informed of a negative result. He expressed concern that families may feel that “no news is good news” and could be informed sooner. Dr Bergin agreed to check this.

8/19.8 Ms Mann-Kler asked for clarity about the PHA staff requirements for this programme. Dr Mairs explained that there are currently two Programme Managers covering 3 programmes, and that programmes are becoming more complex. Ms Mann-Kler asked how the four new areas to be screened were decided. Dr Bergin said that these are set by the UK National Screening Committee who advised to the Health Ministers and Chief Medical Officers in each country of the United Kingdom.

8/19.9 The Board **APPROVED** the Newborn Blood Spot Screening Programme.

9/19	**Item 9 – Northern Ireland Infectious Diseases in Pregnancy Screening Programme Annual Report 2016-2017 (PHA/03/02/19)**
9/19.1	Dr Bergin advised that this is the first report of the Infectious Diseases in Pregnancy Screening Programme (IDPS), a programme which aims to identify conditions which pregnant women may transmit onto their children in the womb. He highlighted that a women who has an HIV infection is up to 45% likely to pass this onto her child, but that this rate reduces to <0.5% through an intervention if picked up through this screening programme. He added that referrals are made to the appropriate physicians, and mothers are cared for by multi-disciplinary teams.
9/19.2	Mr Drew said that it was good to see this report, and noted that it is the first for this particular programme. Dr Bergin advised that the screenings have been carried out for a number of years, but this is the first time a report has been produced. Dr Mairs added that as part of PHA's quality assurance arrangements it is seeking to produce report on all of its screening programmes and part of ensuring consistency in governance arrangements.
9/19.3	Mr Clayton commended the work, but noted that the target for timely assessment of women with hepatitis B was missed, but that the numbers involved were small. Dr Bergin advised that a referral is made quickly, and that historically there may have been a delay with hepatology services, improvements are beginning to be made.
9/19.4	Ms Mann-Kler said that the results for this programme are good compared with other programmes, but asked what further improvements can be made. Dr Bergin said that there remains work to be done in terms of selling the benefits of screening, and also encouraging people to take up referrals. He added that going forward, he would like to see better use of technology to improve efficiency and modernisation of the reporting structures.
9/19.5	The Chair noted the huge achievement of the Agency in delivering more than 400,000 screening episodes each year. Mrs Hinds said that it is positive to note that midwives are taking more of a public health approach and helping individuals make lifestyle choices.
9/19.6	The Board **APPROVED** the Northern Ireland Infectious Diseases in Pregnancy Screening Programme Annual Report.
10/19	**Item 10 – Surveillance of Antimicrobial Use and Resistance in Northern Ireland Annual Report 2018 (PHA/04/02/19)**
10/19.1	Dr Muhammad Sartaj joined the meeting at this point along with Mr Chris Nugent (for item 10), Ms Rachel Spiers (for item 11), Dr Tony Crockford (for item 12) and Ms Caroline McGeary (for item 12).

10/19.2 Dr Sartaj advised members that PHA produces regular reports in this area of work and it operates under a structure of HCAI and surveillance reporting. He explained that there is also a PHA HCAI and AMR Improvement Board, and its priorities are reflected in its action plan. He welcomed the opportunity to present these reports but he noted that some of the terminology in the reports is technical.

10/19.3 Mr Nugent introduced the first report, which related to Antimicrobial Resistance (AMR). He advised that this is the second such report in this area. He explained that PHA obtains data from the Trusts in order to analyse key trends from 2009 to 2017 in Gram-negative bacteraemia as well as antibiotic resistance and the number of antibiotics being prescribed.

10/19.4 Mr Nugent said the key findings of the report show that the number of cases of E. coli have increased as have the number of cases of K. pneumoniae. He added that resistance to these infections has increased. Mr Nugent advised that antibiotic prescribing in primary care is currently at 85.4%, but that there has been a slight decrease in total antibiotic use between 2014 and 2017. He added that antibiotic prescribing in Northern Ireland is higher than in other parts of the UK.

10/19.5 The Chair noted that a couple of years ago the rate of dispensing antibiotics in Northern Ireland was 54% higher than that in England. Mr Nugent said that the difference was now 40% higher.

10/19.6 The Chair asked about the difference between extrinsic and intrinsic resistance. Dr Sartaj explained that an extrinsic infection is one that is picked up from another person, but an intrinsic infection may be picked up while undergoing a type of treatment. He added that any infection picked up in a hospital setting is classed as an HCAI after two days.

10/19.7 Mr Stewart said that although there has been a slight reduction in the amount of antibiotic prescribing, it remains at a high level. He noted that PHA is currently running a public information campaign about this, but he asked what action is being taken to reduce the amount of GP prescribing. Dr Mairs said that a lot of work is taking place. He agreed that there is the awareness campaign and he added that PHA is working with Integrated Care within HSCB to look at practitioner behaviour. It said that it is a cultural issue. Dr Sartaj said that we need to understand the reasons behind the high levels of prescribing. He said that diagnostic testing needed to be looked at, and suggested that prescriptions should be delayed until it was clear whether a patient had a viral or bacterial condition. The Chair asked if there was a swab test that could be undertaken to determine whether a virus or bacteria is present. Dr Sartaj said that a pilot is being rolled out in primary care settings.

10/19.8 Ms Mann-Kler asked about the impact of the current campaign. She said that a campaign is critical in this area. She also asked about the

implications of Brexit. Dr Sartaj said that there is justification in having a campaign, and that PHA is working with the Department to see if this will be possible. In terms of Brexit, he said that PHA is working closely with Public Health England and we are keen to remain part of the European network. Ms Mann-Kler asked about the work undertaken with the Innovation Lab. Dr Sartaj said that a preliminary report has been produced and this could be shared with members.

10/19.9 Mr Clayton asked if Dr Sartaj was familiar with recent work undertaken by Newcastle University looking at environmental factors vis-à-vis antimicrobial resistance. He declared an interest in this matter due to a personal connection with one of the researchers involved in this work. Dr Sartaj said that he was not, but that PHA would continue to focus on human health, but look at other factors including agriculture and the food chain.

10/19.10 In terms of future priorities, Dr Sartaj advised that there is a UK-wide AMR Strategy with each nation producing its own action plan. He said that PHA's focus is now on reducing the Gram-negative bacteraemia.

10/19.11 The Chair said that this is an important issue for PHA.

10/19.12 The Board noted the Surveillance of Antimicrobial Use and Resistance in Northern Ireland Annual Report 2018.

11/19 Item 11 – Surveillance of Healthcare-Associated Infections in Northern Ireland Annual Report (PHA/05/02/19)

11/19.1 Ms Spiers presented the Report on the surveillance of Healthcare-Associated Infections in Northern Ireland in 2017. She explained that the data in the Report is provided by HSC Trusts through a web-based portal. In terms of the overall findings, she reported that the rate of C. difficile in inpatients has increased by 3%, but that the MRSA rate has decreased to its lowest rate since surveillance began. She added that MSSA rates have remained stable, but that the overall rate of Gram-negative infections increased. Finally, with regard to pseudomonas colonisations, she said that no infections were reported in the 13 cases from 9 infants in neonatal units across Northern Ireland.

11/19.2 Ms Spiers said that the low rate of C. difficile and the decrease in the number of MRSA cases is due to the work of the Trusts' Infection Control teams, and she hoped that this would also soon reflect in the rate of Gram-negative infections. She advised that the findings of this Report will be shared with the Trusts and with stakeholders.

11/19.3 Professor Rooney asked if there was any up to date data available for 2018. Dr Sartaj said that feedback is given to Trusts on a monthly basis, and he highlighted that rates of MRSA have been reduced by 85% and that rates of C. difficile have fallen by 75% over the last number of years. He reiterated that the challenge for PHA relates to Gram-negative

bacteraemia, and that this is issue is not solely confined to Northern Ireland.

11/19.4 The Board noted the Surveillance of Healthcare-Associated Infections in Northern Ireland Annual Report.

12/19 Item 12 – Healthcare-Associated Infections and Antimicrobial Use in Long-Term Care Facilities (HALT3) 2017 Survey (PHA/06/02/19)

12/19.1 Dr Crockford informed members that the HALT3 survey which looks at infections in nursing homes and residential homes is a Europe-wide survey and PHA undertake the survey in Northern Ireland, in conjunction with RQIA. He added that the survey was last undertaken in 2012.

12/19.2 Dr Crockford said that the survey aims to measure the prevalence of HCAIs and antimicrobial use in nursing homes and residential homes. In terms of antimicrobial use, he reported that the prevalence was 10.5% in nursing homes, and 9.2% in residential homes. He added that half of the prescriptions (50.4%) given out in nursing homes were for prophylaxis and the percentage for residential homes was 44.4%. He explained that the main target site for prescriptions was urinary tract infections (UTIs).

12/19.3 In terms of HCAIs, Dr Crockford advised that the prevalence in nursing homes was 3.3% and for residential homes, 6.8%, results that were broadly similar to those in 2012. He said that the most commonly reported HCAIs were urinary tract infections, respiratory tract infections and skin and soft tissue infections.

12/19.4 Dr Sartaj said that one of the priorities going forward is to look at the principle of prescriptions and to develop clear guidance for GPs. Ms McGeary explained that there is a UTI decision tool for nursing homes which was designed in Scotland and is being adopted in Northern Ireland. She said that it was launched in nursing homes last year and RQIA monitored its use after 6 months and noted largely positive results. She added that it is hoped to use it in residential care settings.

12/19.5 Mr Stewart said that the report was very interesting, but he noted that the sample size was small. He was also concerned that as the survey was voluntary only those with a good story tell might respond and that therefore the results may well mislead. The Chair suggested that the survey should be mandatory. Dr Sartaj advised that Northern Ireland had the highest participation rate in the survey. Dr Mairs said that although the sample was small, the key messages would have been the same. Dr Crockford agreed saying that even with the numbers, the complexity and the range of results obtained were just as important as the headline messages.

12/19.6 Mrs Hinds asked if this work is linked to other work being led by Kathy Fodey in PHA. Ms McGeary said that a task and finish group is being

established and Ms Fodey will be part of that group.

12/19.7 The Board noted the HALT3 survey report.

12/19.8 The Chair thanked Dr Sartaj and his team for presenting such a wide range of reports to the Board.

13/19 Item 13 – Gastrointestinal Infections in Northern Ireland Annual Surveillance Report 2017 (PHA/07/02/19)

13/19.1 Dr Philip Veal and Mr Paul Cabrey joined the meeting for this item. Mr Cabrey advised that the report is based on surveillance information which is reported on a daily, weekly and monthly basis. He said that the report did not contain any startling trends and that the numbers are quite small, but there have been some changes in recent years in terms of what is being tested and how it is being tested.

13/19.2 Mr Cabrey advised that the number of campylobacter infections has increased as have reports of Giardia Lamblia, however a change in the testing protocol for this type of report may have contributed to the increased number of cases.

13/19.3 Mr Cabrey said that the Health Protection Duty Room in PHA is staffed by health protection consultants and nursing staff who validate the information received and look for outbreaks. He added that PHA also works with local Councils.

13/19.4 Mr Cabrey said that this report will be published on the PHA website and distributed to key stakeholders. The Chair asked if there were any particular messages that PHA would wish to get across following publication of the report. Mr Cabrey said that the main messages would relate to hand hygiene and not to wash raw chicken.

13/19.5 Ms Mann-Kler noted that baselines have changed, and asked if this is material. Mr Cabrey said that is difficult to know as some of the laboratories have not changed over as yet and that PHA would need to be able to analyse several years of data to determine whether this is staying steady, or increasing, and to see if any other countries are noting an increase. Dr Veal added that one of the key functions of surveillance is to identify outbreaks and PHA looks for trends and triggers on a daily basis.

13/19.6 The Chair noted that the Food Standards Agency has money for campaigns. Dr Veal confirmed that it has run campaigns which have led to a UK-wide reduction in campylobacter cases.

13/19.7 The Board noted the Gastrointestinal Infections in Northern Ireland Annual Surveillance Report 2017.

14/19	**Item 14 – Any Other Business**
14/19.1	There was no other business.
15/19	**Item 15 – Details of Next Meeting**

Thursday 21 March 2019 at 1.30pm

Board Room, Gransha Park House, 15 Gransha Park, Clooney Road, Derry/Londonderry, BT47 6FN

Signed by Chair:

Date: 21 March 2019

Public Health Agency

Finance Report

2018-19

Month 10 - January 2019

PHA Financial Report - Executive Summary

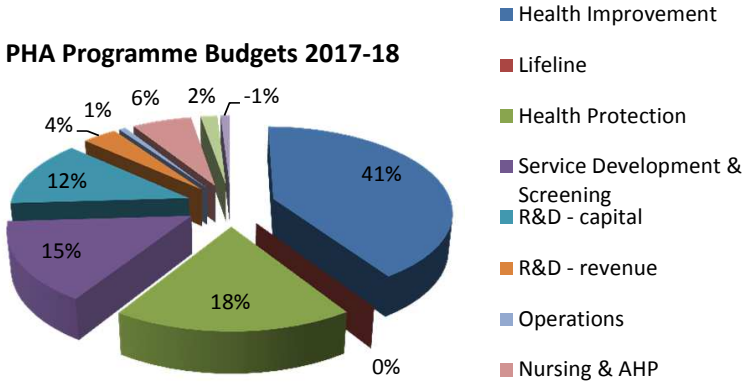
Year to Date Financial Position (page 2)

At the end of month 10 PHA is underspent against its profiled budget by approximately £1.7m. This underspend is primarily within Nursing and Public Health Programme budgets (page 4), 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.

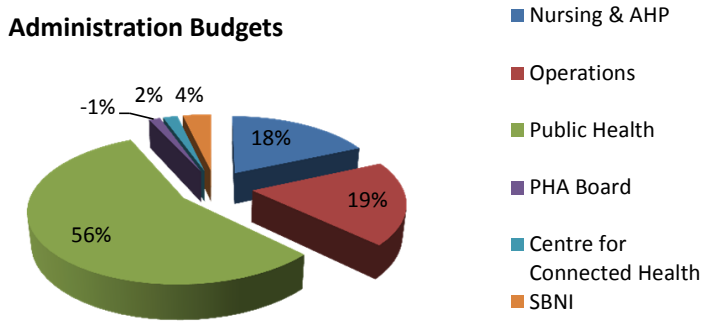


Administration Budgets (page 5)

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. A retraction of £1.8m unspent ringfenced funds, including Confidence and Supply Transformation Funds, has been assumed at month 10.

Public Health Agency
2018-19 Summary Position - January 2019

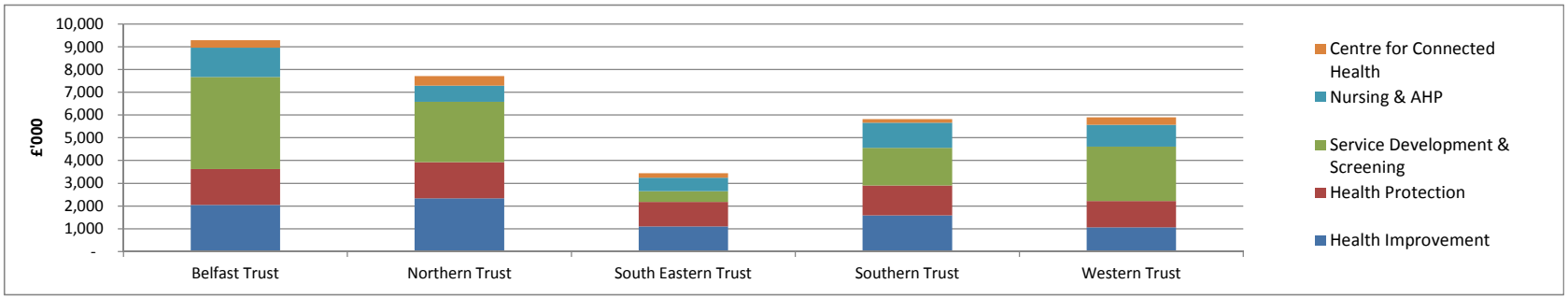
	Annual Budget					Year to Date				
	Programme		Ringfenced	Mgt &	Total	Programme		Ringfenced	Mgt &	Total
	Trust	PHA Direct	Trust & Direct	Admin		Trust	PHA Direct	Trust & Direct	Admin	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources										
Departmental Revenue Allocation	34,504	40,899	8,704	18,907	**103,015**	26,837	35,021	4,734	15,500	**82,091**
Revenue Income from Other Sources	28	308		681	**1,017**	24	308	-	557	**888**
Departmental Allocation Retraction			(1,790)		**(1,790)**					
Total Available Resources	34,532	41,207	6,914	19,588	**102,242**	26,860	35,329	4,734	16,056	**82,980**
Expenditure										
Trusts	32,232	-	3,683	-	**35,915**	28,777	-	3,069	-	**31,846**
PHA Direct Programme *	-	44,090	3,231	-	**47,320**	-	32,088	1,695	-	**33,783**
PHA Administration	-	-		19,006	**19,006**	-	-		15,626	**15,626**
Total Proposed Budgets	32,232	44,090	6,914	19,006	**102,242**	28,777	32,088	4,764	15,626	**81,254**
Surplus/(Deficit) - Revenue	2,300	(2,882)	(0)	582	(0)	(1,917)	3,241	(29)	430	**1,725**
Cumulative variance (%)						***-7.14%***	***9.17%***	***-0.62%***	***2.68%***	***2.08%***

The year to date financial position for the PHA shows an underspend against profiled budget of approximately £1.7m, mainly due to spend behind profile on Nursing and Public Health budgets (see page 4), and also a year to date underspend on Administration budgets (see page 5). This is due to the timing of payments only, and it is currently anticipated that the PHA will achieve breakeven for the full year.

An allocation retraction by the DoH for £1.8m (mainly Confidence and Supply Transformation Funds) has been assumed against ringfenced budgets at this point.

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

Programme Expenditure with Trusts



Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	NIAS Trust £'000	NIMDTA Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	2,043	2,334	1,105	1,587	1,063	-	-	**8,133**	6,777	8,694	(1,917)
Health Protection	1,584	1,598	1,071	1,314	1,151	-	-	**6,719**	5,599	5,599	-
Service Development & Screening	4,047	2,650	477	1,655	2,392	-	-	**11,220**	9,350	9,350	-
Nursing & AHP	1,290	709	588	1,102	958	-	-	**4,648**	3,873	3,873	-
Centre for Connected Health	319	420	204	164	334	-	-	**1,441**	1,201	1,201	-
Other	24	13	11	12	11	-	-	**72**	60	60	-
Total current RRLs	**9,307**	**7,724**	**3,457**	**5,835**	**5,909**	**-**	**-**	**32,233**	**26,860**	**28,777**	**(1,917)**
Cumulative variance (%)											***-7.14%***

	Belfast Trust £'000	Northern Trust £'000	South Eastern £'000	Southern Trust £'000	Western Trust £'000	NIAS Trust £'000	NIMDTA Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / £'000
Ringfenced budgets	**757**	**526**	**747**	**606**	**856**	**89**	**102**	**3,683**	**3,069**	**3,069**	**0**
											0.00%

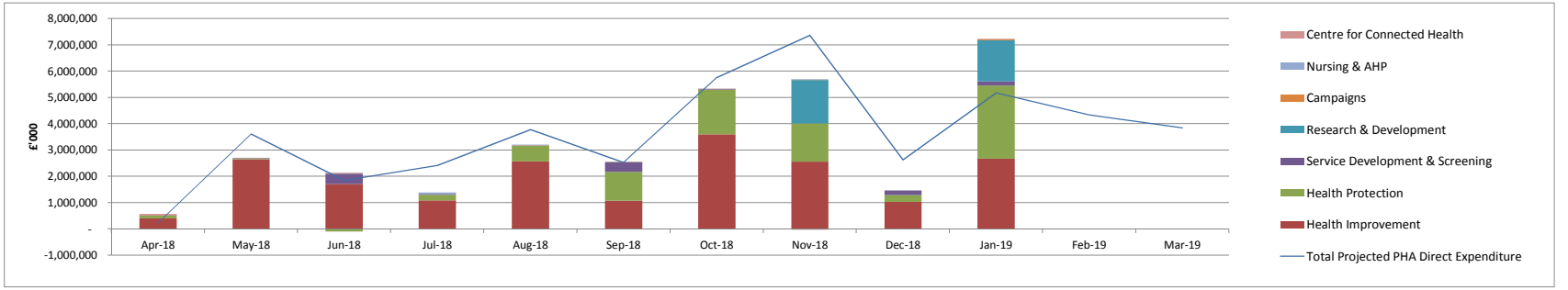
The above table shows the current Trust allocations split by budget area.

The year to date overspend on Trust budgets is primarily due to an outstanding budget transfer to BHSCT for Lifeline Contract (£1.9m year to date effect). The budget is currently held in the PHA Direct budget on page 4, and will be re-aligned when the business case is approved.

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

Ringfenced funds allocated to Trusts have been assumed at breakeven.

PHA Direct Programme Expenditure



	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	3,121	1,291	2,625	3,941	1,274	2,655	3,545	2,925	**27,895**	21,426	19,365	2,061	*9.6%*
Health Protection	56	347	93	78	446	888	2,960	1,471	1,021	809	107	1,147	**9,423**	8,170	8,132	38	*0.5%*
Service Development & Screening	18	140	524	74	74	328	130	80	306	(139)	145	403	**2,084**	1,536	1,526	10	*0.7%*
Research & Development	-	-	-	-	-	-	-	1,648	-	1,563	-	-	**3,211**	3,211	3,215	(4)	*0.0%*
Campaigns	9	9	9	9	9	9	9	24	14	87	382	196	**768**	190	67	123	*-100.0%*
Nursing & AHP	17	17	20	24	130	16	34	199	15	204	155	74	**906**	677	158	518	*76.6%*
Safeguarding Board	-	-	-	-	-	-	-	-	-	-	-	10	**10**	-	-	-	*0.0%*
Centre for Connected Health	40	40	40	8	-	-	-	-	-	9	-	-	**120**	120	65	54	*45.5%*
Other	-	-	-	-	-	-	-	-	-	-	-	(909)	**(909)**	0	(440)	440	*100.0%*
Total Projected PHA Direct Expenditure	**227**	**3,607**	**1,842**	**2,418**	**3,780**	**2,533**	**5,757**	**7,363**	**2,630**	**5,171**	**4,333**	**3,845**	**43,508**	**35,329**	**32,088**	3,241	
Cumulative variance (%)																***9.17%***	
Actual Expenditure	**570**	**2,784**	**2,007**	**1,380**	**3,097**	**2,563**	**5,214**	**5,702**	**1,511**	**7,260**	**-**	**-**	**32,088**				
Variance	**(343)**	**824**	**(165)**	**1,038**	**683**	**(30)**	**543**	**1,661**	**1,119**	**(2,089)**			**3,241**				

	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
Total Projected Ringfenced PHA Direct Expenditure	**-**	**3**	**19**	**501**	**146**	**(24)**	**373**	**156**	**415**	**76**	**79**	**3,276**	**5,021**	**1,665**	**1,695**	**(29)**
-1.77%																
Actual Expenditure	**-**	**170**	**55**	**299**	**24**	**68**	**279**	**321**	**292**	**187**			**1,695**			
Variance	**-**	**(167)**	**(35)**	**202**	**122**	**(92)**	**94**	**(165)**	**123**	**(111)**			**(29)**			

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

The year-to-date position shows a £3.2m surplus, which is mainly due to (i) Lifeline funding (£1.9m) remaining in the Health Improvement budget but which is due to transfer to BHSCT, and (ii) an underspend on Nursing activity (£0.5m). Budget managers are being reminded to closely monitor expenditure against profile to ensure full spend by year-end. The Other line shows a balancing adjustment to reflect the Administration underspend having been issued to Programme budgets to allow PHA to achieve its breakeven obligation for the year.

Non-Trust Ringfenced funds are showing a small overspend at the end of month 10. A breakeven position is anticipated at year end based on an assumed allocation retraction of £1.8m from Confidence and Supply Transformation Funds.

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	3,536	2,523	10,904	173	319	484	**17,939**
Goods & Services	168	1,269	376	35	54	246	**2,149**
Savings target				(500)			**(500)**
Total Budget	**3,704**	**3,792**	**11,281**	**(292)**	**373**	**730**	**19,588**
Budget profiled to date							
Salaries	2,813	2,101	9,069	144	266	403	**14,796**
Goods & Services	133	978	305	(387)	47	184	**1,260**
Total	**2,946**	**3,080**	**9,373**	**(243)**	**313**	**587**	**16,056**
Actual expenditure to date							
Salaries	2,644	2,014	8,732	95	278	288	**14,050**
Goods & Services	185	851	323	1	43	173	**1,576**
Total	**2,829**	**2,865**	**9,055**	**96**	**321**	**461**	**15,626**
Surplus/(Deficit) to date							
Salaries	169	88	337	50	(12)	115	**747**
Goods & Services	(52)	127	(19)	(388)	4	11	**(317)**
Surplus/(Deficit)	**117**	**215**	**318**	**(339)**	**(8)**	**126**	**430**
Cumulative variance (%)	*3.99%*	*6.98%*	*3.39%*	*139.31%*	*-2.42%*	*21.45%*	***2.68%***

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 surplus which has been generated by a number of vacancies during the year. Senior management continue to monitor this closely in the context of PHA's obligation to achieve a breakeven position for the financial year. SBNI budget is ringfenced and any underspend will be returned to DoH prior to year end.

January 2019

Public Health Agency
2017-18 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	6,890	4,261	-	**11,151**	5,742	3,200	-	**8,942**
Expenditure								
Capital Expenditure - Trusts	6,890			**6,890**	5,742			**5,742**
Capital Expenditure - PHA Direct		4,261		**4,261**		2,229		**2,229**
	6,890	4,261	-	**11,151**	5,742	2,229	-	**7,971**
Surplus/(Deficit) - Capital	-	-	-	-	-	971	-	**971**
Cumulative variance (%)					*0.00%*	*30.33%*	*0.00%*	***10.85%***

PHA has received a Capital budget of £11.2m in 2018-19, most of which relates to Research & Development projects in Trusts and other organisations. A surplus of £1.0m is shown for the year to date, and a breakeven position is anticipated for the full year.

PHA Prompt Payment

Prompt Payment Statistics

	January 2019 Value	January 2019 Volume	Cumulative position as at 31 January 2019 Value	Cumulative position as at 31 January 2019 Volume
Total bills paid (relating to Prompt Payment target)	£5,070,026	553	£39,009,985	4,449
Total bills paid on time (within 30 days or under other agreed terms)	£4,988,824	512	£38,384,482	4,203
Percentage of bills paid on time	**98.4%**	**92.6%**	**98.4%**	**94.5%**

Prompt Payment performance for the year to date shows that on value the PHA is achieving its 30 day target of 95.0%, although the volume performance has deteriorated slightly in January. 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 93.4% by value for the year to date, which significantly exceeds the 10 day DoH target for 2018-19 of 60%.

HSC Public Health Agency

minutes

Title of Meeting	Meeting of the Public Health Agency Governance and Audit Committee
Date	12 December 2018 at 10.00am
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

Present

Mr Leslie Drew	-	Chair
Mr John Patrick Clayton	-	Non-Executive Director
Ms Deepa Mann-Kler	-	Non-Executive Director

In Attendance

Miss Rosemary Taylor	-	Assistant Director, Planning and Operational Services
Mr Paul Cummings	-	Director of Finance, HSCB
Ms Jane Davidson	-	Head Accountant, HSCB
Mrs Catherine McKeown	-	Internal Audit, BSO
Mr David Charles	-	Internal Audit, BSO
Ms Anu Kane	-	Northern Ireland Audit Office
Mr Robert Graham	-	Secretariat

Apologies

Mr Joseph Stewart	-	Non-Executive Director
Mr Ed McClean	-	Interim Deputy Chief Executive / Director of Operations

		Action
55/18	**Item 1 – Welcome and Apologies**	
55/18.1	Mr Drew welcomed everyone to the meeting.	
55/18.2	Apologies were noted from Mr Joseph Stewart and Mr Edmond McClean.	
56/18	**Item 2 - Declaration of Interests**	
56/18.1	Mr Drew asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.	

57/18	**Item 3 – Minutes of previous meeting held on 4 October 2018**
57/18.1	The minutes of the previous meeting, held on 4 October 2018 were approved as an accurate record of that meeting, subject to one amendment, a statement, “Mr Cummings confirmed that this was the case” was inserted in paragraph 50/18.8 in response to a question from Mr Stewart.
58/18	**Item 4 – Matters Arising**
	47/18.1 Internal Audit Review of Shared Services
58/18.1	Mrs McKeown gave members an update on the most recent audit of Payroll Shared Services. She advised that the level of assurance remains “limited” as the majority of the previous recommendations have not been fully implemented. She explained that 5 of the 26 recommendations have been fully implemented, with the remaining 21 partially implemented, with 5 of those having had their target implementation date changed.
58/18.2	Mrs McKeown said that 1 of the 5 recommendations that had been fully implemented was a Priority One recommendation. She said that there has been some progress and there is a lot of work ongoing.
58/18.3	Ms Mann-Kler asked what the timeline is for the implementation of all of the recommendations. Mrs McKeown said that she did not have this information to hand, but she advised that this area is audited twice a year, and the end-year audit will be commencing in January 2019. Ms Mann-Kler asked if there were any new issues, but Mrs McKeown said that this report was focusing on the implementation of previous recommendations, and that the audit that will commence next month is a full audit.
58/18.4	Mr Drew acknowledged that while the issues highlighted may not impact on PHA as much as on other HSC bodies the PHA GAC are concerned about the delay in addressing the issues raised in previous audits. Mr Cummings agreed with Mr Drew and expressed his concerns around the system’s ability to manage the pay award.
	50/18.3 NIAS PPI Self-Assessment
58/18.5	Miss Taylor advised that Mrs Hinds had confirmed that the self-assessment is due to be received from the Northern Ireland Ambulance Service by 31 March 2019.

	51/18.3 Update on Fraud Case	
58/18.6	Mr Cummings confirmed that he had sent an update on this to the PHA Chair.	
	52/18.8 Transformation Funding	
58/18.7	Mr Clayton asked about campaigns. Miss Taylor explained that two PHA campaigns, regarding stroke and mental health, would be funded from in-year slippage while a third campaign, regarding AMR, would be funded from Transformation funding. Mr Clayton sought clarification regarding the campaign which is being funded from Transformation and it was agreed that there would be an update on this at the PHA Board meeting on 20 December.	Mr McClean
59/18	**Item 5 – Chair's Business**	
59/18.1	The Chair acknowledged receipt of the correspondence from the Northern Ireland Audit Office regarding the contracting out of external audit services. He asked whether the process would be completed within the designated timeframe.	
59/18.2	Ms Kane said that the process is on schedule and that a meeting is taking place today regarding this. She added that when the contract is awarded, it will be for a period of five years. Ms Mann-Kler asked what the rationale was for the change. Ms Kane explained that the successful bidder will be working across all HSC bodies, rather than having a number of organisations working in that sector.	
59/18.3	Mr Clayton asked if there would be an impact on the planning process. Ms Kane acknowledged that this may be slightly delayed.	
60/18	**Item 6 – Corporate Governance** *Corporate Risk Register (as at 30 September 2018) [GAC/45/12/18]*	
60/18.1	Miss Taylor presented the updated Corporate Risk Register for the period up to 30 September 2018, and advised that two new risks had been added, one relating to EU Exit, and the other relating to the difficulties in filling vacant public health consultant posts. She added that no risks had been deleted, and that none of the risk ratings had been amended.	
60/18.2	Ms Mann-Kler asked about the recent malware issue. Miss Taylor explained that the issue was confined to one GP practice, and was contained.	

60/18.3	Ms Mann-Kler asked about the impact of the number of vacant consultant posts on PHA break-even position, and what the issues are in terms of attracting candidates. Miss Taylor said that Dr Mairs would be best placed to respond, but advised that there would be no newly graduated public health trainees until December 2019. She added that Dr Mairs is speaking to the Department of Health regarding this situation. Ms Mann-Kler asked if this will be brought to the PHA Board for discussion as it is a major concern. Miss Taylor said that a piece of work is currently being undertaken looking at all vacancies across the organisation.
60/18.4	Ms Mann-Kler asked at what stage there will be a line drawn regarding what could be spent as part of Transformation funding this year. Mr Cummings advised that the 7 January is the cut-off point.
60/18.5	Ms Mann-Kler asked about the Procurement Board and the involvement of a Non-Executive Director on that group. Miss Taylor explained that the Procurement Board is an internal group. Mr Drew said that there was some confusion as the second group had been set up to look at how the backlog of procurements could be cleared, and that he would speak to the Board Chair about this. Miss Taylor said that this is a short-term task and finish group set up with the purpose of looking at the current procurement plan, where the delays are, how these could be managed and if any processes could be improved. She added that the Group has input from PHA, HSCB and PALS, and she hoped that it would finish its work by the end of January.
60/18.6	Mr Clayton asked about EU Exit, and particularly issues about the status of non-UK citizens working in Northern Ireland. Miss Taylor said that there is not a huge impact for PHA, but that she sits on a regional EU Exit group facilitated by the Department of Health, and there is HR representation on that group. She added that PALS has undertaken work in relation to contracts, but although contingency planning is being done on the basis of a “no deal”, there are many unknowns. Mr Clayton asked if PHA would be refunding the £65 EU Settlement Scheme fee, and Miss Taylor confirmed that this was the case.
60/18.7	The Chair asked about the gap analysis that is to be undertaken as part of the mitigation of the cyber security risk. Miss Taylor said that the regional HSC Cybersecurity Programme Board had commissioned an external review and report, and that a number of working groups have been set up to take forward recommendations, including training and awareness for staff. She added that a Project Manager has

	been employed by BSO specifically for this work.
60/18.8	Members noted the Corporate Risk Register.
61/18	**Item 7 – Finance – Fraud Liaison Officer Update Report**
61/18.1	Mr Cummings provided members with an update on the current alleged fraud case. He said that a meeting had taken place on Monday as PHA are concerned with a lack of progress, and that a letter will be issued to the organisation shortly. He added that PHA has increased its monitoring and is assured that it is getting the required outputs, however the concerns relate to how the organisation is run.
61/18.2	The Chair asked if PHA has a contingency plan. Mr Cummings said that options are under consideration.
61/18.3	Members noted the update from the Fraud Liaison Officer.
62/18	**Item 8 – Internal Audit**
	Progress Report [GAC/46/12/18]
62/18.1	Mrs McKeown presented the latest Internal Audit Progress report. She advised that there is one audit to report on, which relates to management of contracts within the community and voluntary sector. She said that a satisfactory level of assurance was being given to the management of contracts, but a limited assurance in terms of the procurement.
62/18.2	Mrs McKeown advised that 190 contracts, with a value of £8.7m, are being rolled forward. In terms of other findings, she noted that while performance information is being received, it is not being verified, and in terms of the Lifeline contract, she said that a SLA is not yet in place with the Belfast Trust. She stated that management have accepted all of the recommendations.
62/18.3	Mr Clayton asked whether the issue relates to the fact that the contracts are rolling forward. Mrs McKeown said that the concern is that the contracts are not going through a procurement exercise. Ms Mann-Kler asked if the PHA is adequately resourced in this area. Miss Taylor said that the short life working group is looking at this. She added that not every contract needs to go through procurement, some may be dealt with through grants and others through IPTs with Trusts. She added that a key issue is the need for earlier pre-procurement planning, as well as the actual procurement.
62/18.4	The Chair passed on Mr Stewart's concern about the follow

	up of the declarations that the financial controls and policies are in place. Miss Taylor said that reminders have been sent to staff to have this followed up. The Chair noted that the target date for implementation of this recommendation is not until March 2019. Miss Taylor said that verification is an issue across the whole of the HSC and a paper is being developed to take forward a proportionate approach, but highlighted issues around accessing personal data.
62/18.5	Members noted the update from Internal Audit.
63/18	**Item 9 – Information Governance Strategy [GAC/47/12/18]**
63/18.1	Miss Taylor presented the updated PHA Information Governance Strategy and said that this sets out PHA's commitment to good information governance and compliance with legislation. She said that there are no major changes to the policy, the key ones being that references to DHSSPS are now DoH, and references to GDPR and the Data Protection Act 2018.
63/18.2	Mr Clayton asked about equality monitoring data and if this is impacted by the new GDPR regulations. Miss Taylor said that equality data is given by consent.
63/18.3	Mr Drew noted the concerns expressed at the last meeting regarding attendance at the Information Governance Steering Group meetings. Miss Taylor advised that the Group has not met since, but that its next meeting is due to take place in January.
63/18.4	Members **APPROVED** the Information Governance Strategy which will be brought to the PHA Board meeting on 20 December.
64/18	**Item 10 – Direct Award Contracts – Report for 1 April to 30 September 2018 [GAC/48/12/18]**
64/18.1	Miss Taylor explained that an update on Direct Award Contracts (DACs) is brought to the Committee twice a year. She said that for the period from April to September 2018 a total of 13 applications for DACs, 11 of which relate to procurement of goods and services, and 2 relating to social care procurement.
64/18.2	Miss Taylor advised that the 13 DACs had been RAG rated by PALS and 1 has been rated "amber" and the remaining 12 rated as "green". She explained that there are two entries relating to "safeTALK" because previously this had been classed as goods and services, but following a review by

	PALS, it is now classed as social care procurement which has a higher threshold.
64/18.3	Ms Mann-Kler asked about the two campaigns that are listed. Mr Cummings explained that they are targeted campaigns with a limited catchment.
64/18.4	Members noted the update on Direct Award Contracts.
65/18	**Item 11 – Joint PHA/HSCB/BSO Annual Report on Emergency Preparedness [GAC/49/10/18]**
65/18.1	The Chair welcomed Ms Mary Carey to the meeting to present the Annual Report on Emergency Preparedness.
65/18.2	Ms Carey said this Report relates to the period from 1 April 2017 to 31 March 2018. She added that the Report followed an agreed template. She advised that the Report gave an overview of the incident responses during that period and also gave details on training that has been undertaken with senior staff during the last year.
65/18.3	Mr Clayton said that this was an interesting report and he wished to raise two issues, the first of which related to cross border arrangements, given the uncertainty over Brexit. Ms Carey said that there is work ongoing and that the group she is a member of will continue to meet and carry on its work within its existing MOUs and SLAs. She added that international health regulations will continue to apply. Mr Clayton asked whether the communications issues which had been highlighted following Storm Ophelia had been resolved. Ms Carey said that a lot of work had been done, and there is now clarity in terms of where the responsibility for communications lies.
65/18.4	Mr Drew raised concerns about the role of the Civil Contingencies Group, and he said that he did not feel reassured on reading the report that if another emergency planning issue were to arise that the Group would be well placed to deal with it. Ms Carey said that the debrief exercise following Storm Ophelia had highlighted areas where improvements needed to be made, including clarity on the role of the Civil Contingencies Group, and that there has been significant progress made. Mr Drew asked if all of the actions emanating from the debrief exercise had been completed, and Ms Carey confirmed that they had been.
65/18.5	Mr Drew asked when the report for the period up to 31 March 2019 would be available. Ms Carey said that this report should be available to come to the Governance and Audit

	Committee in September as Trusts had a deadline of June to send in their individual reports. She explained that there had been issues in the preparation of the previous report, but that timescales should be shorter this year.
65/18.6	Members noted the report on Emergency Planning.
66/18	**Item 12 – Any Other Business**
66/18.1	Ms Kane tabled the Northern Ireland Audit Office's Public Reporting Programme which outlines the areas of work of the NIAO during the next year.
67/18	**Item 13 – Date and Time of Next Meeting** *Thursday 28 February 2019 at 10am* *Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast.* Signed by Chair: **Leslie Drew** Date: 28 February 2019

HSC Public Health Agency

item 9

Title of Meeting	PHA Board Meeting
Date	21 March 2019
Title of paper	PHA Business Plan 2019/20
Reference	PHA/03/03/19
Prepared by	Rosemary Taylor
Lead Director	Ed McClean
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The PHA is required to produce an annual business plan.

The draft Plan is being presented to the PHA Board for approval prior to submission to the Department of Health.

2 Background Information

The PHA's current Corporate Plan runs for the period 2017/21. This is the third annual Business Plan derived from that Plan.

3 Key Issues

The draft Annual Business Plan has been developed in line with the PHA's five key outcomes, as set out in the Corporate Plan:

- All children and young people have the best start in life.
- All older adults are enabled to live healthier and more fulfilling lives.
- All individuals and communities are equipped and enabled to live long healthy lives.
- All health and wellbeing services should be safe and high quality.
- Our organisation works effectively.

An outline of the Plan was presented to the PHA Board at a workshop on 17 January 2019 and the detailed draft Plan was subsequently circulated to members. It was

also shared with the Department of Health Sponsor Branch. A number of comments were received back from the DoH; these were shared with relevant staff to review and amend the Plan where appropriate.

4 Next Steps

The draft Annual Business Plan is currently being equality screened; this includes identifying the actions that will require equality screening as part of their implementation.

Once approved by the Board the Plan will be forwarded to the Department of Health for approval and following approval by the Department will be published on the PHA website. The Board will receive updates on progress against the corporate objectives on a six-monthly basis.

HSC Public Health Agency

Annual Business Plan 2019–2020

PUBLIC HEALTH AGENCY ANNUAL BUSINESS PLAN 2019/20

INTRODUCTION

The Public Health Agency (PHA) Annual Business Plan sets out in more detail what the PHA will do to help achieve the outcomes identified in the PHA Corporate Plan. The Annual Business Plan 2019/20 is therefore the action plan for the third year of the PHA Corporate Plan 2017–2021. As such, it incorporates actions that the PHA will take in line with the draft *Programme for Government 2016–2021* (PFG), *Making Life Better* (MLB) and *Community planning* as well as *Health and Wellbeing 2026: Delivering Together* and the transformation agenda arising from this.

While the Annual Business Plan does not set out all the actions that the PHA will take during this year, it reflects the key actions from all functions and directorates across the five strategic outcomes. Our commitment to work to reduce health inequalities is at the core of the PHA Corporate Plan 2017–2021, and is central to the actions set out in this Annual Business Plan for 2019/20.

Supporting and equipping people to live a long, healthy life is central to a number of our strategic outcomes. In working to achieve this, we will continue to support the Department of Health (DoH) during the year in the delivery of the draft PFG delivery plans.

There are, however, many challenges as we enter 2019/20. The financial outlook continues to be uncertain and it is likely that budgets will remain constrained during this coming year and beyond; reform of the HSC is ongoing, with the anticipated date for implementation of the new structures now 1 April 2021; and, at the time of writing, the implications of the UK leaving the EU are still unclear. While this Annual Business Plan sets out the proposed actions for 2019/20, it must be recognised that these may be subject to change in the light of budget allocations and other pressures and demands that may emerge. The impact of these will be reviewed as we go through the year.

Working in partnership and collaborating is central to how we work. While the actions in the Annual Business Plan have one designated lead officer, much of the work is undertaken by staff from our different directorates and functions working together, and often with colleagues from the Health and Social Care Board (HSCB) or other HSC organisations. Furthermore, we seek to include, involve and work with a wide range of appropriate stakeholders, including service users and carers as well as other statutory and non-statutory organisations where possible, to seek the best outcomes.

As stated in the PHA Corporate Plan 2017–2021, the PHA is seeking to move to a more outcomes based approach. While acknowledging that we are still at an early stage and that there is much more to be done, this plan seeks to reflect a more outcomes based approach. It is therefore structured not only to set out the actions for this year, but also to identify some of the anticipated impacts, considering ‘who will benefit’, and ‘what difference will it make’, not only within 2019/20, but in the longer term, where applicable.

Progress against the actions will be monitored and reported on a twice yearly basis.

1: All children and young people have the best start in life

During the course of the PHA Corporate Plan 2017–2021 we will work to:

- improve the health and wellbeing of all children and young people by strengthening universal services, building a sustainable workforce and embedding early intervention approaches;
- introduce and develop antenatal and new-born population screening programmes in line with the recommendations of the national and local screening committees;
- promote and secure the best outcomes for children and young people through implementation of a range of early years evidence-based/informed programmes, and by our contribution to international research on effective practice;
- implement a range of interventions and programmes that support parents and carers to provide a safe and nurturing home environment, and address issues that adversely impact on children and young people;
- protect the health of children and young people through vaccination and immunisation programmes and working with nurseries, pre-schools and schools to prevent spread of infection in those settings.

	During 2019/20 we will:	**Anticipated impact** **Who will benefit and/or what difference will it make?**	**Lead Officer**
1.1	Continue to implement the Breastfeeding Strategy through the Breastfeeding Strategy Implementation Steering Group (BSISG) and Action Plan, in particular seeking new evidence based approaches to promote the action plan during 2019-2020.	Benefiting pregnant women, new mothers, infants and their families, through an increase in breastfeeding attempted and discharge rates and increased support for breastfeeding in public.	Dr Mairs

	During 2019/20 we will:	**Anticipated impact** **Who will benefit and/or what difference will it make?**	**Lead Officer**
1.2	Continue to Implement the Infant Mental Health Action Plan, focusing on workforce training and the establishment of a new service team in Belfast providing child psychotherapy support to families with 0–3s with attachment problems.	Improved outcomes for children and their families, through increased capacity, skills and levels of understanding of neurological and emotional development and attachment theory during pregnancy and in the first three years of life, for parents and early years workforce and staff involved in perinatal care.	Dr Mairs
1.3	Lead implementation and evaluation of Early Intervention Transformation Programme (EITP) work streams 1 and 2.	Improved outcomes for children and young people 0–18 years of age and their families within the catchment areas, through: • improved parental emotional wellbeing • increased parental participation/ involvement in children's education/training/ employment • improved family relationships • improved parenting skills/capacity.	Dr Mairs
1.4	Lead and co-ordinate the provision of health advice provided for children undergoing Statutory Assessment.	Improved outcomes and enhanced access for children with identified Special Educational Needs (SEN), through: • integrated support for children with SEN • standardisation of practice.	M Hinds
1.5	Lead the development, implementation and evaluation of a transformational approach to improve health outcomes for school aged Looked After Children.	Improved outcomes for school aged looked after children/ young people and their families/carers, through: • standardised approaches • improved service provision and reducing inequalities at an earlier stage in the lives of young people • improved opportunities to engage with looked after young people and their families • opportunity to improve partnership work with education colleagues.	M Hinds

	During 2019/20 we will:	Anticipated impact Who will benefit and/or what difference will it make?	Lead Officer
1.6	Continue to implement the Maternity Strategy through the Maternity Strategy Implementation Group (MSIG) including progressing work on the 'saving babies lives' care bundle, antenatal and postnatal care pathways and peri-natal mental health.	Improve health and wellbeing of pregnant women, and provide the best start in life for all babies; Increased capacity within the workforce in order to provide a more comprehensive service for those in need of PNMH care.	M Hinds
1.7	Maintain and improve uptake targets for seasonal influenza vaccinations for children aged 2–4 years and the primary school programme set by DoH.	Providing protection for children and young people against seasonal influenza, which will in turn protect the wider population.	Dr Mairs
1.8	Use research funding programmes (CHITIN, NIHR, EITP, Research Fellowships) to generate new knowledge on effective early years practice which will impact children and young people	Enable access to novel interventions; Provide an evidence-base for 'what works'; Embed research in practice, sustaining the workforce and improving healthcare and social care performance.	Dr Mairs
1.9	Implement expansion of the Newborn Bloodspot Screening Programme to cover four additional inherited metabolic diseases.	Earlier detection and treatment of these inherited metabolic diseases to prevent adverse outcomes; Reduced morbidity and disability in those affected.	Dr Mairs
1.10	Develop and promote a range of communications aimed at helping parents and carers recognise and manage issues relating to the health and wellbeing of children and young people.	Better health literacy around children's health needs amongst adults and carers, leading to improved long term outcomes for children, young people and families.	E McClean

	During 2019/20 we will:	**Anticipated impact** **Who will benefit and/or what difference will it make?**	**Lead Officer**
1.11	Develop a regional protocol for the response to, and review of, sudden deaths in infancy; and take forward as a coordinated approach to monitoring such deaths and providing relevant information to health and social care staff and the public.	Benefit parents, families and infants through an increased knowledge of the risk factors for sudden death in infancy with the aim of decreasing the number of preventable deaths (which will be monitored).	Dr Mairs

2: All older adults are enabled to live healthier and more fulfulling lives

During the course of the PHA Corporate Plan 2017–2021 we will work to:

- develop and implement multi-agency healthy ageing programmes to engage and improve the health and wellbeing of older people;
- promote appropriate intervention programmes within all settings to prevent, detect and manage mental ill health and its consequences;
- promote inclusive, inter-generational physical and mental health messages and initiatives that enable longer, healthier and more fulfilling lives;
- protect the health of older adults through immunisations and screening;
- support programmes and initiatives, including research, e-health and technology-based approaches, that promote independence and self-management.

	During 2019/20 we will:	**Anticipated impact** **Who will benefit and/or what difference will it make?**	**Lead Officer**
2.1	Establish a regional Age Friendly Network and implement, with partners, the WHO Age Friendly Communities model in local government districts in co-operation with DFC 'Active Ageing Strategy'	Support for the implementation and co-ordination of 'Age Friendly' in each council area, through shared learning and resources, and provision of a clear framework which will facilitate local stakeholders to come together, so that local council areas will: • foster health and wellbeing and the participation of people as they age • be accessible, equitable, inclusive, safe and secure, and supportive • promote health and prevent or delay the onset of disease and functional decline • provide people-centred services and support to enable recovery or to compensate for the loss of function so that people can continue to do the things that are important to them.	Dr Mairs
2.2	Continue to develop and implement a regional arts programme to enhance the wellbeing and quality of life of older people across Northern Ireland through	Increase opportunities for older people to engage with the arts, promoting the development of positive relationships between people from different backgrounds and experiences and enabling older people to feel more connected to their local communities and wider society;	Dr Mairs

	During 2019/20 we will:	Anticipated impact Who will benefit and/or what difference will it make?	Lead Officer
	their active engagement and increasing access to participation in high quality arts activities, and in particular in 2019/20 work in partnership with the Institute of Public Health to further develop research evidence and apply to practice and delivery of arts and health programmes for older people.	Decreased feelings of exclusion, isolation, and loneliness amongst older people in society.	
2.3	Continue to lead the work to develop a frailty model for Northern Ireland, including developing and leading a Frailty Network, involving PHA, HSCB and external stakeholders, and testing a frailty model that will include: • falls • continence • mild cognitive impairment • mental wellbeing (including social isolation) • polypharmacy	Earlier identification of frailty, with a focus on prevention; Reduction in the percentage of older people becoming moderate to severely frail.	M Hinds
2.4	Lead and co-ordinate the implementation of the enhancement to Home based Intermediate care developed from National Audit of Intermediate Care audit 2017 findings	Benefit older people, carers and the wider HSC system; Increased home based rehabilitation capacity; Better patient outcomes; Contribute to transforming unscheduled care system pressures.	M Hinds

	During 2019/20 we will:	Anticipated impact Who will benefit and/or what difference will it make?	Lead Officer
2.5	Support the provision of high quality care in the nursing home sector through a programme of education and in-reach activities.	Improved quality of life for people living in Nursing and Residential Care homes, across Northern Ireland; Enhanced confidence and competence for care home staff to manage complex needs, resulting in more appropriate use of out of hour's services and reducing avoidable admission to hospital.	M Hinds
2.6	Continue to enhance the vaccination programmes to protect the health of older adults such as flu and shingles.	Increased awareness among older people of the vaccines available via the various media campaigns; Increased uptake of immunisations, helping to prevent illness and disease in older people.	Dr Mairs
2.7	Use research funding programmes (CHITIN, NIHR, commissioned research, Research Fellowships etc) to generate new knowledge on effective care and practice for older adults.	Enable access to novel interventions; Provide an evidence-base for 'what works' in terms of effective care and practice for older adults.	Dr Mairs
2.8	Influence future practice and policy in the care of older people, through the launch of reports and leaflets from commissioned research in dementia and through follow-up knowledge exchange processes with key stakeholders.	Embed research in practice, sustaining the workforce, improving routine care and providing an evidence-base of knowledge on dementia care.	Dr Mairs
2.9	Prepare for introduction of FIT testing within the bowel cancer screening programme.	Increased uptake, particularly in men and those from more deprived populations; Improved accuracy of screening test results, leading to an increase in early detection and reduced morbidity and mortality from bowel cancer.	Dr Mairs

	During 2019/20 we will:	Anticipated impact Who will benefit and/or what difference will it make?	Lead Officer
2.10	Continue to lead work with HSCB and Trusts to complete the delivery of Phase Two of the Dementia e-Health and Data Analytics Pathfinder Programme for Northern Ireland including: • the implementation of 'My care record' patient portal; • delivery of a dementia apps library; • a number of dementia data analytics projects	Better access for people with dementia and their carers (in the first instance) to information relating to their personal health and care, and to trusted information relating to their health conditions; People with dementia and their carers will have access to a variety of apps that will support them in managing their condition; Improved capacity and capability in the use of data analytics across the HSC to better understand and plan for dementia services in the future.	E Ritson
2.11	Continue to seek opportunities to develop and utilise innovative practices /technologies to improve health and wellbeing working collaboratively with HSCNI and other stakeholders.	Through the delivery of existing and new EU projects and other innovation tools like SBRI we will Improve knowledge and learning of healthcare professionals of the use of connected health tools that can tackle problems like frailty and social isolation.	E Ritson

3: All individuals and communities are equipped and enabled to live long healthy lives

During the course of the PHA Corporate Plan 2017-2021 we will work to:

- ensure people are better informed about health matters through easily accessible up-to-date information and materials;
- introduce and develop adult population screening programmes in line with the recommendations of the national and local screening committees and engage with primary care, pharmacies and relevant voluntary and community groups to promote specific screening programmes in local communities;
- develop and implement with partners a range of coordinated actions across communities and an range of settings to improve mental health and wellbeing and reduce the level of suicide;
- develop and implement a wide range of multi-agency actions across all settings to promote healthy behaviours including promotion of healthy weight and physical activity; improve sexual health; reduce harm from alcohol and drug misuse; reduce home accidents; and prevent skin cancer;
- protect the health of individuals and communities through timely responses to outbreaks and emergency planning, implementing immunisation programmes and promoting key health protection messages;
- support research on innovative approaches to prevention and care.

	During 2019/20 we will:	**Anticipated impact** **Who will benefit and/or what difference will it make?**	**Lead Officer**
3.1	Lead and coordinate regional implementation of the Making Life Better (MLB) Public Health Framework, including introduction of the refreshed regional arrangements and exploring how leadership within HSC can be	Greater emphasis on early intervention and prevention; Improved understanding of healthier choices which in turn will lead to healthier outcomes; More effective collaboration at a strategic level to address the greatest inequalities; In the longer term, the inequalities gap will reduce, life expectancy will improve and there will be improvements in health outcome indicators across a range of health and	Dr Mairs

	During 2019/20 we will:	Anticipated impact Who will benefit and/or what difference will it make?	Lead Officer
	strengthened to operationally promote MLB during 2019/20.	social wellbeing gauges.	
3.2	Continue to participate in the 11 local government community planning partnerships, and work with community planning partners to take forward agreed actions to improve health and wellbeing through the community planning action plans.	Coordinated HSC and public health input to the development of action plans and their implementation, based on local needs in each local council; Improved health and wellbeing through tackling local issues identified in the community planning process and working with the community planning partnership.	E McClean
3.3	Progress and report on PHA-led PfG priorities as outlined in the draft plan and the Outcomes Delivery Plans	This will contribute to the implementation of PfG and thus improved health and wellbeing for the population and will increase the evidence base on the impact of initiatives.	All Directors
3.4	Develop and implement the actions flowing from the Transformation workstream on the expansion of community development approaches and explore how the learning from the community development framework will inform the structure of procurement specifications.	Build community development infrastructure and capacity. The learning from this process is designed to inform the future commissioning of community development services across all government departments and help ensure a more coherent approach in future.	Dr Mairs
3.5	Lead and implement programmes which tackle poverty (including fuel, food and financial poverty) and maximise access to benefits, grants and a range of social inclusion services for vulnerable groups.	Improved health and wellbeing outcomes, including a reduction in health inequalities for vulnerable target groups and at risk individuals supported by PHA interventions to alleviate some of the impacts of fuel, food or income poverty.	Dr Mairs

	During 2019/20 we will:	Anticipated impact Who will benefit and/or what difference will it make?	Lead Officer
3.6	Implement the multi-agency obesity prevention action plan with particular focus on: • development of early years obesity prevention programme; • roll out of revised Physical Activity Referral Scheme; • implementation of minimum Nutritional Standards in HSC; • implementation of revised Nutritional Standards for school meals.	Children and adults, in a range of settings, will be supported with regard to healthy eating, weight management and physical activity. In particular: • Families will be supported to help their young children maintain a healthy weight. • Obese adults with a co-morbidity will be supported to be more physically active. • Healthier food and drink choices will be available to staff and visitors in all HSC settings. • Food and drinks served in schools will meet revised standards on saturated fat, salt and sugar.	Dr Mairs
3.7	Explore the future delivery models for specialist drugs and alcohol services, in particular, the take-home Naloxone programme and the needle and syringe exchange services.	Reduced fatalities from opioid overdose; Increased targeting of opioid misusers who are not currently engaged with a drug treatment service; Increased safe disposal of used injecting equipment; Improved health outcomes for some of the most vulnerable groups in NI; Reduced onward transmission of BBVs.	Dr Mairs
3.8	Lead on the planning and re-procurement of Alcohol and Drug services that will allow for the implementation of a range of programmes and services to deliver and support outcomes within the New Strategic Direction for Alcohol and Drugs.	Provision of appropriate services in communities, for the benefit of substance misusers, communities and service providers working in communities.	Dr Mairs

	During 2019/20 we will:	Anticipated impact Who will benefit and/or what difference will it make?	Lead Officer
3.9	Continue to implement the Ten Year Tobacco Control Strategy in Northern Ireland (2012–2020) proactively targeting young people, pregnant smokers and disadvantaged adults. Following the review of the Tobacco Strategy we will review our direction and focus in line with the findings.	Decrease in smoking prevalence in NI; Improvement in all aspects of the health of the population, in particular in young people, pregnant women, and disadvantaged adults where smoking or exposure to smoke is impacting on their health.	Dr Mairs
3.10	Lead on the planning and procurement of Protect Life services that will allow for the implementation of a range of programmes to promote mental and emotional wellbeing and prevent suicide.	Provision of appropriate services in communities; Improvement in mental health and wellbeing, and reduction in the number of suicides.	Dr Mairs
3.11	Lead the development of healthier workplaces in the HSC and other sectors, working with other HSC organisations, through exploring the development of online toolkits/portal, the development of a charter and exploring options to manage succession planning for an ageing workforce.	Improved staff wellbeing, through increased access to health and wellbeing support for HSC staff in the workplace.	Dr Mairs
3.12	Continue to provide strategic direction for the development of a sustainability programme for Recovery Colleges, and carry out an independent regional evaluation of Recovery Colleges during	To benefit people with lived experience of mental health, their carers and staff working within mental health services across all Trust areas; Increased visibility of recovery college network across Northern Ireland; Increased knowledge on impact of the recovery college model on mental health and wellbeing.	M Hinds

	During 2019/20 we will:	Anticipated impact Who will benefit and/or what difference will it make?	Lead Officer
	2019/20 to inform next phase of development.		
3.13	Provide strategic leadership and coordination for the evaluation of the Regional HSC Hospital Passport for people with learning disabilities.	Evaluation report will include best practice guidelines for the continued roll out of the regional hospital passport; Improve the safety and quality of healthcare for people with a learning disability.	M Hinds
3.14	Informed by the review of Tier 3 Drugs and Alcohol services, ensure there is regional consistency regarding service provision with seamless transitions of care and provide direction on the evidence-based treatment models required to provide the most effective and efficient use of resources to address system pressures.	Benefit drugs and alcohol service users; The review will reduce variation in practice, standardise professional thresholds and provide advice regarding patient flow.	M Hinds Dr Mairs
3.15	Informed by the review of acute mental health service provide direction on the treatment models required to provide evidence based treatments/interventions and guide the most effective and efficient use of resources to address system pressures.	Improved care for those requiring acute mental health care, through a more standardised model of future service delivery for the overall HSC, encompassing the ideal structure, process, outcome.	M Hinds Dr Mairs

	During 2019/20 we will:	Anticipated impact Who will benefit and/or what difference will it make?	Lead Officer
3.16	Continue to lead the implementation of the Regional Palliative Care work plan, including work with primary care, out of hours specialist advice and rapid response service.	It will improve the quality of life for those with palliative and end of life care needs and the experience of those important to them.	M Hinds
3,17	Lead the implementation of an integrated Communication Advice Service	Better patient outcomes, through increased access to Augmentative and Alternative Communication (AAC) devices to improve service user communication needs.	M Hinds
3.18	Continue to take forward the strategic planning and commissioning of prison healthcare for Northern Ireland, and participate in co-ordinating the implementation of the joint health care and criminal justice strategy action plan (to be launched in 2019), including the transformation of health care services in police custody through a nurse-led pathfinder.	Ensuring people get timely healthcare; Establishment of better links and appropriate referral pathways to the wider HSC when required; Provision of opportunity to engage with people who have enduring health needs; Promote innovation to improve quality for detainees.	M Hinds
3.19	Provide access for people across Northern Ireland to participate in leading-edge research focused on the needs of patients and the public.	Improve health and social care through research; Patients and the public will have access to novel interventions; Better able to attract, develop and retain the best research professionals to conduct people-based research.	Dr Mairs
3.20	Prepare for the introduction of a new model of service delivery within the Diabetic Eye Screening Programme.	All patients with diabetes (aged 12 years and over) are offered diabetic eye screening; Improved performance against the recommended screening interval and continued development of the programme in line with national standards.	Dr Mairs

	During 2019/20 we will:	Anticipated impact Who will benefit and/or what difference will it make?	Lead Officer
3.21	Prepare for introduction of primary screening with Human Papillomavirus Virus (HPV) testing within the Cervical Screening Programme.	To benefit all women aged 25–64 who are eligible for cervical screening (approximately 494,000 women); Improved detection and treatment of precancerous cervical changes; Anticipated increased screening interval meaning less frequent testing for some women.	Dr Mairs
3.22	Develop Homeless Hub services to provide access to health care services for people who are experiencing homelessness in Belfast and elsewhere in Northern Ireland.	Improve access to health care for those experiencing homelessness (access to primary care, dental care and other health care services through a dedicated team of staff); Improved co-ordination between relevant health and social care services and with other inter-sectoral (non HSC) partners; Improved health status through providing preventative measures and healthcare interventions; Examine models of service delivery and design and cost future models for enhancing homeless health and social care services regionally.	Dr Mairs
3.23	Continue to lead the implementation and monitoring of key elements of the e-Health and Care Strategy under the objectives of • supporting people • using information and analytics • fostering innovation In particular, through telecare, telehealth, electronic assistive technology, and the further development of video-conferencing and apps libraries.	• Frail and vulnerable people will be enabled to live independently with Telecare support. • Through Telehealth, people in receipt of a range of healthcare services will be able to communicate with care professionals remotely saving them time and enabling them to be more actively involved in their own care. • Video-conferencing will improve access to healthcare professionals for people who are unable or have difficulty in accessing healthcare services. • Delivery of new and innovative services using video technologies. • Improved learning and knowledge on the use of electronic assistive technology and how it can support people with learning or physical disability to live independently at home. • Potential roll out of other apps library that will help healthcare professionals to support their patients and their carer's in self-management as well as improve quality of care.	E Ritson

	During 2019/20 we will:	Anticipated impact Who will benefit and/or what difference will it make?	Lead Officer
3.24	Deliver new communication programmes supporting public health messaging including a new living well programme located in community pharmacies and available on the NIDirect web platform.	Target audiences are better informed about health matters and have access to relevant information encouraging earlier presentation at primary care settings.	E McClean
3.25	Target a range of communications to support adults through behavioural change relating to smoking, obesity, diabetes, drugs and alcohol.	Increased awareness leading to greater motivation to embed small changes in lifestyle activities.	E McClean

4: All health and wellbeing services should be safe and high quality

During the course of the PHA Corporate Plan 2017–2021 we will work to:

- provide leadership and direction to the HSC embedding PPI culture and practice into the development and delivery of services; moving towards the goal of co-designing and co-producing these with service users and carers;
- provide leadership and support to the HSC in the development and implementation of a comprehensive patient and client experience programme;
- improve patient safety and experience by bringing leadership to reducing healthcare-associated infections including MRSA and C difficile, improving antimicrobial stewardship and tackling antimicrobial resistance across the health and social care economy;
- provide professional advice to HSC organisations and work with these organisations to ensure the HSC workforce has the skills, opportunities and supervision arrangements to work with patients and clients to improve the safety, reliability and quality of care;
- drive forward, share and embed regional learning from relevant reviews and recommendations;
- support research on new diagnostic tools and treatments in collaboration with HSC, academia and industry.

	During 2019/20 we will:	**Anticipated impact** **Who will benefit and/or what difference will it make?**	**Lead Officer**
4.1	Implement the comprehensive patient and client experience programme, monitoring the agreed key regional priorities for 2019/20, which include: • continue to develop the 10,000 More Voices initiative to understand the patient client experience, including care of older people in nursing homes, swallowing	To benefit service users, through facilitating Trusts to understand the experiences of service users and make appropriate focused adjustments if required for improvement.	M Hinds

	During 2019/20 we will:	Anticipated impact Who will benefit and/or what difference will it make?	Lead Officer
	difficulties and neurology; • adopt the co-production model when designing and delivering transformational change. • increase the scale and spread of 'Always Events' • undertake an improvement project in relation to mixed gender accommodation and work with Trusts to measure and report compliance with their policy for mixed gender accommodation in 100% of inpatient areas.		
4.2	Continue to implement the District Nursing Framework, including progressing work on the Neighbourhood District Nursing prototype, Key Performance Indicators, education and district nursing career pathway.	Improved clinical outcomes for patients; Improved patient experience; Improved staff work experience; Provision of a cost effective service	M Hinds
4.3	Working in partnership with HSCB and HSCTs, continue to support and develop cancer services nursing, including: • roll out of Clinical Nurse Specialist (CNS) workforce expansion plan across NI HSC Cancer Services • oversee the Acute Oncology	Improved experience for patients living with cancer; Improved access to CNS as key worker and improved access and timely response to AOS; Facilitate regional agreement of systems and processes and standardise through regional CNS forums; Modernise provision of systematic anti-cancer therapies for patients across NI through the expansion of NMP, maximising current workforce capacity; Build a clinical pathway for nurses in cancer services to develop advanced roles and help with recruitment of cancer nursing workforce;	M Hinds

	During 2019/20 we will:	Anticipated impact Who will benefit and/or what difference will it make?	Lead Officer
	Nursing Service (AONS); • develop a sustainable model for Non-Medical Prescribing (NMP) • develop advanced practice nursing roles across cancer services to support the oncology services transformation.	Support the transformation of oncology services.	
4.4	Contribute to the regional DOH review of neurology services.	To benefit service users as well as nurses and AHPs working in Neurology services; Tailored pathway for the assessment, treatment and management of neurological conditions.	M Hinds
4.5	Continue to support the AHP workforce in primary care transformation with an initial focus on first contact physiotherapy, and identifying additional opportunities for the wider AHP workforce including Occupational Therapy and Dietetics.	Improved levels of service user satisfaction, patient empowerment and better clinical outcomes; Contribute to transforming system pressures in primary care.	M Hinds
4.6	Continue to lead on the development of methodology and models for the policy framework for Delivering Care Project NI for the nursing and midwifery workforce.	Supporting the provision of high quality, safe and effective care in hospital and community settings, through the development of a framework to determine staffing ranges for the nursing and midwifery workforce in a range of major specialities; Promote a shared understanding between professionals, management, finance and HR of the essential components to set and review nurse staffing establishments and when establishing new services to provide safe, effective and person-centred care.	M Hinds

	During 2019/20 we will:	Anticipated impact Who will benefit and/or what difference will it make?	Lead Officer
4.7	Implement the recommendations of the GP Nursing Framework including workforce capacity within primary care settings, through the development of Advanced Nurse Practitioner roles; rolling out regional education and training programmes, co-designed with users, carers and communities, professional governance and core competencies.	Benefit service users, GPs, General Practice Nurse and Health Care Assistant staff and education providers; The development of the General Practice Nurse and Health Care Assistant workforce within general practice will assist the management of increased pressures, creating capacity for GPs to have increased time with more complex patients; Access to appropriate structured education and training to better meet the requirements for the complex and changing service needs for patients in primary care settings.	M Hinds
4.8	Increase public awareness of antimicrobial resistance as a health issue and the importance of appropriate use of antimicrobials by everyone through the Keep Antibiotics Working campaign resources and media campaign**.**	Increased public understanding of the threat to health from AMR and knowledge of the steps that can be taken to reduce AMR; Contribute to progress towards the HSC target to reduce inappropriate prescribing by half by 2020.	Dr Mairs
4.9	Commission Flu Fighters to enhance and promote the delivery of influenza vaccine for HSCNI workers to achieve the 40% target set by DoH (*Nb the 2019/20 target will not be confirmed until summer 2019*).	Benefit HSCNI workers, their patients and colleagues throughout Northern Ireland; Reduce the number of staff off sick with the influenza virus; Reduce the spread of the influenza virus among colleagues and patients.	Dr Mairs
4.10	Continue to implement the R&D PPI Strategy through the delivery of training and provision of guidance to researchers and members of the public on PPI in research and facilitate	Research funded by HSC R&D will be influenced by patient priorities and co-designed with patient and public partners leading to clearer information, higher recruitment, better methods and targeted dissemination.	Dr Mairs

	During 2019/20 we will:	Anticipated impact Who will benefit and/or what difference will it make?	Lead Officer
	opportunities for patients and public to be involved as partners and co-designers in the research process through the promotion and expansion of the PIER role and its evaluation.		
4.11	Contribute to the National Institute for Health Research (NIHR) funding programmes,, which aim to fund leading-edge health and care research and translate discoveries into practical products, treatments, devices and procedures.	Research commissioned will have a focus on improving health and social care; Drive faster translation of scientific discoveries into tangible benefits for patients.	Dr Mairs
4.12	Continue to gain assurance on progress with regional safety and quality priorities through Quality Improvement Plans.	Better engagement with Trust teams; Increased awareness of quality improvement interventions; Identifiable and sustained improvement against identified quality improvement indicators; Improved safety and quality of care.	M Hinds
4.13	Provide a strategic role in the management of and learning from the SAI (Serious Adverse Incidents) process, including leading the development of the Learning Matters newsletter, development of thematic reviews and contributing to the SAI biannual learning report.	Increased awareness and dissemination of learning identified from SAIs, which is targeted to the relevant HSC staff; Improved safety and quality of care.	M Hinds

	During 2019/20 we will:	Anticipated impact Who will benefit and/or what difference will it make?	Lead Officer
4.14	Continue to oversee the implementation of the Q2020 Strategy, including providing advice and support to the task streams and coordinating the development of the Annual Quality Report.	Identification of models of improvement for potential regional scale and spread; Raised awareness of quality improvement initiatives; Identifiable and sustained improvement in the quality of health and social care services.	M Hinds
4.15	Work collaboratively with all appropriate stakeholders to ensure the smooth transition towards the Regional Improvement Hub (incorporating HSC Safety Forum, HSCQI and Q 2020.	This will provide a joined up and cohesive approach to Quality Improvement to support scale up and spread of quality initiatives across Northern Ireland, for the benefit of service users, families and carers and HSC staff.	M Hinds
4.16	Implement a range of actions through HSCQI in support of HSC Trusts and other key stakeholders to improve the safety and quality of services delivered	To benefit service users, families, carers and HSC staff; Meet key milestones for each of the following workstreams and sustained engagement with front line clinical staff: • maternity • paediatrics • mental health • sepsis • community emergency response times • early warning score tools Continue to build capacity through programmes such as Q (Health Foundation) and ECHO.	M Hinds
4.17	Provide strategic leadership for the implementation of involvement and co-production at a regional level by:	To benefit service users, carers, members of the public and HSC staff; The implementation of good involvement and co-production practice across HSC organisations and advance and promote regional transformation programmes.	M Hinds

	During 2019/20 we will:	Anticipated impact Who will benefit and/or what difference will it make?	Lead Officer
	• working in partnership with the Regional HSC PPI Forum to implement the co-produced action plan, including a review of monitoring processes, hosting of a regional event and development of high quality training for HSC staff. • working in partnership with DoH, HSCB, PCC, HSC Trusts and the other ALBs to shape best practice involvement and co-production in Transformation programmes.		
4.18	Working with the HSCB, convene a group to review the current Northern Ireland Extreme Surge Framework (Pandemic Flu), identify gaps and plan to take forward work on the necessary elements to address gaps. Draft updated regional guidance for Northern Ireland will be submitted by the end of June to the DoH for consideration and approval.	Development of Regional Pandemic Surge Framework for NI (strategic guidance)	Dr Mairs

5: Our organisation works effectively

During the course of the PHA Corporate Plan 2017–2021 we will work to:

- ensure appropriate resilience measures are in place across the organisation to enable a rapid and appropriate response to a major incident while maintaining and protecting key services;
- support our staff and their wellbeing at all times, especially during a period of reform and restructuring;
- use the research, evidence and health intelligence available to inform our decision-making and further develop appropriate and robust data where required;
- ensure we have the skills, opportunities and staffing levels to deliver our functions;
- ensure high quality and appropriate governance arrangements and processes to support the delivery of PHA functions;
- work in partnership and communicate effectively with our stakeholders and target audiences.

	During 2019/20 we will:	**Anticipated impact** **Who will benefit and/or what difference will it make?**	**Lead Officer**
5.1	Support the Northern Ireland Public Health Research Network (NIPHRN) to identify opportunities for research in PHA priority areas through the organisation of a series of events on key topic areas bringing a wide range of stakeholders together.	Improved public health through research; Embed research in practice, sustaining the workforce and improving routine care.	Dr Mairs
5.2	Implement a change management process in 2019/20 to create a more efficient and cohesive R&D infrastructure that makes it easier to navigate, with collaborative leadership, to ensure an improved service.	Benefit patients, carers, researchers, health and social care professionals; Enhance Northern Ireland reputation as a nationally and internationally recognised centre of research excellence; Strengthened and streamlined systems for research management and governance in Northern Ireland.	Dr Mairs

	During 2019/20 we will:	Anticipated impact Who will benefit and/or what difference will it make?	Lead Officer
5.3	Further develop and embed an outcomes approach and impact measurement across the PHA beginning with PfG and Community Planning actions.	Increased understanding, skills and knowledge regarding outcomes approaches; Clearer reporting, demonstrating impact, better informing decision making.	E McClean
5.4	Review and test the PHA Business Continuity Management Plan to ensure arrangements to maintain services to a pre-defined level through a business disruption.	PHA is able to maintain essential functions in the event of a business continuity disruption.	E McClean
5.5	Ensure appropriate corporate and information governance arrangements are in place to underpin and support the PHA in undertaking its core business.	PHA will have appropriate internal control measures in place, compliant with legislation and DoH regulations, enabling PHA to undertake its core functions.	E McClean
5.6	Undertake a review of PHA contract management processes to ensure they are meeting standards of practice required, are addressing risks to PHA on a proportionate basis and are being managed effectively across the organisation.	Establishment of consistent processes for monitoring contract performance that meet standards of practice required; Improvement in the accuracy of information being returned; Reduction in duplication of process for service providers and PHA staff; Reduced risk to PHA of non-compliance with contract terms and conditions.	E McClean
5.7	Continue to take forward the implementation of the PHA Procurement Plan, taking account of the findings from the Procurement Planning Task and Finish Group	Maximise use of resources to secure best services through appropriate competition; Compliance with legal obligation to re-tender all procured services within contracted timescales; Timely and suitable pre-procurement planning to ensure that key service and population objectives are met and enabling procurements to progress in timely way.	E McClean

	During 2019/20 we will:	Anticipated impact Who will benefit and/or what difference will it make?	Lead Officer
5.8	Develop the PHA Investment Plan and monitor implementation to ensure budgets are allocated and spent in line with agreed strategic priorities.	PHA budgets are managed effectively and opportunities to progress strategic priorities maximised; PHA programme budget is fully utilised in 2019/20 and financial breakeven position achieved.	E McClean
5.9	Support the further integration of involvement and co-production practice into the governance structures of the PHA by: • establishing a service user and carer reference group within pha. • developing an involvement and co-production plan for each PHA directorate. • providing assurance through the corporate monitoring of Involvement and coproduction practice within PHA.	Improve service user/carer involvement in the planning/commissioning of programmes/services; PPI is used to support the achievement of relevant business plan objectives.	E McClean
5.10	Continue to support and develop staff during a period of organisational change, including relevant communication with staff.	Staff feel supported and valued; Improved staff morale; Staff are skilled and equipped for the future.	V Watts

	During 2019/20 we will:	Anticipated impact Who will benefit and/or what difference will it make?	Lead Officer
5.11	Continue to prepare for the new organisational arrangements (anticipated 1 April 2021), working with HSCB and DoH.	Smooth transition to the new organisational arrangements, in particular the transfer of functions and staff from the HSCB Social Care and Children's Directorate into the PHA.	V Watts
5.12	Continue to develop and update the new staff intranet to support communications within the PHA	Effective communication platform in place to support dissemination of information for PHA staff and programmes of work; Improvements in PHA staff awareness of work related issues leading to more effective working patterns.	E McClean

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

Find us on:

05/19

HSC Public Health Agency

item 10

Title of Meeting	PHA Board Meeting
Date	21 March 2019
Title of paper	Review of PHA Standing Orders and Standing Financial Instructions
Reference	PHA/04/03/19
Prepared by	Robert Graham and Jane Davidson (HSCB)
Lead Director	Ed McClean
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to present the annual review of the PHA Standing Orders and Standing Financial Instructions to the Board for approval.

2 Background Information

The PHA Standing Orders and Standing Financial Instructions are a key governance document which outlines the running of the Agency and its Board and Committees.

An annual review is carried out to ensure that they are kept up to date and in line with best practice.

3 Key Issues

List of Changes to Standing Orders

The changes to Standing Orders have been minimal and are outlined below:

Page 7, removal of the word “Office” from the line “…headquarters Office of the Agency…”

Page 10, updated the review of the MS/FM to every 3 years from every 5 years in line with recent Departmental guidance

Page 17, addition of a word, “…issued by the Department on 18 July…”

Page 31, corrections made with capitalisation, “Board Meetings” and “Personal and Public Involvement”

Page 34, removal of “Supervision of Midwives” as no longer a statutory duty of PHA

Page 38, amendment of “Officer” to “officer” in first paragraph

Page 49 (and also Page 112), addition of “Director of Human Resources, BSO” to the list of Agency Management Team members

Page 101, clarification inserted that, “…the approval of the Committee Chair…”

List of Changes to Standing Financial Instructions

As with Standing Orders, the changes to the Standing Financial Instructions are minimal. Any references to specific guidance have been reviewed and updated as required.

Page 4, “HPSS” changed to “HSC”

Page 10, updated the handbook reference to “the Audit and Risk Assurance Committee Handbook (NI) 2018 (DAO (DoF) 03/18)”

Page 49, expanded bullet point on limits for capital expenditure where Departmental approval is required – included £1.5m for PHA R&D

The revised Standing Orders and Standing Financial Instructions were approved by the Governance and Audit Committee at its meeting on 28 February and are now being brought to the PHA Board for approval.

4 Next Steps

Following approval the revised Standing Orders and Standing Financial Instructions will be uploaded onto the PHA Intranet and the PHA website.

HSC Public Health Agency

item 11

Title of Meeting	PHA Board Meeting
Date	21 March 2019
Title of paper	PHA Business Continuity Plan
Reference	PHA/05/03/19
Prepared by	Karen Braithwaite / Carol Hermin
Lead Director	Ed McClean
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The PHA is required to have an up to date Business Continuity Plan (BCP) which is reviewed annually. The purpose of this paper is to present to the Board the most up to date version of the PHA Plan and to seek Board approval.

2 Background Information

The Business Continuity Plan is an essential element of PHA governance, setting out the plan to ensure that the PHA can maintain its essential functions in the event of an incident and recover full services. The BCP is regularly reviewed and updated, and a desktop test is held at least annually.

A number of PHA managers participated in a desktop exercise in November 2018, the aim of which was to test the Plan and ensure it is as up-to-date and robust as possible to ensure continuation of essential services and help the organisation recover its key services during or after a Business Continuity incident.

3 Key Issues

Following the exercise, only minor amendments were required to the Corporate Business Continuity Plan. These are as follows:-

- Table 1 – version control updated.
- Table 2 – distribution control updated.
- Page 5 – Location and Access information updated.
- Figure 1, page 6 – Corporate Structure amended.

- Page 19 – P Crossan’s name added to reflect departure of M Bloomfield.
- Page 21 – Names of Directors, Assistant Directors and Deputies amended to reflect departure of L Doherty, M Black, U Turbitt and L Charlton.
- Page 23 – Incident Management Action Team updated.
- Page 24 – Administrative Support Team roles updated (R Graham).
- Page 67 – Out of Hours contact for Health and Social Care Board amended to reflect departure of M Bloomfield (P Crossan named).
- Appendix 1 – key services/strategies shaded to indicate priorities.

The revised Plan was approved by the Governance and Audit Committee at its meeting on 28 February and is now being brought to the PHA Board for approval.

With issues such as Cyber Security and EU Exit presenting potential challenges to PHA, the Business Continuity Plan will continue to be kept under review and updated as appropriate to ensure that the PHA is as well prepared as possible.

4 Next Steps

Following approval the revised Business Continuity Plan will be shared with relevant staff.

HSC Public Health Agency

item 12

Title of Meeting	PHA Board Meeting
Date	21 March 2019
Title of paper	Data Protection Impact Assessment Policy and Guidance
Reference	PHA/06/03/19
Prepared by	Karen Braithwaite
Lead Director	Ed McClean
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The PHA is required to have a Data Protection Impact Assessment Policy. The purpose of this paper is to present to the Board the PHA Policy and Guidance for approval.

2 Background Information

The General Data Protection Regulations (GDPR) and Data Protection Act (DPA) 2018 require public authorities to integrate data protection concerns into every aspect of processing activities. It is now a mandatory requirement to consider/carry out a Data Protection Impact Assessment (DPIA) for any project large or small that involves the collection of personal information. A DPIA must be carried out where a type of processing is likely to result in a high risk to the rights and freedoms of individuals.

3 Key Issues

Following the requirement to develop this Policy, PHA developed the following suite of documents for carrying out DPIAs for use by PHA staff to ensure compliance with these regulations.

- Data Protection Impact Assessment (DPIA) Policy
- DPIA Guidance
- DPIA Flowchart
- DPIA Screening Exercise Template

- DPIA Template Report

The Data Protection Impact Assessment Policy and Guidance were approved by the Information Governance Steering Group at its meeting of 16 January and by the Governance and Audit Committee at its meeting on 28 February and are now being brought to the PHA Board for approval.

4 Next Steps

Following approval the Policy and Guidance will be published on the PHA Intranet and the PHA website and brought to the attention of all PHA staff.

DATA PROTECTION IMPACT ASSESSMENT (DPIA) POLICY

Version	**1.0**
Date version 1.0 approved by IGSG	**16/01/19**
Date version 1.0 approved by AMT	
Date version 1.0 approved by PHA board	
Scheduled review date	**31/03/22**

Table of Contents

Glossary of Terms

Term	Definition
Data Protection Impact Assessment (DPIA)	Screening tool/process to help identify, analyse and minimise the data protection risks of any project involving the use of personal data.
Project	Any activity or function where the collection or processing of personal data is being considered (for example, a new system, database, programme, policy or initiative).
Information Asset Owner (IAO)	Assistant Director/Senior member of staff who is the nominated owner for one or more information assets, by virtue of managerial position.
Information Asset Administrator (IAA)	Staff member who provides support to the IAO in their role.
Data Protection by Design	Data protection by design (previously referred to as 'privacy by design') is a broad concept that applies organisationally and requires the PHA to consider data protection at the very onset of any project, even before a decision is made as to whether the processing is likely to result in a high risk or not. It is an approach that ensures privacy and data protection are considered at the design phase of any system, service, product or process and then throughout the lifecycle.

Data Protection by Default	Data protection by default requires that we only process the data that is necessary to achieve our specific purpose, linking to the fundamental data protection principles of data minimisation and purpose limitation.
Data Protection Officer (DPO)	The DPO is the first point of contact for the ICO and for individuals whose data is processed (employees, members of public etc). In the Public Health Agency, the DPO is Rosemary Taylor, Assistant Director of Planning and Operational Services. Email: **dpo.pha@hscni.net**
Information Commissioner's Office (ICO)	The UK's independent authority set up to uphold information rights in the public interest, promoting openness by public bodies and data privacy for individuals.
Purpose limitation	Collected for specified, explicit and legitimate purposes and not further processed in a manner that is incompatible with those purposes.
Data minimisation	Adequate, relevant and limited to what is necessary for the purpose.
Storage limitation	Kept in a form which permits identification of data subjects for no longer than is necessary for the purposes for which the personal data is processed.

Function creep	A change or increase in size of a project which changes the project so significantly as to become something different.
Data minimisation	Collecting, storing and processing only that data which is required for a specific purpose.
Information Privacy	The ability of data subjects to control, edit, manage and delete information about them and to decide to what extent such information is communicated to others.
Intrusion	The collection of excessive personal information, disclosure of personal information without consent and the misuse of such information.
A Privacy Risk	The threat of causing harm or distress to someone through collecting, holding or using their personal information, or otherwise intruding into their privacy.

1.0 Introduction

The Public Health Agency (PHA) must ensure that any processing of personal information for which it is responsible complies with the General Data Protection Regulations (GDPR) and the Data Protection Act (DPA) 2018.

The GDPR introduced new obligations which require Public authorities to integrate data protection concerns into every aspect of our processing activities. This approach is called 'data protection by design' (the consideration of data protection at the very onset of any project) and data protection by default (only processing the data that is necessary to achieve our specific purpose). This requires the PHA to consider privacy and data protection issues at the design phase of any system, service, product or process and then throughout the lifecycle, particularly for any high risk projects where risk cannot be accepted.

Before implementing a project involving the use of personal data, the responsible Information Asset Owner (IAO) must ensure that it is compliant with GDPR and the DPA 2018.

In a data protection context, this will include:

- confirming that the PHA is complying with the data protection principles;
- identifying the relevant conditions for processing personal data; and
- ensuring the PHA's entry on the Information Commissioner's Office (ICO) register of data controllers is still accurate.

There is also a legislative requirement for IAOs or senior managers to undertake a Data Protection Impact Assessment (DPIA) to help ensure compliance with data protection obligations. This is necessary where a type of processing is likely to result in a high risk to the rights and freedoms of individuals; however it is also good practice to undertake a DPIA in cases where there is a lower risk to individuals. A DPIA is a tool which should be used at the outset to identify any risks of processing personal data (see separate DPIA Guidance document for further details).

Sometimes you may consider that after this process has been undertaken, and where a high risk still remains, that this risk may still be acceptable, given the benefits of the processing and the difficulties of mitigation. However if there is still a high risk, the ICO must be consulted before you can go ahead with the processing. You must also consult with the PHA Data Protection Officer in the first instance.

The term 'project' is used in this policy in its widest possible sense to refer to any activity or function where the collection or processing of personal data is being considered. It could refer to the development of a new system, database, programme or application, a new policy or initiative, an enhancement to or review of an existing process, or a new way of working.

Examples include, but are not limited to:

- developing a policy, strategy or legislation that has privacy implications;
- collecting new information from individuals;
- designing a new IT system for storing or accessing personal data;
- outsourcing a function or IT service where personal information will be held or processed off-site or may be accessible to a third party provider;
- embarking on a major change project to introduce a new business process, for example, a new shared or centralised service;
- processing personal data in a different way;
- embarking on a data sharing initiative with other departments/agencies;
- developing data analytics to analyse existing customer information so you can better target services;
- developing a website or mobile app that collects names, contact information or locations;
- using personal data for a new purpose;
- installing a CCTV camera system or using other technology to monitor individuals.

2.0 Data Protection

2.1 Why is managing privacy important?

People care how their information is handled. They are more likely to trust organisations that treat them fairly and openly and that can clearly justify how they handle personal information. By managing privacy successfully and showing we take care with personal information, PHA will be able to provide a better service and be able to meet people's expectations of us.

By contrast, people object to unreasonable intrusions into their personal space and their private activities. They quickly lose trust in organisations that do not treat their information properly or that act intrusively.

So, while data protection is something the PHA is legally required to do, there are other good reasons for taking care with personal information.

2.2 What are the data protection principles?

The data protection principles are simply common sense rules to ensure personal information is handled appropriately. Under GDPR and the DPA 2018 they require personal data to be:

1) processed lawfully, fairly and in a transparent manner;
2) collected for specified, explicit and legitimate purposes and not further processed in a manner that is incompatible with those purposes (purpose limitation);
3) adequate, relevant and limited to what is necessary for the purpose (data minimisation);
4) accurate and, where necessary, kept up-to-date (accuracy);

5) kept in a form which permits identification of data subjects for no longer than is necessary for the purposes for which the personal data are processed (storage limitation);
6) processed in a manner that ensures appropriate security of the personal data (integrity, confidentiality – security); and
7) the data controller shall be responsible for, and be able to demonstrate compliance with the above (accountability).

These principles will form the basis of any DPIA. Referring to them frequently throughout the process will help you to identify where the project is likely to breach data protection legislation.

2.3 Data Protection by Design and Default

Data protection by **design** (previously referred to as 'privacy by design') is a broad concept that applies organisationally and requires the PHA to consider data protection at the very onset of any project, even before a decision is made as to whether or not the processing is likely to result in a high risk. It is an approach that ensures privacy and data protection are considered at the design phase of any system, service, product or process and then throughout the lifecycle.

While this has always been good practice, there is now an explicit requirement under the GDPR that the PHA:

- Puts in place appropriate technical and organisational measures designed to implement the data protection principles; and
- Integrates safeguards into our processing so that we meet the GDPR's requirements and protect individual rights.

Data protection by design has broad application, including developing new IT systems, services, products and processes that involve processing personal data; developing organisational policies, processes, business practices and/or strategies that have privacy implications; physical design; data sharing initiatives and using personal data for new purposes.

Data protection by **default** requires that we only process the data that is necessary to achieve our specific purpose, linking to the fundamental data protection principles of data minimisation and purpose limitation.

Both data protection by design and default must be considered from the initial phase of any system, service, product or process and throughout its life cycle.

2.4 How do we put this into practice?

Data protection by design and default must underpin all aspects of PHA business. It means that we:

- Consider data protection issues as part of the design and implementation of systems, services, products and business practices;
- Make data protection an essential component of the core functionality of any processing systems and services;
- Only process the personal data that we need in relation to our purpose(s) and only use the data for those purposes;
- Ensure that personal data is automatically protected in any IT system, service, product and/or business practice, so that individuals should not have to take any specific action to protect their privacy;
- Provide contact information for the information governance team;
- Use 'plain language' for any public documents so that individuals easily understand what we are doing with their personal data;
- Provide individuals with tools so that they can understand how we are using their personal data;
- Offer strong privacy defaults, user-friendly options and controls and respect user preferences.

2.5 Data Protection by Design and Default – Principles and Practical Tips

Seven 'foundational principles' of privacy by design were developed by the Information and Privacy Commissioner of Ontario. Although privacy by design is not necessarily equivalent to data protection by design, these foundational principles can nevertheless underpin our approach:

- Positive not reactive; preventative not remedial;
- Privacy as the default setting;
- Privacy embedded into design;
- Full functionality – positive sum, not zero sum (win-win);
- End-to-end security – full lifecycle protection;
- Visibility and transparency – keep it open;
- Respect for user privacy – keep it user-centric.

3. Data Protection Impact Assessment (DPIA)

A suite of documents – Screening template, DPIA template, DPIA Guidance and Flowchart – have been developed for use in this process. These can be found on the Intranet Site (Connect) under Policies and Procedures.

A Data Protection Impact Assessment (DPIA) is a process or tool to help staff in business areas systematically analyse, identify and minimise the data protection risks of any project involving the use of personal data. It forms part of the 'data protection by design' approach and is a key part of our accountability obligations under GDPR. Unfortunately, these aspects are often considered as an after-thought or omitted altogether.

While a DPIA is not required in all circumstances, it is a legal requirement for any type of processing, including certain specified types of processing that are likely to result in a high risk to the rights and freedoms of individuals. Where a DPIA indicates high risk data processing (i.e. a high risk that cannot be mitigated) the PHA will be required to consult the ICO before starting the processing.

DPIAs are relevant for new projects or proposals and also when planning to make changes to an existing system. It is vital that the outcomes of the DPIA are integrated back into the project plan. The DPIA is also a 'living' process to help manage and review the risks of the processing and measures that have been put in place, on an on-going basis.

A DPIA is a practical analytical tool that you can use:

- to identify whether a proposed project is likely to impact on the privacy of individuals affected, either positively or negatively;
- to check whether your project is likely to comply with the data protection principles;
- to make decisions about whether and how to adjust the proposal to manage any privacy risks and to maximise the benefits of protecting privacy well; and
- as a reference point for future action as the project, or your business, changes.

It is designed to be flexible and does not have to be complex or time-consuming in every case, however there must be a level of rigour in proportion to the privacy risks arising.

3.1 When is a DPIA required?

Consideration of a DPIA is a mandatory requirement for any project, large or small, that:

- involves collection of personal information – that is, information about living people, who can be identified;
- involves information that may be used to identify, profile or target individuals;
- may result in surveillance of individuals or intrusions into their personal space or bodily privacy; or
- may otherwise affect whether people's reasonable expectations of privacy are met.

A DPIA must be carried out where a type of processing is likely to result in a high risk to the rights and freedoms of individuals (taking account of both the likelihood and severity of any potential harm). If in doubt, a DPIA should be carried out.

The GDPR also stipulates that the following three types of processing will always require a DPIA:

- Systematic and extensive profiling with significant effects;
- Large scale use of sensitive data;
- Public monitoring.

An effective DPIA will be used throughout all development and implementation stages and will enable staff to systematically and thoroughly analyse how a particular project will affect the privacy of individuals involved.

Although this guidance focuses on using a DPIA as part of assessing and managing change, you may also consider using it to assess how good your existing systems are, particularly if individuals are raising concerns about how their personal information is being managed.

4. Risk

4.1 What kind of risk does a DPIA assess?

The focus of a DPIA is the risks to individuals' interests. It should therefore consider any potential harm to individuals, considering actual harm as well as the possibility for more intangible harm, such as reputation.

The wider impacts on society should also be considered, for example any risk of a loss of public trust as a result of the intended processing.

4.2 Identifying Risks

Possible risks include: -

Risks to individuals
• Inadequate disclosure controls increase the likelihood of information being shared inappropriately. • The context in which the information is used or disclosed can change over time, leading to it being used for different purposes without people's knowledge. • New surveillance methods may be an unjustified intrusion on their privacy. • Measures taken against individuals as a result of collecting information about them might be seen as intrusive. • The sharing and merging of datasets can allow organisations to collect a much wider range of information than individuals might expect. • Identifiers might be collected and linked which prevent people from using a service anonymously. • Vulnerable people may be particularly concerned about the risks of identification or the disclosure of information. • Collecting information and linking identifiers might mean that an organisation is no longer using information which is safely anonymised.

- Information which is collected and stored unnecessarily, or is not properly managed so that duplicate records are created, presents a greater security risk.
- If a retention period is not established, information might be used for longer than necessary.
- The use of biometric information or potentially intrusive tracking technologies may cause increased concern.

Corporate risks
• Non-compliance with data protection and other legislation can lead to enforcement action, fines and reputational damage. • Problems which are only identified after the project has launched are more likely to require expensive fixes. • Information which is collected and stored unnecessarily, or is not properly managed so that duplicate records are created, is less useful to business areas. • Public distrust about how information is used can damage the PHA's reputation. • Data losses which damage individuals could lead to claims for compensation.

Compliance risks
• Non-compliance with data protection legislation. • Non-compliance with the Privacy and Electronic Communications Regulations (PECR). • Non-compliance with human rights legislation. • Non-compliance with sector specific legislation or standards.

Please note these are only some suggestions to help you identify risks relevant to your project. This is NOT a list of all possible risks.

4.3 Some questions to consider as you identify risks:

Is the purpose of your project clear?
How will individuals be told about the use of their personal data?
Is the lawful basis for processing clear?
Does your project plan cover all the purposes for which the personal data will be processed?
Have any potential new purposes been identified as the scope of the project expands?
Is the information you are using of good enough quality for the purposes for which it will be used?
Do you need to collect all the personal data proposed, i.e. could you collect less, without compromising the needs of the project (data minimisation)?
If you are acquiring software/IT, does it allow you to amend/delete personal data where necessary?
How are you ensuring that personal data is accurate (and continues to be accurate)?

What retention periods are suitable for the personal data you will be processing?
Are you procuring software/IT which will allow you to delete information in line with your retention periods?
Will the systems you are putting in place allow you to respond to subject access requests within required timescales?
If the project involves marketing, have you got a procedure for individuals to opt out of their information being used for that purpose?
Do new systems/processes provide protection against security risks (including, for example, access controls, cyber security etc.)?
What training and instructions are necessary to ensure staff know how to operate IT systems and manual processes securely and correctly?
Will the project require you to transfer data outside the EU?
(if the answer to the last question is yes, note that the GDPR imposes restrictions on the transfer of personal data outside the EU, to third countries or international organisations).

5 Benefits

Designing projects, or developing policies with privacy in mind at the outset, can lead to benefits which include:

- identifying potential problems at an early stage, when addressing them will often be simpler and less costly. It is much simpler to build in good privacy management throughout the process, rather than trying to bolt it on at the end;
- increased staff awareness of privacy and data protection;
- meeting our legal obligations and reducing the likelihood of a breach of data protection legislation;
- ensuring our actions are less privacy intrusive and unlikely to have a negative impact on data subjects;
- providing reassurance to individuals that the PHA has followed best practice when using their personal data.
- improved transparency, making it easier for individuals to understand how and why we are using their information;
- building trust with people who use our services;
- better information management practices.

6 Lawful Basis for Processing

The first data protection principle states that personal data must be processed lawfully, fairly and in a transparent manner. In practice, this means that the PHA as a data controller must:

- be open and honest with individuals about how we intend to use the information we collect about them;
- handle their information in ways that they would reasonably expect;
- have legitimate grounds for collecting and using the information;
- not use the data in ways that will have unjustified adverse effects on individuals;

- be transparent about how we intend to use the information and give individuals appropriate privacy notices when collecting their personal data;
- explain our lawful basis for processing personal data to individuals; and
- ensure we do not do anything unlawful with the data.

To satisfy this principle, you need to have identified the lawful basis for processing the personal information. There are six options, which depend on your purpose and your relationship with the individual. There are also specific additional conditions for processing some especially sensitive types of data (including, for example, health data).

In order for processing of personal data to be lawful, the lawful basis (or bases, if more than one applies) must be identified. If no lawful basis applies to your processing, your processing will be unlawful.

Under GDPR the six lawful bases for processing are:

a) **Consent:** the individual has given clear consent for you to process their personal data for a specific purpose;
b) **Contract:** the processing is necessary for a contract you have with the individual, or because they have asked you to take specific steps before entering into a contract;
c) **Legal obligation:** the processing is necessary for you to comply with the law (not including contractual obligations);
d) **Vital interests:** the processing is necessary to protect someone's life;
e) **Public task:** the processing is necessary for you to perform a task in the public interest or for your official functions, and the task or function has a clear basis in law;
f) **Legitimate interests:** the processing is necessary for your legitimate interests or the legitimate interests of a third party unless there is a good reason to protect the individual's personal data which overrides those legitimate interests. (This cannot apply if you are a public authority processing data to perform your official tasks).

NOTE: Public authorities (i.e. PHA) must consider the 'public task' basis first. We have only limited scope to rely on consent or legitimate interests. Further guidance on the lawful bases can be found on the ICO website - here.

6.1 Documenting Your Lawful Basis

The lawful basis for processing must be clearly identified, and recorded, at the very beginning of any project.

Once you have identified your lawful basis and condition for processing, this should be documented on the DPIA template and PHA Information Asset Register to help you comply with the GDPR's accountability requirements and ensure all staff handling the information are aware of it. Your lawful basis should also be explained in your privacy notice and when answering subject access requests.

(Special category data also needs to be documented – see Section "Special Category Data" below).

6.2 Special Category Data

Special category data is more sensitive, and requires greater protection. For example, information about an individual's:
Race;
Ethnic origin;
Politics;
Religion;
Trade union membership;
Genetics;
Biometrics (where used for ID purposes);
Health;
Sex life; or
Sexual orientation

In particular, this type of data could create more significant risks to a person's fundamental rights and freedoms, for example, by putting them at risk of unlawful discrimination.

In order to lawfully process special category data, you must identify both a lawful basis and a separate condition for processing special category data.

The conditions for processing special category data are as follows:

(a) the data subject has given explicit consent to the processing of those personal data for one or more specified purposes, except where Union or Member State law provide that the prohibition referred to in paragraph 1 may not be lifted by the data subject;

(b) processing is necessary for the purposes of carrying out the obligations and exercising specific rights of the controller or of the data subject in the field of employment and social security and social protection law in so far as it is authorised by Union or Member State law or a collective agreement pursuant to Member State law providing for appropriate safeguards for the fundamental rights and the interests of the data subject;

(c) processing is necessary to protect the vital interests of the data subject or of another natural person where the data subject is physically or legally incapable of giving consent;

(d) processing is carried out in the course of its legitimate activities with appropriate safeguards by a foundation, association or any other not-for-profit body with a political, philosophical, religious or trade union aim and on condition that the processing relates solely to the members or to former members of the body or to persons who have regular contact with it in connection with its purposes and that the personal data are not disclosed outside that body without the consent of the data subjects;

(e) processing relates to personal data which are manifestly made public by the data subject;

(f) processing is necessary for the establishment, exercise or defence of legal claims or whenever courts are acting in their judicial capacity;

(g) processing is necessary for reasons of substantial public interest, on the basis of Union or Member State law which shall be proportionate to the aim pursued, respect the essence of the right to data protection and provide for suitable and specific measures to safeguard the fundamental rights and the interests of the data subject;

(h) processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services on the basis of Union or Member State law or pursuant to contract with a health professional and subject to the conditions and safeguards referred to in paragraph 3;

(i) processing is necessary for reasons of public interest in the area of public health, such as protecting against serious cross-border threats to health or ensuring high standards of quality and safety of health care and of medicinal products or medical devices, on the basis of Union or Member State law which provides for suitable and specific measures to safeguard the rights and freedoms of the data subject, in particular professional secrecy;

(j) processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes in accordance with Article 89 (1) based on Union or Member State law which shall be proportionate to the aim pursued, respect the essence of the right to data protection and provide for suitable and specific measures to safeguard the fundamental rights and the interests of the data subject.

.

7.0 Policy Implementation, Training and Education

This policy states PHA commitment to data protection by design and default, explains what DPIAs are, how to assess if a DPIA is necessary, how to undertake and record a DPIA and approval requirements.

It is particularly important to refer to this policy (and guidance) at the early stages and throughout the lifecycle of any project to ensure that privacy and data protection are central considerations.

The Senior Operations Manager (Delivery) will ensure the provision of any necessary training with regard to this policy.

A copy of this policy will be placed on the PHA's intranet site (Connect).

All PHA managers must ensure that their staff have access to this policy, understand its content, and are aware of its aims and purpose immediately upon its release.

All PHA staff must comply with the requirements of this policy.

This policy is based on the **ICO Guide to the GDPR** and **ICO 'Accountability and governance: Data Protection Impact Assessments (DPIAs) (March 2018).**

8.0 Equality and Human Rights Considerations

This policy has been screened for equality implications as required by Section 75, Schedule 9, of the Northern Ireland Act, 1998. Equality Commission for Northern Ireland Guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to them.

Using the Equality Commission's screening criteria, no significant equality implications have been identified. This policy will therefore not be subject to an equality impact assessment.

This policy has been considered under the terms of the Human Rights Act, 1998, and was deemed to be compatible with the European Convention Rights contained in that Act.

This policy will be included in the PHA's Register of Screening Documentation and maintained for inspection whilst it remains in force.

This document can be made available on request in alternative formats and in other languages to meet the needs of those who are not fluent in English.

9.0 Review of Policy

The PHA is committed to ensuring that all policies are kept under review to ensure that they remain compliant with relevant legislation.

This policy will be reviewed as per the schedule on the title page, or earlier if relevant guidance is issued. That review will be noted on a subsequent version of this policy, even where there are no substantive changes made or required.

January 2019

DATA PROTECTION IMPACT ASSESSMENT (DPIA) GUIDANCE

Version	**1.0**
Date version 1.0 approved by IGSG	**16/01/19**
Date version 1.0 approved by AMT	
Date version 1.0 approved by PHA board	
Scheduled review date	**31/03/22**

This guidance document should be read in conjunction with the Data Protection Impact Assessment Policy which gives further detailed information on the process.

1 Introduction – what is a Data Protection Impact Assessment?

Historically, consideration of the data protection risks of projects involving the use of personal data were often considered by organisations late in the project planning/execution process, or omitted altogether. A Data Protection Impact Assessment (DPIA) is a process or tool to help staff in business areas systematically analyse, identify and minimise the data protection risks of any project involving the use of personal data. It therefore ensures that the protection of personal data collected as part of projects and processes is considered at the appropriate times and stages, and forms part of the 'data protection by design' approach. The PHA is committed to this approach as part of its accountability obligations under GDPR.

While a DPIA is not required in all circumstances, it is a legal requirement for any type of processing, including certain specified types of processing that are likely to result in a high risk to the rights and freedoms of individuals. Where a DPIA indicates high risk data processing (i.e. a high risk that cannot be mitigated) the PHA will be required to consult the ICO before starting the processing.

DPIAs are relevant for new projects or proposals and also when planning to make changes to an existing system. It is vital that the outcomes of the DPIA are integrated back into the project plan. The DPIA is also a 'living' process to help manage and review the risks of the processing and measures that have been put in place, on an on-going basis.

A DPIA is a practical analytical tool that you can use:

- to identify whether a proposed project is likely to impact on the privacy of individuals affected, either positively or negatively;
- to check whether your project is likely to comply with the data protection principles;
- to make decisions about whether and how to adjust the proposal to manage any privacy risks and to maximise the benefits of protecting privacy well; and
- as a reference point for future action as the project, or your business, changes.

It is designed to be flexible and does not have to be complex or time-consuming in every case, however there must be a level of rigour in proportion to the privacy risks arising.

2 When is a DPIA required?

Consideration of a DPIA is a mandatory requirement for any project, large or small, that:

- involves collection of personal information – that is, information about living people, who can be identified,
- involves information that may be used to identify, profile or target individuals;
- may result in surveillance of individuals or intrusions into their personal space or bodily privacy; or
- may otherwise affect whether people's reasonable expectations of privacy are met.

A DPIA must be carried out where a type of processing is likely to result in a high risk to the rights and freedoms of individuals (taking account of both the likelihood and severity of any potential harm). If in doubt, a DPIA should be carried out.

3 How do we carry out a DPIA?

Consideration of the need for a DPIA should begin early in the life of a project, before you begin processing, and run alongside the planning and development process. It includes the following steps:

- Screening Exercise
- Full DPIA:
  - Step 1: identify the need for a DPIA
  - Step 2: describe the processing
  - Step 3: consultation process
  - Step 4: assess necessity and proportionality
  - Step 5: identify and assess risks
  - Step 6: identify measures to reduce risks
  - Step 7: approval process
  - Step 8: implementation (integrate outcomes into project plan)

Depending on the nature and scale of the project, a number of people should be involved in considering and undertaking a DPIA. These should include (but not be limited to) the Information Asset Owner (IAO), project lead/senior manager, project team (where relevant), IT security, legal, any processors etc.

4 Screening Exercise (to decide if a full DPIA is needed)

At the start of any project involving the processing of personal data, IAOs will be responsible for considering the requirement for a DPIA.

The screening exercise is designed to assist with this process and help you decide whether or not it will be necessary to conduct a full DPIA. Through the exercise, you will also gather some initial information which will assist with the DPIA itself.

It is important to identify at an early stage why the project is being planned and what it is intending to achieve. (Remember, if you have any major project which involves the use of personal data it is good practice/recommended to carry out a DPIA).

The advice of the Data Protection Officer (DPO) must always be sought at an early stage (email: dpo.pha@hscni.net).

Not all projects will require the same level of assessment. There will be a greater impact on privacy when data is sensitive or when its uses are more intrusive. However, most projects will benefit from a systematic analysis of how they will use personal data.

An IAO might decide after completing the screening exercise that the project does not require a DPIA because there will be a minimal impact on privacy. In such cases, IAOs will still be required to retain a copy of the screening exercise, documenting the reasons for not carrying out a DPIA, so that they can be referred to in the future, if necessary.

The scale of a DPIA should reflect the complexity of the associated project and a well-implemented DPIA process can sit alongside a project of any size. Integration of the principles of Data Protection by Design into the project management process will ensure that the DPIA and privacy requirements will have been considered from the project design stage and incorporated into project management processes. The activities to be carried out as part of the project will match those required for an effective DPIA. It can be integrated within the project by including privacy issues alongside existing meetings, consultations and other processes.

If following completion and review of the screening exercise, a DPIA is not needed because, for example, the project does not involve personal data, or the information used will be uncontroversial or the privacy risk negligible, this should be formally recorded as the outcome of the screening exercise. The details collected through the screening exercise should be retained as part of the project records and will provide transparency regarding the processes undertaken.

Use the screening exercise template to record your decision and store the document where you can refer to it again. If issues around privacy considerations arise at a later stage, you can use this record to demonstrate accountability.

If in doubt you should carry out a DPIA.

If it is decided a DPIA is required:

The information recorded as part of the screening exercise will form the basis of a full DPIA, through which further details can be collected, and more in-depth analyses completed. The DPIA template allows you to record the information you collect in a standardised format, and will take you step-by-step through the process.

5 Full Data Protection Impact Assessment (DPIA)

Step 1: Identify the need for a DPIA

Use the information gathered from the screening exercise to document the need for a DPIA. Additionally, document the lawful basis for processing.

Under GDPR the six lawful bases for processing are:

a) **Consent:** the individual has given clear consent for you to process their personal data for a specific purpose;
b) **Contract:** the processing is necessary for a contract you have with the individual, or because they have asked you to take specific steps before entering into a contract;
c) **Legal obligation:** the processing is necessary for you to comply with the law (not including contractual obligations);
d) **Vital interests:** the processing is necessary to protect someone's life;
e) **Public task:** the processing is necessary for you to perform a task in the public interest or for your official functions, and the task or function has a clear basis in law;
f) **Legitimate interests:** the processing is necessary for your legitimate interests or the legitimate interests of a third party unless there is a good reason to protect the individual's personal data which overrides those legitimate interests. (This cannot apply if you are a public authority processing data to perform your official tasks).

NOTE: Public authorities (i.e. PHA) must consider the 'public task' basis first. We have only limited scope to rely on consent or legitimate interests. Further guidance on the lawful bases can be found on the ICO website - here.

The lawful basis for processing must be clearly identified, and recorded, at the very beginning of any project.

Once you have identified your lawful basis and condition for processing, this should be documented on the DPIA template and PHA Information Asset Register to help you comply with the GDPR's accountability requirements and ensure all staff handling the information are aware of it. Your lawful basis should also be explained in your privacy notice and when answering subject access requests.

(Special category data also needs to be documented – see Section "Special Category Data" below).

Special Category Data

Special category data is more sensitive, and requires greater protection. For example, information about an individual's:
Race;
Ethnic origin;
Politics;
Religion;
Trade union membership;
Genetics;
Biometrics (where used for ID purposes);
Health;
Sex life; or
Sexual orientation

In particular, this type of data could create more significant risks to a person's fundamental rights and freedoms, for example, by putting them at risk of unlawful discrimination.

In order to lawfully process special category data, you must identify both a lawful basis and a separate condition for processing special category data.

The conditions for processing special category data are as follows:

(a) the data subject has given explicit consent to the processing of those personal data for one or more specified purposes, except where Union or Member State law provide that the prohibition referred to in paragraph 1 may not be lifted by the data subject;

(b) processing is necessary for the purposes of carrying out the obligations and exercising specific rights of the controller or of the data subject in the field of employment and social security and social protection law in so far as it is authorised by Union or Member State law or a collective agreement pursuant to Member State law providing for appropriate safeguards for the fundamental rights and the interests of the data subject;

(c) processing is necessary to protect the vital interests of the data subject or of another natural person where the data subject is physically or legally incapable of giving consent;

(d) processing is carried out in the course of its legitimate activities with appropriate safeguards by a foundation, association or any other not-for-profit body with a political, philosophical, religious or trade union aim and on condition that the processing relates solely to the members or to former members of the body or to persons who have regular contact with it in connection with its purposes and that the personal data are not disclosed outside that body without the consent of the data subjects;

(e) processing relates to personal data which are manifestly made public by the data subject;

(f) processing is necessary for the establishment, exercise or defence of legal claims or whenever courts are acting in their judicial capacity;

(g) processing is necessary for reasons of substantial public interest, on the basis of Union or Member State law which shall be proportionate to the aim pursued, respect the essence of the right to data protection and provide for suitable and specific measures to safeguard the fundamental rights and the interests of the data subject;

(h) processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services on the basis of Union or Member State law or pursuant to contract with a health professional and subject to the conditions and safeguards referred to in paragraph 3;

(i) processing is necessary for reasons of public interest in the area of public health, such as protecting against serious cross-border threats to health or ensuring high standards of quality and safety of health care and of medicinal products or medical devices, on the basis of Union or Member State law which provides for suitable and specific measures to safeguard the rights and freedoms of the data subject, in particular professional secrecy;

(j) processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes in accordance with Article 89 (1) based on Union or Member State law which shall be proportionate to the aim pursued, respect the essence of the right to data protection and provide for suitable and specific measures to safeguard the fundamental rights and the interests of the data subject.

Step 2: Describe the processing

A thorough assessment of privacy risks is only possible if you fully understand how personal data will be used in a process. If the project involves a change to how information will be handled, for example, moving from a manual process to an electronic system, you will need to understand how information is used in both the old and new processes and the differences between the two. Be aware of any changes involved and how these could impact on the privacy of the data subjects.

Understanding the information flow and documenting the processing is a key part of the DPIA process. An incomplete understanding of the activities around data use can be a significant privacy risk as information might be processed unfairly or disclosed inappropriately.

It is important to have a clear understanding of how your information will be used from the beginning to the end of the process. Describe how and why you plan to use the personal data. The description must include the nature, scope, context and purposes of the processing.

The nature of the processing is what you plan to do with the personal data. This should include, for example:

- How you will collect the data:
- How you will store the data;
- How you will use the data;
- Who will have access to the data;
- Who you will share the data with;
- Whether you will use any processors;
- Retention periods;
- Security measures;
- Whether you are using any new technologies;
- Whether you are using any novel types of processing; and
- Which screening criteria you flagged as likely high risk.

The scope of the processing is what the processing covers. This should include, for example:

- The nature of the personal data;
- The volume and variety of the personal data;
- The sensitivity of the personal data;
- The extent and frequency of the processing;
- The duration of the processing;
- The number of data subjects involved; and
- The geographical area covered.

The context of the processing is the wider picture, including internal and external factors which might affect expectations or impact. This might include, for example:

- The source of the data;
- The nature of your relationship with the individuals;
- The extent to which individuals have control over their data;
- The extent to which individuals are likely to expect the processing;
- Whether they include children or other vulnerable people;
- Any previous experience of this type of processing;
- Any relevant advances in technology or security; and
- Any current issues of public concern.

The purpose of the processing is the reason why you want to process the personal data. This should include:

- Your lawful basis for processing;
- The intended outcome for individuals; and
- The expected benefits, for example, to the service, the PHA or society as a whole.

Fully documenting all data processing activities can help to identify potential, unforeseen or unintended uses of the information, even if they are not immediately obvious, for example, data sharing.

Describing the information flow can take any format. For simple processes, using bullet points may suffice while in complex cases, a flow chart will be invaluable.

The description of the processing should be recorded at Step 2 of the DPIA template. Include any flow charts or information maps you have drawn up as these will form part of the final DPIA report, or reference to where these are available, for example in the relevant business case.

Step 3: Consider Consultation

Consultation is an important part of the DPIA process as it allows stakeholders to highlight privacy risks and solutions based on their own area of interest or expertise. This should not be considered as a separate step. It should be built into all stages and can be carried out as part of the planning process for the wider project.

There is no set process for consultation. It will depend on a number of factors such as the size and scale of the project.

<u>Internal consultation</u>

Effective consultation with colleagues is an important part of the DPIA process. Data protection risks are more likely to remain unmitigated on projects which have not involved discussions with the people building the system or carrying out procedures.

Internal consultation can include informal discussions and emails, more formal project management meetings and approval at project board or Senior Management Team level. Most internal stakeholders will already have had some level of involvement in the project – the aim of the DPIA is to focus their attention on privacy issues.

The project may relate to an initiative involving a number of HSC Organisations or other public bodies, for example a plan to centralise a service. In such cases, all interested parties will be stakeholders.

Identifying a full range of internal stakeholders will be easier if the description of processing and information flow has been clearly set out (see Step 2) but you may also need to do some initial internal consultation in order to describe the information flows in the first place.

Always consult the Information Governance Team at the start of any DPIA, for advice on the process.

The following are examples of internal stakeholders:

- Senior Management Team
- IAOs
- Project board
- Project management team
- Information Governance Steering Group
- Information Governance Team
- Data users
- BSO ITS
- BSO PALS
- BSO DLS

External consultation

External consultation means seeking the views of people who will be affected by the project. They may be members of the public but could also be PHA staff involved in a wider project. If there is a separate data processor, they should also be consulted with.

Consultation with the people affected is an important part of a DPIA for two reasons. Firstly, it enables the business area to understand the concerns of those individuals and, secondly, the consultation will improve transparency by making people aware of how information about them is being used. If you decide that it is not appropriate to consult individuals this decision must be recorded as part of the DPIA along with a clear explanation.

The timing and nature of consultation can be important if a project is sensitive. How extensive the consultation needs to be will be driven by the types of risk and the number of people affected. A business area may already have consultation mechanisms such as focus groups or user groups that can be used. Where possible, existing consultation tools should be used to gain a better understanding of privacy expectations and experiences.

The consultation should be designed so that data subjects can have a meaningful impact on the project. The business area should be clear about which aspects of the project are open to change and which aspects are less so. Consultation must be set out in clear terms that can be easily understood. Public consultation can be an effective way to communicate to people about how the PHA uses their information.

External consultation also provides the opportunity for a business area to benefit from wider views and from expertise that may not exist within the PHA. It should follow these principles:

- Timely – at the right stage and allow enough time for responses;
- Clear and proportionate – in scope and focus;
- Reach and representative – ensure those likely to be affected have a voice;
- Focus – ask objective questions and present realistic options;
- Feedback – ensure those participating can get feedback at the end of the process.

If the DPIA decision is at odds with the views of individuals, the reasons for disregarding their views must be documented.

Step 4: Assess necessity and proportionality

In order to consider if your plans will achieve your purpose, or if there is any other way of achieving the same result, the following compliance and proportionality measures should be described:

- Your lawful basis for the processing;
- How you will prevent function creep *(i.e. make sure that the data continues to be used for the original purpose for which it was collected)*;
- How you intend to ensure data quality;
- How you intend to ensure data minimisation *(i.e. make sure that data is not held or further used beyond the reasons originally given for the data collection)*;
- How you intend to provide privacy information to individuals;
- How you implement and support individuals rights;
- Measures to ensure your processors comply (where appropriate); and
- Safeguards for international transfers (where appropriate).

NB: You may identify risks as you consider the above bullet points, and the solutions may form part of the mitigation measures (Steps 5 and 6).

Step 5: Identify and assess risks

A DPIA is a form of risk management. When conducting a DPIA, a business area will systematically consider how the project will affect individuals' privacy.

Privacy is about the right of an individual to be left alone. Information privacy is the ability of data subjects to control, edit, manage and delete information about them and to decide to what extent such information is communicated to others.

Intrusion can come in the form of collections of excessive personal information, disclosure of personal information without consent, misuse of such information or failing to have appropriate security measures in place. It can include the collection of information through surveillance or monitoring of how people act in public or private spaces and through the monitoring of communications whether by post, phone or online. It extends to monitoring the records of senders and recipients as well as the content of messages.

A privacy risk is the threat of causing harm or distress to someone through collecting, holding or using their personal information, or otherwise intruding into their privacy. Some of the ways this risk can arise is through personal information being:

- inaccurate, insufficient or out of date;
- excessive or irrelevant;
- inaccessible;
- kept for too long;
- disclosed to individuals who the data subject does not want, or would not expect, to have it;
- used in ways that are unacceptable to or unexpected by the data subject;
- not kept securely.

Causing harm or distress

Harm can present itself in different ways. Sometimes it will be tangible and quantifiable, for example, financial loss, identity theft or losing a job. At other times it will be less defined, for example, damage to personal relationships and social standing arising from the disclosure of confidential or sensitive information. Within healthcare organisations, cognisance needs to be taken of the risk of harm or distress caused by the inappropriate releasing of personal health information about individuals.

Sometimes harm might still be real even if it is not obvious, for example, the fear of identity theft that comes from knowing that the security of information could be compromised. There is also harm which goes beyond the immediate impact on individuals. The harm arising from the use of personal information may be imperceptible or inconsequential to individuals but cumulative and substantial in its impact on society. It might, for example, contribute to the loss of personal autonomy or dignity or exacerbate fears of excessive surveillance.

There are various ways in which a project can impact on privacy or can introduce a risk to privacy. Privacy risks to individuals usually have associated compliance risks and risks to the PHA. For example, a project that is seen as intrusive or insecure by data subjects also increases the risk of enforcement action and reputational damage to the PHA.

Risks can be categorised in different ways and it is important that all types of risks are considered. These range from the physical safety of individuals, material impacts (such as financial loss) or moral (for example, distress caused).

By conducting a DPIA, you will be able to consider privacy risks at the outset of any project involving the use of personal data. As a result, risks can be eliminated, reduced or accepted and managed effectively.

Consider the potential impact on individuals and any harm or damage that might be caused by your processing, whether physical, emotional or material. In particular look at whether the processing could possibly contribute to:

- Inability to exercise rights (including but not limited to privacy rights);
- Inability to access services or opportunities;
- Loss of control over the use of personal data;
- Discrimination;
- Identify theft or fraud;
- Financial loss;
- Reputational damage;
- Physical harm;
- Loss of confidentiality;
- Re-identification of pseudonymised data; or
- Any other significant economic or social disadvantage.

You should also include an assessment of the security risks, including sources of risk and the potential impact of each type of breach (including illegitimate access to, modification of or loss of personal data).

(See Section 4 of the DPIA Policy for examples of possible risks).
Risks should also be assessed against the data protection principles (see Section 2.2 of the DPIA Policy).

The risk assessment stage can be incorporated with existing risk or project management methodologies. You should build on the earlier work of describing the project and the processing. This will help staff take a thorough and consistent approach.

Once you have described the processing (Step 2), examine it closely to assess all activities where processing may pose a risk, either to individuals or to the PHA. For example, where information is shared with a third party, is the method of transmission secure and are there robust data sharing arrangements in place? If personal information is sent by post, is a risk assessment of the service used required? If a new manual process or IT system is introduced, will there be training for staff and operational guidance to follow? When you fully understand how information will be used, privacy issues associated with the project will be more easily assessed.

Assess the risk in terms of likelihood and impact (consequence). To assist in making an objective assessment of the risk, refer to the HSC regional Risk Matrix which can be found in the PHA Risk Management Strategy and Policy. The Information Governance Team can also be contacted for advice on assessing risks. Once risks are identified, they should be documented as at Step 5 of the DPIA template and will form part of the DPIA final report.

Step 6: Identify measures to mitigate risks

Once all risks have been identified, you should consider what actions can be taken to address risks to privacy.

It is important to remember that the purpose of a DPIA is not to try to completely eliminate the entire impact on privacy, as this may not be feasible, but to reduce the impact to an acceptable level while still allowing a useful project to be implemented.

The process of identifying and implementing changes should be integrated with the wider project management process.

When deciding on privacy solutions, you need to consider whether the impact on privacy is proportionate to the aims of the project. Privacy solutions are steps which can be taken to reduce the privacy impact. The aim of this stage of the process is to balance the project's outcomes with the impact on individuals. Business areas should record whether each privacy solution that has been identified results in the risk being:

- eliminated
- reduced; or
- simply accepted and managed.

There are many different steps which can be taken to reduce a privacy risk. Some of the more likely measures include:

- Deciding not to collect or store particular types of personal data (data minimisation);
- Reducing the scope of the processing;
- Devising retention periods which only keep information for as long as necessary and planning destruction of information;
- Implementing appropriate technological or organisational security measures;
- Ensuring staff are properly trained and are aware of the potential privacy risks;
- Developing ways to safely anonymise the information when it is possible to do so (data anonymisation);
- Producing guidance for staff on how to use new systems and how to share data appropriately;
- Using a different technology;
- Using procedures which allow data subjects to access their information more easily and make it simpler to respond to subject access requests;
- Taking steps to ensure that individuals are fully aware of how their information is used and can contact the PHA for assistance if necessary (privacy notice);
- Selecting data processors who will provide a greater degree of security and ensuring that contacts with robust data sharing clauses are in place to protect the information which is processed on the PHA's behalf;

- Producing data sharing agreements which make it clear who is the data controller, what information will be shared, how it will be shared and who it will be shared with.

This is not an exhaustive list and you may be able to devise other ways to help reduce or avoid the risks.

The costs and benefits of possible privacy solutions should be assessed, for example, additional software may need to be purchased to give greater control over data access and retention. Costs can be balanced against the benefits such as the increased assurance against a data breach or a reduced risk of regulatory action and reputational damage. The assessment of the costs and benefits of each measure can be taken into account when deciding whether or not they are appropriate.

The measures to deal with the risk; whether each risk has been eliminated, reduced or accepted; the overall level of 'residual risk' after taking additional measures and whether or not the ICO needs to be consulted should be recorded in the format set out in Step 6 of the DPIA template. This will form part of the final report.

Step 7: Approval and Record Outcomes

Conducting a DPIA is primarily about the process of identifying and reducing risks. A key part of the process is deciding which privacy solutions to take forward and recording whether the risks that have been identified will be eliminated, reduced or accepted and managed. This will provide assurance that the PHA is using information in a way which is appropriate for their objectives and safe for individuals.

Once privacy risks have been fully assessed, the decision to eliminate, reduce or accept that risk must be taken at an appropriately senior level, depending on the scale of the project. For formal, large-scale projects, such decisions will usually be taken by the project lead. In all other cases, responsibility will fall to the relevant IAO.

Where a risk will be accepted, the decision to do so should be documented, along with an explanation as to how it will be managed. In some cases, the Senior Information Risk Owner (SIRO), Project Board, Directorate or Senior Management Team may need to be consulted, as well as the DPO.

Approvals should be recorded in the template provided at Step 7 of the DPIA template to form part of the formal written DPIA report.

Step 8: Integrate outcomes into project plan and keep under review

A DPIA is primarily concerned with the identification and reduction of risks. To be effective, the results must be fed back into the wider project management or business area process.

Most of the work required by a DPIA will take place during the planning and early implementation of a project. However, IAOs and project managers should also ensure that steps taken as a result of the DPIA have been properly implemented and are having the desired effect. Actions arising should be recorded (Step 8 of the template in the DPIA template), together with target dates for completion and details of who has been assigned to take them forward.

The DPIA is a 'living document'. If a project's aims develop or change during the project lifecycle, it may be appropriate to revisit the screening questions and/or DPIA. This will be especially important for projects which may not have a fixed set of requirements at the outset or as the process evolves.

As with other aspects of the DPIA, a review of the privacy outcomes can be built into existing procedures. If a business area would review the general implementation of a new project after a certain period, a process should be included for checking the work arising from the DPIA as well.

The DPIA process should be developed to integrate with a business area's own processes and most projects include a post project review.

The DPIA should also be revisited if changes are made to a process at a later date, for example, a software upgrade, introduction of new technology, an additional data sharing partner or changes in the way information will be handled.

6 DPIA Report

Keeping a formal record of a DPIA will assure the public, the Senior Management Team, the ICO and other stakeholders that the project has been thoroughly assessed for risks.

The completed DPIA template is the formal record of the DPIA process. It should therefore be fully completed during the process, clearly documenting all the steps of the DPIA. It should also contain or reference other relevant information, e.g. flow charts, consultation records etc. The DPIA should be held alongside any business case or other project documentation.

Once the report has been signed off, the IAO must ensure that details of the assessment are entered in the PHA Data Sharing/DPIA Register maintained by Information Governance (via email: **dpo.pha@hscni.net).**

The ICO encourages organisations to consider publishing material relating to a DPIA, including the report. Publication improves transparency and can increase the public's understanding of how their information is used.

There can, however, be sensitivities around publishing material relating to a DPIA. The report may sometimes contain information which is not appropriate to disclose, such as information on security measures. Any decision to publish should therefore be made on a case by case basis.

In conclusion

Any changes in how we process personal data may require us to review and amend the PHA and/or business area privacy notices.

We may also need to review and amend the PHA Information Asset Register. The Information Asset Register is an inventory of information assets and their systems, including personal data held. Each IAO is responsible for maintaining their local Information Asset Register, and they should make sure that it is updated appropriately.

If, as a result of the new process you are implementing, there will be a requirement to share personal data with another public body or organisation, ensure that suitable arrangements are in place in the form of a robust contract or data access agreement. Further information can be found in the PHA Data Protection and Confidentiality Policy and the ICO Data Sharing Code of Practice.

This Guidance should be read in conjunction with the PHA Data Protection Impact Assessment (DPIA) Policy and Templates (Screening and DPIA) – available on Connect *here*.

7 Equality and Human Rights Considerations

This guidance has been screened for equality implications as required by Section 75, Schedule 9, of the Northern Ireland Act, 1998. Equality Commission for Northern Ireland Guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to them.

Using the Equality Commission's screening criteria, no significant equality implications have been identified. This policy will therefore not be subject to an equality impact assessment.

This guidance has been considered under the terms of the Human Rights Act, 1998, and was deemed to be compatible with the European Convention Rights contained in that Act.

This guidance will be included in the PHA's Register of Screening Documentation and maintained for inspection whilst it remains in force.

This document can be made available on request in alternative formats and in other languages to meet the needs of those who are not fluent in English.

8 Review

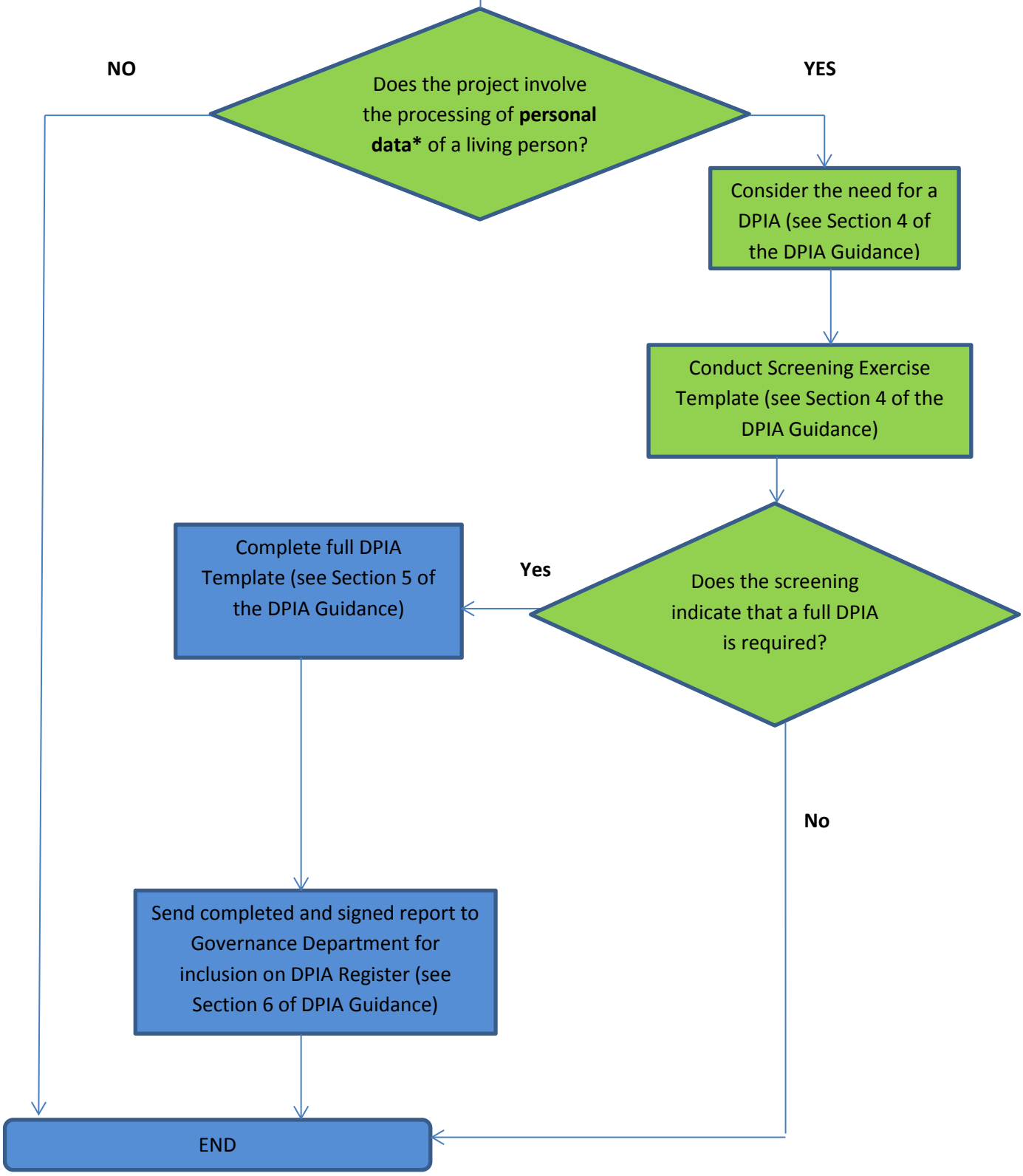
The PHA is committed to ensuring that all policies and procedures are kept under review to ensure that they remain compliant with relevant legislation.

This guidance will be reviewed as per the schedule on the title page, or earlier if relevant guidance is issued. That review will be noted on a subsequent version of this policy, even where there are no substantive changes made or required.

January 2019

HSC Public Health Agency

DATA PROTECTION IMPACT ASSESSMENT (DPIA) FLOWCHART



*** Personal data refers to any information about a living person which can be used to identify them.**

PHA DATA PROTECTION IMPACT ASSESSMENT (DPIA)
SCREENING EXERCISE TEMPLATE

Please read Paragraph 3 of the DPIA Guidance before completing this template

Project Name:

Business Area:	**Directorate:**

1. PROJECT SUMMARY
Briefly describe your project, plan or proposal. Set out its purpose and any projected benefits.

2. STAKEHOLDERS
Identify the main stakeholders or bodies involved and their role in the project.

3. BRIEF DESCRIPTION OF INFORMATION INVOLVED

4. PRIVACY ASSESSMENT			
Use this checklist to assess the project for privacy risks. The questions below will help you consider whether a DPIA is necessary. Answering 'Yes' to any of the questions is an indication that a DPIA would be a useful exercise.			
Does the project involve any of the following?	**Yes**	**No**	**If yes, explain your response**
Information management			
A change to an existing policy, process or system that involves personal information (for example, new legislation or policy that makes it compulsory to collect or disclose information).	☐	☐	
A change in location of a business area or branch (for example, plans to centralise a service or an office move).	☐	☐	
Any practice or activity that is listed on a risk register (for example, activities listed on your business area's risk register or health and safety register).	☐	☐	
Collection			
Collecting new information about an individual (for example, gathering information about individuals' participation in a new project).	☐	☐	
A new way of gathering personal information (for example, collecting information online rather than on paper forms).	☐	☐	
Storage, security and retention			
A change in the way personal information is stored or secured (for example, cloud storage).	☐	☐	

A change to how sensitive personal information is managed (for example, moving health records to a new database).	☐	☐	
Transferring personal information offshore (for example, using a cloud based application to store data).	☐	☐	
A decision to retain personal information for longer than previously kept (for example, keeping information for 10 years when you previously only held it for 7).	☐	☐	
Use or disclosure			
Using information classed as 'sensitive personal data' (for example, information about an individual's health).	☐	☐	
Using personal data already held for a new purpose (for example, to monitor trends of a new infection).	☐	☐	
Disclosing information to a third party (for example, following a request from another organisation to provide information for a particular purpose).	☐	☐	
Sharing or matching personal information held in different datasets or by different organisations (for example, combining data with other information held on systems or sharing information to enable organisations to provide services jointly).	☐	☐	

Individuals' access to their information			
A change in policy that results in people having less access to information that you hold about them (for example, archiving documents after 6 months into a facility from which they cannot be easily retrieved).	☐	☐	
Identifying individuals			
Establishing a new way of identifying individuals (for example, a unique identifier, a biometric or online identity system).	☐	☐	
New intrusions on individuals' property, person or activities			
Introducing a new system for searching individuals' property, persons or premises (for example, adopting a new policy of searching data on mobile phones that have been returned for upgrading).	☐	☐	
Surveillance, tracking or monitoring of movements, behaviour or communications (for example, installing a new CCTV system or monitoring a member of staff's email account).	☐	☐	
Changes to premises impacting on private spaces where clients/staff may discuss personal data (for example, relocating a branch where sensitive personal data is processed).	☐	☐	
New regulatory requirements that could lead to compliance action against individuals on the basis of information about them (for example, adding a new medical condition to the requirements of a licence).	☐	☐	

Other privacy intrusions such as body searches, or intrusion into physical space.	☐	☐	

Additional Comments/Notes

5. INITIAL RISK ASSESSMENT

If you answered 'Yes' to any of the questions in section 4, use the table below to give a rating - either Low (L), Medium (M), or High (H) – to each of the aspects of the project set out in the first column. If you answered 'No' to all the questions in section 4, move on to section 6.

Aspect of the Project	**Rating (L, M or H)**	
Level of personal data handling	L – Minimal personal information will be handled	☐
	M – A moderate amount of personal information (or information that could become personal information) will be handled	☐
	H – A significant amount of personal information (or information that could become personal information) will be handled	☐
Sensitivity of information	L – The information is not sensitive	☐
	M – The information may be considered to be, or may become, sensitive	☐
	H – The information is highly sensitive	☐
Significance of the changes	L – Only minor change to existing functions/activities	☐
	M – Substantial change to existing functions/activities; or a new initiative	☐
	H – Major overhaul of existing functions/activities; or a new initiative that's significantly different	☐
Interaction with third parties	L – No interaction with other agencies	☐
	M – Interaction with one or two other agencies	☐
	H – Extensive cross-agency (government) interaction or cross-sectional (non-government and government) interaction	☐

Public impact	L – Minimal impact on the organisation and individuals	☐
	M – Some impact on individuals is likely due to changes to the handling of personal information; or the changes may raise public concern	☐
	H – High impact on individuals and the wider public; concerns over aspects of project or negative media interest is likely	☐

6. SUMMARY OF PRIVACY IMPACT	
The privacy impact for this project has been assessed as:	
Low – There is little or no personal information involved; or the use of personal information is uncontroversial; or the risk of harm eventuating is negligible; or the change is minor and something that the individuals concerned would expect; or risks are fully mitigated.	☐
Medium * ** – Some personal information is involved, and several low to medium risks have been identified	☐
High * ** – Sensitive personal information is involved, and several medium to high risks have been identified	☐
Reduced risk – The project will lessen existing privacy risks	☐
Inadequate information – More information and analysis is needed to fully assess the privacy impact of the project.	☐
Briefly summarise reasons for the rating given	

* Refer to Section 5 (Special Category Data) in the DPIA Guidance when determining level of privacy impact.

** If you have assessed the privacy impact as high or medium, a DPIA must be carried out.

7. RECOMMENDATION	
A full data protection impact assessment **is** required	☐
A full data protection impact assessment **is not** required	☐
Reasons	

8. SIGN OFF	
Project Manager	
Name:	Date:
Signed:	
Senior Responsible Owner/Information Asset Owner	
Name:	Date:
Signed:	

Public Health Agency

DATA PROTECTION IMPACT ASSESSMENT TEMPLATE REPORT

DPIA Ref no. *(Information Governance to provide)*	
Project Name	
Business Area	
Information Asset Owner	**Project Manager**

Note: Please delete all guidance notes in italics from your final report

Please refer to Steps 1-8 outlined in the DPIA Guidance Notes before completing this template.

Step 1: Identify the need for a DPIA
Give a short overview of the project. You will have to provide more detail in sections below so it can be kept very brief.
Purpose
Describe the project and what it is meant to achieve. It may be helpful to refer to other documents, such as a project proposal. (Information contained in the screening exercise a helpful starting point).
Need for a DPIA
Describe how the project will impact on privacy and why a DPIA was undertaken. *Identify if there are any limitations to the DPIA. For example, no arrangement in place to cover the use of personal information by third party.*
Lawful Basis for Processing
In this section, set out your lawful basis for processing.

Step 2: Describe the processing
Describe the nature of the processing:
How will you collect, use, store and delete data? What is the source of the data? Will you be sharing data with anyone? You might find it useful to refer to a flow diagram or other way of describing data flows. What types of processing identified as likely high risk are involved?
Describe the scope of the processing:
What is the nature of the data, and does it include special category or criminal offence data? How much data will you be collecting and using? How often? How long will you keep it? How many individuals are affected? What geographical area does it cover?
Describe the context of the processing:
What is the nature of your relationship with the individuals? How much control will they have? Would they expect you to use their data in this way? Do they include children or other vulnerable groups? Are there prior concerns over this type of processing or security flaws? Is it novel in any way? What is the current state of technology in this area? Are there any current issues of public concern that you should factor in? Are you signed up to any approved code of conduct or certification scheme (once any have been approved)?

Describe the purposes of the processing:
What do you want to achieve? What is the intended effect on individuals? What are the benefits of the processing – for you, and more broadly?
Step 3: Consultation process
Set out your key stakeholders and their role in the project. This information may have been gathered for the screening exercise.
Consultation
Explain how you consulted with stakeholders and the extent of any consultation.
Step 4: Assess necessity and proportionality
Describe compliance and proportionality measures. Does the processing actually achieve your purpose? Is there another way to achieve the same outcome? How will you prevent function creep? How will you ensure data quality and data minimisation? What information will you give individuals? How will you help to support their rights? What measures do you take to ensure processors comply? How do you safeguard any transfers, including international transfers?

Step 5 Identify and assess risks			
Describe source of risk and nature of potential impact on individuals. Include associated compliance and corporate risks as necessary.	**Likelihood of harm**	**Impact (consequence) of harm**	**Overall risk**
	Almost certain, likely, possible, unlikely or rare	Insignificant, minor, moderate, major or catastrophic	Low, medium, high or extreme

Step 6 Identify measures to reduce risk				
Explain how you could address each risk identified in Step 5. Some risks might be eliminated altogether and others might be reduced. For others, you may be required to accept some level of risk. Evaluate the likely costs and benefits of each approach. Think about available resources, and the need to deliver a project which is still effective.				
Risk	**Options to reduce or eliminate risk**	**Effect on risk**	**Residual risk**	**Measure approved**
		Eliminated, reduced or accepted	Low, medium, high or extreme	Yes/no

STEP 7 Approval Process		
Ensure privacy solutions are approved at an appropriately senior level. In general, the DPIA will be signed off by the responsible Information Asset Owner. For larger scale projects, the Senior Information Risk Owner will be required to approve solutions and sign off the process. In this section, you should summarise the steps taken to reduce risks to privacy and record decisions taken to eliminate, mitigate or accept the identified risks.		
Item	**Name/date**	**Notes**
Measures approved by:		*Integrate actions back into project plan, with date and responsibility for completion (see step 8)*
Residual risks approved by:		*If accepting any residual high risk, ICO must be consulted before going ahead. Advice of DPO must be sought first.*
DPO/Information Governance advice provided:		*DPO/Information Governance to advise on compliance*

Step 8 Implementation		
What actions need to be taken forward as a result of the DPIA? Who is responsible for integrating DPIA outcomes back into the project plan and updating any project management paperwork? Who is responsible for implementing the solutions that have been approved and what is the timescale? Who is responsible for any privacy concerns that may arise in the future?		
Action to be taken	**Date for Completion**	**Responsible Owner**
Contact point for future privacy concerns		
SIGN OFF		
Senior Responsible Owner/Information Asset Owner		
Name:	**Date:**	
Signed:		
Project Manager		
Name:	**Date:**	
Signed:		
Director		
Name:	**Date:**	
Signed:		