agenda

Title of Meeting	126th Meeting of the Public Health Agency Board
Date	15 October 2020 at 1.30pm
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

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 17 September 2020		Chair
4 1.35	Matters Arising		Chair
5 1.40	Chair's Business		Chair
6 1.45	Chief Executive's Report		Chief Executive
7 2.00	Finance Report	**PHA/01/10/20**	Director of Finance
8 2.10	Update on COVID-19 a) Northern Ireland data on new infections, hospitalisations, admissions to ICU and deaths for each of the last five weeks b) Coping with the surge in positive tests c) Variation in location (in hospital, in care homes and in home residence) of excess deaths in March/April compared with September/October 2020 d) Opportunities for quality control initiatives in tracking and tracing		Chief Executive

committee updates

9 2.40	Update from Chair of Governance and Audit Committee	**PHA/02/10/20**	Mr Stewart

items for approval

10 2.50	PHA Mid-Year Assurance Statement	**PHA/03/10/20**	Chief Executive
11 3.00	PHA Corporate Risk Register	**PHA/04/10/20**	Chief Executive
12 3.15	ALB Self-Assessment	**PHA/05/10/20**	Chair

items for noting

13 3.25	Update on Population Screening Programmes	**PHA/06/10/20**	Professor van Woerden

closing items

14 Any Other Business
3.30

15 Details of next meeting:

Thursday 19 November 2020 at 1.30pm

Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast, BT2 8BS

minutes

Title of Meeting	125th Meeting of the Public Health Agency Board
Date	17 September 2020 at 1.30pm
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

Present

Mr Joseph Stewart	-	Non-Executive Director (*Chair*)
Mrs Olive MacLeod	-	Interim Chief Executive
Mr Edmond McClean	-	Interim Deputy Chief Executive / Director of Operations
Mr Rodney Morton	-	Director of Nursing and Allied Health Professionals
Professor Hugo van Woerden	-	Director of Public Health *(via video link)*
Alderman William Ashe	-	Non-Executive Director
Mr John-Patrick Clayton	-	Non-Executive Director (*via video link*)
Ms Deepa Mann-Kler	-	Non-Executive Director
Alderman Paul Porter	-	Non-Executive Director
Professor Nichola Rooney	-	Non-Executive Director

In Attendance

Mr Paul Cummings	-	Director of Finance, HSCB
Dr Aideen Keaney	-	Director of Quality Improvement *(via video link)*
Ms Marie Roulston	-	Director of Social Care and Children, HSCB *(via video link)*
Mr Robert Graham	-	Secretariat

Apologies

Mr Andrew Dougal	-	Chair

88/20	**Item 1 – Welcome and Apologies**
88/20.1	The Chair welcomed everyone to the meeting. Apologies were noted from Andrew Dougal.
88/20.2	The Chair noted that this would be the last PHA Board meeting attended by Mr McClean and Mr Cummings prior to their retirements.
89/20	**Item 2 – Declaration of Interests**
89/20.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.

90/20	**Item 3 – Minutes of previous meeting held on 20 August 2020**
90/20.1	The minutes of the Board meeting held on 20 August 2020 were approved as an accurate record of that meeting, subject to minor amendments.
90/20.1	In paragraph 78/20.21, the Chair said that additional wording needed to be inserted to clarify that business should not be closing until a risk assessment has been carried out.
90/20.2	In paragraph 78/20.23, Mr Clayton said that he was seeking clarity that lessons from the first wave were applied.
90/20.3	Professor Rooney requested that the Chief Executive's Report is prepared along the lines of the PHA's strategic themes as outlined in paragraph 78/20.19. The Interim Chief Executive said that the format of the Report continues to be refined, but she took that feedback on board.
91/20	**Item 4 – Matters Arising**
91/20.1	There were no matters arising.
92/20	**Item 5 – Chair's Business**
92/20.1	The Chair advised that he had participated in a Zoom teleconference on behalf of Mr Dougal with the UK Public Health Network, the focus of which was to prepare a submission to the 2020 Comprehensive Spending Review. Participants felt that this was an opportunity to make a bid for increased public funding. He noted that the debate focused on the fate of Public Health England and health inequalities which he said was interesting as there was no clear understanding yet as to what was going to happen.
92/20.2	Mr Cummings noted that within Mr Dougal's report which had been circulated to members in advance, there was a reference with regard to how PHA allocates its funding and how this is monitored. He assured members that all funding is monitored and if PHA wished to make a decision to stop a particular Trust programme, it would be liable for the redundancy costs of any staff associated with that programme.
92/20.3	The Chair said that the Non-Executive Directors would wish to have an opportunity to review the terms of reference for the review of PHA, but recognising that this is ultimately a matter for the Permanent Secretary and the Minister. Mr Cummings said that, given that some of the officers of PHA are due to retire, he wished to put on record that at no point during his tenure has there been any suggestion that the PHA is underperforming in its duties. The Chair agreed that it is important that this is recorded but he added that in the correspondence received by the Chief Executive, the Chief Medical Officer pointed out that PHA has been performing well despite the pressures that it is under.

93/20 **Item 6 – Chief Executive's Business**

93/20.1 The Chair thanked the Interim Chief Executive and Executive Directors for producing a comprehensive Report and invited the Interim Chief Executive to present the Report.

93/20.2 The Interim Chief Executive thanked the Executive Directors for the Report and said that it was a useful mechanism for reflecting on what the teams have achieved over the last month. She said that the teams are working hard to discharge their responsibilities as well as deal with the day to day business. She added that the demands in relation to COVID-19 work continue to build. She noted that there has been a lot of media interest in relation to testing and capacity, but pointed out that testing is run by the National Initiative and that PHA does not determine how many tests are carried out in Northern Ireland.

93/20.3 Ms Mann-Kler welcomed the Report, but she sought assurance that its compilation is not placing additional workload on staff. The Interim Chief Executive felt that it is useful to have such a record, but that the format still needs refined. She said that there is so much happening with the PHA, the Report is useful for Executive Directors to keep each other informed. Ms Mann-Kler suggested there should be a cover sheet with three or four key headlines.

93/20.4 Ms Mann-Kler asked if PHA is responding to the consultation on the changes to the HSC Framework Document, and whether there should be a joint response from Executive and Non-Executive Directors. Mr Cummings pointed out that PHA Executives would not be expected to respond, but he encouraged Non-Executives Directors to do so as it has an impact on them. He advised that HSCB Non-Executives have taken legal advice on the matter. The Chair noted that it is disappointing that Mr Dougal has not yet received a response to the correspondence he sent to the Permanent Secretary on this matter and there are potentially implications in the amended Framework in terms of how PHA discharges its statutory responsibilities. He said that he had thought there may be a joint response from all HSC Chairs, but he felt that PHA should prepare its own response and that a meetings of Non-Executives may need to be convened to discuss this. He agreed to speak to Mr Dougal concerning this. **[ACTION – Mr Stewart]**. Alderman Porter asked how legal advice could be obtained. Mr Cummings advised that this would be through BSO through the PHA Chair.

93/20.5 Ms Mann-Kler asked for an update on the Chief Medical Officer's review of PHA and the terms of reference for this. She noted that she and Professor Rooney sit on a working group looking at the development of the new PHA Corporate Strategy and that its work would need to align with this review as well as any actions emanating from the recent review of the epidemiology function. The Interim Chief Executive reported that she and Mr Dougal had met with the Chief Medical Officer and that the outset, he expressed his gratitude to the hard work and commitment of

PHA at this time. She said that he felt that as the PHA is 10 years old it is opportune to carry out a review as he acknowledged that PHA is under resourced to deal with the demands of COVID-19, but that it has risen to the challenge. She added that there will be challenges to get through this coming winter so it would be useful to review where PHA needs to strengthen and what resilience is needed. She explained that the Chief Medical Officer has asked her and Mr Dougal to develop terms of reference, and that she and Professor van Woerden had shared a draft with Mr Dougal. She said that a meeting is planned with the Permanent Secretary on 25 October. She expressed concern about carrying out such a review in the midst of a pandemic as staff have been working hard and COVID-19 work may have to continue until at least next summer. She agreed to share the terms of reference with the Board **[Action – Interim Chief Executive]**. Professor Rooney queried whether the review was taking into account any new roles that the PHA may be taking on following the closure of HSCB. The Interim Chief Executive said this review is aimed to look at how PHA discharges its responsibilities as a public health organisation and that it needs to have a strategy and a roadmap to build on. Professor Rooney said that there still needs to be plan in terms of the closure of HSCB. The Interim Chief Executive explained that there is a Programme Board run by the Department of Health looking at this. Alderman Porter agreed that there are a lot of staff working in good faith and that resilience is important.

93/20.6 Ms Mann-Kler asked about the rapid learning review in care homes. Mr Morton reported that he and Ms Roulston had been involved in this work and agreed to share the report **[Action – Mr Morton]**. He outlined that there were 24 recommendations which will be built into the surge planning care home programme. He added that an updated action plan has been developed which has implications in terms of strengthening the system's response to the care homes sector. He said that the focus of the review was on learning, rather than blame. Ms Roulston added that a similar review has been carried out in domiciliary care and she agreed to share that report **[Action – Ms Roulston]**. Ms Mann-Kler agreed that it would be useful to see such types of learning review reports.

93/20.7 Ms Mann-Kler noted that there was recently an issue with regard to a meat processing plant and asked if this had been resolved. The Interim Chief Executive said that the plant has now re-opened after an intense period of work and there will now be a specific programme of testing in such plants similar to that being carried out in care homes.

93/20.8 Mr Clayton asked about the rationale behind the decision to discontinue the prescription of Priadel and what PHA's role is in this. He expressed concern about the number of patients who used this medication. Mr Morton agreed to share the Early Alert notice that was issued by the Department regarding this and it outlines the rationale behind the decision **[Action – Mr Morton]**. He added that, from a mental health point of view, Mrs Briege Quinn from PHA is leading the work to ensure

patients are safely switched over to a suitable alternative.

93/20.9 Alderman Porter asked about the return of transport facilities for service users with learning needs and their carers and if public health concerns have been taken on board when restarting this. Ms Roulston said that she was not fully aware of the detail on this, but each Trust should be considering this as part of its rebuild plan. Alderman Porter suggested that although the restart programme has commenced, some services are not operating buses as before and he asked what PHA's role in this would be as it is important that these service users are not forgotten about. Mr cummings said that HSCB would have a commissioning role. Mr Morton added that there would be a mental health and learning disability lead in his team who would be able to provide advice as required.

93/20.10 Dr Keaney noted that the rapid learning review of care homes was carried out using a QI approach and some of the recommendations will feed into a learning system and she is waiting to hear how this will be taken forward.

93/20.11 The Chair thanked the Interim Chief Executive for the Report and noted that it will continue to be tailored. Professor Rooney reiterated that she would wish to see the Report prepared along the lines of PHA's corporate aims.

94/20 Item 7 – Finance Report (PHA/01/09/20)

94/20.1 Prior to presenting the Finance Report, Mr Cummings addressed a query from Professor Rooney regarding expenditure incurred by PHA relating to COVID-19, and whether there should be a separate COVID-19 expenditure line in the budget. Mr Cummings advised that the cost to PHA has been quite small barring some additional staffing costs. Professor Rooney asked about the cost of the contact tracing programme. The Interim Chief Executive explained that PHA is paying rent on premises and there are also costs for IT equipment, but many of the staff are bank staff so costs are being recharged by their Trusts and the core staff are on one year contracts. Mr Cummings said that all of this expenditure is within PHA's current resource allocation. The Chair noted this, but asked what would happen if PHA continued to incur costs where the necessary approvals were not in place. Mr Cummings said that if PHA spent monies in advance of approval, this would be picked up and concerns raised, but he preferred that eventuality rather than a delay having an impact on the establishment of a vital service which will save lives. He said that this issue lies with the Department and its processes and the timeliness of decision making. He added that the Department has instructed PHA to bring in more staff. He reiterated that while PHA is spending within its allocation there will be no issue. He also noted that there is £600m of unallocated COVID-19 funding. In terms of PHA's expenditure to date, he explained that PHA is in an underspend situation because it is unable to activity is down and this

	funding cannot be reallocated to non-recurrent initiatives because PHA does not have the permission to do this. He projected that PHA's underspend is currently in the region of £1m-£2m, and that once PHA receives COVID-19 funding it will then return this underspend to fund wider HSC pressures.
94/20.2	The Chair noted that the COVID-19 bids that PHA has submitted equate to the total of the projected underspend. Mr Cummings agreed, but added that he would be surprised if PHA can find all of the staff it needs to do this work as all HSC organisations will be recruiting in the same pool.
94/20.3	Alderman Porter asked if PHA has received any correspondence relating to the delay in approving its business case for the contact tracing programme, given that the business case was written for a scenario where PHA was dealing with 50 positive COVID-19 cases per day, but the figure may rise to 500. The Interim Chief Executive advised that there are e-mails and that a bid has been put in for more resource. Alderman Porter asked if PHA is content that it has permission to proceed. Mr Cummings said that the permission is not in place, but the process is in place and that a total of 148 business cases have been submitted to the Department for COVID-19 funding. Alderman Porter said that he understood the process, but he was seeking assurance that PHA has permission to do this work. Mr McClean advised that a number of his staff have been involved in the development of the business case and that PHA is diligently adhering to process, but it is a fast changing situation and any delay to the approval process is due to any issue regarding the business case. Mr Clayton asked if the 148 business cases all relate to PHA, but Mr Cummings advised that the total was for the HSC as a whole, and that only a small number of these related to PHA.
94/20.4	Professor Rooney noted that Trusts are continuing to receive their full programme funding, but yet expenditure on community and voluntary sector programmes is reduced. Mr Cummings explained that community and voluntary sector organisations are unable to deliver on their activity so PHA cannot allocate funding, and cited smoking cessation as an example. He assured members that PHA is not making anyone redundant or unemployed. Mr McClean added that within Trusts, activity has probably been reduced, but the staff are now working on COVID-19 related work. He said that COVID-19 has impacted on PHA's ability to get new programmes up and running.
94/20.5	The Chair thanked Mr Cummings for his Report and for his advice and guidance over the years.
94/20.6	The Board noted the Finance Report.

95/20 **Item 8 – Update on COVID-19**

95/20.1 The Interim Chief Executive advised that the PHA contact tracing centre was initially established to deal with approximately 50 cases per day, but the current average is around 90 and today there were 320 cases awaiting follow up. She said that a similar picture is beginning to form across the UK and the Republic of Ireland with increasing numbers of cases among younger people. She reported that at the joint HSCB/PHA senior management team meeting earlier that day there had been a presentation from Professor Ian Young outlining the current thinking.

95/20.2 The Interim Chief Executive said that the main contact tracing centre is located in Ballymena but that any positive cases in nursing homes are reported through to the Duty Room. She advised that a schools team has been set up at short notice to deal with the demand of calls coming in from headmasters, teachers and parents of pupils and that this team has had to deal with almost 100 queries per day. She noted that headmasters had asked why PHA had not set up this service earlier but she pointed out that it was not the responsibility of PHA to deal with these queries. She added that the team will continue its work throughout the coming weeks as universities will be starting back soon. She noted that PHA is not resourced to deal with this volume of queries, and added that over the coming weeks PHA will train Education Authority Liaison Officers to deal with these types of query.

95/20.3 The Interim Chief Executive advised that approximately 70 staff have been recruited to the contact tracing centre to date and at the outset the approach had been to appoint professionally trained contact tracers, but that approach may need to change. She suggested that dentists could be employed but that it would be important to have medical staff to help with risk assessments. She outlined the plan that as the centre continues to grow contact tracing of index cases could be carried out in the centre, but their contacts could be carried out by other staff working remotely. She said that technology is being looked at whereby a text message could be sent to contacts. She added that an app is being developed whereby people can input details of their contacts.

95/20.4 Professor Rooney raised a concern about reports on the lack of local availability testing. The Interim Chief Executive explained that Pillar 1 testing is carried out in Trust laboratories for hospital staff and patients and Pillar 2 testing is the National Initiative which can carry out up to 2,000 tests per day. She advised that the tests carried out by the National Initiative are allocated on a pro rata basis across the UK. She said that the responsibility for testing lies with the Department. Professor van Woerden said that one of the challenges for PHA is having to work with other Departments directly instead of working through the Department for Health.

95/20.5 Alderman Porter said that he had spoken to Professor van Woerden last week regarding schools. He suggested that there should have been

some PR work around this with getting simple messages out for parents and pupils as there are a lot of concerns. He went on to raise a concern about testing as many people are being required to self-isolate for 14 days and get tested but yet 98% of tests are negative. He said that it is important to get messages out through politicians, MLAs and Local Councillors. Professor van Woerden agreed that there are lessons to be learnt. He said that PHA received almost 1,000 calls on Monday and its systems are not set up for that volume so PHA is trying to change its out of hours message. He pointed out that the difficulty with the guidance is that it is not PHA guidance and PHA is limited in terms of what direct guidance it can provide. He explained that PHA had assisted the Department for Education prepare its guidance, but that the guidance issued was very lengthy. He acknowledged that there are issues in terms of sustainability for people having to self-isolate for 14 days and that this needs to be reviewed given the risk of catching COVID-19 falls each day. He said that in England, only 20% of contacts are self-isolating for the full 14 days.

95/20.6 Professor van Woerden said that mobile testing is important and agreed that there should be improved PR. He noted that social media is particularly important for reaching young people as they do not watch as much TV or listen to the radio.

95/20.7 The Chair said that there is confusion in terms of what is Department of Health guidance and what is PHA guidance. He also expressed concern about the ability to "scale up", given the potential lack of laboratory capability.

95/20.8 Mr Clayton noted that PHA contact tracing centre has a target of aiming to contact 80% of people within 48 hours and he asked if this target was being met. He asked whether there is a risk that contact tracing would be suspended as it was during the first wave due to the high volume of cases. The Interim Chief Executive said that PHA is meeting its target, but it is challenging as the centre aims to make five attempts to contact an individual. She said that individual who have received a positive test result should know to expect a call and the telephone number that will appear on their mobile has been well promoted. She noted that there are issues with the current IT system as it cannot produce data on how many attempts have been made to contact people. She said that PHA is trying to build the system as the programme is evolving, but she assured members that targets are being met even though the team was overwhelmed last weekend.

95/20.9 Ms Mann-Kler felt that when it comes to the messaging around contact tracing there are two groups of people, those who will comply, and those who feel that the measures being put in place are an infringement on their freedom. She said that PHA needs to understand its audience. She noted that at the moment there is not the same high number of hospital admissions as there was at the peak which is in some way due to change in people's behaviour. However, she noted that in countries

such as France, Spain and Belgium where there has been an increase again in the number of positive cases, but not the same level of hospital admissions, and she asked if this meant that there will be a reduction here, or if there is some form of herd immunity. The Interim Chief Executive advised that only 5% of the population will have developed immunity and that presently, the highest proportion of cases is amongst younger people and they are not getting ill, but the numbers are increasing. Ms Mann-Kler asked if there will be an impact on hospital admissions, and the Interim Chief Executive responded that there will likely be an impact soon. Professor van Woerden said that he did not feel the deaths in the second wave would be as high as the first wave. He expressed concern about the attitude of those who do not heed the advice to self-isolate, and also those who are getting tested when they do not require testing. He also highlighted the issue of house parties and gatherings and conceded that this is a hard group to influence. He felt that Northern Ireland is in a relatively good place and that the local lockdowns should help.

95/20.10 Alderman Ashe highlighted an issue with a testing centre in Carrickfergus that was relocated, but the website allowed bookings to be made there. He acknowledged that while this was not a PHA issue, he said that during a pandemic, the public needs to see that there is a joined up system that is working across all departments and this is also important for the PHA Board to see. Mr Clayton agreed, saying that the perception of the public is that this is being dealt with by the public sector. He suggested that how PHA links with other agencies may be looked at as part of the review with the Chief Medical Officer.

95/20.11 Mr Clayton asked about care homes, and in particular those care homes which fall under the Pillar 2 testing programme. He sought assurance that the programme will continue over the winter. Professor van Woerden said that there has been a small increase in the number of positive cases and that the second cycle of testing has commenced. He noted that it is possible for individuals to display symptoms for up to 12 weeks so in some countries only staff are being tested instead of residents. Mr Morton said that in care homes it was found that many residents are asymptomatic and he assured members that PHA is doing everything it can to protect vulnerable citizens. He said work is continuing between nursing and social care colleagues to strengthen the preventative approach with enhanced cleaning. He reiterated that any learning from the rapid learning review is being taken on board.

95/20.12 Ms Roulston advised that Ms Heather Reid from PHA will meet with a stakeholder group looking at testing. In terms of social care, she reported that a proposal is being sent to the Minister regarding terms and conditions for social work staff. Mr Morton said that guidance is being developed in terms of the lowest possible footfall within nursing homes set in the context of the increase in the number of diagnosed cases in the community. He added that the Department is working on an adjunct to resident guidance, including options for an environment

where relations can visit their loved ones as the current position is not sustainable. Professor van Woerden said that PHA recognises that there may be issues in terms of access to testing for universities, further education colleges and also prison and airport staff.

95/20.13 Professor Rooney asked if there was anybody in the PHA with expertise in behaviour change and in particular someone to advise on influencing behaviour change in young people. Mr McClean explained that as part of one of the business cases that had been submitted to the Department, PHA is seeking to increase the expertise of the communications team by employing an individual with a behavioural change background to help with messaging. He said that Mr Stephen Wilson is linking with Mr Dan West in terms of broadening out the scale of social media messages as this is the best method of engaging with younger people. He added that this type of approach should be considered as part of other elements of PHA's work including mental health and drugs and alcohol.

95/20.14 Professor Rooney asked how HSC staff avail of testing. The Interim Chief Executive explained that this is done through the Occupational Health departments in their Trusts.

95/20.15 Alderman Ashe said that he had spent time with a constituent who has been separated from her partner as he is in a care home, and over time this separation has had an impact on her physical and mental health. He queried how PHA is dealing with this area. The Chair noted that there has been discussion about the emotional impact of the pandemic. Professor van Woerden acknowledged that there is a difficult balance to be struck across a range of factors and there will be individuals who will be disadvantaged in a disproportionate way. Ms Mann-Kler asked how the voices of these individuals are being heard as she learnt that on average people spend up to 18 months in a care home. The Interim Chief Executive said that at a recent Rebuilding Management Board meeting there was discussion about hospital visiting and how people need to be able to see their loved ones. She said that there is funding available so it should be used creatively to facilitate this. Professor Rooney asked if there is any service user representation on that Board and the Interim Chief Executive advised that there is not. Mr Morton said that there is a number of programmes looking at ensuring that people are getting the right care at the right time. He added that there needs to be a recognition of mental health issues for those people who have been shielding or who have been furloughed and to have a proactive strategy for helping them. The Interim Chief Executive said that as part of a discussion on intermediate care it was said that "home first" should be promoted as people recover better at home. She said that Northern Ireland is not good at "step up", but there has now been an endorsement of NICE guidance on intermediate care. Professor Rooney asked what PHA's role is in this regard, and the Interim Chief Executive replied that PHA would provide professional advice.

95/20.16 Alderman Porter asked if there was a list of those individuals who were asked to self-isolate and how many of them became positive within the 14 days. The Interim Chief Executive explained that when the initial phone call is made a risk assessment is carried out and then an individual is asked to self-isolate. Professor van Woerden said that only 5% of contacts would be expected to become positive. Alderman Porter expressed concern that this meant that 95% of people have had to self-isolate for 14 days and never caught COVID-19.

95/20.17 Alderman Ashe said that there may be many people who are living behind closed doors on their own and that there is no awareness of them. Ms Roulston advised that within the Northern Trust she was aware of an initiative whereby if a resident of a care home became positive then a Family Liaison Officer would link with the family and this proved to be valuable for families. The Chair agreed that there could be many people self-isolating and feeling alone. Professor van Woerden noted that during the first wave there were voluntary organisations delivering food parcels who would have communicated with those who were self-isolating.

95/20.18 Ms Mann-Kler asked why Sweden has proved to be such an outlier in terms of its approach to lockdown. Professor van Woerden said that there was no logical explanation for this and it may be due to specific cultural factors.

95/20.19 The Chair thanked PHA staff for their ongoing work and support during this pandemic.

96/20 Item 9 – Any Other Business

96/20.1 The Chair expressed his thanks to Mr McClean and Mr Cummings for filling the roles they have worked in for PHA over such an extended period of time. He said while there has not always been agreement, he valued their efforts and commitment to the people of Northern Ireland for the work they did to enable others to carry out their roles. On behalf of all of the Non-Executive Directors, he wished them both a long and happy retirement.

96/20.2 Mr McClean thanks the members for their support and for their advice and guidance. He reflected that during the 11 and a half years he worked in the PHA, and the 18 months preceding that when the Agency was being established, it is important to bring people with you, to empower staff and to bring the right people in. He hoped that this would continue to be how PHA operates, particularly at Director level, and he cited the example of the joint working at the time when there were issues to be resolved with regard to the Lifeline contract. He said that in the current climate the area of values has become particularly challenging, especially for Boards, and he asked that the Board ensure that it protects those values in everything that PHA does. He acknowledged the contributions of his staff supporting him, and in

	particular Mr Stephen Wilson and Miss Rosemary Taylor. He passed on his best wishes to the Board for the future.
96/20.3	Mr Cummings thanked the Non-Executives, and noted that the role of Non-Executives is to provide support and challenge and he found that came across in equal measure over the years. He suggested that perhaps his passion may have been over-enthusiastic at times, but there was respect. He agreed with Mr McClean's comments about values and felt that the NHS has lost sight of those values and that collective leadership needs to be got back. He wished members and finished by saying that when there is a difficult situation, to always do the right thing.
97/20	**Item 10 – Details of Next Meeting**
	Thursday 15 October at 1:30pm
	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast, BT2 7ES
	Signed by Chair:
	Date:

Public Health Agency

Finance Report

2020-21

Month 5 - August 2020

PHA Financial Report - Executive Summary

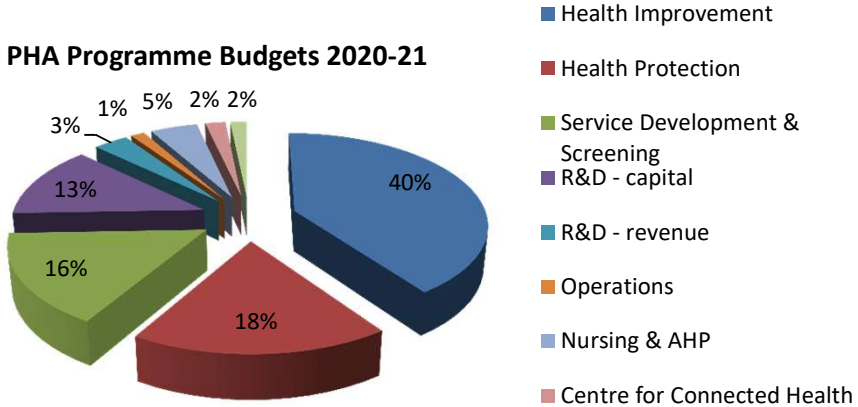
Year to Date Financial Position (page 2)

At the end of month 5 PHA is reporting an underspend (£2.0m) against its profiled budget. This underspend is primarily the result of year-to-date underspends on PHA Direct budgets (page 4) and Administration budgets due to vacant posts and different working arrangements (see page 5).

Budget managers continue to be encouraged to closely review their profiles and financial 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.

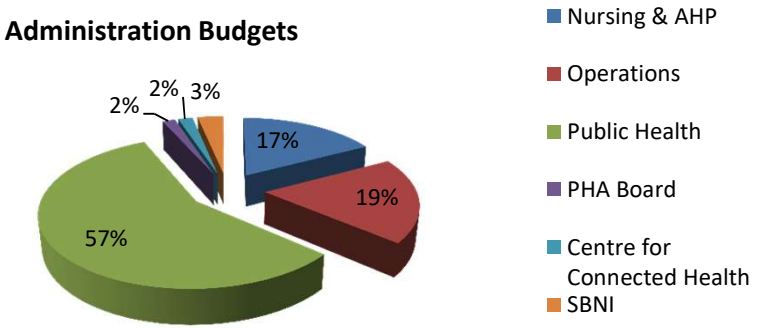


Administration Budgets (page 5)

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 surplus of £1m for the full year. Slippage is expected to arise from Administration budgets in particular. In previous years this has been used to fund a range of in-year pressures and initiatives, however the impact of COVID-19 has reduced the potential to absorb this slippage in 2020-21. Ringfenced funds, including Transformation Funds, are being monitored closely to ensure full spend by year end.

Public Health Agency
2020 -21 Summary Position - August 2020

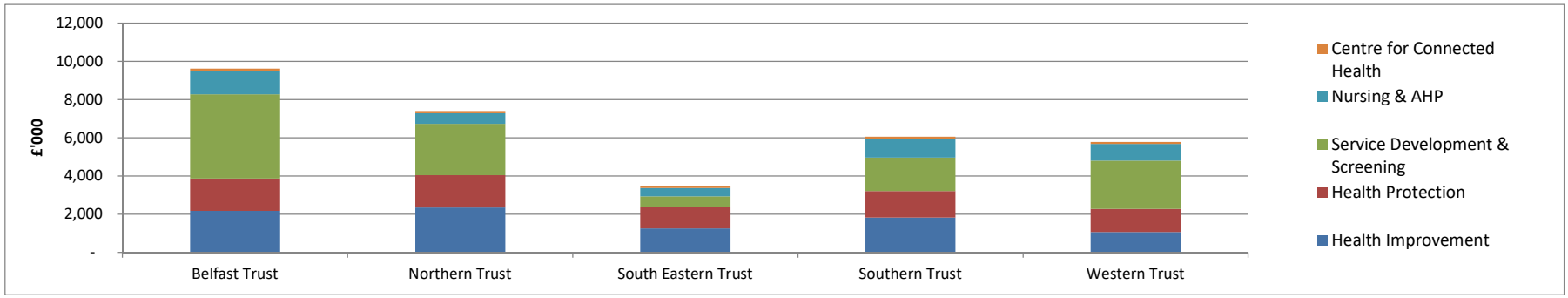
	Annual Budget					Year to Date				
	Programme		Ringfenced	Mgt &	Total	Programme		Ringfenced	Mgt &	Total
	Trust	PHA Direct	Trust & Direct	Admin		Trust	PHA Direct	Trust & Direct	Admin	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources										
Departmental Revenue Allocation	32,862	50,197	7,025	21,925	**112,009**	13,692	14,095	420	9,019	**37,226**
Assumed Retraction					**-**					**-**
Revenue Income from Other Sources	-	19	-	755	**774**	-	19	-	296	**316**
Total Available Resources	32,862	50,216	7,025	22,680	**112,783**	13,692	14,113	420	9,315	**37,541**
Expenditure										
Trusts	32,862	-	-	-	**32,862**	13,692	-	-	-	**13,692**
PHA Direct Programme *	-	50,216	7,025	-	**57,241**	-	12,092	983	-	**13,075**
PHA Administration	-	-	-	21,680	**21,680**	-	-		8,819	**8,819**
Total Proposed Budgets	32,862	50,216	7,025	21,680	**111,783**	13,692	12,092	983	8,819	**35,586**
Surplus/(Deficit) - Revenue	-	-	-	1,000	1,000	-	2,021	(563)	496	**1,955**
Cumulative variance (%)						***0.00%***	***14.32%***	***-133.95%***	***5.33%***	***5.21%***

The year to date financial position for the PHA shows an underspend of £2.0m, which consists primarily of year-to-date underspends on PHA Direct and Administration budgets, offset by expenditure ahead of profile on Ringfenced budgets

A year-end surplus of £1m is currently forecast. This is primarily the result of a forecast surplus in the Administration budget, with the impact of COVID-19 restricting the potential to utilise this funding on Programme priorities as in previous years.

** 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	2,172	2,349	1,252	1,820	1,061	-	-	**8,655**	3,606	3,606	-
Health Protection	1,697	1,686	1,121	1,393	1,208	-	-	**7,105**	2,960	2,960	-
Service Development & Screening	4,408	2,702	555	1,751	2,538	-	-	**11,954**	4,981	4,981	-
Nursing & AHP	1,241	544	446	990	868	-	-	**4,089**	1,704	1,704	-
Centre for Connected Health	109	117	109	104	104	-	-	**543**	226	226	-
Other	152	122	56	91	95	-	-	**516**	215	215	-
Total current RRLs	**9,781**	**7,521**	**3,538**	**6,149**	**5,874**	**-**	**-**	**32,862**	**13,692**	**13,692**	**-**
Cumulative variance (%)											***0.00%***

	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	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
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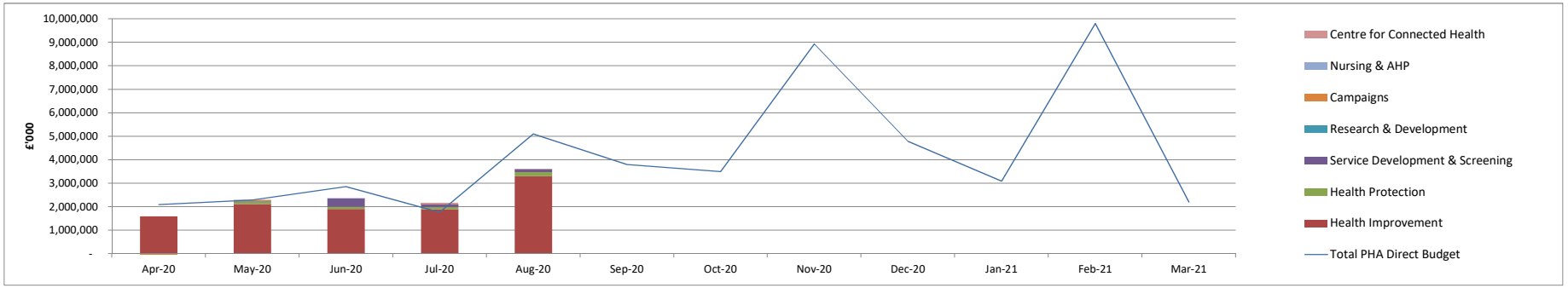
The above table shows the current Trust allocations split by budget area. Budgets have been realigned in the current month and therefore a breakeven position is shown for the year to date as funds previously held against PHA Direct budget have now been issued to Trusts.

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-20 £'000	May-20 £'000	Jun-20 £'000	Jul-20 £'000	Aug-20 £'000	Sep-20 £'000	Oct-20 £'000	Nov-20 £'000	Dec-20 £'000	Jan-21 £'000	Feb-21 £'000	Mar-21 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000	
Profiled Budget																	
Health Improvement	2,096	2,096	2,096	1,239	4,555	1,314	989	6,207	564	844	7,020	543	**29,563**	12,082	10,812	1,270	*10.5%*
Health Protection	-	100	160	192	186	2,209	2,213	2,242	2,213	242	270	283	**10,311**	638	455	183	*28.6%*
Service Development & Screening	-	95	562	215	364	215	215	364	215	215	391	352	**3,203**	1,236	816	420	*34.0%*
Research & Development	-	-	-	-	-	-	-	-	1,000	1,000	1,211	-	**3,211**	-	-	-	*0.0%*
Campaigns	-	-	-	10	20	45	60	85	350	345	332	30	**1,277**	30	(37)	67	*223.5%*
Nursing & AHP	-	-	39	39	- 21	19	19	39	39	39	39	41	**295**	58	17	41	*100.0%*
Centre for Connected Health	-	-	-	70	-	-	-	-	400	400	537	(70)	**1,337**	70	70	0	*100.0%*
Other	-	-	-	-	-	-	-	-	-	-	-	1,018	**1,018**	-	(41)	41	*100.0%*
Total PHA Direct Budget	**2,096**	**2,291**	**2,857**	**1,765**	**5,105**	**3,803**	**3,497**	**8,937**	**4,782**	**3,085**	**9,801**	**2,196**	**50,215**	**14,114**	**12,092**	**2,022**	
Cumulative variance (%)																***14.33%***	
Actual Expenditure	**1,504**	**2,380**	**2,394**	**2,219**	**3,594**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**12,092**				
Variance	**592**	**(89)**	**463**	**(454)**	**1,510**								**2,022**				

Ringfenced Budgets	Apr-20 £'000	May-20 £'000	Jun-20 £'000	Jul-20 £'000	Aug-20 £'000	Sep-20 £'000	Oct-20 £'000	Nov-20 £'000	Dec-20 £'000	Jan-21 £'000	Feb-21 £'000	Mar-21 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000
Profiled Ringfenced PHA Direct Budget	20	20	20	275	85	49	61	46	47	45	55	6,302	**7,025**	**420**	**983**	**(563)**
																-133.95%
Actual Expenditure	-	98	275	305	306							-	**983**			
Variance	**20**	**(78)**	**(255)**	**(30)**	**(221)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**(563)**			

The year-to-date position shows an approximate breakeven position, with underspend on a number of Health Improvement budgets being offset by expenditure ahead of profile on Service Development & Screening budgets.

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

Some slippage is expected to arise on PHA Direct budgets due to the impact of COVID-19 on service delivery levels. This slippage will be quantified in the comng months, and the impact on PHA's breakeven obligation will be closely monitored. In addition the organisation expects a surplus to arise on Administration budgets. In previous years this would have been absorbed through PHA Direct budgets to address programme priorities, but this is unlikely to be an option in 2020-21 and therefore represents a risk which will be kept under close review.

PHA Administration

2020-21 Directorate Budgets

	Nursing & AHP £'000	Quality Improvement £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Annual Budget								
Salaries	3,714	326	2,901	12,345	304	348	542	**20,480**
Goods & Services	148	18	1,322	407	54	58	193	**2,200**
Total Budget	**3,861**	**344**	**4,223**	**12,753**	**359**	**406**	**735**	**22,680**
Budget profiled to date								
Salaries	1,547	136	1,208	5,156	95	145	226	**8,513**
Goods & Services	62	7	551	55	23	24	80	**802**
Total	**1,608**	**143**	**1,759**	**5,212**	**118**	**169**	**306**	**9,315**
Actual expenditure to date								
Salaries	1,547	158	1,121	5,004	102	158	165	**8,257**
Goods & Services	42	2	451	35	16	2	14	**562**
Total	**1,589**	**160**	**1,572**	**5,040**	**118**	**160**	**179**	**8,819**
Surplus/(Deficit) to date								
Salaries	(0)	(23)	87	152	(8)	(13)	61	**256**
Goods & Services	19	6	100	20	7	22	66	**240**
Surplus/(Deficit)	**19**	**(17)**	**187**	**172**	**(1)**	**9**	**127**	**496**
Cumulative variance (%)	*1.19%*	*-11.57%*	*10.61%*	*3.31%*	*-0.71%*	*5.20%*	*41.39%*	***5.33%***

PHA's administration budget is showing a year to date surplus of £0.4m, which is being generated by a number of long standing vacancies. Although efforts continue to fill vacant posts as far as possible, this has proved to be challenging, and the surplus on the salaries budget continues to be high. In addition in 2020-21 many staff are largely working from home, and this has driven a downturn in Goods & Services expenditure, which is expected to lead to increased slippage at year-end. Senior management continue to monitor the position closely in the context of the PHA's obligation to achieve a breakeven position for the financial year. The full year surplus is currently forecast to be £1.0m.

DoH has required PHA to meet the cost of the first 1% of the pay award in each of the last 2 years (2019-20 and 2020-21). The impact of this is currently being masked by high levels of vacancies.

The SBNI budget is ringfenced and any underspend will be returned to DoH prior to year end.

Public Health Agency
2020-21 Capital Position

	Annual Budget				Year to Date			
	Programme		Mgt & Admin		Programme		Mgt & Admin	
	Trust £'000	PHA Direct £'000	£'000	Total £'000	Trust £'000	PHA Direct £'000	£'000	Total £'000
Available Resources								
Capital Grant Allocation & Income	7,996	4,033	-	**12,029**	3,332	1,326	-	**4,658**
Expenditure								
Capital Expenditure - Trusts	7,996			**7,996**	3,332			**3,332**
Capital Expenditure - PHA Direct		4,033		**4,033**		288		**288**
	7,996	4,033	-	**12,029**	3,332	288	-	**3,619**
Surplus/(Deficit) - Capital	-	-	-	-	-	**1,039**	-	**1,039**
Cumulative variance (%)								

PHA has received a Capital budget of £13.5m including income in 2019-20, most of which relates to Research & Development projects in Trusts and other organisations. Expenditure of £8.8m is shown for the year to date, and a breakeven position is anticipated for the full year.

PHA Prompt Payment

Prompt Payment Statistics

	August 2020 Value	August 2020 Volume	Cumulative position as at 31 August 2020 Value	Cumulative position as at 31 August 2020 Volume
Total bills paid (relating to Prompt Payment target)	£3,675,656	373	£17,802,472	1,767
Total bills paid on time (within 30 days or under other agreed terms)	£3,652,113	330	£17,354,262	1,626
Percentage of bills paid on time	**99.4%**	**88.5%**	**97.5%**	**92.0%**

Prompt Payment performance for the year to date shows that on value the PHA is achieving its 30 day target of 95.0%, although performance on volume is below target cumulatively in August and cumulatively to date. Overall PHA is making 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 92.8% by value for the year to date, which significantly exceeds the 10 day DoH target for 2020-21 of 60%.

HSC Public Health Agency

minutes

Title of Meeting	Meeting of the Public Health Agency Governance and Audit Committee
Date	1 July 2020 at 9.30am
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

Present

Mr Joseph Stewart	-	Chair
Mr John Patrick Clayton	-	Non-Executive Director
Ms Deepa Mann-Kler	-	Non-Executive Director *(via telephone link)*

In Attendance

Mr Ed McClean	-	Interim Deputy Chief Executive / Director of Operations
Miss Rosemary Taylor	-	Assistant Director, Planning and Operational Services
Mr Paul Cummings	-	Director of Finance, HSCB
Ms Jane Davidson	-	Head Accountant, HSCB *(via video link)*
Ms Wendy Thompson	-	Assistant Director of Finance, HSCB *(via video link)*
Mrs Catherine McKeown	-	Internal Audit, BSO *(via video link)*
Ms Christine Hagan	-	ASM *(via video link)*
Mr Roger McCance	-	NIAO *(via video link)*
Mr Robert Graham		Secretariat

Apologies

None

		Action
24/20	**Item 1 – Welcome and Apologies**	
24/20.1	Mr Stewart welcomed everyone to the meeting. There were no apologies.	
25/20	**Item 2 - Declaration of Interests**	
25/20.1	Mr Stewart asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.	
26/20	**Item 3 – Minutes of previous meeting held on 20 May 2020**	
26/20.1	The minutes of the previous meeting, held on 20 May 2020	

	were **approved** as an accurate record of that meeting.
27/20	**Item 4 – Matters Arising**
27/20.1	Mr Stewart noted that at the last meeting there had been discussion about convening a special meeting of the Committee to consider the updated Corporate Risk register, but given that the Agency Management Team had spent a considerable time reviewing the Register there was no need to convene a special meeting in advance of today's meeting.
28/20	**Item 5 – Chair's Business**
28/20.1	Mr Stewart said that he had no Chair's Business.
29/20	**Item 6 – Internal Audit** *Progress Report [GAC/15/07/20]*
29/20.1	Mrs McKeown presented the progress report and advised that there was one audit to update members on, and that was an audit of information governance where a satisfactory level of assurance was being provided. She said that there were no significant findings in the audit but she highlighted a need for PHA contracts requiring to be reviewed in light of GDPR requirements. She noted issues around the uptake of information governance training, particularly after 2018, and that there was poor attendance at Information Governance Steering Group (IGSG) meetings. Finally, she advised that Internal Audit had carried out a review of the availability of PHA Board and Committee papers following a recommendation from the Hyponatraemia Review, and that PHA was largely compliant although one set of Board minutes was not available.
29/20.2	Mr Clayton welcomed the level of assurance provided, but asked for further detail of the scale of work required in order to update all of the legacy contracts to ensure they are compliant with GDPR, and how long this might take. He also noted that PHA will be gathering a significant amount of data in relation to contact tracing, and this reinforced the importance of the need for staff to undertake training. In relation to the contracts. Miss Taylor acknowledged that this is a huge piece of work, not only for PHA, but across the HSC as a whole, and through information governance and social care procurement networks PHA is working with Trusts and Legal. She assured members that there are existing clauses in contracts regarding the need to comply with information governance requirements, but going forward a lot of work needs to be undertaken to map out

	data flows. As this is a new area of work, she noted that there is an ongoing debate in terms of what is required. Mr Stewart asked whether a catch-all clause could be used. Miss Taylor said that this exists, but Mr Stewart asked what more is required. Miss Taylor explained that as part of carrying out Data Protection Impact Assessments (DPIAs), there is lot of work involved in mapping out data flows and specifying them. Mr McClean added that PHA does not currently have sufficient capacity to do this work. He said that this is an area that carries a risk given the volume of contracts and that given the complexity of the data, there is a need to increase capacity in the short term.
29/20.3	Following on from Mr McClean's comments, Ms Mann-Kler asked whether this risk has been discussed at Executive Team level and should it go on directorate risk register. She said that following the recent public sector data breach there is a need to ensure training is up to date. She went on to express concern at the low turnout at IGSG meetings and sought further detail on why this is the case. She also noted that PHA will have access to a large amount of contact tracing data. Finally, she asked about the non-availability of the PHA Board minutes from April 2009. Mr Stewart said that it was his sense that staff did not view attendance at IGSG as a priority. Miss Taylor acknowledged that there is more work to be done on training, but she assured members that it will be critical that any new staff who are recruited to the contact tracing centre will have to undertake online information governance training. She said that the only outstanding Board minutes relate to the first meeting of the PHA, and that a copy should exist.
29/20.4	Mr McClean said that the points raised by Ms Mann-Kler were well-made and on reflection, there is perhaps a view among staff that information governance is a very specialised area and is distinct from their day to day work. He felt that the challenge for PHA is how to better communicate the importance of information governance and that it is the responsibility of everyone, but he added that staff training is an issue across all HSC organisations.
29/20.5	Miss Taylor advised that in light of the COVID-19 work approval has been given to the appointment of a temporary information governance manager, but the difficulty may be in obtaining an individual with the right skills and knowledge. She explained that staff in Operations can provide advice and guidance, but it is the programme leads themselves who need to carry out any required DPIAs etc.
29/20.6	Mr Stewart said that he hoped that with PHA's enhanced

	role in contact tracing, that there is accurate data management and control. Mr Clayton noted that a data breach can dent public confidence. Mr Cummings said that the data breach referred to in the Victims' Commissioner's Office was simply human error.
29/20.7	The Committee noted the Internal Audit progress report.
	Annual Plan 2020/21
29/20.8	Mrs McKeown informed members that this was the second year of the 3 year Internal Audit plan. She said that the introduction to the Plan was largely unchanged but that there was some narrative included on COVID-19. She reminded members that Internal Audit had offered its services to PHA during the first quarter of the year, but by the end of the quarter PHA had not called upon these services.
29/20.9	Mrs McKeown advised that the summary Plan, outlined at the end of the document, can be kept flexible during the year. She said that she had engaged with PHA Directors to review the Plan before COVID-19, and then again in June and she expressed her thanks to the Directors for working with her at short notice to complete this review. She explained that this latest Plan has been aligned with the updated version of the corporate risk register.
29/20.10	Mrs McKeown outlined the audits that will be conducted which will be in the areas of financial management, management of contracts with the community and voluntary sector, governance during COVID-19 and risk management.
29/20.11	Mr Stewart queried the need for an 8-day audit on complaints and claims. Mrs McKeown advised that this audit, which is scheduled for next year, is mandated as public sector bodies are required to carry out review of complaints on a regular basis.
29/20.12	Ms Mann-Kler welcomed the Plan and that it was important to see that COVID-19 has been incorporated as it is becoming more important that PHA's governance arrangements are of the highest standard. She noted, however, that the Plan focuses on those areas that PHA has control over, but she was concerned about those elements that are being led by the Department and whether there are any gaps and how these could be considered as part of the remit of this Plan. She also asked whether the order of the audits in the Plan represents the order in which they will be carried out as she felt that there was an urgency in carrying

	out a review of governance arrangements Mr Stewart noted that he did not disagree with Ms Mann-Kler's comments and added that maybe there is an issue for the PHA Board with regard to the amended HSC Framework, but he said he would return to this as part of the discussion on the corporate risk register.
29/20.13	Mr Clayton welcomed the audit on governance during COVID-19, but he queried why a separate audit on the contact tracing programme is not scheduled until next year. He conceded that this may be to allow the programme to bed in, but he asked whether the audit would be done early in the year. He recognised that there is a steering group and oversight board which has PHA input, but given that this programme is integral to PHA's COVID-19 response, it is important that it is fit for purpose. He also queried why the offer of the services of Internal Audit services was not taken up by the PHA. Mr McClean said that the pressures PHA was facing were in other areas. Mr Cummings added that where a need was identified, PHA obtained assistance from the Leadership Centre from staff with project management skills. Mr Stewart said that for the contact training programme, he is aware that there is a separate risk register, updated by the Department, which goes into considerable detail on the risks. Mr McClean advised that at this moment the programme is still being set up, so later in the year may be a better time. Mr Cummings cautioned that it would be inappropriate to carry out an audit over the winter if there is a second surge as this would distract from the work of the programme. Mr Stewart suggested that perhaps a shorter audit could be carried out at the end of the year. Mr McClean said that doing an earlier audit will give an overview of the architecture of how the service is set up, but a later audit will allow for an overview of the service being in operation. Mrs McKeown proposed that as part of the audit on governance during COVID-19, due to be carried out this year, there could be a high level review of the contact tracing centre governance arrangements in advance of a more in-depth audit the following year. Ms Mann-Kler agreed that would be a suitable solution.
29/20.14	Members **approved** the audit plan.
30/20	**Item 7 – Annual Report and Accounts incorporating Governance Statement and Letter of Representation**
30/20.1	Mr Cummings tabled the Annual Report and Accounts but noted that members had received a draft copy in advance. He advised that following the audit by NIAO, there were no additional disclosures to the financial statements and no

	adjustments required to the content of the Report.
30/20.2	Mr Cummings took members through the Report. He said that the first section set out the role and purpose of the PHA and the next section contained an overview of PHA's performance in 2019/20 against the objectives in its business plan. He advised that the next section contained the financial performance and how PHA used its funding and there then followed the Directors' Report and the Governance Statement which is set out as per set guidance.
30/20.3	Mr Cummings advised that within the Governance Statement, there have been some further additions to the narrative which have been received from the Department of Health. He reminded members that the wording given by the Department is not mandated and it is within the gift of the Board to amend it. He said that the affected parts are the narratives around the financial position, EU Exit and COVID-19. He noted that the HSCB's Governance Committee had accepted the Department's wording.
30/20.4	Mr Cummings said that the next section contained the remuneration report and finished where the certificate from the Comptroller and Auditor General (C&AG) will be inserted.
30/20.5	Mr Cummings moved onto the accounts section and said that on page 69 there is a statement of comprehensive net expenditure which shows that PHA finished the year with a surplus of £119k, therefore within limits. He advised that the statement of financial position followed. He drew members' attention to the statutory financial duties of the PHA in Note 23, where an overspend against the Capital Resource Limit (CRL) of £2k was noted, and whilst technically a breach, was of no concern. He went on to say that PHA's prompt payment performance was slightly below the 95% target for paying invoices within 30 days but he commended the performance for payments within 10 days.
30/20.6	Mr Clayton said that he had no substantial comments to make, but he queried the wording regarding EU Exit and the uncertainty around the Northern Ireland protocol. Mr Cummings said that perhaps the issue is that there is uncertainty in how it will be implemented.
30/20.7	Ms Mann-Kler said that there is a challenge for PHA in terms of the narrative in COVID-19 while appreciating the period that this Report covers. She said that while the Chief Executive's foreword sets out the position, she felt that there needed to be more said about the impact of COVID-19 on

	inequalities. She appreciated that these issues became more apparent in April, May and June, PHA's position and mandate as an organisation that has a role in addressing health inequalities would merit a strengthening of the wording of this section. Mr McClean advised that there had been discussion on this, but that there is no clear authoritative data for the period up to 31 March. He said that this will be a major theme of next year's Report. He advised that the Health Intelligence team in PHA has been carrying out monitoring as there has been no reporting from a Northern Ireland context.
30/20.8	Ms Mann-Kler suggested that the wording should say that PHA will be mindful of the potential of COVID-19 to exacerbate inequalities. She said that there was an issue identified early on in the pandemic regarding the impact on BME. Mr Stewart said that he was not sure the impact on BME and HSC was apparent in February or March. Mr Cummings said that there is a lack of evidence around this in Northern Ireland, and there has been a big difference in how COVID-19 has affected Northern Ireland in comparison to other parts of the UK, therefore he cautioned what should be included in the Report. Ms Mann-Kler stated that her request is that there is reference made to being mindful of inequalities. Mr Stewart noted that there is general agreement about the inclusion of wording on inequalities, but this needs to be presented to the Chair. Mr McClean proposed that some wording could be put at the end of the Chair's Report about the ongoing concern about health inequalities. Members were content with that approach.
30/20.9	Subject to the change to the Chair's section, and following discussion with the internal and external auditors (Item 9), members **approved** the Annual Report and Accounts which will be brought to the PHA Board on 7 July.
31/20	**Item 8 – External Auditor's Report to those Charged with Governance (Draft)**
31/20.1	Mr McCance said that members will be familiar with the Report. He noted that this has not been a normal year and he passed on this thanks to the Finance team in HSCB for their co-operation with the audit. He advised that this Report is a summary of the work carried out by ASM and he invited Ms Hagan to take members through the Report.
31/20.2	Ms Hagan advised that following the audit, ASM will be proposing that the C&AG give an unqualified audit opinion without modification and that there are no adjustments required. She added that there are no misstatements and

	no priority 1, 2 or 3 findings as a result of the audit. She advised that there is still some work to be finalised and a final view of the Report needs to be undertaken following receipt of comments from the Department of Health. She said that in terms of management of information and personal data she was not aware of any issues.
31/20.3	Ms Hagan advised that at today's meeting the Committee is required to review the findings of the audit, including the draft letter of representation and the audit certificate.
31/20.4	Ms Hagan said that the audit was carried out in line with the audit strategy and that no significant risks were identified.
31/20.5	In terms of other risks she noted that in terms of confidence and supply funding, she was pleased to report that there were no issues from a PHA perspective and that there were controls in place and all spend was deemed appropriate. Under governance structures, she said that there had been concern about who would sign off the annual accounts, but it has now been confirmed that it would be Mrs Olive MacLeod. Finally, with regard to shared services, she advised that there were no concerns identified.
31/20.6	Ms Hagan went through the audit findings. She said that the Annual Report was considered to be consistent with its understanding of PHA business and that only a small number of minor observations which required amendment. She said that the financial reporting was appropriate and that there were no issues of irregularity or impropriety. She advised that the Governance Statement had been reviewed and was a fair reflection of the state of internal control. She said that the remuneration report had been correctly prepared and that some suggestions had been made around the financial disclosures,
31/20.7	Ms Hagan noted the reliance on Internal Audit and BSO legal services. She gave an overview of the 2020/21 outlook and issues relating to the closure of HSCB and the publication of the new HSC Framework.
31/20.8	Ms Hagan reiterated that there were no Priority 1, 2 or 3 findings, no adjusted or unadjusted misstatements, thus giving a clean audit report. She advised that the appendices contained the draft letter of representation, and the audit certificate which has some minor wording changes. She added that there were no prior audit recommendations to be reported on.

32/20	**Item 9 – Annual meeting with Auditors (External and Internal) without officers present**
32/20.1	This meeting took place at the conclusion of the meeting.
33/20	**Item 10 – Corporate Risk Register (as at 31 May 2020) [GAC/16/07/20]**
33/20.1	Mr Stewart said that while there has been a slight delay in the production of this updated Corporate Risk Register, he was pleased that the outcome of the review showed that an extensive amount of work has gone into this update, and the new risks reflect the issues raised by the Board and the Committee around staff resilience, financial expenditure and other risks. He proposed that the Committee go through each risk in turn.
33/20.2	Beginning with risk 26 relating to procurement and the delay in market testing contracts, Mr Stewart said that he was not sure how this could be alleviated during the current COVID-19 pandemic. Miss Taylor advised that the Interim Chief Executive has taken an interest in this and that a meeting of the PHA Procurement Board has been set up during July which will help to refocus on some of the priority areas. She said that there are a number of areas that need dealt with, but due to COVID-19 work had been redirected to other programmes.
33/20.3	Mr Cummings advised that there is an issue in terms of BSO's ability to support procurement across the HSC as a whole with some procurement exercises have taken up to 3/4 years to complete and that PHA would not have anticipated this when it was developing its procurement plan.
33/20.4	Ms Mann-Kler asked for an assurance that PHA has a handle on this, and is in control. She said that she did not feel she had oversight of the gravity of the situation, but understand that COVID-19 has had an impact. Miss Taylor advised that the biggest risk for PHA is around those contracts which had previously been procured, but now require to be procured again. She added that some other contracts e.g. those in the areas of suicide prevention and mental health need to be commenced, but there have been external factors such as the delay in the publication of the Protect Life 2 Strategy. She said that there are rolling contracts in place, however, a process needs to be put in place to review these as well as others that need re-procured. She explained that initially there was one overall procurement plan for all contracts, but now there is a need

	to separate those which need procured immediately, and those which require more detailed planning to ascertain if they should be procured, or if commissioning from other HSC organisations or grants may be more appropriate.
33/20.5	Mr Stewart suggested that it would be useful for the Committee to see the revised prioritised plan at a future meeting. He said it would be catastrophic from the PHA's perspective if there were any gaps in areas such as drugs and alcohol and suicide prevention. Mr McClean noted that there has been a turnover of staff and that some key areas where input has not been available. He advised that up to £35m of PHA's programme activity should go through a strategic planning process and the Procurement Board, and he suggested that there should be a sub-committee of the Board to look at this. He said that procurement exercises are unpredictable by nature, but it is important that they are got right as there are political sensitivities around some of the areas and it would be helpful to have the Board's support in this.
33/20.6	Mr Stewart said that he was confident that the staff would have the support of the Non-Executive Directors on the Governance and Audit Committee. He added that he has previous experience in this area and acknowledged the importance of being supportive to staff and being able to focus on the important issues. Mr McClean advised that when carrying out the pre-procurement planning, PHA has to ensure that there is proper engagement, screening arrangements and data to inform the exercise.
33/20.7	Ms Mann-Kler said that she would support this way forward. She acknowledged that there are issues emanating from COVID-19, but is happy to provide any support. Miss Taylor advised that PHA is working to build up its planning function with staff to support the programme leads. She explained that one person is already in post with another due to commence in September. Mr Stewart said that any procurement exercise always needs to start with a clear specification of what is required and over what period of time.
33/20.8	Mr Clayton noted that in risk 39, relating to cyber security, there was reference to a desktop exercise being undertaken. He added that the risk of losing the functionality of the PHA website would be heightened during COVID-19. Miss Taylor advised that the desktop exercise was due to be a regional exercise, but it did not happen due to COVID-19. She assured members that cyber security remains on the agenda and that a lot of upgrades have taken place to the

	security of HSC systems. Mr Clayton noted that given the increasing use of technology at this time across the HSC, cyber security should be high up the agenda.
33/20.9	Miss Taylor advised that for risk 46 on emergency planning, issues relating to payment and compensation to senior staff involved in an emergency situation were temporarily resolved with reimbursement for overtime for staff at Bands 8 and 9 working on COVID-19 during April to June 2020. However, she said that there has not been a permanent resolution and therefore the risk needs to remain on the register.
33/20.10	Miss Taylor moved on to risk 47 which concerns the PHA Intranet. She advised that work was due to be completed on a new platform for the Intranet but due to COVID-19 this was put on hold. Mr Clayton asked whether PHA staff can update the website. Miss Taylor said that staff need to go through communications staff. Mr McClean explained that although the PHA communications staff can update both the Intranet and the PHA website, the key constraint is that the architecture supporting the site is out of date and there is a need to make the site more interactive. Mr Clayton asked if there is a reliance on external agencies. Mr McClean said that there is a reliance in terms of the design element, but not for updating information on the site.
33/20.11	Mr Stewart moved onto the new risks that have been added to the register. There was no discussion on risk 48 relating to the website as this was covered under risk 47.
33/20.12	Mr Cummings took members through risks 49 and 50 which concern finance. He explained that there is a risk of procurements not being done in a timely manner given the speed in which decisions need to be made. He gave the example of the need to buy ventilators for hospitals and having to make a decision based on urgent need, but he said that the correct process had been followed in terms of putting a business case through HSC Silver and HSC Gold, however he was not certain at this point that all the business cases that were submitted will receive the funding that was applied for.
33/20.13	Mr Stewart noted that his concern would be that there needs to be a context for each decision that was made, particularly given Mr Cummings' impending retirement as Director of Finance. Mr Clayton added that given forthcoming retirements there is a risk that any learning from this first phase will not be captured and there needs to a rationale for each decision that was made in the event that similar

	decisions need to be made if/when there is a second surge. He asked how learning is being captured. Mr McClean said that in PHA, Dr Keaney is leading a piece of work on this. He added that leaving interviews will also be important so that any learning can be passed on to those succeeding the staff who have retired.
33/20.14	Mr Cummings advised that the issue of procurement is more relevant to HSCB than to PHA.
33/20.15	Ms Mann-Kler said that it is important that there is an opportunity to capture any lessons learnt. She asked about the level of financial exposure specifically to PHA, and if there are any other areas where PHA could be exposed. She added that it would be useful to see exactly what new expenditure has been approved, and what has not been approved. Mr Cummings advised that PHA's exposure would be very limited and would be in the areas of contact tracing and contracts with the community and voluntary sector where there may be misappropriation of funds if organisations were using funding but furloughing staff.
33/20.16	Mr Stewart advised that he has raised his concerns with the Interim Chief Executive. He said that the business case for contact tracing has been approved but no funding has yet been received and that the outcome remains unknown. Mr Cummings reiterated that compared to the HSC as a whole, PHA's exposure is not significant. Ms Mann-Kler said that she would welcome further detail on the costs of contact tracing as she does not have a measure of that to date. Mr Cummings advised that he can provide a copy of the business case.
33/20.17	Mr Clayton asked about the community and voluntary sector and the furlough scheme. Mr Cummings said that organisations would be subject to scrutiny from HMRC and so HMRC would pursue them for any overpayments.
33/20.18	Members considered risk 51 about the contact tracing service. Miss Taylor explained that the service needs to be able to scale up and down at short notice in order to control community transmission, and that there is a reputational risk to the PHA if the service does not function effectively.
33/20.19	Mr Stewart expressed his concern about the scaling aspects, but also the lack of control over those who are carrying out the contact tracing in NI Direct. Miss Taylor clarified that the contact tracing element will be carried out by PHA staff and that the NI Direct part is more akin to an information giving service assisting those who do not have

	access to technology in a similar way to the 111 service in England. Mr Stewart said that it is his understanding that the first contact people have will be with NI Direct so he wished to know measures are being put in place to ensure good customer service. Miss Taylor advised that a lot of work has been undertaken in terms of developing scripts for the call handlers and there will be monitoring and supervision of calls. She added that it had been hoped that the NI Direct service would be operational during June, but it will now be the end of July so as to ensure that the scripts are fully thought through and tested.
33/20.20	Mr Clayton referenced the audit and governance arrangements and the lack of control PHA has in this regard. He noted that the contact tracing service is a Department initiative that PHA is operationalising, and that at the start of the pandemic a decision was made to stop contact tracing and looking back, this may be a decision that is challenged. He queried what control PHA would have in such a decision if there was a second surge. Mr McClean advised that would be a decision for the Department of Health and the Chief Medical Officer. He acknowledged that it is confusing in terms of who has accountability for the NI Direct element, and there will inevitably be comparisons between what is being done here and what is being done in the Republic of Ireland. However, he said that Miss Taylor and Ms June Turkington from BSO Legal have been providing as much advice and support as possible to this work. He agreed that it is an odd arrangement, but he noted that at present the scale of the work required is limited.
33/20.21	Mr Clayton asked what would happen in the event of there being 100 cases per day. Mr Cummings said that no system would be able to cope with that level. Mr McClean said that the service may have change accordingly.
33/20.22	Ms Mann-Kler said that she has concerns regarding the accountability of the contact tracing programme in terms of the governance and the quality, and asked how as a Non-Executive Director she could be assured that there are no gaps. Mr Stewart said that if there is a better way of wording this risk, they should share this. He stated that he would like the Governance and Audit Committee to receive a detailed briefing from the Interim Chief Executive as she has full oversight of this programme.
33/20.23	Mr Stewart said that the issues around information governance (risk 52) have already been discussed. He added that it was important that risk 53 around corporate priorities featured in this revision. Under risk 54 relating to

	contracts, he asked how often contracts would be reviewed. Miss Taylor advised that there should be ongoing liaison and performance monitoring, at least on a quarterly basis.
33/20.24	Mr Clayton queried whether risk 55 on public health staffing issues should be extended across all of the PHA given other discussions about the level of vacant posts and the number of staff in temporary positions. Ms Mann-Kler added that there is a broader issue for PHA as a whole in terms of senior appointments. She noted that the Director of Operations is due to retire and asked if a process has commenced to fill that role. She expressed concern if there were to be another interim appointment as this would not reflect well on the culture of the organisation. She said that this risk needs to be broadened.
33/20.25	Ms Mann-Kler said that the risks being presented today are unprecedented, and as such she felt that that only reviewing them on a quarterly basis is not sufficient. Mr Stewart said that this risk register should be presented to the Board so there will be a further opportunity to give these matters consideration.
33/20.26	Mr Stewart said that he had the same concern in terms of only highlighting vacancies in the public health directorate, and that the risk needs to be broadened across the whole organisation. He went on to say that he had discussed with the Interim Chief Executive the risk about the transient nature of the senior management team given that there have been 3 new appointments and 2 others moving on, and that the Board, and in particular the Chair, need to consider this as a risk that requires mitigation. He advised that he had shared some draft proposed wording of this risk with the Interim Chief Executive.
33/20.27	Mr Stewart highlighted another concern, which relates to the amended HSC Framework and the implications this has for the PHA Board and the PHA as a whole. He said that there may be a mitigating factor in that the Minister has written to Chairs, but he said he has raised this with the Interim Chief Executive and it should go onto the risk register. Ms Mann-Kler said that she would support this.
33/20.28	Mr Stewart said that he hoped that he would have the wording of the two new risks finalised in advance of the next full PHA Board meeting.
33/20.29	Mr Stewart noted that he had concerns about Transformation funding, but this was covered under finance.

33/20.30	Mr Clayton noted that the risk on EU Exit has been removed. Mr McClean said that it can be added back on if required.	
34/20	**Item 11 – Information Governance Update**	
34/20.1	Miss Taylor advised that she had no further specific issues to raise as these has been covered under Item 6.	
35/20	**Item 12 – Any Other Business**	
35/20.1	Ms Mann-Kler advised that she has written to Mr Stewart, Mr McClean and Miss Taylor about the recent NIAO good practice guide on raising concerns. She said that given recent events including the RHI scandal and the recent resignations in RQIA, it may be useful to see if there are any implications for PHA's Whistleblowing Policy. Miss Taylor agreed to meet with Ms Mann-Kler to discuss this.	Miss Taylor
36/20	**Item 13 – Details of Next Meeting** *Thursday 1 October 2020 at 9:30am* *Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast.* Signed by Chair: Joseph Stewart Date: 1 October 2020	

HSC Public Health Agency

item 10

Title of Meeting	PHA Board Meeting
Date	15 October 2020
Title of paper	Mid-Year Assurance Statement
Reference	PHA/03/10/20
Prepared by	Rosemary Taylor
Lead Director	Olive MacLeod
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to seek PHA Board approval of the PHA Mid-Year Assurance Statement for submission to the Department of Health.

2 Background Information

All arm's length bodies are required to submit a Mid-year Assurance Statement to the Department of Health in a template that is set by the Department.

The Statement was approved by the Agency Management Team at its meeting on 22 September 2020 and by the Governance and Audit Committee at its meeting on 1 October 2020.

3 Key Issues

The Mid-Year Assurance Statement provides assurance on the systems of internal control in line with Departmental guidance. It includes details of Internal Audit assignments for 2020/21 completed to date. Two new control divergences have been identified relating to HSCQI and Staff Resilience during COVID-19. The remaining divergences have been reviewed and updated from the previous Governance Statement.

4 Next Steps

Following approval by the PHA Board, the Statement will be signed by the Chief Executive and forwarded to the Department of Health.

DoH ARM'S LENGTH BODY: MID-YEAR ASSURANCE STATEMENT

This statement concerns the condition of the system of internal governance in the Public Health Agency as at 30 September 2020.

The scope of my responsibilities as Accounting Officer for the Public Health Agency, the overall assurance and accountability arrangements surrounding my Accounting Officer role, the organisation's business planning and risk management, and governance framework, remain as set out in the Governance Statement which I signed on 7 July 2020. The purpose of this mid-year assurance statement is to attest to the continuing effectiveness of the system of internal governance. In accordance with Departmental guidance, I do this under the following headings.

1. Governance Framework

The Governance framework as described in the most recent Governance Statement continues in operation. The Governance and Audit Committee and Remuneration Committee have continued to meet and to discharge their assigned business. Minutes of their meetings, together with board meeting minutes containing the Committees' reports, are available for Departmental inspection to further attest to this.

2. Assurance Framework

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

3. Risk Register

I confirm that the Corporate Risk Register has been regularly reviewed by the board of the organisation and that risk management systems/processes are in place throughout

the organisation. As part of the board-led system of risk management, the Register is presented to the Governance and Audit Committee for discussion and approval and all significant risks are reported to the Board – most recently on 15 October 2020.
In addition I confirm that Information Risk continues to be managed and controlled as part of this process.

4. Performance against Business Plan Objectives/Targets

I confirm satisfactory progress towards the achievement of the objectives and targets set out in the organisation's business plan as approved by the Department.

5. Finance

I confirm that proper financial controls are in place to enable me to ensure value for money, propriety, legality and regularity of expenditure and contracts under my control, manage my organisation's budget, protect any financial assets under my care and achieve maximum utilisation of my budget to support the achievement of financial targets.

I confirm compliance with the principles set out in MPMNI and the Financial Memoranda which includes:

- safeguarding funds and ensuring that they are applied only to the purposes for which they were voted;
- seeking Departmental approval for any expenditure outside the delegated limits in accordance with Departmental guidance;
- preparation of business cases for all expenditure proposals in line with the Northern Ireland Guide Expenditure Appraisal and Evaluation (NIGEAE) and Departmental guidance and ensuring that the organisation's procurement, projects and processes are systematically evaluated and assessed;
- accounting accurately for the organisation's financial position and transactions;

- securing goods and services through competitive means unless there are convincing reasons to the contrary; and
- procurement activity should be carried out by means of a Service Level Agreement with a recognised and approved Centre of Procurement Expertise (CoPE)

6. Information Governance - General Data Protect Regulation (GDPR) & Data Protection Act (DPA) 2018

I can confirm that my organisation has taken appropriate steps and is carrying out the necessary actions to ensure ongoing compliance with GDPR and DPA 2018.

7. External Audit Reports

No priority 1, 2 or 3 recommendations were identified by the external audit in 2019/20.

8. Internal Audit

I confirm implementation of the accepted recommendations made by internal audit.

Internal Audit carried out a full review of the recommendations from the 2019/20 internal audits and provided a detailed progress report to the Governance and Audit Committee on 1 October 2020. The outcome of this report highlighted that of the 65 recommendations identified, 69% have been fully implemented and 31% partially implemented. Action is currently being taken to ensure the remaining recommendations are being fully implemented. A copy of this report is available if required.

One report has been finalised in 2020/21:

Title	Level of Assurance
Risk Management	Satisfactory

9. RQIA and Other Reports

I confirm implementation of the accepted recommendations made by RQIA.

The HSCB/PHA has a system in place via the Safety and Quality Alerts Team (SQAT) to provide the appropriate assurance mechanism that all HSCB/PHA actions contained within RQIA reports are implemented.

10. NAO Audit Committee Checklist

I confirm completion of the NAO Audit Committee Checklist and that action plans will be implemented to address any issues. I also confirm that any relevant issues will be reported to the Department.

11. Board Governance Self Assessment Tool

I confirm completion of the Board Governance Self-Assessment Tool and that action plans will be implemented to address any issues. I also confirm that any relevant issues will be reported to the Department. (To be brought to October board)

12. Internal Control Divergences

I confirm that my organisation meets, and has in place controls to enable it to meet, the requirements of all extant statutory obligations, that it complies with all standards, policies and strategies set by the Department; the conditions and requirements set out in the MSFM, other Departmental guidance and guidelines and all applicable guidance set by other parts of government. Any significant control divergences are reported below.

New Divergences:

HSCQI

The establishment of the HSCQI function was a key action from '*Health and Wellbeing 2026: Delivering Together'*. The DoH established the HSCQI within the PHA, providing temporary funding through transformation monies for the Director of HSCQI and a number of additional posts. (The Safety Forum, already within the PHA, also became part of the new HSCQI Directorate.)

However, HSCQI has never been funded for all the posts required, making it challenging for the HSCQI to deliver on the design intent. There is therefore a risk that the HSCQI will be unable to fulfil its core function, service corporate requirements or undertake additional requests from the HSC system to support work and training.

The PHA Chief Executive and Director HSCQI will continue to work with the Department to agree the priorities for HSCQI (in light of constrained resources) and to discuss funding for HSCQI.

Staff Resilience during COVID 19

As a result of the necessary response to COVID 19 the PHA was required to move to 7 day working in April 2020. While there was a little respite during July and August, the organisation is again entering a period of 7 day working, which is likely to be required through to the end of winter.

PHA has however limited staff capacity, and while additional staff have been brought in over recent weeks, including through redeployment and some honorary contracts, there is concern that in order to maintain this response a significant number of staff will have to work more than 5 days a week over a long and sustained period. It is noted that staff are already tired, with many unable to take a proper break during

July and August, and therefore there is a risk that staff may become ill and/or no longer be able to continue.

The PHA will continue to work with HR and the wider HSC and the Department to support staff and seek ways to build resilience and maintain the required and necessary response to COVID 19.

Update on Previous Divergences:

Business Services Transformation Project/Shared Services (Payroll)

The audit assignment finalised in March 2017 on Payroll Shared Services resulted in an unacceptable level of assurance being received from the Internal Auditor. While the issues raised in this audit report had less impact on the PHA than some other HSC organisations, it was of some concern that progress on issues identified previously had not been made. As a result of this Payroll audit, an action plan was developed by BSO to attempt to address the control and system stability issues identified.

Internal Audit subsequently provided limited assurance in the 2017/18 audits of Payroll Shared Services and have continued to provide this level of assurance until the latest report finalised in April 2020. For the first time since the establishment of PSSC, Internal Audit can provide satisfactory assurance in respect of elementary PSC processes. Internal Audit continue to provide limited assurance in respect of timesheets, management of overpayments and reconciliations on Real Time Information (RTI) between the payroll system and HMRC.

Quality, Quantity and Financial Controls

While acknowledging the difficulties in commissioning and supporting services provided to the population of Northern Ireland in an environment where demand for these services continues to increase and the budget available for commissioning

them remains constrained, the actions taken by the PHA during 2019/20 enabled it to maintain the integrity of existing services commissioned and to ensure that additional priorities were implemented and progressed, within budget.

The Assembly passed the Budget Act (Northern Ireland) 2020 in March 2020 which authorised the cash and use of resources for all departments and their Arms' Length Bodies for the 2019/20 year, based on the Executive's final expenditure plans for the year. The Budget Act (Northern Ireland) 2020 also authorised a Vote on Account to authorise departments' access to cash and use of resources for the early months of the 2020/21 financial year. While it would be normal for this to be followed by the 2020/21 Main Estimates and the associated Budget (No. 2) Bill before the summer recess, the COVID-19 emergency and the unprecedented level of allocations which the Executive has agreed in response, has necessitated that the Budget (No. 2) Bill is instead authorising a further Vote on Account to ensure departments and their Arms' Length Bodies have access to the cash and resources through to the end of October 2020, when the Main Estimates will be brought to the Assembly and the public expenditure position is more stable.

Management of Contracts with the Community and Voluntary Sector

Previous Internal Audit reports on the management of health and social wellbeing improvement contracts have provided satisfactory assurance on the system of internal controls over PHA's management of health and social wellbeing contracts, reflecting the significant work that has been undertaken by the PHA. Service level Agreements are in place, appropriate monitoring arrangements have been developed, payments are only released on approval of previous progress returns and a procurement plan is in place, with action being taken against it during the year.

PHA's ability to continue to implement the Procurement Plan since March 2020, has been significantly impacted by the need to prioritise staffing resources to respond to the Covid-19 pandemic. The ongoing social distancing restrictions also make it

difficult to undertake appropriate engagement with stakeholders that is necessary to inform the planning and procurement process. The PHA Procurement Board met on the 24 July 2020 to review the Procurement Plan and agreed those areas of work that need to be prioritised and progressed. These include the re-tender of Drug and Alcohol services, Relationship and Sexual Education services and the Self-Harm Intervention programme. Revised timelines for the Drug and Alcohol tender have now been agreed by AMT and additional clinical support is being secured to help progress this work.

The PHA is also continuing to take forward preparatory work for mental health and suicide prevention support services linked to the delivery of the Protect Life 2 strategy.

The report of a Task and Finish Group established to review how the PHA could improve its planning and procurement processes continues to be implemented. Actions progressed include: a baseline review of the Procurement Plan timelines and development of a Thematic Planning timetable; awareness training for PHA staff in planning and Procurement processes was undertaken in January and February 2020; and, the appointment of 2 new senior planning posts who will provide additional specialist capacity to support planning for procurement.

The PHA will continue to work closely with colleagues in HSCB, BSO (Directorate of Legal Services and Procurement and Logistics service), HSC Trusts and the DoH, to ensure that procurement processes continue to meet regional policy and guidance.

EU Exit

On 29 March 2017, the UK Government submitted its notification to leave the EU in accordance with Article 50. On 31 January 2020, the Withdrawal Agreement between the UK and the EU became legally binding and the UK left the EU. The

future relationship between the EU and the UK will be determined by negotiations taking place during the transition period ending 31 December 2020. As uncertainty still exists regarding the implementation of the Northern Ireland Protocol, this is under review in conjunction with key stakeholders. The Public Health Agency will continue to work collaboratively with colleagues during 2020/21 across the Department, HSC and wider to ensure we are appropriately prepared for the end of the transition period and the new dispensation.

Neurology Call Back

Due to concerns being raised in relation to the practice of a consultant neurologist at the Belfast Trust including work he undertook on behalf of other Trusts and in relation to his private practice, the HSCB and PHA, at the direction of the DoH, established a regional Coordination Group (which included representatives from each of the five Trusts and relevant independent sector providers) to co-ordinate the work necessary to complete a call-back review of those patients who remained under active review of the consultant (phase 1) followed by a call-back of a defined cohort of patients who had been discharged by the consultant (phase 2). The PHA has been working closely with the HSCB, Trusts and independent providers to ensure that a consistent approach is taken relating to the call back and review of patients who may be affected including providing consistent situation reports to the DoH on activity and progress.

Phase 1 of the call-back exercise was completed in 2018 and a report on the activity and outcomes associated with Phase 1 was published.

Phase 2 was completed in October 2019 and a report submitted in January 2020. The PHA and HSCB continue to work with the DoH, BHSCT and relevant private providers to confirm the next steps on this matter.

PHA Staffing Issues

The PHA has continued to work closely with DoH colleagues to take actions to address the number of vacancies and posts filled on a temporary basis across all Directorates and at all levels of the organisation. It has been noted that budget reductions over the past number of years and on-going budget constraints have curtailed the ability to further develop and grow the workforce to meet new and increasing demands. This has impacted on the work of the PHA through constrained capacity in a number of key areas and functions.

While significant progress was made during 2019/20 to address staffing issues, most notably with the appointment of a number of new permanent and locum health protection and service development consultants, it is recognized that some longer term actions are required.

With the emergence of COVID-19 in early 2020 additional pressure has been placed on PHA staff, particularly the health protection team. It is recognized that further work is required as a matter of urgency to increase the workforce with suitably qualified staff (both short and long term), given that the nature of the COVID 19 pandemic will require significant additional work for the foreseeable future.

Two business cases were submitted to the DoH in August 2020 seeking funding for additional staff to enhance the Health Protection and Communications/Operations functions, from COVID 19 funds. A decision is awaited.

PHA will continue to work with DoH colleagues to progress this.

COVID-19

The World Health Organisation (WHO) declared the outbreak of Coronavirus disease (COVID-19) a global pandemic on 11 March 2020. Following which the Department and its ALBs immediately enacted emergency response plans across the NI Health sector. There is UK-wide coordinated approach guided by the scientific and medical advice from respective Chief Medical Officers and Chief Scientific Advisers informed by the emergent evidence nationally and internationally. Evidence-based UK-wide policies and guidelines continue to be carefully followed in conjunction with the PHA issuing local guidelines and ensuring readily accessible and continually updated advice.

The pandemic has had extensive impact on the health of the population, all health services and the way business is conducted across the public sector. Protecting the population, particularly the most vulnerable, ensuring that health and social care services are not overwhelmed, saving lives through mitigating the impact of the pandemic and patient and staff safety has remained at the forefront throughout health's emergency response. This has required a number of measures to urgently repurpose and temporarily reconfigure the provision of services, and to identify additional capacity including the need to ensure availability of appropriate Personal Protective Equipment. Financial measures have been put in place by the NI Executive to enable NI to tackle the response to COVID-19 and Health has obtained essential financial support from this package of measures to assist in the ongoing fight against COVID-19.

Contingency arrangements were put in place including the establishment of an Emergency Operations Centre within the Department to support HSC colleagues' frontline response to the pandemic. Given the wide ranging impact and the need to react immediately to changing healthcare needs, this had an effect on the ability to conduct routine health business with a need to curtail non-urgent healthcare activity in order to re-direct resources to deal with the pandemic. Work has been underway

over recent months to resume services, albeit in a way that ensures the protection of patients and staff from COVID 19.

There have been substantial resourcing impacts across the Department and ALBs to scale up the response and to ensure adequate staff resourcing to meet increasing demands which included calling on volunteers, retired medical staff and medical students to rally together to strive to enable an optimum response to the pandemic.

Social distancing measures were implemented in line with The Health Protection (Coronavirus, Restrictions) (Northern Ireland) Regulations 2020 and the health sector continues to play an important part in ensuring the NI population are aware of the need to adhere to the measures to reduce risk of transmission.

The actions of the health sector throughout the continued response to the pandemic are based on the ongoing assessment of three key criteria: the most up-to-date scientific evidence; the ability of the health service to cope; and the wider impacts on our health, society and the economy.

Across healthcare, leading on the testing of COVID-19 in NI has and continues to be a key priority with testing centres being set up across the country including mobile testing. The Department's Expert Advisory Group has overseen the strategic approach to testing in NI. The Minister of Health is a member of the Ministerial Testing Taskforce, chaired by the Secretary of State for Health, and so NI is fully engaged with the strategy for testing at a national level. NI testing capacity has also been increased through Health's facilitation of the UK Coronavirus National Testing Programme.

Northern Ireland Contact Tracing Service, operated by the PHA, began contact tracing all confirmed cases of COVID-19 on 18 May 2020. The team continues to be

scaled up to strive to ensure that every conceivable effort is made to continue to limit transmission.

The Department prepared a COVID-19 Test, Trace and Protect Strategy which sets out the public health approach to minimising COVID-19 transmission in the community in Northern Ireland. The Chief Medical Officer has established a Strategic Oversight Board for the NI COVID-19 strategy which brings all of the key elements together – namely testing, contact tracing, information and advice, and support - working together with colleagues across the HSC to endeavour to maintain community transmission at a low level and respond to clusters of infection localised in NI.

As lockdown was lifted and gradual increased levels of social and economic activity, the number of positive cases has increased. The coming winter months and 'flu season' will present an additional pressure. Maintaining the contact tracing service and wider health protection response over the coming months as the prevalence of COVID 19 increases in the community will be the primary challenge for the PHA over the next 6 months.

This at the same time as work continues to rebuild wider healthcare services and confidence in the community. A new Management Board for Rebuilding HSC Services has also been created. This broadly consists of senior Department of Health officials, Trust Chief Executives and other HSC leaders. COVID-19 has had a profound impact on the delivery of health and social care services and across the HSC plans are incrementally being enacted to begin recovery whilst planning for a potential second wave. The Department is continuing to work closely across the HSC to support and define the requirements and opportunities to meet continuing and rapidly changing pressures in these unprecedented and challenging times.

13. <u>Mid-year assurance report from Chief Internal Auditor</u>

I confirm that I have referred to the Mid-Year Assurance report from the Chief Internal Auditor, which details the organisation's implementation of accepted audit recommendations.

Signed *Date*

CHIEF EXECUTIVE & ACCOUNTING OFFICER

HSC Public Health Agency

item 11

Title of Meeting	PHA Board Meeting
Date	15 October 2020
Title of paper	Corporate Risk Register
Reference	PHA/04/10/20
Prepared by	Rosemary Taylor
Lead Director	Olive MacLeod
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to seek PHA Board approval of current PHA Corporate Risk Register.

2 Background Information

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

3 Key Issues

The attached Corporate Risk Register reflects the review as at 31 August 2020 and has been carried out in conjunction with individual directorate register reviews for the same period.

Two risks have been added from the Corporate Risk Register this quarter:

- CR 56 - Staffing Compliment in HSCQI Directorate
- CR 57 - PHA Leadership

A third new risk was added following discussion at the Governance and Audit Committee on 1 October:

- CR 58 – Staff Resilience

One risk had its risk rating reduced from High to Medium:

- CR 46 - Failure to meet statutory and legal requirements in relation to Emergency Planning (EPRR)

The Corporate Risk Register was approved by the Agency Management Team at its meeting on 22 September 2020 and by the Governance and Audit Committee at its meeting on 1 October 2020.

4 Next Steps

The next review will be undertaken as at 31 December 2020.

PHA Corporate Risk Register

Date of Review:
31 August 2020

Introduction

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

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

The PHA has recognised the need to adopt such an approach and has a systematic and unified process in place to ensure a fully functioning risk register at both corporate and directorate levels as set out in the PHA Risk Management Srategy and Policy.

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

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

Overview of Risk Register Review as at August 2020

Number of new risks identified	**3**
Number of risks removed from register	**2**
Number of risks where overall rating has been reduced	**1**
Number of risks where overall rating has been increased	**0**

CONTENTS

58	Staff Resilience	Chief Executive	**HIGH**	33

Key:

Risk rating:

↑ increased from previous quarter

↓ decreased from previous quarter

→ remained the same as previous quarter

Corporate Risk 26			
RISK AREA/CONTEXT: Delays in market testing health and social care contracts, as set out in the PHA Procurement Plan.			
DESCRIPTION OF RISK: The PHA has an extensive range of Health and Social Care contracts with non HSC providers (primarily health improvement contracts with voluntary and community sector). An approved PHA Procurement Plan is in place, and a range of large and smaller services have been procured. Some contracts are however rolled forward year on year, without the benefit of market testing. Full compliance with the PHA Procurement Plan has not been achieved due to limited capacity, skill constraints and the complexity of some contracts. It is therefore likely that the timescales in the current plan will not be met, with an additional challenge in respect of the requirement to re-procure the first contracts tendered by 2020. There is a risk that VFM is not being achieved in the current contracts and a potential reputational risk to the PHA.			**DATE RISK ADDED:** September 2012 (Amalgamated with Corporate Risk 28, September 2013) Revised June 2018
LINK TO ASSURANCE FRAMEWORK: Operational Performance and Service Improvement Dimension			
LINK TO ANNUAL BUSINESS PLAN 2019/20: Corporate Objective 5 Our Organisation Works Effectively			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	Possible	Moderate	**MEDIUM**
LEAD OFFICER: Mrs Olive Macleod, Interim Chief Executive			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
Procurement Plan has been developed and agreed by AMT setting out the timescales for achieiving the re-tendering of baseline contracts. Revised processes and documentation developed for PHA in liaison with PALS to ensure tender process is applied where required in line with Procurement regulations. Suite of documentation and guidance for tendering in place.	Progress reports on implementing the Procurement Plan will be provided to PHA Procurement Board and annually to PHA board Leadership at AMT and Assistant Director level via PHA Procurement board.	Legacy contracts may not be providing value for money Limited capacity within BSO PALS Limited capacity and planning skills to undertake essential pre-procurement planning, business cases etc	Action Plan to implement the recommendations of the Task & Finish Group Report will continue to be taken forward during 2020/21. However, this will be impacted by staff priorities be re-focused on addressing Covid 19. • Procurement Plan timelines to be continually reviewed in light of COVID 19 (November 2020) • Revised re-tender plans for drug and alcohol / RSE /SHIP and Screening uptake service to be taken forward in line with agreed	Dec 2020

Training has been provided for relevant staff, including legal aspects of procurement. Internal management structures established to oversee implementation of the Procurement Plan~~.~~ Review of Procurement Plan and wider support requirements standing item on agenda of Procurement Board Review of procurement processes and future approach undertaken taking into account lessons learnt from experience over the past 3 years and the introduction of the new Procurement regulations in Feb 2015 and the introduction of a Light Touch Regime. Temporary arrangement from core Ops admin to support social care procurement, kept under review, with Director of Operations. PHA membership and attendance at HSCNI Regional Procurement Board	PIDs for larger procurements (including pre-procurement) brought to AMT and, where appropriate, PHA board.		timelines to be approved by PHA Procurement Board (November 2020) • Review of Contract Management Processes to be completed by December 2020 However,~~ d~~delay due to staffing prioirities being re-directed to manage re-purposing of existing contracts to address Covid 19 pressures may impact on this.	

Report of the Planning and Procurement Task and Finish Group approved by AMT and presented to PHA Board workshop in June 2019. Training for staff in planning and procurement processes initiated in Feb 2020. 80 senior staff attended prior to Covid 19 impacting in March 2020. All key staff currently engaged in Procurements have been trained. Training slides are available on Connect via business manual and contact details for advice and support. 2 senior planning posts recruited DACs in place to extend drugs & alcohol, SHIP, RSE and screening uptake services in line with revised procurement timelines (into 2021)				

Corporate Risk 39			
RISK AREA/CONTEXT: Cyber Security			
DESCRIPTION OF RISK: Information security across the HSC is of critical importance to delivery of care, protection of information assets and many related business processes. If a cyber incident should occur, without effective security and controls, HSC information, systems and infrastructure (including those used by the PHA, as well as Trusts providing services for the PHA) may become unreliable, not accessible when required (temporarily or permanently), or compromised by unauthorised 3rd parties including criminals. This could result in significant business disruption. It could also lead to unauthorized access to any of our systems or information, theft of information or finances, breach of statutory obligations, substantial fines and significant reputational damage.			**DATE RISK ADDED:** June 2017
LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension			
LINK TO ANNUAL BUSINESS PLAN 2019/20: Corporate Objective 5 Our Organisation Works Effectively			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	Likely	Major	**HIGH**
LEAD OFFICER: Mr E McClean, Deputy Chief Executive (interim) and Director of Operations			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
Technical Infrastructure: • HSC security hardware (eg firewalls); • HSC security software (threat detection, antivirus, email & web filtering); • Server/client patching; • 3rd party Secure Remote Access; • Data & system backups • Regional funding provided & Sophos Intercept X &	Internal Audit/BSO ITS self-assessment against 10 Steps towards NCSC; Technical risks assessments and penetration tests; HSC SIRO Forum for shared learning and collaborative action planning and delivery; Reports to GAC/PHA board on reported incidents as appropriate.	Insufficient corporate recognition and ownership of cyber security threat as a service delivery risk Full extent of gaps are not understood at this point – a gap analysis regionally and by HSC organisations is required to capture a considered extent of vulnerabilities Insufficient User	BSO ITS provides PHA IT services. PHA will continue to work with BSO ITS, HSCB e-health and through the HSC SIRO forum Regional Cyber Security Programme Board has developed a draft incident management plan and handbook, with the intention of undertaking a desk top test across the region (late 2019/20 or early 20/21) Regional IT Security training has been refreshed and will be launched	Dec 2020

Sophos Sandstorm software & PKI hardware purchased & being installed. **Policy, Process:** • Regional & local ICT/information security policies; • Data protection policy; • Change Control Processes; • User Account Management processes; • Disaster Recovery Plans; • Emergency Planning & Service/Business Continuity Plans; • Corporate Risk Management Framework, processes & monitoring; • Regional & local incident management & reporting policies & procedures; **User Behaviours – influenced through:** • Induction; • Mandatory Training; • HR Disciplinary Policy; • Contract of employment; • 3rd party contracts/data access agreements PHA BCP tested and updated February 2018 with a focus on cyber security		Awareness of impact of personal behaviours in relation to cyber threat	early September 2020. To be reviewed Dec 2020	

PHA member of the Regional HSC Cyber Security Business Continuity Group BSO cyber security project manager co-ordinating regional cyber security work. Regional cyber security programme board (BSO representing PHA) taking forward actions arising from DXC report and recommendations Ongoing work being taken forward and overseen by the Regional Cyber Security Programme Board. Internal Audit of 'user behaviour' relating to cyber security (conducted January 2020) provided satisfactory assurance.				

Corporate Risk 46			
RISK AREA/CONTEXT: Failure to meet statutory & legal requirements in relation to Emergency Planning (EPRR)			
DESCRIPTION OF RISK: Disruption, loss of reputation, inefficient response, failure to meet statutory and legal requirements for Emergency Preparedness, Resilience and Response (EPRR) The PHA Health Protection Team has a statutory responsibility for emergency response. Inadequate mechanisms to financially compensate staff (across all pay bands) that are not on a service rota, has meant that staff are reluctant to participate in training or emergency response. This directly contributes to the following areas of risk for organisational resilience and emergency response; Inability to fully operationalise the Joint Response Emergency Plan. Absence of identified group of staff for activation of the Emergency Operation Centre Plan and vulnerability to organisational resilience for a sustained emergency response, management of an outbreak and pandemic response.			**DATE RISK ADDED:** April 2019
LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension			
LINK TO ANNUAL BUSINESS PLAN 2019/20: Potentially all corporate objectives; particularly corporate objectives 4 (working together to ensure high quality services) and 5 (our organisation works effectively).			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	Likely	Moderate	~~**HIGH**~~ **MEDIUM**
LEAD OFFICER: Professor Hugo Van Woerden, Director of Public Health			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
• Number of senior staff trained in emergency response (PHA,HSCB, BSO). • The proposal for staff	• Reports to AMT.	• Availability for out of hours response. • Sustaining an out of hours response. • Compensation under	• Following learning from COVID-19 a further review of service business continuity plans and business impact analysis is required to	Dec 2020

payment has been agreed by HR, SMT/AMT and consultation completed with Trade Union colleagues.		AFC T&Cs for extended working hours.	support the redeployment and training of staff to support an emergency response and maintaining the function of the EOC (in hours and out of hours). (March 2021) • Continue to work with HR to seek clarification and solution regarding payment and compensation for senior staff who are not on an on-call rota and who are involved in emergency response (Band 8a and above). (review Dec 2020)	

Corporate Risk 47			
RISK AREA/CONTEXT: Connect – PHA Intranet			
DESCRIPTION OF RISK: The PHA has been working with BSO ITS to redevelop the Connect Intranet site as a WordPress site that can be hosted and supported by BSO. Development has been slow due to a combination of factors including competing priorities within the ITS web development programme and ITS staff capacity. The site currently sits on an old unsupported version of Drupal and this means that the site is now operating at an increased risk of critical failure and non recovery which would negatively impact the operational efficiency of the PHA. Moving the site onto a more recent version of Drupal would be a significant workload commitment and largely nugatory given the pending transition to Wordpress for the ITS project. Furthermore, the site is hosted on Linode, a third party provider. Linode brought the site down in June which impacted on business continuity for 24 hours; while the site was restored there is potential for this to reoccur.			**DATE RISK ADDED:** June 2019
LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension			
LINK TO ANNUAL BUSINESS PLAN 2019/20: Corporate Objective 5 Our Organisation Works Effectively			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	Possible	Major	**HIGH**
LEAD OFFICER: Mr E McClean, Deputy Chief Executive / Director of Operations			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
• Site maintained/managed under BT48 support contract • Weekly backups of the current site are also conducted off site. • Inclusion in Business Continuity planning	Work is progressing with BSO ITS on the development of a new intranet on the Wordpress platform. A new server has been employed by BSO ITS which has permitted additional functionality and capacity. Regular communication with BSO ITS is ongoing.	• It sits on an unsupported version of Drupal; the platform and application are insecure; • It is hosted on Linode, a third party site which poses an additional risk; • BT48 support is limited to low level maintenance	Work is ongoing with BSO ITS to reach a stage where it can be launched with an acceptable site map. Content migration completed. Transfer pending final migration review. Launch delayed due to COVID 19 response, existing intranent being used and updated. New intranet to be rolled out when resources allow. Review Dec 2020	Dec 2020

Corporate Risk 48			
RISK AREA/CONTEXT: PHA Public Website			
DESCRIPTION OF RISK: The existing PHA public facing website has very restricted functional utility. This has proven to be a signifiacant liability in the response to COVID-19 and has restricted significantly what can be hosted. It is essential for the PHA's messaging to have excellent contemporary functionality, be able to host dynamic content, digital presentations and plug-in directly other content/functionality from other PHA websites including new COVID 19 platforms. As the current website is at the end of its life there is increased and material risk in respect of support arrangements. Risk that key messages are not communicated and reputational risk for the PHA.			**DATE RISK ADDED:** March 2020
LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension			
LINK TO ANNUAL BUSINESS PLAN 2019/20: Corporate Objective 5 Our Organisation Works Effectively			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	Possible	Major	**HIGH**
LEAD OFFICER: Mr E McClean, Deputy Chief Executive / Director of Operations			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
• Hosting, maintenance and updating services have been procured via an external provider (contract is due for procurement in year) • New web spec/business case developed and submitted Digital Health team for consideration/approval	• Regular contact ongoing between Communications team and maintenance provider	• Level of functionality remains limited within the existing website and constrains our ability to more effectively communicate with key audiences. Latest research shows that shortcomings can only be addressed by rebuilding the site • No contingency	• Programme of maintenance and updating planned (ongoing); • Procure re-development contract and take forward work to deliver new website on an alternative hosting platform which is supported via BSO/NICS in house (review Dec 2020) • Recruite vacant web developer post (review Dec 2020)	Dec 2020

		arrangements in place		

Corporate Risk 49				
RISK AREA/CONTEXT: Finance – COVID 19 (allocation)				
DESCRIPTION OF RISK: The requirement to respond rapidly to the developing coronavirus epidemic has resulted in expenditure being authorised and incurred before financial allocations are secured. There is a risk to financial stability if financial allocations subsequently made are not sufficient to cover expenditure commitments.			**DATE RISK ADDED:** May 2020	
LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension				
LINK TO ANNUAL BUSINESS PLAN 2019/20: Corporate Objective 5 Our Organisation Works Effectively				
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**	
	Likely	major	**HIGH**	
LEAD OFFICER: Director of Finance				

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
• Finance proformas required for COVID related expenditure – process to feed through HSC Silver to Gold for approvals. • DOH finance also sighted on finance implications of COVID-19 related service proposals. • Business case processes for major expenditure.	• Approvals of COVID-19 templated noted at GOLD, where financial consequences are noted. • Monthly monitoring returns to DOH highlighting spend to date and forecast – COVID 19 related spend is highlighted separately. • Finance reports will highlight extent of financial risk to PHA SMT/Board on regular basis. • COVID templates now being manage through central finance resource in HSCB, to ensure appropriate scrutiny.	• No allocation letters in advance of expenditure being committed.	- Monthly monitoring of spend separately identified. - Level of financial risk highlighted to DOH and PHA board on regular basis. Actions to be reviewed Dec 2020	Dec 2020

Corporate Risk 50				
RISK AREA/CONTEXT: Finance – COVID 19 (procurement)				
DESCRIPTION OF RISK: The requirement to respond rapidly to the developing coronavirus epidemic results in expenditure being incurred without due regard to the principles of Managing Public Money NI, leading to poor value for money, irregular expenditure and the potential for legal challenge.			**DATE RISK ADDED:**	
LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension				
LINK TO ANNUAL BUSINESS PLAN 2019/20: Corporate Objective 5 Our Organisation Works Effectively				
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**	
	Likely	Major	**High**	
LEAD OFFICER: Director of Finance				

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
• All Direct Award contracts (DACs)are reviewed by COPE. • Automated SODA process for approval of order/invoices • DACs require DOF/AO approval.	• List of DACs reviewed regularly by GAC. • Normal DAC approvals have continued.	• Normal procurement processes and timescales have been temporarily suspended in a number of cases.	• Review DACs awarded during COVID-19 timescales to determine extent of commitment and if it can be replaced with full procurement. December 2020 • Monitor expenditure for unusual variances that cannot be explained. December 2020	Dec 2020

Corporate Risk 51			
RISK AREA/CONTEXT: Contact Tracing Service			
DESCRIPTION OF RISK: The PHA has been tasked with the rapid establishment of a COVID 19 Contact Tracing Service. Failure to fully implement an appropriate Contact Tracing service, with the capacity to scale up and down, within the necessary timescale will result in an inability to control and prevent community transmission of COVID 19, leading to increased deaths and a surge in activity that the HSC would not have the capacity to cope with. PHA would also face significant reputational damage.			**DATE RISK ADDED:** May 2020
LINK TO ASSURANCE FRAMEWORK: Operational Performance and Service Improvement Dimension			
LINK TO ANNUAL BUSINESS PLAN 2019/20: All Health and Wellbeing Services should be Safe and High Quality (4)			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	Possible	Major	**High**
LEAD OFFICER: CX and DPH			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
• Relevant senior PHA staff represented on the Contact Tracing Steering Group (chaired by Dr L Mitchell and Mr A Findlay on behalf of the DoH); • Programme lead overseeing all elements; • Interim Contact Tracing Centre Manager appointed. • PHA staff represented on the Digital TTIS Steering Group • Accommodation business case approved and funding allocated. License signed for County Hall accommodation and	• Reports to Departmental Oversight Group (chaired by CMO, the SRO for Contact Tracing) through Chief Executive and CT Steering Group Chair; • Reports to PHA Board through the Chief Executive	• Complexity of digital and manual systems to be developed in a very tight timescale; • Uncertainities & unknowns regarding COVID 19	• BC for funding for staffing, accommodation & G&S submitted & waiting approval of funding (expected by 30/09/20); • Recruitment continuing for additional staff (review 31/12/20); • Work underway with Digital Health to ensure analytics for tier 1 & 2 contact tracing, digital self trace system (review Dec 2020); • Extensive communications programme continues taking account of changing developments (review Dec 2020)	Dec 2020

CTS operationg from the facilty July 2020. • Work of the CTS supported by DoH STOPCOVIDNI (proximity) app • Dynamics CRM operational in CTS • Tier 3 call centre (provided by NIDirect) operational (through DoH MOU) • Extensive communication programme with MLAs and key sectors including human rights, equality, older people and children's commissioners)				

Corporate Risk 52			
RISK AREA/CONTEXT: Information Governance			
DESCRIPTION OF RISK: As a result of the COVID 19 PHA has been required to collect and hold significant new personal identifyable data. There has also been a requirement to put in place new arrangements for data sharing with other bodies. There is a risk that given the scale, especially of the testing and contact tracing services, the need to establish new digital and manual systems and services rapidly, and the complexity of interfaces with other bodies (including the DoH and DHSC and NHSX), that all GDPR principles are not fully complied with, with the potential for a data breach, and/or reputational or financial consequences for the PHA as a result.			**DATE RISK ADDED:** May 2020
LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension			
LINK TO ANNUAL BUSINESS PLAN 2019/20: Corporate Objective 5 Our Organisation Works Effectively			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	possible	major	**HIGH**
LEAD OFFICER: Director of Public Health			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
• PHA Data Protection Policy; • PHA Data Protection Impact Assessment Policy and Guidelines; • Established processes in PHA, including Health Protection; • Existing training programme for all PHA staff and IAOs • Engagement with the PHA DPO and information governance team; • Information Governance Workstream established	• DPO attends Contact Tracing Steering Group & chairs the IG Workstream; • PHA SIRO and PDG attend & report to AMT and PHA Board	• Speed of implementation resulting in less time to consider & implement IG measures; • Complexity of data flows & lack of clarity about ownership;	• DPIA for testing programme being developed to be completed (review Nov 2020) • DPIA for manual contact tracing & digital self trace being developed. To be submitted to ICO w/c 7/9/20 • All staff for the contact centre (tier 1 & 2, permanent and bank) to complete IG training (on-going as recruited); • DPIA to be completed for analytics platform currently in development (November 2020); • DPIA to be completed for digital-	Dec 2020

under the CT Steering Group; • Close working & regular liaison between PHA DPO and DoH DPO; • Engagement with ICO • DPIA for contact tracing pilot completed; • PN for testing on PHA website; • PHA represented at 4 Nations IG meetings • PN for Contact Tracing published on PHA website • MOU between PHA Health Protection, HSCB, BSO and HSC Trusts updated and approved (June 2020)			self trace system (November 2020)	

Corporate Risk 53			
RISK AREA/CONTEXT: Corporate Priorities			
DESCRIPTION OF RISK: There is a risk, that due to COVID 19, the PHA may not be able to deliver on its key objectives. Firstly as a result of the need to refocus staff to prioritise work in response to the COVID 19 pandemic, including planning for and putting measures in place to help prevent/minimise the impact of a second wave. As a result it has not been possible to take forward all other areas of PHA business. There is therefore a risk that the PHA will not be able to deliver on its key objectives			**DATE RISK ADDED:** May 2020
LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension			
LINK TO ANNUAL BUSINESS PLAN 2019/20: All objectives			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	likely	major	**HIGH**
LEAD OFFICER: Chief Executive			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
• Corporate summary of all Directorate COVID 19 and 'rebuilding' priorities prepared. • Discussion with CMO at SRM; • Director meetings with Chief Executive; • Director meetings with their senior teams	• Discussion at AMT • Reports from AMT/Chief Executive to PHA Board	• Limited capacity to take forward some core work.	• Development of revised ABP 2020/21 identifying priorities for remaining 9 months Delayed due to COVID 19 – Oct 2020 • AMT/Board workshops to agree priorites for year ahead (on-going); • Development of new 5 year Corporate Plan (March 2021)	Dec 2020

Corporate Risk 54			
RISK AREA/CONTEXT: Ability of 3rd Party Providers to Deliver Commissioned Services			
DESCRIPTION OF RISK: In order to deliver on its corporate objectives, the PHA commissions many 3rd party providers to deliver a wide range of services. As well as Trusts and local government, many services are provided by a large number of voluntary, community and private organisations. As a result of COVID 19, including the economic consequences, some of these organisations may no longer be able to deliver services (in whole or in part), with the risk that PHA may not be able to deliver the necessary services to achieve its corporate objectives.			**DATE RISK ADDED:** May 2020
LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension			
LINK TO ANNUAL BUSINESS PLAN 2019/20: All objectives			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	possible	major	**High**
LEAD OFFICER: Director of Public Health and Director of Nursing/AHP			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
• Continuation of existing performance management arrangements; • On-going dialogue with providers	Reports to AMT and PHA board	• Services may not be delivered, resulting in greater inequalities; • Funding may be allocated with no/less service delivered	• Contract managers to review all contracts (ongoing – review Dec 2020)	Dec 2020

Corporate Risk 55

RISK AREA/CONTEXT: Public Health Staffing Issues

DESCRIPTION OF RISK:
The Public Health Directorate has a number of vacancies in key areas as well as a number of posts filled on a temporary basis. In the Health Improvement Division, 46% of posts are filled on a temporary basis.
The vacancies, and the increasing demands, particularly due to the impact of COVID-19, work to rebuild services and the transformation agenda mean that the existing staff resources are stretched significantly in a number of areas. The number of temporary staff adds further instability. This is not a sustainable position, with constrained capacity in a number of key areas and functions, potential delays taking forward new initiatives, the potential for significant issues to be missed, reduced organisational resilience at times of pressure or emergency limited ability to respond adequately to and deliver on statutory responsibilities and the personal strain on individuals, with the potential for increased sickness absenteeism and further loss of staff.

DATE RISK ADDED:
June 2020

LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension

LINK TO ANNUAL BUSINESS PLAN 2019/20: Potentially all corporate objectives; particularly corporate objectives 4 (working together to ensure high quality services) and 5 (our organisation works effectively).

GRADING	LIKELIHOOD	IMPACT	RISK GRADE
	Likely	Major	**HIGH**

LEAD OFFICER: Director of Public Health

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
• Contact has been made with individuals working elsewhere to see if they would consider applying for any of the public health consultant posts. • Funding was made available for 2 additional public health trainee posts in 2019.	• Reports to AMT. • Updates to GAC via Corporate Risk register • Briefing provided to PHA Board.	• Number of temporary posts. • Skill mix issues • Delays in HR/RSSS recruitment process Length of time for JD evaluations to be returned to recruiter, & lack of	• Public Health Directorate continue to look at other options with HR to recruit public health specialists (December 2020) • Business case has been developed to take forward an enhanced health protection service to ensure there is the expertise and system wide	December 2020

• Action Plan developed (in respect of all PHA staffing), approved by AMT, and agreed with DoH • Arrangements for non-medical PH trainee (from Feb 2020) • New permanent & locum consultants commenced between December 2019 and February 2020. • Development and implementation of 'Retire & Return' policy – 2/3 Consultants • Additional temporary posts offered to retired Public Health Consultants (7 posts) • A number of staff external to PHA have been engaged to support work associated with COVID-19 contact tracing, project delivery etc • Some PHA have been redeployed to support COVID-19 where they had particular skills relevant to the response to the pandemic (eg from nursing, project management, data analysis, communications etc) • Dedicated HR support has been identified as a point of contact to help take forward recruitment within Public		communication, leading to further delays in recruitment.	resilience created to deal with the long term impact of Covid 19 and to plan for and manage future pandemics (COVID funding for 2 years; a further BC will be required for permanent funding)- awaiting DoH response (review Dec 2020) • Ongoing prioritisation of work and reflecting capacity in the development of PHA Annual Business Plan (December 2020) • Continue to review and take forward actions agreed with DoH (on-going – review Dec 2020) •	

Health Directorate • An internal Public Health HR Group meets on a monthly basis to discuss any issues and agree way forward				

APPENDIX

RISKS ADDED TO THE CORPORATE RISK REGISTER AS AT 31 July 2020

Corporate Risk 56			
RISK AREA/CONTEXT: Staffing Compliment in HSCQI Directorate			
DESCRIPTION OF RISK: The HSCQI was established in the PHA by the DoH, with temporary funding through transformation monies for the Director and a number of other posts. However recurring funding has not yet been provided for HSCQI. The current staffing compliment in HSCQI Directorate makes it challenging for corporate work to be undertaken, and for HSCQI to deliver on the design intent, which included additional staffing, to build a QI infrastructure for NI HSC services. Establishing HSCQI was a key action stated within Health and Well-Being 2026: Delivering Together. The risk is that the directorate will be unable to fulfil it's core function, service corporate administration needs plus undertake additional requests from the NI HSC system to support improvement work and training.			**DATE RISK ADDED:** August 2020
LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension			
LINK TO ANNUAL BUSINESS PLAN 2019/20: Potentially all corporate objectives; particularly corporate objectives 4(working together to ensure high quality services) and 5 (our organisation works effectively).			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	Likely	Major	**HIGH**
LEAD OFFICER: Director of HSCQI			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
• On-going monitoring and prioritising of HSCQI work. • Ongoing Director review of existing HSCQI Directorate structures. • Prioritisation of scale and spread activity and all programmes of work. • Discussions ongoing between Director of HSCQI PHA CEO and DoH quality and safety directorate, and HSCQI Leadership Alliance re workload and capacity	• Ongoing engagement with HSCQI Leadership Alliance and Network • Reports to AMT • Link with DOH Quality and Safety Unit	• Staffing levels are insufficient to build a reliable and responsive HSCQI infrastructure for NI HSC services. • Delays with HR processes resulting in posts that are unfilled with recurrent funding.	• Permanent recruitment process for 8B Senior Regional Improvement Advisor underway following approval at scrutiny. Completion of requisition is imminent (review Dec 2020) • Band 3 admin post to be filled from waiting list. HR are in the process of offering this post to suitable candidates. Post should be filled by end October/early November 2020 (review Dec 2020).	December 2020

• Temporary transformation funded posts extended: Band 6 admin extended to 31st March 2021 Data analyst part time post extended to end Dec 2020.			• Director will pursue with PHA CEO and AMT, the possibility of extending the part time data analyst post beyond the end December 2020 (review Dec 2020). • CX to consider potential for slippage from other vacant posts to help provide temporary capacity (review Dec 2020) • Ongoing discussions around funding/temporary funding between Director HSCQI, CEO PHA and DOH (review Dec 2020). • Director has requested a meeting with the newly appointed 'Head of the Quality & Safety Unit, DOH' to discuss (review Dec 2020).	

Corporate Risk 57

RISK AREA/CONTEXT: PHA Leadership

DESCRIPTION OF RISK:	**DATE RISK ADDED:**
The PHA faces many challenges during 2020/21, continuing to lead the public health response to the COVID 19 pandemic, in an environment where there are still many uncertainties and unknowns about how the virus will develop over the coming months, at the same time as seeking to re-start and prioritise other PHA business, reflecting and responding where appropriate to the impact of COVID 19. At the same time the PHA has a new management team, with the interim Chief Executive and two Directors taking up post in the last quarter of 2019/20. In addition one Director retires early autumn 2020, and a second at the end of December 2020. Additionally the HSCB Director of Finance and AD Finance, who lead the provision of finance input/advice to the PHA, will be vacant from October and August respectively. At the same time there is a vacant Non-Executive post. While there are many opportunities with a fresh senior team in place, the scale of change has also the potential to lead to instability, with a loss of corporate memory and resources required to gain organizational knowledge and build teams.	August 2020

LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension

LINK TO ANNUAL BUSINESS PLAN 2019/20: Potentially all corporate objectives; particularly corporate objectives 4(working together to ensure high quality services) and 5 (our organisation works effectively).

GRADING	LIKELIHOOD	IMPACT	RISK GRADE
	Likely	Major	**High**

LEAD OFFICER: Chief Executive and Chair

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
• Regular AMT meetings; • Experience of new Directors; • Established processes and continuing knowledge of staff under Director level; • Interim CX contract confirmed to August 2021;	• Regular Board meetings, with reports and updates to Board members; • Regular Sponsorship Review meetings with CMO in DoH; • Established corporate	• Loss of corporate knowledge and experience across a number of areas.	• ADs (Operations) will report to and meet regularly with CX; • CX to review the role of DOps over next months in light of other changes in PHA and review of HSC structures, while seeking Interim Director cover	December 2020

• Chair re-appointment confirmed to May 2021	governance processes – Risk Register, Assurance Framework etc.		via an expression of interest (December 2020); • Process in place to offer DPH post via waiting list (Nov 2020); • AD Finance recruited to take up post November 2020 • DoH to initiate recruitment process for permanent CX (Spring 2021)	

Corporate Risk 58			
RISK AREA/CONTEXT: Staff Resilience			
DESCRIPTION OF RISK: The PHA was required to move to a 7 day working pattern in the initial phase of the COVID 19 pandemic. The organization is again entering a period of 7 day working, which is likely to be required through to the end of the winter. PHA has limited staff capacity, and while additional staff have been brought in, there is concern that a significant number of staff will have to work more than 5 days a week over a long and sustained period. As staff are already tired from the first phase, and with many unable to take a proper break during July and August due to the continuing work pressures, along witth the increasing workload, there is a risk that staff may become ill and/or no longer able to continue.			**DATE RISK ADDED:** October 2020
LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension			
LINK TO ANNUAL BUSINESS PLAN 2019/20: Potentially all corporate objectives; particularly corporate objectives 4(working together to ensure high quality services) and 5 (our organisation works effectively).			

GRADING	LIKELIHOOD	IMPACT	RISK GRADE
	Possible	Major	**High**

LEAD OFFICER: Chief Executive

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
• Regular AMT meetings; • Business Continuity SITREP reporting initiated October 2020; • Staff monitoring information collected and reported to HR	• Regular Board meetings, with reports and updates to Board members; • Established corporate governance processes – Risk Register, Assurance Framework etc.	• Potential loss of staff with knowledge and skills to be able to deliver COVID response; • Potential insufficient staff to fulfil business continuity.	• Redeployment of staff internally within PHA to provide cover to critical functions (review December 2020); • Seek additional staff to support via HSC Leadership Centre (November 2020); • Seek redeployment of staff from HSCB/BSO (review December 2020); • Review of work that can be stood down to allow concentration of resources on	December 2020

			COVID response and other critical areas (review December 2020) • Working with BSO HR regarding mechanisms to support staff and build resilience (review December 2020).	

APPENDIX

RISKS REMOVED FROM CORPORATE RISK REGISTER AS AT 31 August 2020

- NIL -

HSC Public Health Agency

item 12

Title of Meeting	PHA Board Meeting
Date	15 October 2020
Title of paper	ALB Self-Assessment
Reference	PHA/05/10/20
Prepared by	Robert Graham
Lead	Andrew Dougal
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to approve the draft ALB Self-Assessment for 2019/20.

2 Background Information

The Public Health Agency is required to complete an annual self-assessment tool. In previous years it was a requirement to send the completed tool to the Department of Health, but while this is not the case, reference is made to it in PHA's Governance Statement.

3 Key Issues

The tool is in the same format as previous years, with the good practice section in the first half of the document and then PHA's responses to that in the second half.

Due to COVID-19 it has not been possible to convene an additional workshop to carry out an in-depth assessment which had been proposed in 2019. It is suggested to carry out a "light touch" assessment this year with a commitment to a fuller in-depth assessment in May/June 2020.

4 Next Steps

An action plan will be developed in relation to any gaps.

Department of Health
www.health-ni.gov.uk

BOARD GOVERNANCE SELF ASSESSMENT TOOL

For use by Department of Health Sponsored Arms Length Bodies

Updated 16th June 2016

Contents

Introduction

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

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

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

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

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

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

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

Application of the Board Governance Self-Assessment

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

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

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

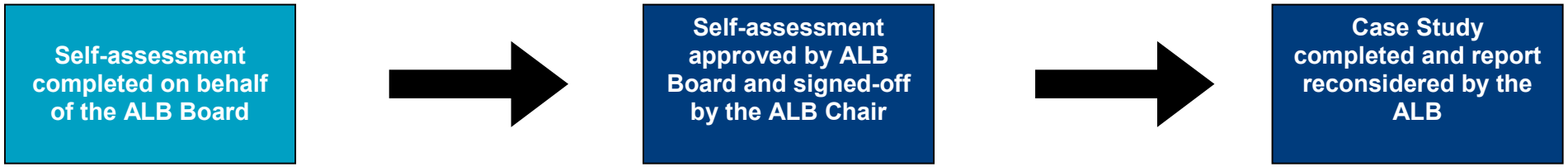
Complete the self-assessment: It is recommended that responsibility for completing the self-assessment sits with the Board and is completed section by section with identification of any key risks and good practice that the Board can evidence. The Board must collectively consider the evidence and reach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

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

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

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

Overview



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

1. Board composition and commitment (e.g. Balance of skills, knowledge and experience);

2. Board evaluation, development and learning (e.g. The Board has a development programme in place);

3. Board insight and foresight (e.g. Performance Reporting);

4. Board engagement and involvement (e.g. Communicating priorities and expectations);

5. Board impact case studies (e.g. A case study that describes how the Board has responded to a recent financial issue).

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

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

Step 1

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

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

Step 2

In addition to the RAG rating and evidence described above, the Board is required to complete a minimum of 1 of 3 mini case studies on;

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

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

Step 3

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

Scoring Criteria

The scoring criteria for each section is as follows:

Green if the following applies:

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

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

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

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

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

Red if the following applies:

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

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

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

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

1. Board composition and commitment

1. Board composition and commitment overview

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

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

1. Board composition and commitment

1.1 Board positions and size

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

1. Board composition and commitment

1.2 Balance and calibre of Board members

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

1. Board composition and commitment

1.3 Role of the Board

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

Examples of evidence that could be submitted to support the Board's RAG rating.	• Terms of Reference • Board minutes • Job descriptions • Scheme of Delegation • Induction programme

1. Board composition and commitment

1.4 Committees of the Board

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

1. Board composition and commitment

1.5 Board member commitment

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

2. Board evaluation, development and learning

2. Board evaluation, development and learning overview

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

1. Effective Board-level evaluation;

2. Whole Board Development Programme;

3. Board induction, succession and contingency planning;

4. Board member appraisal and personal development.

2. Board evaluation, development and learning

2.1 Effective Board level evaluation

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

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

2. Board evaluation, development and learning

2.2 Whole Board development programme

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

2. Board evaluation, development and learning

2.3 Board induction, succession and contingency planning

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

2. Board evaluation, development and learning

2.4 Board member appraisal and personal development

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

3. Board insight and foresight

3. Board insight and foresight overview

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

1.Board Performance Reporting

2.Efficiency and productivity

3.Environmental and strategic focus

4.Quality of Board papers and timeliness of information

3. Board insight and foresight

3.1 Board performance reporting

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

3. Board insight and foresight

3.2 Efficiency and Productivity

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

3. Board insight and foresight

3.3 Environmental and strategic focus

Red Flag	Good Practice
1. The Board does not have a clear understanding of Executive/Departmental priorities and its statutory responsibilities, business plan etc. 2. The Board's annual programme of work does not set aside time for the Board to consider environmental and strategic risks to the ALB. 3. The Board does not formally review progress towards delivering its strategies.	1. The Chief Executive presents a report to every Board meeting detailing important changes or issues in the external environment (e.g. policy changes, quality and financial risks). The impact on strategic direction is debated and, where relevant, updates are made to the ALB's risk registers and Board Assurance Framework (BAF). 2. The Board has reviewed lessons learned from SAIs, reports on discharge of statutory responsibilities, negative reports from independent regulators etc and has considered the impact upon them. Actions arising from this exercise are captured and progress is followed up. 3. The Board has conducted or updated an analysis of the ALB's performance within the last year to inform the development of the Business Plan. 4. The Board has agreed a set of corporate objectives and associated milestones that enable the Board to monitor progress against implementing its vision and strategy for the ALB. Performance against these corporate objectives and milestones are reported to the board on a quarterly basis. 5. The Board's annual programme of work sets aside time for the Board to consider environmental and strategic risks to the ALB. Strategic risks to the ALB are actively monitored through the Board Assurance Framework (BAF).
Examples of evidence that could be submitted to support the Board's RAG rating.	• CE report • Evidence of the Board reviewing lessons learnt in relation to enquiries • Outcomes of an external stakeholder mapping exercise • Corporate objectives and associated milestones and how these are monitored • Board Annual programme of work • BAF • Risk register

3. Board insight and foresight

3.4 Quality of Board papers and timeliness of information

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

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

3. Board insight and foresight

3.5 Assurance and risk management

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

4. Board engagement and involvement

4. Board engagement and involvement overview

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

1.External Stakeholders

2.Internal Stakeholders

3.Board profile and visibility

4. Board engagement and involvement

4.1 External stakeholders

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

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

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

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

4. Board engagement and involvement

4.2 Internal stakeholders

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

4. Board engagement and involvement

4.3 Board profile and visibility

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

5. Board Governance Self- Assessment Submission

Name of ALB – Public Health Agency

Date of Board Meeting at which Submission was discussed – 15 October 2020

Approved by Andrew Dougal (ALB Chair)

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2020

1.1 Board positions and size

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Amber	The PHA Board currently has a full compliment of a Chair, 7 Non-Executive Directors and 4 Executive Directors. Two Executive Directors have only recently taken up post. It should be noted that one of the Non-Executives will be leaving their role at the end of March. A new Interim Chief Executive has been appointed with the recruitment process of a permanent Chief Executive suspended. Another Executive Director is due to retire later in 2020.			
GP2 Green	The Board is content that it is provided with the appropriate guidance, support and advice to effectively discharge its responsibilities. This is done through its present membership and if required, others have been invited to attend to ensure informed decisions.			

GP3 Green	The process for voting, and who the voting members are is outlined in Standing Order 5.2.17. Members are aware of their responsibilities in this area from induction and through guidance from the chair.			
GP4 Green	The composition of the Board is set out in the Standing Orders and accords with the establishing legislation. The responsibility for appointing non-executive board members lies with the Public Appointments Unit for approval by the Minister, therefore ensuring that the composition is in accordance with legislation is outside the remit of PHA. Executive Board Members are in line with DoH requirements. Membership of Board and committees complies with the terms of reference set out in the PHA Standing orders.			
GP5 Green	The non-executives on the Board have variation in terms of appointment. However, the process of appointments from requisition to interviews can take up to 12 months. Terms of appointment are determined by the Minister.			

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

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2020

1.2 Balance and calibre of Board members

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The current balance of skills, knowledge and experience amongst Board members is appropriate to effectively govern the PHA. There are members witih backgrounds in public health, research, finance, procurement, legal, human resources and clinical psychology.			
GP2 Green	The PHA board members have backgrounds from the public, private and voluntary sectors as well as local councillors. (biographical information on Board members in Annual Report). Members terms of appointment and renewal dates are staggered.			
GP3 Green	Non Executive Board members are appointed through the PAU, who have responsibility for complying with Section 75. Executive Board members are appointed through the HSC recruitment and selection processes which are compliant			

	with Section 75. The Board understands its responsibility in relation to Section 75 and regularly meets with Equality staff to ensure compliance of its statutory obligations and good practice. Members of the board are most anxious that they have a greater grasp of the work on section 75 and on the effectiveness And the efficiency of the equality proofing work.			
GP4 Green	Several non executive directors have a background related to health care/ health improvement. Non-executive backgrounds also include governance and financial management. (biographical information on Board members in Annual Report)			
GP5 Green	As per legislation, the board is constituted from local government and lay members. The Board includes people with relevant technical and professional expertise.			
GP6 Green	There is a balance between Executive and non-Executive members which ensures an excellent mix of skills and knowledge etc			

GP7 Green	Board members (both executive/non-executive) have served on boards for a number of years, some at the level of Chair. (biographical information on Board members in Annual Report)			
GP8 Green	The Chair has 33 years' experience of working in a large voluntary organisation in the health sector at Chief Executive level.			
GP9 Green	The Chair has over 10 years' non-executive experience in the private sector and other voluntary organisations e.g. UK Health Forum and World Heart Federation.			
GP10 Green	There is a member appointed to the Board with financial experience.			

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

RF6		

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2020

1.3 Role of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The role and responsibility of the board is outlined within Standing Orders. Members will have a copy of Standing Orders as part of their induction. Standing Orders are reviewed annually with the last update approved at the Board meeting of January 2020.			
GP2 Green	Ministerial/Departmental policies and expectations are communicated to members, through Board meetings, workshops and the issue of papers. This is also included in the business planning and strategy processes which include full Board involvement. The closure of HSCB and its implications for the future work of the PHA will continue to be an area of focus for PHA Board members given that PHA will take on the functions of the social care and children's directorate.			

GP3 Green	There is a clear understanding of the distinct roles of the executive officers and the non-executive board members as this is outlined in job descriptions and the scheme of delegation within Standing Orders.			
GP4 Green	The Board recognises fully its collective responsibility in relation to the performance of the PHA. This is outlined in Standing Orders, Management Statement / Financial Memorandum and in the induction process. The chair reminds members on a regular basis of this responsibility			
GP5 Green	NEDs are totally independent of management but work with Executive Directors when required.			
GP6 Green	The previous Chairs have had a positive relationship with the Minister and sponsor department. The current Chair has not yet had the opportunity to meet with the Minister since his appointment but is anxious to do so. However, given the current political situation, this is not possible at present.			

	The Chair and the Chief Executive have Accountability Review meetings with the Permanent Secretary and Chief Medical Officer twice a year.			
GP7 Green	At Board and Committee meetings, NEDs regularly and constructively challenge members on the papers and verbal updates given. This can be seen in the minutes of the meetings.			
GP8 Green	The Agency Board works as an effective team. A series of learning and development workshops is currently under way to improve even further the effective functioning of the Board.			
GP9 Green	The PHA board shares corporate responsibility for decisions taken and makes its decisions based on best evidence available.			
GP10 Green	Board members are aware of which papers are brought to public sessions and which are brought to confidential sessions and the need to respect confidentiality and sensitive information.			
GP11 Green	Yes, Executive Directors have responsibility for operational			

	management of the PHA, while the PHA board governs as set out in the PHA Standing Orders. The Chair has stated to the Chief Executive that if he or any other Non-Executive Director strays into operational territory this matter should be drawn to his attention.			
GP12 Green	The Board members contribute openly and fully to deliberations and exercise a healthy challenge function.			
GP13 Green	The Chair acts as first port of call for any advice, help or support. If he is not able to provide the help himself, he will refer members on as appropriate.			
GP14 Green	The Chair maintains a clear focus on the important issues facing the Board and facilitates the Board discussions so that all members are heard, engaged and actively involved in debate and constructive challenge prior to making a Board decision.			
GP15 Green	The PHA considers the needs of all its stakeholders and fully participates in partnership and public involvement to ensure			

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

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

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2020

1.4 Committees of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	Terms of reference for board Committees are clear and specified in Standing Orders. They are systematically reviewed.	There is a need to clarify the functions of the Remuneration Committee. The chair has written to the Department of health requesting that it clarifies some of the functions of this committee and that it might be permitted to have a more extensive role in human resources policies and organisation development.		
GP2 Green	Tasks, functions and responsibilities are delegated to appropriate committees as per Standing Orders, but the members of Board in totality recognise that they carry the ultimate responsibility for the actions of Committees. The Chair often reminds members of their liabilities as Directors.			
GP3 Green	The scheme of delegation is outlined in Standing Orders.			
GP4 Green	There are clear lines of reporting and accountability in respect of each Committee with			

	the Board receiving full minutes and a verbal update.			
GP5 Green	There is an Assurance Framework in place that covers the Board, and its Committees, and this is reviewed and approved by the Governance and Audit Committee and also the board.			
GP6 Green	The Committee Chair provides a verbal update to the board at the meeting following the Committee meeting. This can be seen in the board minutes. Minutes of the committee meetings are brought to the next board meeting after their approval. PHA attempts, where possible, to synchronise Committees so that they give timely updates to the PHA Board.			
GP7 Green	The Governance and Audit Committee has undertaken the Audit Committee Self-Assessment for a number of years taking action to address gaps. An annual GAC Report is included in the Annual Report.			
GP8 Green	The terms of reference for the Governance and Audit Committee and Remuneration			

	Committee highlight who is responsible for reporting to Board. The terms of reference are included within Standing Orders.			

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

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2020

1.5 Board member commitment

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	An attendance record is maintained by the Secretariat. Attendance is generally very good for board and committee meetings. The Chair discusses attendance with members as part of their appraisal.			
GP2 Green	Members' commitment is 5 days per month which is broken down as 1 day for board meeting, 1 day for committee meetings and general background reading, 2 days for reading papers and 1 day available for any other ad hoc events and launches			
GP3 Green	Board members have all received a copy of the DHSSPS Code of Conduct and Code of Accountability. Compliance is included in the Chair's annual appraisal of NEDs.			

GP4 Green	An annual schedule of meetings is prepared and agreed with members in relation to Board meetings, workshops and strategic days. Schedules are also in place for Governance and Audit and Remuneration Committees and other specific meetings.			

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

2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2020

2.1 Effective Board level evaluation

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The PHA Board completed its annual self-assessment in 2018/19.	The PHA Board will continue to undertake the DHSSPS ALB Board self-assessment annually.		
GP2 Green	The PHA Board continues to review itself to ensure improvement and development. To assist with Board effectiveness members were each issued with a copy of the recent Northern Ireland Audit Office publication, "Board Effectiveness: A Good Practice Guide" (Nov 2016). The Chair also shared with members a copy of the ICSA publication, "Effective Board Reporting", and the FRC's "Guidance on Board Effectiveness" and "UK Corporate Governance Code".	The PHA Board will continue to use the self-assessment and other tools as a basis for identifying further improvements / changes.		
GP3 Green	The PHA Board undertook a Board effectiveness programme in early 2017. This			

	was undertaken by On Board training. The Board monitors the action plan that emanated from this review. A follow up review commenced in 2018/19, facilitated by Anne McMurray.			
GP4 Red	The Board has not obtained the perspective of staff or external stakeholders in the completion of this questionnaire.			
GP5 Green	The current self-assessment has covered those questions/areas included in the DHSSPS checklist, both 'hard' and 'soft' dimensions of effectiveness.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3	The Board will undertake a survey of those outside the Board as part of its self-assessment in 2020/21.	
RF4		

2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2020

2.2 Whole Board development programme

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	Following the review of Board effectiveness, a paper was prepared during 2018/19 outlining a suggested series of workshops on a range of public health topics. A series of workshops, facilitated by Anne McMurray took place during 2019/20 giving members an overview of different work programmes within the PHA.			
GP2 Green	The relationship between the Minister, Department and ALB board members is included in the Management Statement, which is brought to a board meeting annually. The Management Statement and Financial Memorandum was updated by the Department of Health in 2018, with the updated version signed by the previous Interim Chief Executive.			

GP3 Green	Reports on action plans to address governance issues arising from internal audit reports or other significant control issues are reported to the GAC. GAC minutes are brought to the PHA board, and the Chair of the GAC also provides a verbal update to board members. The GAC also prepares an Annual Report.			
GP4 Amber	This will be covered as part of the Board Development Programme referenced at GP1 above.			
GP5 Amber	This will be covered as part of the Board Development Programme referenced at GP1 above.			
GP6 Amber	This will be covered as part of the Board Development Programme referenced at GP1 above.			

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

2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2020

2.3 Board induction, succession and contingency planning

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	All Board members have had induction which includes attendance at the On Board training course. Specific induction is also provided for new members of the Governance and Audit Committee.			
GP2 Green	Induction is undertaken as soon as possible after appointment.			
GP3 Green	At the induction, new members will receive a pack of relevant corporate and strategic documentation. As part of the Board effectiveness review, the induction process was reviewed.			
GP4 Amber	Deputising arrangements are specified within Standing Orders.	This will be reviewed in 2020/21.		

	An Interim Deputy Chief Executive was appointed, but is retiring later in 2020. The role of Deputy Chair is currently vacant as the previous Deputy has resigned from the Board.			
GP5 Green	Appropriate action has been taken by the PHA. The Chair will liaise with PAU to ensure that any future vacancies do not impact on the governance of the PHA.	In the context of changes within the HSC, a sub-Committee will look at succession planning.		

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

2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2020

2.4 Board member appraisal and personal development

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	Annual appraisals are carried out by the Chair in line with the requirements of the PAU. The Chair has initiated a series of more regular 1:1 meetings with members.			
GP2 Green	The Chief Executive carries out appraisals with Executive Directors. The performance of the Chief Executive and Executive Directors is discussed at the Remuneration Committee.			
GP3 Green	The Chair receives an appraisal from the Chief Medical Officer.			
GP4 Amber	As part of the appraisal system, this is clearly discussed and specified to ensure continuous development. Not all will have been given specific responsibilities, this will be reviewed by the Chair.			

GP5 Green	Board members appraisals allow members to highlight development needs.	It is proposed by the Chair that 1:1 meetings shall be held at least annually with members to ensure communication and any issues can be openly discussed.		
GP6 Green	This is covered through the appraisal system and PDPs, as well as through Director/Chief Executive away days. Relevant training/awareness is also built in where particular needs arise during the year.			
GP7 Green	Where appropriate, this is the case.			

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

3. Board insight and foresight

ALB Name - Public Health Agency Date – 31 March 2020

3.1 Board performance reporting

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

GP2 Green	The board receives a biannual performance report outlining progress against objectives in the Business Plan. It also receives monthly financial report.			
GP3 Green	The Committee Chairs provide updates to the Board following each Committee meetings as specified in Standing Orders. The approved minutes of each Committee are brought to the Board for noting.	There is a need to expand the role of the Remuneration and Terms of Service Committee to include more general issues regarding human resource management and organisation development.		
GP4 Green	The Corporate Risk Register is openly discussed and challenges on same are made at the Governance and Audit Committee. The Corporate Risk Register is brought to the Board annually, or more frequently at the request of the Governance and Audit Committee. The Board is reviewing how corporate risks outside the control of PHA might better be managed. Long standing risks are regularly reviewed to ensure they remain within PHA's risk appetite.			
GP5 Amber	Actions should be better recorded in the minutes of Board meetings so that named officers can provide updates at	Actions arising from Board workshops should be recorded with details of the PHA officer responsible for following up.		

	the next meeting.			

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

3. Board insight and foresight

ALB Name - Public Health Agency Date – 31 March 2020

3.2 Efficiency and Productivity

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

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

3. Board insight and foresight

ALB Name - Public Health Agency Date – 31 March 2020

3.3 Environmental and strategic focus

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

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

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

3. Board insight and foresight ALB Name - Public Health Agency Date – 31 March 2020

3.4 Quality of Board papers and timeliness of information

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	A plan of Board and Committee meetings is set annually to ensure diary management, for example Board meetings are normally scheduled for the third Thursday of each month. Deadlines such as Annual Reports and Accounts and Governance Statements are also taken account of to ensure completion in a timely manner.			
GP2 Green	Board and Committee papers are issued at least one week in advance of the meeting to ensure adequate time for reading etc. It is hoped that during 2020/21 the Board will go fully "paperless" as i-pads have been procured and given out to members.			
GP3 Green	Board papers have a cover sheet which clearly outlines	The Board wishes to draw up a system whereby written guidance		

	what decision is required of the Board i.e. noting or approval. The format of Board cover sheets was further reviewed during 2018/19 to ensure that papers clearly outlined the reason why papers are coming to the Board, the key points, the recommendation for the Board, and next steps.	will be issued to those commissioned to write reports for the Board. This will outline the emphasis on strategy, policy, risk and other issues in which the Board wishes to be briefed. Through the Executive Directors the Board will give guidance as to the length and content of such reports. In accordance with the recommendations of the Institute of Chartered Secretaries and Administrators, the Directors will review and edit reports before they are dispatched to the Board.		
GP4 Green	Biannual performance reports are brought to the board. If members wish to raise a specific item at a board meeting, they can do so. The PHA has clearly defined procedures for bringing significant issues to the Board's attention outside the formal monthly meetings.			
GP5 Green	Board papers include the relevant information in respect of proposals or decisions that have been proposed or made. They also state if they have been considered by the Executive Team, or other board committee before they are brought to the board.			

GP6 Green	The Board is presented with quality updates. The PHA has a robust mechanism for ensuring the collection and analysing of data. Board members regularly question and challenge data to ensure quality and understanding of same when both verbal and formal papers are brought to Board meetings. Also, the Governance and Audit Committee have the opportunity to challenge and question data provided. Internal and External Audit consider data quality in relevant audits.			
GP7 Green	Board minutes clearly demonstrate where members have challenged and questioned information brought in relation to performance management and the grading of same.			
GP8 Green	The Assurance Framework outlines clearly the information being brought to the Board for approval/noting etc. Board members discuss the information status at various workshops.			

GP9 Green	Board members can clearly demonstrate that they understand information presented and openly challenge the collection and presentation of same.			
GP10 Green	The PHA takes all steps to ensure that documentation presented to the Board complies with DoH guidance where appropriate.			

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

3. Board insight and foresight

ALB Name - Public Health Agency Date – 31 March 2020

3.5 Assurance and risk management

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

GP3 Green	The Assurance Framework identifies a range of sources of assurance for the board, including internal and external audit.			
GP4 Green	The Board regularly reviews/updates governance arrangements and practices against DoH standards, good practice and good governance standards for public service.			
GP5 Green	Given the nature of the PHA functions it does not have a separate clinical and social care risk assessment and management. All types of risk are included in the Directorate and Corporate risk registers and are subject to systematic review.			
GP6 Green	The Director of Public Health is responsible for professional issues in respect of medical staff, and the Director of Nursing and AHP for nursing and AHP staff.			

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

RF3		
RF4		

4. Board engagement and involvement ALB Name - Public Health Agency Date – 31 March 2020

4.1 External stakeholders

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The PHA has an approved PPI consultation scheme and has had service users present to the Board.	The board is keen to see a requirement included in every job description regarding PPI, following the example of the Southern Health and Social Care Trust.		
GP2 Green	A variety of methods is used across the PHA to engage with service users and the wider public. Board members can attend a range of activities/events/conferences of voluntary, community organisations as well as other HSC events. The Chair and Chief Executive report at monthly board meetings in respect of events etc they have attended. Executive Directors will also have direct contact with a range of external stakeholders. It is the plan to consult with those users who are in “hard to			

	reach" groups.			
GP3 Green	When the PHA developed its Corporate Plan for the period 2017/21, this involved a public consultation exercise, part of which saw two stakeholder events which offered an opportunity for stakeholders to attend and give their views on PHA's future strategic direction.			
GP4 Green	The PHA Business Plan is available in a number of formats to ensure access to a wide range of stakeholders. The Business Plan is in a format that has been tried and tested to ensure a wide range of stakeholders understand the work of the PHA.			
GP5 Green	The PHA ensures that the learning from SAIs is disseminated and where appropriate influences the commissioning of services			
GP6 Green	PHA Board / Agency has very constructive and effective relationships with a range of key stakeholders.			

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

4. Board engagement and involvement ALB Name - Public Health Agency Date – 31 March 2020

4.2 Internal stakeholders

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The organisation culture is reviewed by the Remuneration committee bi-annually and discussed at confidential session. Follow up actions in respect of organisational culture are discussed at committee/board. Staff events are regularly held. There are also "away days" held in different directorates. There are other mechanisms for staff to input their views, e.g. through OWD or the Staff Health and Wellbeing Group.			
GP2 Green	Staff are involved in the development of corporate and directorate business plans at directorate/function level. This information is then fed through to the corporate business plan.			
GP3 Green	This is communicated through Directors to their teams, and is the basis for appraisals.			

GP4 Green	The Board regularly thanks individuals and departments at Board meetings or other group functions, it acknowledges contributions and achievements as and when appropriate. A new weekly staff newsletter, inPHA, was launched in June 2016 and this highlights and acknowledges achievements of PHA staff.			
GP5 Green	The PHA Board and Agency have clear values and behaviours that have been communicated to staff not only in internal meetings by management, but clearly in policies and procedures.			
GP6 Green	Staff are informed about major risks etc through a range of channels, including emails from the Chief Executive, and through Chief Executive and Directorate briefings.			

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

4. Board engagement and involvement ALB Name - Public Health Agency Date – 31 March 2020

4.3 Board profile and visibility

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

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

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

Summary Results **ALB Name - Public Health Agency** **Date – 31 March 2020**

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

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

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

3.5 Assurance and risk management	Green	

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

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

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

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

6. Board impact case studies

6. Board impact case studies

Overview

This section focuses on the impact that the Board is having on the ALB and considers a recent case study in one of the following areas:

1. Performance failure in the area of quality, resources (Finance, HR, Estates) or Service Delivery;

2. Organisational culture change; and

3. Organisational strategy.

6. Board impact case studies

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

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

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

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

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

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

6. Board impact case studies ALB Name - Public Health Agency Date – 31 March 2020

6.1 Case Study 1

Performance issues in the area of quality, resources (finance, HR, Estates) or Service Delivery	
Brief description of issue	
Outline Board's understanding of the issue and how it arrived at this	
Outline the challenge/scrutiny process involved	
Outline how the issue was resolved	
Summarise the key learning points	
Summarise the key improvements made to the governance arrangements directly as a result of above	

6. Board impact case studies ALB Name.....Date.....

6.2 Case Study 2

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

6. Board impact case studies ALB Name.....Date.....

6.3 Case Study 3

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

HSC Public Health Agency

item 13

Title of Meeting	PHA Board Meeting
Date	15 October 2020
Title of paper	Update on Population Screening Programmes
Reference	PHA/06/10/20
Prepared by	Dr Stephen Bergin
Lead Director	Professor Hugo van Woerden
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

To update the Board regarding the key issues and concerns within Population Screening Programmes. These are considered in the two papers referenced directly below:

(i) Population Screening Programmes – summary of key service issues
This paper considers the key issues and concerns within screening programmes.

(ii) Restoration of Population Screening Programmes – update to HSC Restoration Management Board (23 Sept)
This paper considers the process to restore the previously paused screening programmes (paused as a consequence of the COVID pandemic).

2 Background Information

The Public Health Agency is responsible for the commissioning and quality assurance of the eight Population Screening Programmes in N.Ireland. Prior to the COVID pandemic, screening programme performance was broadly in line with national standards. However, a range of challenges persist across the individual programmes.

In March 2020, five of the eight population programmes were paused given the COVID pandemic. The process to restore screening commenced from end June.

3 Key Issues

The first paper explores the challenges within the individual screening programmes – a number of these challenges are cross-cutting across programmes.

To provide good governance and oversight of these issues, the paper identifies (ie) the PHA ‘Screening Programme Board’ and (ii) signals the need for an in-depth review of screening (to explore these issues/concerns in more detail).

This second paper explores the process to restore the paused screening programmes. In summary, reasonable progress has been achieved. However, it is estimated that up to eighteen months will be required before normal service provision can be fully achieved. The paper was approved by the HSC Restoration Management Board on the 23 Sept.

4 Next Steps

The PHA Screening Board is scheduled to meet in November. This will consider the issues and concerns identified in these updates. In addition, the PHA will continue to provide regular updates to the HSC Restoration Management Board. The need for an in-depth review of screening will explored through discussion with DOH.

POPULATION SCREENING PROGRAMMES – SUMMARY OF KEY SERVICE ISSUES (non COVID)

The aim of this paper is to summarise the key (non-COVID) issues relating to Population Screening Programmes. The paper encompasses 3 main section: (1) programme-specific issues and achievements, (2) cross-cutting programme issues, (3) recommendations.

Background

The Public Health Agency is responsible for the commissioning, coordination and quality assurance of the eight Population Screening Programmes in N.Ireland. In total, around 400,000 invitations for screening are issued per annum across the eight programmes - there three antenatal and newborn programmes, and the five young person and adult programmes:

- Infectious diseases in pregnancy screening;
- Newborn blood spot screening
- Newborn hearing screening
- Abdominal aortic aneurysm screening
- Bowel cancer screening
- Breast cancer screening – including: Very High Risk Breast Surveillance Screening
- Cervical screening
- Diabetic eye screening

Programme-specific issues and achievements

1. NEWBORN HEARING

Target audience: babies aged up to 1yr (including those who 'move in'), to detect hearing loss at an early stage: about 1 in every 1,000 babies is born with a significant hearing loss.

Key achievement - SEPT 20: **successful procurement of the new regional Smart4Hearing' utility** – this key software will, in due course, improve programme safety and quality given (a) the capacity to digitally store screening results and (b) enhanced capability to undertake quality assurance activities. The implementation of the Smart4Hearing utility is being progressed within Trusts – to be completed by Dec 20.

2. NEW BORN BLOODSPOT

Target audience: Children born in N.Ireland, ideally by day 5 after birth, to detect inherited, rare, metabolic disorders

Key achievement - MARCH 2020: **successful expansion of the screening programme**– after a complex development process, the programme has now been expanded and is screening for nine inherited metabolic disorders; previously five diseases were screened for phenylketonuria (PKU), congenital hypothyroidism (CHT), cystic fibrosis (CF), medium chain acyl coA dehydrogenase deficiency (MCADD) and sickle cell disorders (SCD). Four disorders were added to the programme from end March: MSUD, IVA, HCU and GA1. The programme has therefore increased its capacity to detect a wider range of these potentially life-threatening conditions.

3. BOWEL CANCER

Target audience: Men and women, aged 60-74 yrs; screening invitation every 2yrs.

Key Issue - DECEMBER 20: **imminent introduction of Faecal Immunochemical Testing (FIT)**: to date, screening has been based upon the Faecal Occult Blood (FOB) test. Faecal Immunochemical Testing is more sensitive, ie. improved accuracy to identify individuals 'at risk'. FIT will be more acceptable given the number of samples required (undertaken at home) reduces from 'three' to 'one'. As a consequence, it is hoped that screening uptake will improve, particularly in more deprived areas.

4. BREAST CANCER

Target audience: Women, aged 50-70 yrs; screening invitation every 3yrs.

Key Issue – 2021/22: the programme is mostly delivered using mobile breast screening units. This is the case for 4 Trusts. In Belfast Trust breast screening is provided in the static unit in Linenhall Street. Some screening is carried out at the static sites in the other Trusts. The current suite of mobile screening units, both the trailers and the mammography equipment on board, will be 7 years old next year (2021) and therefore due for replacement. This is also the case for most of the other mammography machines used for breast screening, screening assessment and symptomatic work in Northern Ireland. Overall and above capacity to replaced mobiles, additional stock is required given the demographic expansion of the eligible screening population (women aged 50 and over), i.e. existing units are close to capacity. Additional mobile units are therefore required to manage this pressure (capacity is further exacerbated by social distancing at present). The need for capital funding has been requested within the recent bidding round to DOH (2021-2024).

Within the Very High Risk Breast Surveillance Screening programme, a new (PHE) protocol is being introduced, from October 2020, for women being screened from December 2020.

5. CERVICAL CANCER

Target audience: Women aged 25-49 yrs invited for screening every three years; those aged 50-64 yrs invited every five years.

Key Issue – Initiate screening based upon HPV testing – currently the programme is based upon a visual examination (microscopy) of slides (the 'smear'). However, there is a pressing need to initiate screening based upon HPV testing: this is more accurate screening test. It has been introduced in all other UK countries. HPV based screening would increase the ability of the screening programme to detect cervical cancer.

The process to introduce HPV testing will be complex and likely to require an 18-24 month development period. i.e. to establish a new end-to-end screening pathway encompassing primary care, new IT systems and a revised laboratory service model – additional colposcopy services within Trusts must also be explored (given the anticipated increase in referrals).

In terms of moving ahead, formal DOH approval is required to initiate the above 'change project' (a related factor is that capacity within the screening team is considerably reduced given the redeployment of key staff, and also the need to focus upon screening restoration, i.e. the programme was previously paused for five months given COVID).

6. DIABETIC EYE

Target audience: Screening is offered each year to registered diabetics, aged 12 years and over to detect early stage eye disease (diabetes is the no.1 cause of blindness).

Key Issue - Access to Trust facilities - following a public consultation exercise (Jan 2019), a service modernisation programme was established to revise the screening programme. The aim is change screening location from being mainly primary care based (this is proving difficult to sustain) to fixed site screening locations, within mainly Trust based facilities/premises. However, given COVID, Trusts are reluctant to release capacity: this issue was raised at a recent HSC Restoration Management Board meeting – the PHA Chief Executive has agreed to raise the issue with her Trust counterparts.

Cross Programme Issues

7. SUSTAINING A ROBUST QA FUNCTION - STAFFING

Key Issue – Undertaking the Quality assurance of Population Screening programmes – this is a core objective of the PHA. As demonstrated by recent experience nationally, failure to undertake this function robustly increases the likelihood of a major 'screening incident' (as evidenced in the recent past, by the CervicalCheck incident (ROI) and in Breast Screening (UK).
There is a lack of (staffing) resilience, with individual programmes reliant on a single programme manager and a single information officer.

While the QA function is more robust and established within some screening programmes, the QA function within the antenatal, newborn and DESP programmes is most vulnerable. Additional staff are required to undertake these functions effectively – the recent challenge of COVID, necessitating the re-deployment of staff, has therefore been challenging, particularly given the need to restore the previously paused screening programmes.

8. BSO AUDIT - CALL RECALL FUNCTIONS

Key Issue - BSO call-recall functions and associated IT systems: BSO provide the call-recall functions for the bowel and cervical cancer screening programmes. An internal audit of these functions was undertaken in Nov 2019. The report, issued in April 2020, provided only 'limited assurance'. The report notes: *significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved*.' The report includes a number of recommendations. Some issues are attributable to aged (30 years+) IT systems; these require multiple manual processes, i.e. the system risk becoming redundant and no longer fit for purpose (IT issues are consider separately below). An action plan has been developed. A new IT system is required, however, to provide immediate and interim solution, £185 additional recurrent funding is required to provide staff, based within BSO, to address these issues: this has been requested within the recent bidding round to DOH (2021-2024).

9. SCREENING IT SYSTEMS

Key Issue – IT systems associated with individual screening programmes becoming outdated: integral within each population screening programme are discrete IT systems delivered by a range of providers. An emerging concern is that some of the associated IT systems are relatively aged and risk losing key functionality over the medium term 3-5yrs. This will compromise the safe delivery of these programmes.

Taking a worst case scenario, the non-functionality of an IT system could potentially prevent the safe delivery of, for example, a cancer screening programme. Taking a worst case scenario, the potential consequences could be a large scale failure of the programme to detect individual cases of cancer: this would be perceived as a major, large scale incident.

Another risk is that an outdated IT system will no longer be supported by the original provider: as the IT infrastructure becomes more out of date, in the absence of vendor support, the software and operating systems will reach a critical end point, placing significant risk on the systems. At this stage, key systems can no longer be upgraded to, for example, adopt revised screening parameters.

Taking a medium to long term view, a dedicated screening-specific IT platform is required. However, such functionality is not anticipated to be in place until circa 2025.

Given these risks, a formal assessment of the individual IT systems is now required. This will examine the scope for existing system to operate safely up until 2025, i.e. when a 'Screening IT solution' would hopefully be in place. This will be evaluated within a formal Screening IT appraisal, or 'risk assessment'. This is planned to start Nov 2020. HSCB DHCNI have commissioned BSO ITS to appoint a reviewer to complete this piece of work. Confirmation of dates for interviews/workshops (with PHA leads) will be shared by BSO ITS when a reviewer has been appointed and confirmation of the reviewers availability to start the assessment.

RECOMMENDATIONS

Approval is sought from the PHA Board for the following actions:

1. Corporate Risk Register

While the issues and risks within this paper are identified within the PH directorate register, the Chief Executive has directed that these issues/concerns should be escalated and therefore included with the PHA Corporate Risk Register.
(**S Bergin to prepare submission for AMT approval**)

2. Population Screening Governance Framework - Screening Programme Board

An updated and enhanced PHA governance framework for population screening was approved by AMT in October 2019. A key element of the framework is the 'Screening Programme Board' (SPB). Where an issue of concern arises within an individual screening programmes, these can generally be addressed within the respective governance structure of the programme. However, where such issues and concerns persist, and/or are of a particularly serious nature, these should be escalated to the director level Screening Programme Board - this encompasses senior PHA, HSCB and BSO representation (Terms of Reference for the SPB are in place – the initial meeting of the group was held in Feb 2020).

The SPB, in bringing together senior officers from the PHA, HSCB and BSO will ensure the effective coordination, quality assurance and governance of population screening programmes. Where required, agreed actions identified by the SPB will be communicated by the PHA/HSCB to the relevant Trust/provider for action (the HSCB may take the lead where the issue is mainly service / secondary care commissioning related).

Given the issues outlined in this paper, a meeting of the Screening Programme Board' has been scheduled for 11 Nov: the agenda, to be prepared, will reflect these issues.
(**S Bergin to prepare agenda on behalf of Chief Executive**)

3. 'Review of Screening' – a review of screening to scope out the issues outlined in this paper, in more detail, had been scheduled during the first half of 2020. However,

this was postponed given COVID. A specific Terms of Reference for this work had been prepared (by DOH). It is clearly still important that this review should be progressed: discussions are required to finalise/confirm the Terms of Reference for the Review, to clarify the timing/scheduling of the review (given COVID) and to confirm the lead agency (whether DOH or PHA).

(**Chief Executive to explore with DOH**)

Aligned to this review, and as referenced in this paper, a formal assessment of IT systems across screening programme is also required. This, being a specialist / technical appraisal will be progressed in partnership with HSCB/BSO Digital eHealth service colleagues. This work will be scheduled during the first half of 2021.

(**S Bergin to confirm with HSCB/BSO**)

A subsequent update on the issues identified within this paper, and actions proposed directly above, will be submitted to the PHA Board within 4 months.

Restoration of Population Screening Programmes

UPDATE 23 Sept 20

SUMMARY: *progress achieved and current status*

The *process* to restore the provision of paused population screening programmes commenced in June. The initial 'progress report' towards the restoration of these programmes was provided to the HSC Restoration Management Board on the 08 July.

This report outlines progress since then. In summary, progress has been achieved across each of the five previously paused programmes. In summary:

- **CERVICAL SCREENING: end June** - the initial invitations for screening were issued (high priority women) in the final week of June; routine invitations recommenced from mid-August.
- **ABDOMINAL AORTIC ANEURYSM (AAA) SCREENING: early July** - surveillance clinics for men with medium-large AAA restarted 10th July; clinics for medium AAA commenced in August. Routine invitations have recommenced for 9 of the 24 screening venues across the region.
- **BREAST SCREENING: mid-late July** - routine breast screening recommenced in all Trusts during July. Social distancing and infection control requirements has meant that screening clinic throughput has significantly decreased (from 10 to 6 per slots per hour).
- **DIABETIC EYE SCREENING: August** - a limited number of screening clinics, for the higher risk cohort, recommenced from 03 August; clinic throughput has reduced to circa 50% of previous levels.
- **BOWEL SCREENING: August** - routine bowel screening invitations have recommenced from week beginning 17 August; the backlog in screening colonoscopy was substantially cleared in all Trusts before invites restarted.

Detailed, programme-specific, progress reports are provided within Annex A, at the end of this report.

1 Background

1.1 The PHA commissions and quality assures eight population screening programmes:

- Abdominal aortic aneurysm screening;
- Bowel cancer screening;
- Breast cancer screening (also encompasses surveillance of women at very high risk of breast cancer)
- Cervical screening;
- Diabetic eye screening;
- Infectious diseases in pregnancy screening;
- Newborn blood spot screening; and
- Newborn hearing screening.

In total, around 400,000 invitations for screening are issued per annum across the eight programmes.

2 Pause in Screening

2.1 In response to the pandemic, five screening programmes were paused from the second week of March 2020: the bowel, breast and cervical cancer screening programmes, diabetic eye (DESP) screening programme and the abdominal aortic aneurysm (AAA) screening programme.

2.2 The surveillance programme for women at very high risk of breast cancer; diabetic eye screening for pregnant women; the infectious diseases in pregnancy screening programme; the newborn blood spot screening programme and the newborn hearing screening programme were not paused.

2.3 It is estimated that over 100,000 screening invitations were not issued during the pause.

3 Restoration – principles to guide the restoration of services

3.1 Restoring the paused programmes has necessitated a consistent and, as far as possible, an evidence-based approach to ensure programmes were reintroduced in a planned and safe way. To this end, the restoration process was guided by the following principles, derived from PHE guidance.

3.2.1 **Principle 1:** Emerging capacity, both within screening services and across the HSC in general, should be *targeted* at people assessed as '*higher risk*'. The nature of this varies across the screening programmes. For example, men with large aneurysms (AAA) awaiting surgery are at greatest risk (of rupture) and were therefore prioritised within the programme-specific

restoration process. Thereafter, men with medium sized aneurysms were prioritised (and so on, etc).

3.2.2 The need to clear the backlog of people already within a screening pathway also had to be considered, i.e. restoration has therefore not been a simple 'recommencement of screening' (based upon inviting those delayed longest first), but has been based upon a *risk assessed* and *phased approach* within each programme.

4.4 **Principle 2:** The benefits of screening should be greater than the clinical risks associated with COVID. This benefit/risk assessment varies between programmes and between groups of people eligible for screening. To illustrate, there are individuals within each programme who are clinically vulnerable (to COVID) and some programmes are focused on more vulnerable groups e.g. the diabetic eye screening programme is focused on people with diabetes (with no upper age limit) and the AAA screening programme on men aged 65 and over.

4.7 **Principle 3:** There must be adequate staffing and facilities to undertake screening, provide diagnostic services, and deliver high quality treatment and programme management thereafter. This needs to be supported by appropriate quality assurance arrangements to minimise risk and maximise benefits. It is understandable that different providers are at different position in terms of the wider HSC Restoration process.

5 Restoration – current position

5.1 The PHA established, in early June, a 'Screening Restoration Group' to provide regional coordination and oversight. The group continues to work, in partnership with Trusts, to restore and recover the paused screening programmes. In addition, the Group has been liaising with the various UK four Nations' groups and colleagues in the Republic of Ireland planning the restoration of their paused screening programmes.

5.2 While it is relatively easy to pause screening, the 're-start' and recovery of programmes has not been straightforward. The process has necessitated significant attention and regional oversight across the paused programmes. An initial key step was the preparation of programme-specific 'Restoration Plans' – these were completed over the June-July period.

5.3 Since then, reasonable progress towards the actual restoration of services has been achieved across all of the paused screening programmes: see **Annex A** for detailed programme-specific updates.

5.4 Impact: as a consequence of the pandemic and associated pause in screening, over 100,000 invitations for screening were not issued. While in

'normal' circumstances this would be equivalent to around a 4-5 month backlog, the fact that many aspects of service and practice have changed (as a result of the pandemic) dictates that considerably longer will be required to achieve full restoration.

5.5 The process to recover screening programmes, as for other HSC services, must take account of PPE requirements, social distancing, etc. These factors have considerably reduced programme throughput, i.e. the time to undertake individual screening and subsequent diagnostic tests has significantly increased: on average, individual programme 'throughput' has decreased by around 50%. It is therefore estimated that at least 12 months will be required before the full restoration of all screening programmes. In effect, this milestone will not be reached until the latter part of 2021.

5.6 In parallel to screening restoration, a number of significant change projects are current/imminent, including:

- the introduction of a new screening test for bowel cancer screening (FIT);
- the need to introduce Human Papilloma Virus (HPV) testing in (cervical cancer screening;
- the introduction of new surveillance protocols for women at very high risk of developing breast cancer and
- the modernisation of screening IT platforms.

5.7 A key aim over the coming month is to develop 'Screening contingency plans', i.e. outlining the measures and steps necessary to maintain population screening during a resurgence of COVID over the months ahead (plans would, of course, be proportionate and scaled to the level and impact associated with any resurgence).

TRUSTS ARE ASKED TO NOTE THE FOLLOWING:

6.1 Funding – the PHA continues to work with Trust screening leads to ensure that key service restoration priorities, and associated funding requirements, are considered appropriately. These have been appropriately reflected within the recent funding bids submitted to DOH.

6.2 Trust premises – specific screening programmes require access to relatively small scale clinic space, for example, screening clinic/locations are already in place/agreed for the AAA programme.

Recognising existing pressures, Trusts are asked to facilitate access to clinic space to support population screening. For the Diabetic Eye Screening Programme, it has been agreed that screening should shift from primary care to Trust-based screening locations: this is currently being explored with individual Trusts (applies in all Trusts except the Western).

In the Breast Cancer Screening Programme, Trusts are asked to consider the provision of appropriate waiting areas to facilitate social distancing and infection control to support more efficient use of the mobile breast screening units. This might include the provision of dedicated waiting areas or the provision of suitable Portakabins.

6.3 Diagnostic and Intervention services – as referenced in this paper, the restoration of screening may impact upon both diagnostic and intervention services, i.e. increased referrals for assessment (to confirm diagnosis) and subsequent intervention (often surgical-based). To this end, the restoration of screening is being undertaken within a managed, phased and risk stratified approach. The PHA (in partnership with the HSCB) is working with Trusts to ensure that referrals, arising from population screening, can be appropriately managed within the recommended timeframes for each programme.

Please see Annex A for individual programme updates on the current position for each of the formerly paused population screening programmes.

ANNEX A: UPDATE ON RESTORATION OF POPULATION SCREENING PROGRAMMES

PROGRAMME	UPDATE	Comments / issues
BOWEL CANCER **Target audience:** Men and women, aged 60-74 yrs; screening invitation every 2yrs.	Screening invitations were paused from week beginning 23 March 2020: - Previously issued kits, which can be submitted up to 6 months following issue, continue to be received and reported by the screening laboratory throughout the surge period, though numbers were small. Result letters continued to be issued for these patients. - Pre-assessments were initially converted to telephone appointments and later paused as staff were redeployed as part of the Covid-19 response. - Screening colonoscopy and CTC investigations were paused due to the potential for virus transmission. The inability to progress screen positive participants means that a considerable number of individuals were paused at different stages of the screening pathway. SCREENING RESTORATION: **Position as of 08 July** - In line with elsewhere in the UK, the initial aim was to significantly reduce the backlog in those waiting for screening colonoscopy or pre-assessment *prior to recommencing* the issue of new screening invitations. While all Trusts have now recommenced screening colonoscopy, this is at a reduced throughput (reduction from 4 patients per list to 3). Some Trusts are using qFIT as a means to risk stratify patients for this procedure (this is similar to the process adopted within the symptomatic endoscopy service). It is anticipated that most Trusts will have cleared their waiting list by end August, so provisionally invites may be able to recommence from early August. While the screening	

	programme will recommence with queued invitations using FOBt kits, restoration plans are also taking into account the transition to qFIT. IT developments are being expedited to facilitate introduction of qFIT from December 2020. CTC (CT colonoscopy) procedures remain paused across all Trusts and consideration may need to be given to alternative management of participants paused in this pathway. A catch up exercise is unlikely to be viable in the short term due to limitations in colonoscopy capacity. The introduction of qFIT to the programme may facilitate this later, dependant on the resultant screen positivity rate at that time. **Progress since 08 July** - Since 08 July substantial progress has been achieved across most Trusts with clearing backlogged screening colonoscopy waiting lists, facilitating the programme to recommence routine invitations from week beginning 17 August. The number of completed kits (FOB) being returned to the lab are being monitored to assess the ongoing impact of COVID on screening uptake. Some backlogs continue to exist in CTC services where capacity continues to be restricted. Screening colonoscopy services are close to returning to full capacity, including with 4 patients per list. The aim for the next 1-3 months is to continue to issue routine invites, develop a contingency plan for a second wave of COVID and continue to take forward planning for the implementation of qFIT by end December 2020.	

PROGRAMME	UPDATE	Comments / issues
BREAST CANCER **Target audience:** Women, aged 50-70 yrs; screening invitation every 3yrs.	Routine breast cancer screening was formally paused from the 16 March. Higher Risk Breast Screening continued during the pandemic: all higher risk screening is undertaken at the Northern Trust unit, but uptake decreased during the pandemic with some women electing to cancel or not to attend. SCREENING RESTORATION: **Position as of 08 July** - The breast screening team is working closely with the relevant HSC Trusts. Technical guidance for restart and restart checklists were sent to Trusts on the 23 June. These are based on PHE guidance documents. The PHA met with each of the Trusts, week beginning 29 June, and quality assured their check lists and their restoration and recovery plans, ahead of restart. Each of the Trusts is planning to restart by the beginning of August, i.e. they will establish their first regular screening clinics by then. Considerable logistical issues remain regarding the capacity to screen safely within fixed and, in particular, mobile screening facilities. Redesign of mobile units is under consideration. However, there is currently conflicting advice from the makers of the mammography equipment about the impact of developing a one way system on the functioning of these machines. The PHA is currently liaising with the other UK countries regarding the specification for any adaptations required to the mobile facilities. Capital funding will be required where significant adaptations are required and the mobile units would need to be returned to the manufacturer in Bristol for such work to be carried out. It is planed that screening will recommence using a phased and risk-based approach, with the mobile units as they are currently configured. However, the phased reintroduction of breast screening will see a significant reduction in throughput compared to pre-pandemic levels. Given the impact of social distancing, compared to the 6 minute appointment slots pre-pandemic (10 slots per hour), restart will commence with 15 minute appointments (4	

	slots per hour) quickly moving to 10 minute appointments (6 slots per hour). It is estimated that a one way system would enable 8 minute appointments to be provided. <u>Phase 1</u> of the restart will focus on those women who should have been screened during the pause in screening (mid-March – end of July). This phase should be completed by November 2020. However, this is dependent on funding being available for additional clinics to enable Agenda for Change staff (including band 8 Superintendent Radiographers) to provide clinics out of hours. <u>Phase 2</u> - time scales for Phase 2 (essentially catching up in order to invite women when they would normally expect to be screened) are being determined. In addition PHA is liaising with Action Cancer to explore the potential for additional breast screening capacity being proved for the HSC. Action Cancer may be able to provide some additional screening slots (4,000 - 6,000 per year). Discussions are ongoing. This would also require additional funding. **Progress since 08 July** – Two of the four Trusts that provide breast screening restarted week beginning 20 July 20 and the other two restarted week beginning 27 July 2020. All units are providing 10 minute appointments in order to comply with social distancing and infection control requirements. Pre-Covid-19 appointment slots were every 6 minutes. In addition, Trusts would previously have used a system (called SMART clinics) that maximises the number of women that can be invited to attend a screening clinic based on probability of attendance. This system is not being used at present, in line with PHE guidance, as it can result in more than one woman turning up at the same time. The longer appointments and lack of SMART clinics mean that the programme is running at around 50% capacity. We have therefore piloted the use of SMART clinics at the static unit in Linenhall Street which was successful and rolled these out to other static units. A pilot has also been conducted in two mobile units where a Portakabin has been successfully used to manage multiple attendances. Discussion is ongoing about further roll out of this or similar approaches to other units in order to enhance efficiency.	

	Ground work has been completed on the costs and logistics of adapting the mobile breast screening units so that a one-way system could be introduced. We want to get evidence of benefit from units in England and Wales before progressing this i.e. does it actually reduce appointment times and by how much. The preparatory work regarding the use of capacity at Action Cancer has been completed. A decision regarding funding is required before the Trusts can commence procurement with the independent sector in year.	
PROGRAMME	**UPDATE**	**Comments / issues**
CERVICAL CANCER **Target audience:** Women aged 25-49 yrs invited for screening every three years; those aged 50-64 yrs invited every five years.	Invites for March and April (usually sent in the middle of the month in a batch) were paused: women already invited were able to attend their GP for screening, with cervical smear samples being processed and managed as usual. SCREENING RESTORATION: **Position as of 08 July** - The first cohort of women were issued with invitation letters in the week beginning 29 June – this included those who are due a screening test and are currently coded as suspended, and those with a previous inadequate result which is recommended to be repeated. This was approximately 5,000 women. A letter was issued to primary care / GPs on the 19 June to advise of this step. The next group to be invited (mid-July) will be women where either colposcopy or laboratories have requested a repeat smear test. Routine recall invitations (e.g. 3 or 5 yearly recall) at normal volumes will begin to be issued from mid-August. This will include routine reminder letters for those women who may have chosen not to attend for screening in the weeks before the Covid-19 lockdown. GPs have been asked to ensure that women with cancelled appointments and those who were non-responders are also followed up. A longer term catch-up exercise is being considered and will be dependent on primary	

	care, lab and colposcopy capacity going forward. **Progress since 08 July** Invitations for cervical screening recommenced as planned with routine invites issued from August. Laboratory activity has rapidly increased as primary care practices have reinstated these services. A catch up exercise to reduce the 5 month delays in screening invites is unlikely to be viable in the short term due to the expected pressures on primary care in the coming months. A contingency plan to maintain the programme during a second wave of covid is being developed.	
PROGRAMME	**UPDATE**	**Comments / issues**
DIABETIC EYE **Target audience**: Screening offered each year to registered diabetics, aged 12 years and over.	Newly diagnosed, routine and surveillance screening invitations and clinics paused from week beginning 23 March 2020. Screening continued to be offered to pregnant women only at consultant led clinics. All image reading was completed and referrals to ophthalmology triaged to identify any requiring emergency follow up. SCREENING RESTORATION: **Position as of 08 July** - In line with other UK countries and ROI, a phased and risk stratified approach is proposed - patients will be invited for screening, based on their due date for screening and their assessed risk of progression to sight threatening retinopathy. - Phase one will focus on those considered higher risk (i.e. previously known retinopathy and in enhanced surveillance, newly diagnosed) - Phase two will focus on those who are considered low risk (i.e. attended last screening appointment and no retinopathy detected). These patients will have their screening interval extended to a maximum of 24 months – this is in line with evidence and proposed future UK changes to the screening programme.	

	Clinic workflow will significantly alter as a consequence of Covid-19 with an anticipated 50% reduction in throughput. Capacity planning is being based on a decrease to 7 patients per session, where previously 15 patients would have been screened. This will have marked impact on the ability of the service to meet standards relating to screening timeliness. While the screening service will shortly be ready to recommence clinics, the main barrier is the availability of suitable venues. The programme was largely based in primary care, and was beginning an implementation project to move to a new service model of fixed site venues. As primary care settings are now unlikely to be a viable option, alternative accommodation for fixed sites is urgently required across all Trust areas. **Progress since 08 July** - Screening clinics recommenced from mid-August, on a limited basis, using the risk stratification approach outlined above. The main barrier has been gaining access to screening venues and our established fixed sites have been slowly opening up to the service. A complete remodel of the service away from using primary care practices is proving challenging with HSC venues not being available either. We continue to explore all potential options for screening venues, even on an interim basis to support restoration. These include community and council venues.	

PROGRAMME	**UPDATE**	**Comments / issues**

ABDOMINAL AORTIC ANEURYSM **Target audience**: Men, offered screening during the year they turn 65 yrs.	**Position at 8th July 2020** NIAAASP has prioritised men requiring intervention (currently five) and those with AAAs of diameter 5.0-5.4cm (currently 54) who require quarterly surveillance and are most at risk of reaching the threshold for referral. To that end, clinics have been arranged to screen the above during the July to August period. All necessary steps are being taken to ensure compliance with infection control, PPE, social distancing requirements and staff training needs relating to these clinics. The programme will also need access to redeployed staff and adequate scanning equipment. Ongoing risk assessments and arrangements will be required as the programme works through the layers of the risk-stratified prioritisation approach due to lack of access to men's telephone details and the increased number of men to be screened lower down the model. At least one NIAAASP screening clinic venue has become available in each of the five Trust areas; these will be utilised to provide surveillance for a phased resumption of screening. <u>Ongoing challenges</u> The programme will need to ensure all necessary treatment/intervention resources are in place before there can be any realistic expectation of a safe and effective phased restoration of screening. In addition, to support fulfilment of projected capacity and planning projections for restoring screening, funding will be required for: <u>four new ultrasound scanners (capital),</u> <u>two x screening technicians (revenue</u>) and <u>access to a GP practice venue(s) (revenue)</u> which is necessary to ensure maximum utilisation of new scanning equipment and screening technicians **Programme activity since 20th August Update and priorities for Oct-Dec 2020**	

	Activity i) Submission of restoration funding bid to DOH and clarification of queries submitted by DOH. ii) Submission of revenue and capital monies bid to DOH re: programme pressures for 21/22 - 23/24. iii) Update meeting between PHA and Belfast Trust staff to review programme status, performance, priorities and to hear from service users/patient representatives. iv) Latest Four Nation Meeting (held on 16/9/20) confirmed all four nations still apply risk stratification approach to resumption of surveillance screening, the ongoing challenge of securing sufficient interventional resource and the threat this poses to provision of a safe and effective programme. v) Successful engagement with regional GP rep regarding streamlining of their responsibilities relating to referral process for large AAAs and U&E requests. vi) Appointment of new Clinical Lead for programme. **Challenges** i) Programme unable to resume primary screening in the short-medium term without access to funding for additional screening technicians, scanning equipment and access to sufficient interventional resource. ii) Staffing: the programme manager and lead sonographer will leave the programme before the end of the year while the clinical lead is in the process of stepping down from the programme. iii) Without additional resource the programme will no longer able to provide an equitable service to all men within eligible cohorts. Even with a phased return to primary screening as per the Trust Operational Plan there is no provision to screen men who wish to self-refer or re-invite DNAs. iv) The programme continues to see its yearly cohort increase; from inception in 2012 the programme has seen an annual increase in 100 extra men needing screened. An ageing population will see this continue and future investment will be required to make the programme sustainable.	

v) Securing ring-fenced funding for the baseline six portable ultrasound machines required is critical as without this essential equipment the programme will be unable to function safely.

vi) Without restoration funding the programme will no longer be able to achieve its stated aim of saving lives from ruptured AAAs as there will be a continual delay in the start date for each cohort prohibiting the programme from optimising service delivery as it has done up to now.

Current update as at 21st September 2020

RISK LEVEL	**Prioritisation order for phased restoration**	**Number of men**
High risk of AAA rupture / AAA related death	i) Large AAAs (≥ 5.5cms) referred to vascular services ii) Medium AAAs (≥5-5.4cms)	11 men waiting for surgery or undergoing furthe to assess fitness for surgery ii) **45** men on quarterly surveillance
Medium Risk: Screen positive	i) Medium AAA (4.5-4.9cms) ii) Small AAA (≥3-4.4cms)	i) **42** men on quarterly surveillance ii) **515** men on annual surveillance
Medium Risk: Screening results not read/assessed	Awaiting medical imaging result or QA result	**20**
Low Risk: Men delayed an invitation	2019/2020 cohort (men still to be invited) 2020/2021 cohort	**623** **10,595**