Public Health Agency board Meeting

1:30pm, Thursday 15 October 2015

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

HSC Public Health Agency

AGENDA

78th Meeting of the Public Health Agency board to be held on Thursday 15 October 2015, at 1:30pm, Fifth Floor Meeting Room, 12/22 Linenhall Street Belfast, BT2 8BS

No	Time	Item	Paper	Sponsor
1.	1.30	Welcome and Apologies		Chair
2.	1.30	Declaration of Interests		Chair
3.	1.30	Minutes of previous Meetings: • Meeting of 20 August 2015		Chair
4.	1.35	Matters Arising		Chair
5.	1.35	Chair's Business		Chair
6.	1.40	Chief Executive's Business		Chief Executive
7.	1.45	Finance Update • PHA Financial Performance Report	**PHA/01/10/15 (for Noting)**	Mr Cummings
8.	1.55	Investment Plan Update	**PHA/02/10/15 (for Noting)**	Mr McClean
9.	2.05	Governance and Audit Committee Update • Draft Minutes of 10 June 2015 meeting • Verbal briefing from Chair	**PHA/03/10/15 (for Noting)**	Mr Coulter
10.	2.15	Mid-Year Assurance Statement	**PHA/04/10/15 (for Approval)**	Chief Executive
11.	2.25	Review of Disability Action Plan 2013-18	**PHA/05/10/15 (for Noting)**	Mr McClean

12.	2.35	Presentation on Public Information Campaigns	Mr McClean
13.	3.00	PHA Tobacco Control Update	Dr Harper
14.	3.15	Update on Corporate Strategy	Chair
15.	3.30	Any Other Business	

16. **Date, Time and Venue of Next Meeting**
    Thursday 19 November 2015
    1:30pm
    Conference Rooms 3+4, 2nd Floor
    12/22 Linenhall Street
    Belfast
    BT2 8BS

HSC Public Health Agency

MINUTES

Minutes of the 77th Meeting of the Public Health Agency board held on Thursday 20 August at 1:30pm, in Conference Rooms, 12/22 Linenhall Street, Belfast, BT2 8BS

PRESENT:

Mr Andrew Dougal	-	Chair
Dr Eddie Rooney	-	Chief Executive
Dr Carolyn Harper	-	Director of Public Health/Medical Director
Mrs Michelle Tennyson	-	Assistant Director (*on behalf of Mrs Hinds*)
Mr Stephen Wilson	-	Assistant Director (*on behalf of Mr McClean*)
Mr Brian Coulter	-	Non-Executive Director
Mrs Julie Erskine	-	Non-Executive Director
Mrs Judena Leslie	-	Non-Executive Director

IN ATTENDANCE:

Mr Robert Graham	-	Secretariat
Mr Paul Cummings	-	Director of Finance, HSCB
Mrs Fionnuala McAndrew	-	Director of Social Care and Children, HSCB
Mrs Joanne McKissick	-	External Relations Manager, Patient Client Council

APOLOGIES:

Mrs Mary Hinds	-	Director of Nursing and Allied Health Professionals
Mr Edmond McClean	-	Director of Operations
Councillor William Ashe	-	Non-Executive Director
Mr Leslie Drew	-	Non-Executive Director
Mr Thomas Mahaffy	-	Non-Executive Director
Alderman Paul Porter		Non-Executive Director

		Action
78/15	**Item 1 – Welcome and Apologies**	
78/15.1	The Chair welcomed everyone to the meeting and apologies were noted from Mrs Mary Hinds, Mr Edmond McClean, Councillor Billy Ashe, Mr Leslie Drew, Mr Thomas Mahaffy and Alderman Paul Porter.	
78/15.2	The Chair offered his congratulations to Mrs Judena Leslie who	

has been appointed as a Commissioner for Public Appointments. He added that he would be contacting the Public Appointments Unit at DHSSPS to seek a replacement for Mrs Leslie.

78/15.3 The Chair wished to record the passing of Dr Jeremy Harbison who had served on the Board of the PHA from its inception until April 2015. He said that Dr Harbison was an outstanding individual and his death was a great loss.

79/15 Item 2 - Declaration of Interests

79/15.1 The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.

80/15 Item 3 – Minutes of previous meetings:

- **Special Meeting of 10 June 2015**
- **Meeting of 18 June 2015**

80/15.1 The minutes of the previous meetings, held on 10 and 18 June 2015, were approved as an accurate record of the meeting.

81/15 Item 4 – Matters Arising

66/15 Commissioning Plan 2015/16

81/15.1 The Chief Executive noted that at the last meeting the Board had given conditional approval to the Commissioning Plan subject to the outcome of June monitoring. Mr Cummings advised that there was unlikely to be any additional funding emanating from June monitoring but that there were two bids for additional funding with the Minister for priorities highlighted in the Commissioning Plan. In response to a query from the Chair, he added that he hoped that some in-year slippage may reduce the impact on other projects.

67/15.3 Voluntary Exit Scheme

81/15.2 Mr Coulter asked for an update on the Voluntary Exit Scheme. The Chief Executive advised that information sessions had taken place with staff and that staff who had expressed an interest confidentially were now being asked to submit a formal request. However, he noted that there remained some uncertainty with regard to funding.

82/15	**Item 5 – Chair's Business**
82/15.1	The Chair advised members that he had received an excellent briefing from Mary Hinds regarding the work of the nursing directorate. He said that he, along with the Chief Executive, had met with the Chair and Chief Executive of HSCB. He added that he had visited the PHA team based in the south eastern area.
83/15	**Item 6 – Chief Executive's Business**
83/15.1	The Chief Executive said that he had attended a meeting of the Strategic Leadership Group, chaired by the Permanent Secretary.
83/15.2	The Chief Executive said that he, along with the Chair, had attended the end of year Accountability Review meeting. He said it was a challenging meeting, but that there was genuine appreciation of the work of the PHA.
84/15	**Item 7 – Lifeline Strategic Outline Business Case (PHA/03/08/15)**
84/15.1	Dr Harper introduced the Lifeline strategic outline business case and explained how it sets out a list of options and a preferred model, and that PHA Board approval is sought to move forward to public consultation on that basis. She added that once the consultation is complete, the responses would be collated and a full business case on the agreed final model brought to the Board for approval. She noted that the outline case had been developed following a pre-consultation exercise in 2014 which had proved useful.
84/15.2	Mr Brendan Bonner delivered a presentation to members outlining the background to the current Lifeline service needs analysis and trends relating to the types of calls dealt with by the service. Following the pre-consultation exercise, the PHA produced a report and he highlighted the feedback from that publication and, in addition he referenced the experience derived from elsewhere and outlined the required aims and objectives for a new service model.
84/15.3	Mr Bonner explained that the proposed new service would retain a 24/7 telephone-based crisis intervention but would separate the

	helpline element from the follow-on support services. He gave an overview of the main options that were considered and advised that the preferred option was to commission the telephone service to be managed by the Northern Ireland Ambulance Service, with support services provided separately within each LCG area.
84/15.4	Mr Bonner presented the benefits of the new model and finished by confirming the proposed timetable for the completion of the consultation and the procurement of the new service.
85/15.5	Mr Coulter asked about the capital costs to be incurred by NIAS for the new service, and if these had been costed within the business case. Mr Bonner said that the £500k was an indicative figure. Mr Cummings explained that this would not be a cost incurred by the PHA. He added that he was confident that when a detailed costing exercise is, the cost would not be as high at £500k.
85/15.6	The Chair asked how NIAS would charge for the service. Mr Bonner explained that with an anticipated demand for 90,000 calls per annum, NIAO would be paid a block payment. The Chair asked if this would be reduced if the demand was reduced but Mr Cummings explained that this could only be reduced if NIAS were to reduce their staff. He added that the costs are high as it is a 24-hour service.
85/15.7	Mr Coulter asked whether calls are recorded. Mr Bonner said that calls are not recorded as this may deter callers. However, he said that currently calls are listened into by a supervisor, as part of clinical management, and this is considered good practice. The Chair asked about what training is required. Mr Bonner explained that all call operators will be required to have Safetalk Mental Health 1st Aid and ASSIST and he added that the new model is about more than listening, it is about empowering people. Dr Harper added that it is also about making a clinical judgement on calls as to the appropriate next stage.
85/15.8	Mr Coulter noted that there is also important that there is support given to staff, in addition to their training. Dr Harper agreed that this is critical and she said that there are ongoing audits and there is core quality governance issue around the service.

85/15.9	Mr Coulter said that given the reputational risks he would wish to be assured that legal advice had been sought in terms of the procurement exercise. The Chair agreed.
85/15.10	Members approved the strategic outline business case. *At this point the Chief Executive left the meeting.*
85/15	**Item 8 – Finance Update – PHA Financial Performance Report (PHA/01/08/15)**
85/15.1	Mr Cummings gave an overview of the Finance Report for the period up to 30 June 2015. He said that the year to date position showed a surplus of £215k which was made up of a surplus in programme expenditure of £189k and a small surplus of £26k within the management and administration budget.
85/15.2	The Chair raised a query on behalf of member Leslie Drew with regard to the R&D expenditure for the Belfast Trust. Dr Harper explained that this funding would be used to award fellowships to support staff to develop research skills and on smaller scale specific projects linked to the overall R&D Strategy. She added that the funding is higher in the Belfast Trust as part of the R&D infrastructure is based in Belfast, but covers the whole of Northern Ireland.
85/15.3	Mrs Leslie asked how R&D is linked to current priorities. Dr Harper said that the HSC R&D function represents the whole of the HSC and although it is based within PHA it does retain a degree of independence and it now unduly influenced. She said that all potential research projects are subject to the same degree of scrutiny.
85/15.4	Mr Coulter asked whether the programme expenditure projection was based on historical data. Mr Cummings said that the projections had been based following discussions with managers and that he was confident with this, given that in previous years the expenditure tended to be more heavily weighted towards the year-end.
85/15.5	Mr Coulter asked about the strategic review referenced on page 4. In the absence of the Chief Executive, Dr Harper responded by saying that following the outcome of the Voluntary Exit

	Scheme, there may be a need to carry out a review of the organisation as whole. Mr Coulter acknowledged the difficulty of not knowing how the outcome of VES would affect PHA, but he hoped that PHA could begin to start thinking about its future priorities soon. The Chair said that this point had been raised at the recent Accountability Review meeting with DHSSPS.
85/15.6	Members noted the Finance Report.
86/15	**Item 9 – PHA Annual Business Plan 2015/16 (PHA/02/08/15)**
86/15.1	Mr Wilson presented the updated Business Plan which had been amended to reflect members' comments at the meeting in March regarding the financial context within which the Plan was developed.
86/15.2	Mrs Erskine asked whether a list of non-executive Directors should be included. This amendment was agreed.
86/15.3	Mrs McKissick asked about the funding for chronic pain management. Dr Harper said that the self-management programmes would include this as they are not disease specific, but she noted that wasn't prioritised within the Commissioning Plan and therefore required additional funding.
86/15.4	Subject to amendments, members approved the PHA Business Plan 2015/16.
87/15	**Item 10 – Update from Corporate Strategy Project Board**
87/15.1	The Chair said that he had attended the last meetings of the Corporate Strategy Project Board and that there would be a full day for members in September to progress this. He said that he also wished to have a separate meeting with non-executives as part of the workshop.
87/15.2	The Chair said that the workshop would focus on the Corporate Strategy and in particular areas such as, how the PHA can demonstrate value for money, public awareness of the role of PHA, and reprioritising into the future.

88/15	**Item 11 – Human Resources Report (PHA/05/08/15)**
88/15.1	The Chair welcomed Mr Hugh McPoland to the meeting.
88/15.2	Mr McPoland said that this was the first quarterly Human Resources Report for 2015/16. He highlighted some of the key information within the report starting with the sickness absence which he said for PHA was 3.17%, and although this was lower than the health service average, HR would continue to work with managers to seek to reduce this further. He added that with improved use of HRPTS it was easier to determine trends. He said that the most common reason for sickness was mental health-related issues, but he added that PHA has run sessions for staff on areas such as mindfulness and dealing with stress.
88/15.3	Mr McPoland advised that Section 3 of the Report focused on Learning and Development and he drew members' attention to the new suite of programmes under the Moving Forward initiative.
88/15.4	The Chair said that he was pleased to note the low level of absenteeism and recorded appreciation to all staff. He raised a query on behalf of member Leslie Drew who asked whether Trusts have undertaken similar calculations relating to sickness absence and time lost. Mr McPoland said that Trusts were beginning to develop their own reports using the information obtained from HRPTS.
88/15.5	Mrs Erskine said that she would like to see an Action Plan contained within the Report, and also specific targets set out. Mr McPoland said that DHSSPS would be shortly confirming the sickness absence target for PHA. He added that the Attendance Management policy is currently being reviewed.
88/15.6	Mr Coulter asked whether there was a link between the learning and development outlined in the Report and CPD requirements. Mr McPoland said there is an established process of appraisals and performance management related to professional staff, but that this is not yet included on HRPTS, the information is not captured on this Report. He said that PHA is committed to continuing to invest in its staff, but within the current financial context.
88/15.7	

Mr Coulter asked about staff surveys. Mr McPoland said that the DHSSPS regional staff survey will be run in October 2015. The Chair asked whether PHA has undertaken its own surveys. Mr McPoland advised that a climate survey had been undertaken three years ago, and that he hoped another survey would be done so that trends could be compared.

88/15.8 Ms Leslie asked whether there was a process in-house for sharing expertise e.g. through information seminars. Dr Harper said that when staff attending training events there is an expectation that there is feedback to peers. She added that there are internal CPD events from time to time, and she welcomed the suggestion about business case development.

88/15.9 The Chair noted that Leslie Drew had suggested that there could be a target of 100% of staff having had appraisals. Mrs Erskine said that with staff sickness and turnover, a 100% target was unrealistic and that 90-95% is realistic.

88/15.10 Members noted the Human Resources report.

89/15 Item 12 – Local Supervising Authority (LSA) Report (PHA/06/08/15)

89/15.1 Mrs Tennyson introduced Ms Verena Wallace and Ms Una Turbitt and invited them to present the Local Supervising Authority Report.

89/15.2 Ms Wallace introduced the Report and informed members that since the last Report, there continues to be a development of midwifery-led units. She went on to say that PHA had been working with a multi-disciplinary group to develop an online toolkit to provide guidance for midwives across a range of areas and that this was launched at NIPEC's annual conference.

89/15.3 Ms Wallace noted the positive feedback that had been received from service users as part of the PHA's 10,000 Voices initiative. She said that these findings had been presented at the LSA conference in January 2015. Ms Wallace informed members that maternity supervision is not currently a statutory obligation. Finally, Ms Wallace noted that there had been work undertaken in the area of midwifery and medicine.

89/15.4	Mrs Erskine asked whether the new template was easier to complete online. Ms Wallace said that Mott MacDonald is continuing to review the format of the report. She said that the timing of changes will be to coincide with the Queen's Speech so that this is completed by March 2017. The Chair asked what implications this would have for PHA. Ms Wallace said that in future annual reviews will be linked to revalidation.
89/15.5	Ms McKissick advised that the Patient Client Council had undertaken a piece of work on miscarriages, with a view to running an event in October. Ms Wallace said that work was being undertaken on bereavement care pathways, and that there were bereavement co-ordinators in each Trust.
89/15.6	Mr Coulter asked whether the ratio of 1:13 was appropriate. Ms Wallace said that the standard requirement is 1:15, and that Northern Ireland did have issues previously in achieving this. She added that although a 1:13 standard is being achieved, allowance has been made for retirements.
89/15.7	Mr Coulter asked about the challenges in relation to the recruitment of lay reviewers and about supervision. Ms Wallace said that Maternity Services Liaison Committees had lists of people who were interested, but these were now out of date, but a piece of work was being organised to take this forward. She went on to say that a piece of research has also been commissioned. With regard to supervision, Ms Wallace said that midwives prefer to be supervised by someone who is familiar with their work.
89/15.8	Members noted the Local Supervising Authority Report.
90/15	**Item 13 – Serious Adverse Incidents Learning Report (PHA/07/08/15)**
90/15.1	Mrs Tennyson introduced Ms Lynne Charlton to the meeting, and Ms Charlton gave members an overview of the Serious Adverse Incidents (SAIs) Learning Report. She said that this was the eighth report and that during this quarter a total of 366 SAIs had been reported compared to 300 for the same period last year.
90/15.2	Ms Charlton gave members an outline of the SAI process and governance structures. She explained the involvement of service

	users within the process and the role of the Designated Responsible Officer. She explained the roles of the Quality, Safety and Experience (QSE) Group and the Safety Quality and Alerts Team (SQAT). She noted that the outcome of the Donaldson Review may have an impact on the SAI process.
90/15.3	Mrs Erskine expressed surprise at the low numbers of incidents relating to older people's services reported by the Belfast Trust. Ms Charlton explained that the Trust investigated their own falls, but not did report on them. The Chair suggested a footnote be inserted to explain this. Dr Harper explained that there is a falls prevention bundle, and if the Trust are using it, there should not be an issue.
90/15.4	Ms McKissick noted that following Sir Liam Donaldson's meeting with families to discuss the SAI process, their feedback had been taken into account in the amended guidance that had been issued. Ms Charlton added that there had also been a learning set event at which there was representation from patients and families and that this had been a worthwhile event.
90/15.5	The Chair asked whether the support mechanisms for staff were proactive and Ms Charlton said that there was still some improvement to be made in this area, as there was not a culture of seeking support. The Chair asked how the learning from events was promulgated. Ms Charlton said that at each event, each Trust presented its own learning and then there was general discussion about shared learning.
90/15.6	Mr Coulter noted the references to NICE guidance and recalled that there are limited resources available to implement NICE guidance as suggested within the Commissioning Plan. He also noted that are more strict deadlines for some parts of the system to implement learning letters than for others. Dr Harper noted this, but explained that in terms of process there is not the capacity to monitor and seek assurance from 400 GP practices, but she said that this could be picked up as part of regular visits to GP practices.
90/15.7	Members noted the Serious Adverse Incidents report.

91/15	**Item 14 – PHA and HSCB Annual Quality Report 2014/15 (PHA/08/08/15)**
91/15.1	Ms Charlton said that the Annual Quality Report would be launched on World Quality Day on 2 November. She said that the reported followed a set format along five strategic themes.
91/15.2	Mr Coulter said that he found the format of the report made it difficult to follow.
91/15.3	The Chair asked whether there were any quantifiable measures in regard to PPI. Mrs Tennyson conceded that this is an area that PHA is struggling with, but she said that research has been commissioned to see how best it can be demonstrated that PPI is making a difference.
91/15.4	Members approved the Annual Quality Report.
92/15	**Item 15 – Any Other Business**
92/15.1	There was no other business.
93/15	**Item 16 – Date and Time of Next Meeting**

Date: Thursday 15 October 2015
Time: 1:30pm
Venue: Fifth Floor Meeting Room
12/22 Linenhall Street
Belfast
BT2 8BS

Signed by Chair: _____

Date: _____

HSC Public Health Agency

Public Health Agency

Finance Report

2015-16

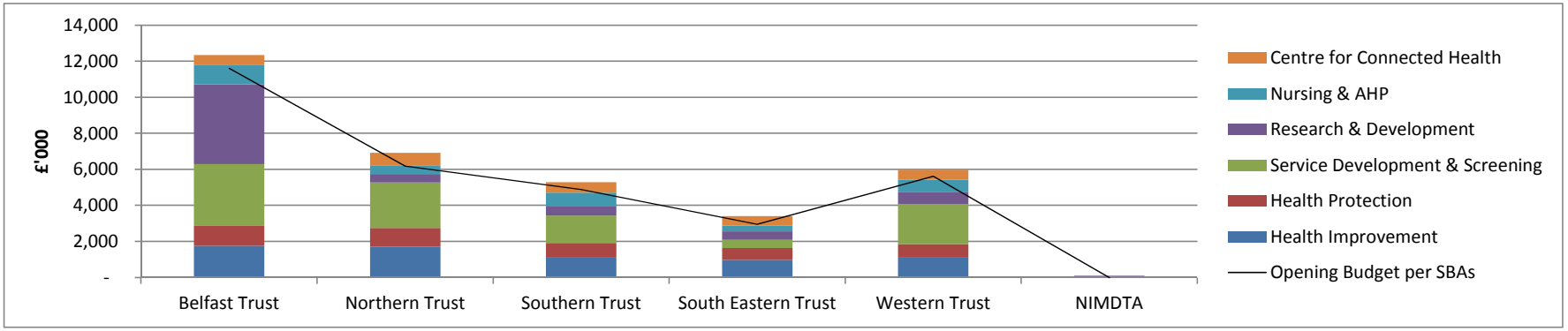
Month 5 - August 2015

Public Health Agency
2015-16 Summary Position - August 2015

	Annual Budget				Year to Date			
	Programme		Mgt & Admin	Total	Programme		Mgt & Admin	Total
	Trust	Non-Trust			Trust	Non-Trust		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources								
Adjusted Departmental Allocation	34,077	48,012	19,353	**101,442**	14,173	11,547	7,967	**33,688**
Income from Other Sources	-	654	535	**1,188**	-	589	210	**798**
Total Available Resources	34,077	48,666	19,888	**102,630**	14,173	12,136	8,177	**34,487**
Expenditure								
Trusts	34,077	-	-	**34,077**	14,173	-	-	**14,173**
Non-Trust Programme	-	48,666	-	**48,666**	-	11,836	-	**11,836**
PHA Administration	-	-	19,888	**19,888**	-	-	8,028	**8,028**
Total Proposed Budgets	34,077	48,666	19,888	**102,631**	14,173	11,836	8,028	**34,038**
Surplus/(Deficit)	-	-	-	**-**	-	300	149	449

The year to date financial position for the PHA shows an underspend against profiled budget of £433k. This is mainly due to slower than anticipated expenditure on Non-Trust Programme activity (primarily Lifeline), which is £300k behind profile as shown on page 3, combined with reduced Management & Administration expenditure for the year to date, primarily in the Public Health Directorate as detailed on page 4. It is currently anticipated that the PHA will breakeven on its full year budget.

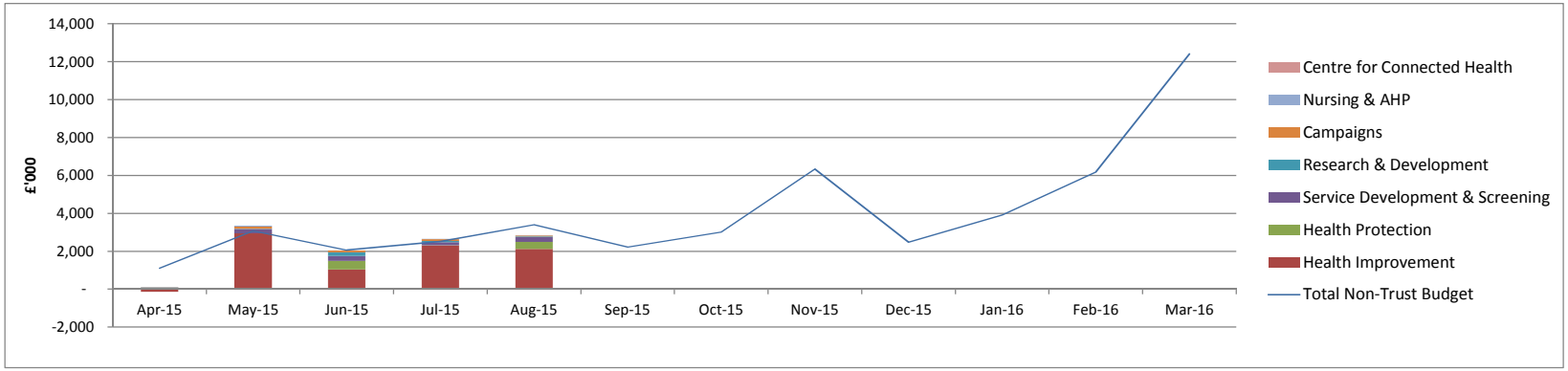
Programme Expenditure with Trusts



Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	Southern Trust £'000	South Eastern Trust £'000	Western Trust £'000	NIMDTA £'000	Total Current Budget £'000
Health Improvement	1,762	1,717	1,099	974	1,112	-	**6,665**
Health Protection	1,138	1,040	820	659	742	-	**4,400**
Service Development & Screening	3,404	2,520	1,520	460	2,227	-	**10,130**
Research & Development	4,411	475	506	465	675	107	**6,638**
Nursing & AHP	1,099	445	765	327	677	-	**3,312**
Centre for Connected Health	536	732	590	525	549	-	**2,932**
Total current RRLs	**12,349**	**6,928**	**5,300**	**3,411**	**5,981**	**107**	**34,077**
Opening Budget per SBAs	**11,604**	**6,183**	**4,887**	**2,950**	**5,626**	**-**	**31,250**

As part of a service improvement project the Finance Directorate has coded the opening Service & Budgetary Agreements (SBAs) to their budget area, as shown by the summary above. During August additional commitments of £2.2m were made to HSC Trusts primarily for Telemonitoring and Telecare activity.

Non-Trust Programme Expenditure



	Apr-15 £'000	May-15 £'000	Jun-15 £'000	Jul-15 £'000	Aug-15 £'000	Sep-15 £'000	Oct-15 £'000	Nov-15 £'000	Dec-15 £'000	Jan-16 £'000	Feb-16 £'000	Mar-16 £'000	Total £'000	Budget (YTD) £'000	Expenditure (YTD) £'000	Variance (YTD) £'000
Budget																
Health Improvement	719	2,378	919	2,006	2,190	1,033	916	3,267	686	2,384	3,252	4,953	**24,704**	8,212	8,273	(60)
Lifeline	292	292	292	292	292	292	292	292	292	292	292	292	**3,500**	1,458	1,063	395
Health Protection	-	15	418	12	460	626	1,364	1,231	1,185	787	671	1,242	**8,010**	905	868	37
Service Development & Screening	83	368	85	83	368	93	127	380	123	106	395	303	**2,514**	986	940	47
Research & Development	-	-	237	60	45	101	173	1,120	113	112	1,429	4,473	**7,862**	342	311	31
Campaigns	-	1	131	58	32	80	135	50	50	190	130	195	**1,052**	222	353	(131)
Nursing & AHP	-	3	3	-	3	-	-	3	23	39	3	861	**940**	10	58	(48)
Centre for Connected Health	12	12	- 24	-	-	-	-	-	-	-	-	62	**62**	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	-	21	**21**	-	(29)	29
Total Non-Trust Budget	**1,106**	**3,068**	**2,061**	**2,511**	**3,390**	**2,225**	**3,006**	**6,343**	**2,473**	**3,910**	**6,172**	**12,402**	**48,666**	**12,136**	**11,836**	**300**
Actual Expenditure	**233**	**3,506**	**2,306**	**2,681**	**3,109**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**11,836**			

The PHA expects that, due to unanticipated events, in-year slippage will accrue from these budgets during 2015-16, as this has historically been the case. To ensure timely reinvestment of these resources into key programme activities, a prioritised list of non-recurrent service developments has been developed.

The financial position to date shows a small underspend of £300k which primarily relates to lower than anticipated expenditure on Lifeline, offset by expenditure ahead of profile in Nursing and Campaigns. However, all variances are being closely managed and a plan is in place to reinvest this slippage and achieve a breakeven position for the financial year.

A significant portion of the budget for the year is currently profiled in the last quarter. Budget managers should review these figures closely and liaise with the Financial Management team if amendments to profiles are required.

PHA Administration

2015-16 Directorate Budgets

	Nursing & AHP £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Annual Budget							
Salaries	2,827	3,443	10,088	272	301	475	**17,405**
Goods & Services	205	1,404	533	(121)	79	382	**2,482**
Total Budget	**3,032**	**4,847**	**10,621**	**152**	**380**	**857**	**19,888**
Budget profiled to date							
Salaries	1,169	1,434	4,192	112	125	207	**7,239**
Goods & Services	86	575	214	(50)	33	80	**938**
Total	**1,255**	**2,009**	**4,406**	**62**	**158**	**287**	**8,177**
Actual expenditure to date							
Salaries	1,177	1,460	4,183	100	134	205	**7,260**
Goods & Services	45	512	145	(23)	9	79	**768**
Total	**1,222**	**1,972**	**4,328**	**78**	**143**	**284**	**8,028**
Surplus/(Deficit) to date							
Salaries	(8)	(27)	9	12	(9)	2	**(21)**
Goods & Services	41	63	69	(27)	24	1	**171**
Surplus/(Deficit)	**33**	**37**	**78**	**(16)**	**15**	**3**	**149**

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

Total recurrent budgets allocated to Directorates have been reduced by the actual 2014-15 surplus and a 20% travel saving, totalling £1.1m. A further £0.151m saving remains to be identified against the £1.3m target. This balance has currently been charged to the PHA Board cost centre and is being managed across all PHA M&A budgets. PHA must continue to manage discretionary expenditure and savings plans to ensure a breakeven position at the end of the financial year.

PHA Prompt Payment

Prompt Payment Statistics

	August 2015 Value	August 2015 Volume	Cumulative position as at 31 August 2015 Value	Cumulative position as at 31 August 2015 Volume
Total bills paid (relating to Prompt Payment target)	£2,381,243	340	£9,768,945	2,090
Total bills paid on time (within 30 days or under other agreed terms)	£2,305,610	290	£9,062,825	1,875
Percentage of bills paid on time	**96.8%**	**85.3%**	**92.8%**	**89.7%**

The BSO has not yet been able to provide a comprehensive prompt payment report which is accurate for PHA. In the interim HSCB finance, on behalf of PHA, continue to generate a prompt payment report based on the audited method which was used to provide the Annual Accounts figures. This will ensure consistency of information reported to PHA on a monthly basis, while BSO works to produce a meaningful report. Progress is being made with BSO colleagues and it is expected that a formal report will be produced from quarter 3.

Prompt Payment performance for PHA for the first five months of the year is 92.8% on the value paid within 30 days which is slightly below the 30 day target of 95%. However, the performance in August (96.8%) shows continued improvement and efforts are being made to sustain this good performance. Cumulatively for the year to date the volume figures show an improvement in comparison to the same period in the previous year (89.7% v 88.7%).

The overall 10 day performance was 86.1% by value for the year to date, which exceeds the 10 day DHSSPS target for 2015-16 of 60%.

PUBLIC HEALTH AGENCY BOARD PAPER

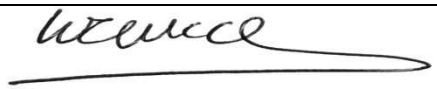
Date of Meeting	15 October 2015
Title of Paper	Investment Plan Update
Agenda Item	8
Reference	PHA/02/10/15

Summary

This report provides an update on overall progress with implementing the programme expenditure plans as set out in the Investment Plan 2015/16.

In June 2015, programme expenditure of £82.65m was approved by PHA board. Subsequently additional funding of £2.176m has been allocated by DHSSPS to take forward specific areas of work, giving a current baseline budget of £84.82m.

PHA has still to receive from DHSSPS £0.8m in relation to the Early Years Intervention Transformation Programme and the Integrated Services for Children and Young People Programme and will continue to highlight to DHSSPS the need to have this funding allocated as soon as possible to meet the contractual commitments that are in place.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This update was considered by AMT on 6 October.
Recommendation / Resolution	For Noting
Director's Signature	
Title	Director of Operations
Date	6 October 2015

Investment Plan Update

This report provides an update on overall progress with implementing the programme expenditure plans as set out in the Investment Plan 2015/16, which were approved by the PHA board at its meeting in June 2015.

The information presented is based on the Programme Expenditure Monitoring System (PEMS) and other relevant sources.

Baseline Programme Budget

In June 2015, programme expenditure of £82.65m was approved by PHA board. Subsequently additional funding of £2.176m has been allocated by DHSSPS to take forward specific areas of work, giving a current baseline budget of £84.82m.

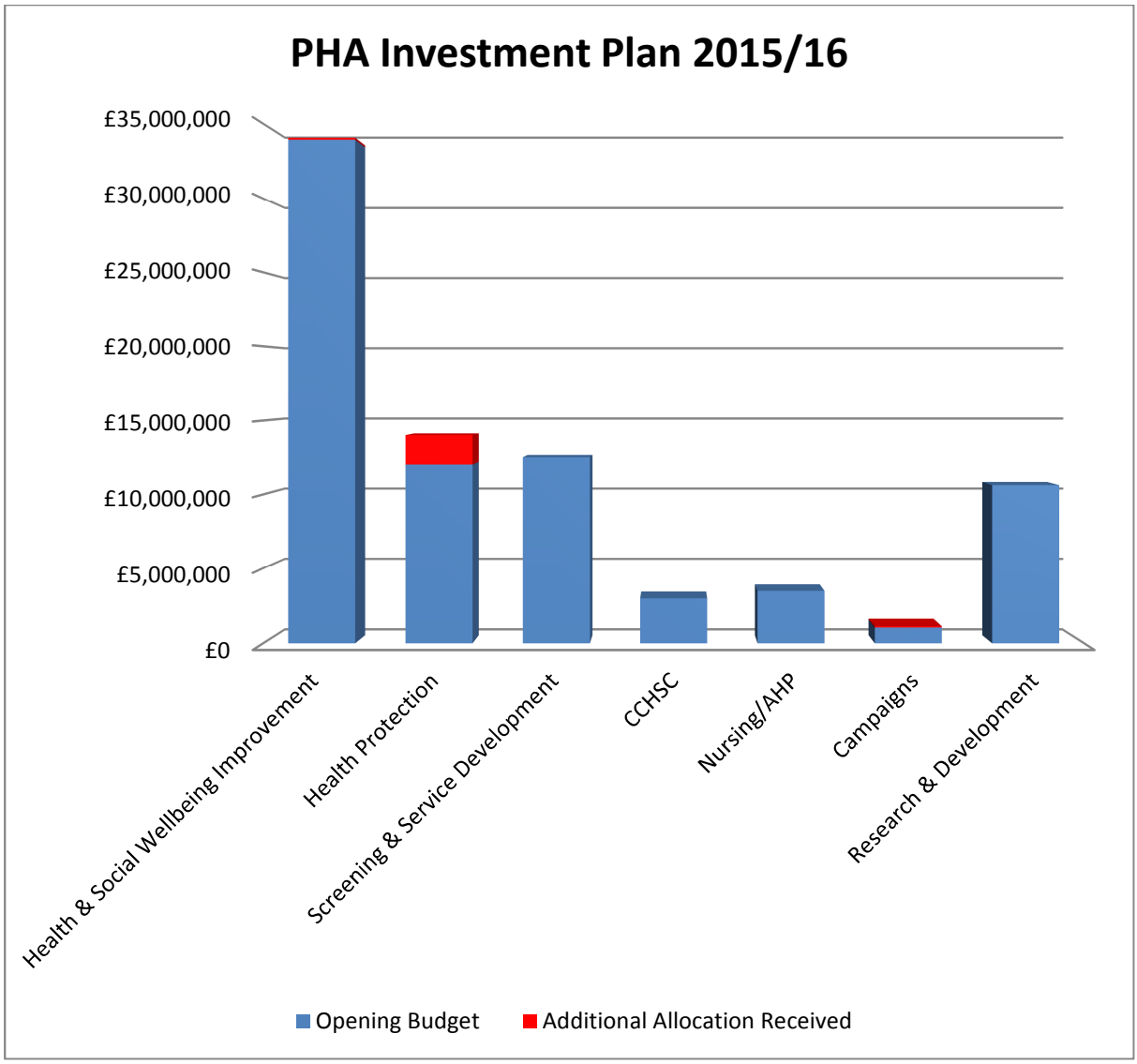
The additional £2.176m allocated by DHSSPS is in respect of: the implementation of additional vaccination programmes namely Meningococcal ACWY vaccine (£1.62m) and Pertussis vaccine (£0.36m); Farm Families Health Check programme (£0.134m) and Stroke services (£0.082m).

A breakdown of the full baseline budget is summarised in Table 1 and diagram 1 below.

Table1: Baseline Budget as at 30 September 2015

Area	Opening Budget	Additional Allocation Received	Baseline Budget
Health & Social Wellbeing Improvement	£35,164,082	£134,000	**£35,298,082**
Health Protection	£12,071,446	£1,959,220	**£14,030,666**
Screening & Service Development	£12,554,221		**£12,554,221**
CCHSC	£2,993,289		**£2,993,289**
Nursing/AHP	£4,267,116		**£4,267,116**
Campaigns	£1,052,481	£82,356	**£1,134,837**
Research & Development	£14,547,804		**£14,547,804**
Total	**£82,650,439**	**£2,175,576**	**£84,826,015**

Diagram 1 :Distribution of Baseline Funding across key areas



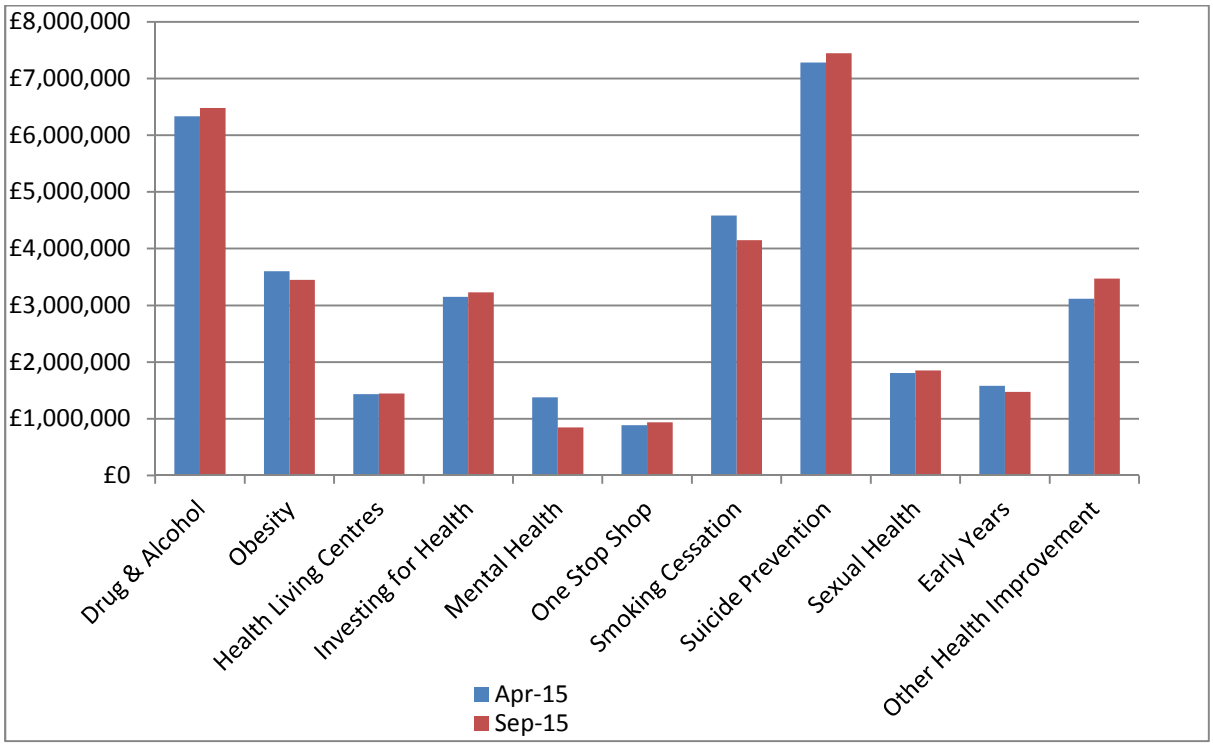
PHA has still to receive from DHSSPS £0.8m (included in the baseline budget above) in relation to the Early Years Intervention Transformation Programme and the Integrated Services for Children and Young People Programme and will continue to highlight to DHSSPS the need to have this funding allocated as soon as possible to meet the contractual commitments that are in place.

Progress Against Planned Programme Expenditure

This section provides an update on progress with implementing the agreed programme of Investments.

Health Improvement

Diagram 2 : Breakdown of planned Health Improvement expenditure



Key issues to note:

Since 1 April 2015, 47 new contracts with an annual value of circa £6m have been awarded under formal tender and are now operational (see Appendix 1 for breakdown). These cover contracts linked to Drug and Alcohol services, Relationship and Sexuality Education; Mental health Training and Self Harm services. The implementation of these contracts will ensure that there is now a consistent level of service available across all areas with greater focus being placed on achieving the outcomes expected by having clear specifications and key performance indicators in place

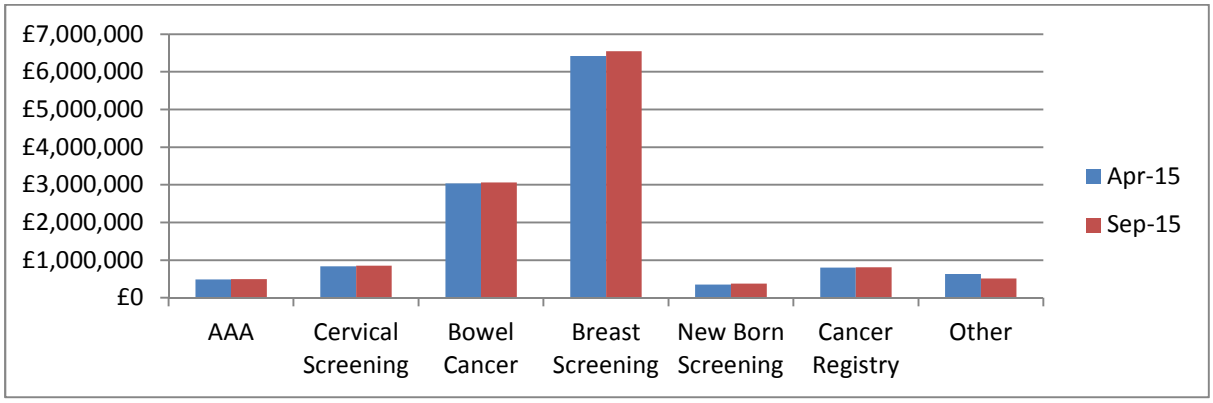
- Planned funding for Mental Health is lower than the planned budget due to a number of technical adjustments that have been made. Elements of the budget have been transferred to other budget areas to support mental health focused initiatives such as suicide prevention and supporting the mental health needs of Travellers.
- A number of new planned initiatives are still being finalised and, in some instances, tender processes are still being completed. As a result of this, implementation timelines have slipped slightly and some in-year slippage has

arisen. In addition, there continues to be a reported downturn in some demand led contracts. To ensure all PHA funding is fully utilised, AMT has agreed to prioritise £0.7m of additional in-year developments. These are summarised in Appendix 2.

- Contracts have recently been awarded for EITP workstream 2 (Incredible Years – parenting programmes). PHA is progressing with this initiative on the basis that the full costs will be met by DHSSPS. A further £0.3m has still to be formally allocated.

Screening and Service Development

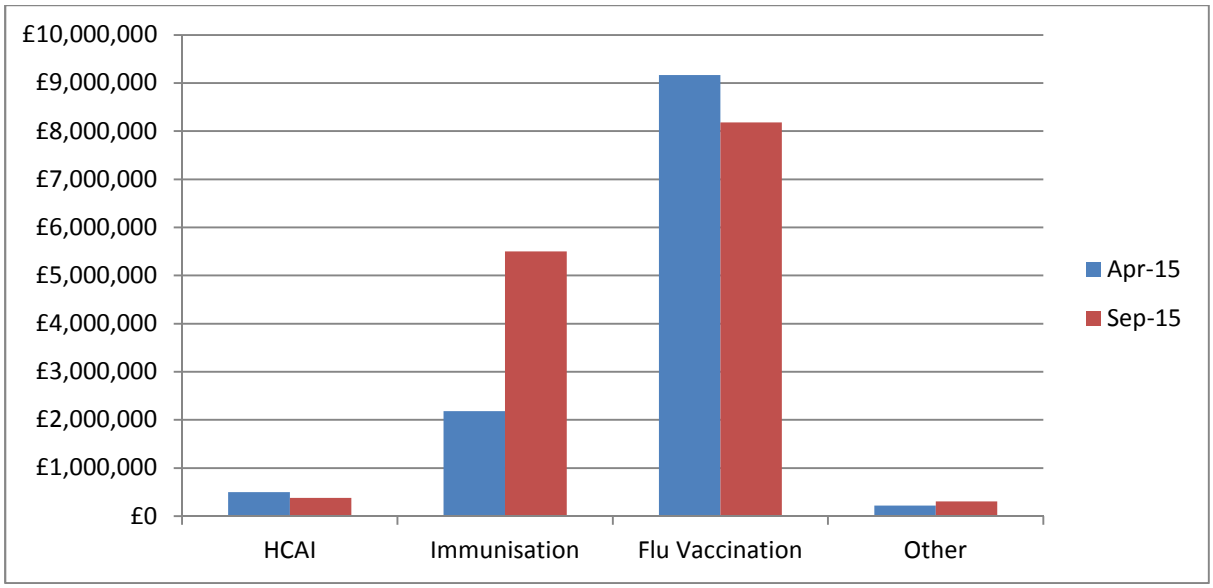
Diagram 3: Breakdown of planned Screening and Service Development expenditure



All investments under Screening and Service Development are progressing as planned.

Health Protection

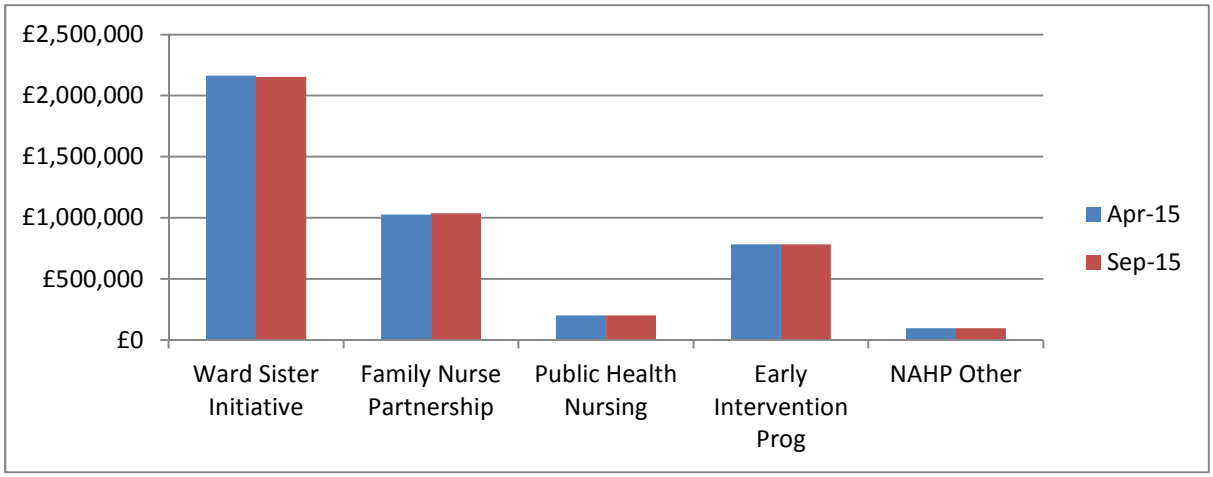
Diagram 4: Breakdown of planned Health Protection expenditure



As outlined above, additional funding has been allocated for 2 vaccination programmes - Meningococcal ACWY vaccine (£1.62m) and Pertussis vaccine (£0.36m). Plans are well progressed and it expected that all vaccination programmes will be implemented on time and funding fully utilised.

Nursing and AHP

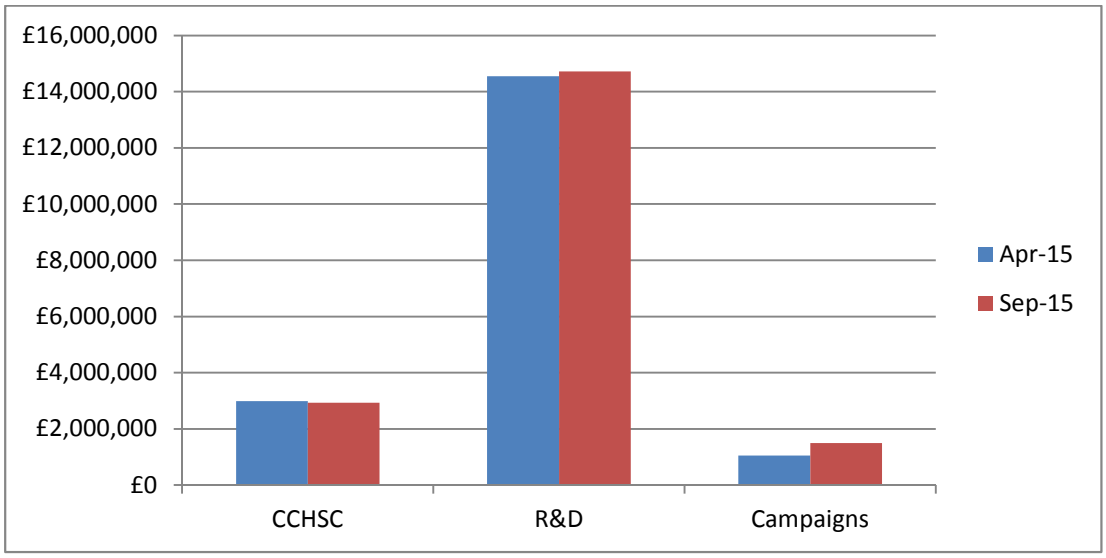
Diagram 5: Breakdown of planned Nursing and AHP expenditure.



Investment proposals for the EITP Workstream 1 initiative (Transformation of Health Visiting Services) are currently being finalised with the 5 Trusts. It is expected that this development will be implemented by November 2015. PHA is still awaiting DHSSPS to allocate the full amount of funding agreed to support this development.

Centre for Connected Health and Social Care (CCHSC) / Research and Development / Campaigns

Diagram 6: Breakdown of planned expenditure for CCHSC / R&D/Campaigns



Centre for Connected Health and Social Care (CCHSC); Research and Development and Campaigns budgets are all expected to fully spend in 2015/16.

Next Steps

PHA officers will continue to keep the programme budget under review to ensure that planned developments are is on track to spend. The Chief Executive will chair a mid-year budget review meeting (scheduled to be held on 3 November 2015) involving all Directors and budget leads to review progress against the planned budget and ensure any risks to planned spend are identified early.

PHA board is asked to **note** this paper

Breakdown of PHA Contracts Awarded Under Tender (APPENDIX 1)

Title	Annual Contract Value	Number of Contracts Awarded
Relationship and Sexuality Education (RSE) in the community across Northern Ireland	£ 275,500	4
Awareness Programmes to support Mental and Emotional Health and Wellbeing- Tier 1 Programmes	£ 44,000	2
Services to support the mental and emotional wellbeing of Lesbian and Bisexual Women, Gay and Bisexual Men and Transgender individuals and their families	£ 50,000	3
Community Based Psychological Intervention and Support Services for People who Self-Harm including provision of Family/Carer services	£ 719,000	5
Service to raise awareness and promote informed choice for the Cancer Screening Programmes	£ 180,000	1
Therapeutic services for children, young people and families affected by parental substance misuse	£ 816,777	5
Support, Care, Facilitation and Harm Reduction Services for People who are misusing Substances (Low Threshold Services)	£ 910,000	5
Community based intervention services for adults and family members affected by substance misuse	£ 551,208	5
Community based services for young people who are identified as having substance misuse difficulties	£ 924,274	5
Community Alcohol and Drugs Information Network Services	£ 600,000	5
Targeted Prevention for young people and parents / carers	£ 692,859	5
Workforce Development Programmes	£ 172,000	2

(APPENDIX 2)

Breakdown of Additional Initiatives Prioritised on an In-year basis.

Programme Area	£000's
Additional funding to meet Public Information Campaign Commitments as agreed with DHSSPS	300
Review of Older persons Nursing services	100
R&D Project for CCHSC	100
Support for Procurement Plan Implementation	50
Extension of Parenting ur teen project	40
One Stop Shop Evaluation	30
Year 3 of ARC project (West)	25
Relationship and Sexuality Education service Evaluation	25
Review of AHP support for Children with Special Educational Needs	20
Support for Making Life Better	10
Total	700

HSC Public Health Agency

MINUTES

Minutes of the 30th Meeting of the Public Health Agency Governance and Audit Committee held on 10 June 2015, at 9.30am Fifth Floor Meeting Room, 12-22 Linenhall Street Belfast, BT2 8BS

Present:

Mr Brian Coulter	-	Chair
Alderman Paul Porter	-	Non-Executive Director

In Attendance:

Mr Edmond McClean	-	Director of Operations,PHA
Mr Paul Cummings	-	Director of Finance, HSCB
Mr Simon Christie	-	AD Finance, HSCB
Miss Rosemary Taylor	-	AD Planning & Operational Services
Mr David Charles	-	Internal Audit, BSO
Mr Brian Clerkin	-	ASM
Mr Tomas Wilkinson	-	NIAO
Mr Mark Anderson	-	Sponsor Branch, DHSSPSNI
Ms Tara McBride	-	Sponsor Branch, DHSSPSNI
Mrs Cathy McAuley	-	Secretariat

Apologies:

Mr Thomas Mahaffy	-	Non-Executive Director

43/15	**Item 1 – Welcome and Apologies** The Chair welcomed everyone to the meeting and noted apologies. He welcomed Tomas Wilkinson (NIAO) and Tara McBride (DHSSPSNI).	**Action**
44/15	**Item 2 - Declaration of Interests** The Chair asked if anyone had any interests to declare relevant to any items on the agenda. None were declared.	
45/15	**Item 3 - Chair's Business** The Chair referred to correspondence from NIAO re: Change in Director responsibilities.	
46/15	**Item 4 - Notes of previous Meeting – 10 June 2015** The minutes of the previous meeting, held on 15 April 2015 were approved.	

47/15	**Item 5 - Matters Arising** <u>7/16 – IA Annual Plan 2015/16</u> This matter has been deferred as no formal decision has been agreed by PHA and BSO. <u>35/15 – Governance Statement 2014/15</u> The governance statement has been amended to take account of accommodation issues with regards to property leases at Alexander House and Anderson House. PHA staff continue to work with DHSSPS, DFP Health Division, LPS and other HSC organisations.	
48/15	**Item 6 – Annual Accounts incorporating Governance Statement and Letter of Representation** Mr McClean presented the PHA Annual Report 2014/15 and the Governance Statement to members and summarised the report to members for recommendation for PHA board approval. Mr Christie presented the PHA Accounts for the year ended 31 March 2015 and summarised the report to members. Members recommended the annual report and annual accounts including the governance statement to the PHA board for approval.	**Mr McClean/ Mr Christie**
49/15	**Item 7 – External Auditor's Report to those Charged with Governance (Draft)** Mr Clerkin presented the draft report to those charged with Governance to members for noting and gave a verbal summary of the report. Mr Wilkinson asked members to note that there may be an amendment to the report to include the potential impact to HSC organisations regarding the budgets. He advised that this amendment will not impact upon the approval of the annual accounts for 2014/15. Members noted the report.	
50/15	**Item 8 - Annual meeting with auditors (External and Internal) without officers present** Officers left the room for this part of the meeting.	
51/15	**Item 9 - Corporate Risk Register (at 31 March 2015)** Mr McClean presented the Corporate Risk Register for the approval. He confirmed 2 risks had been added:	

- CR33: VOIP Telephone System
- CR34: £2.8m (15%) Reduced in Management and Administrative Funding.

He added that 2 risks have been removed;

- CR31: Shared Services (this has been de-escalated to the Operations Directorate Risk Register)
- CR32: Programme Budget Expenditure.

Mr McClean asked the GAC to approve the register as at 31 March 2015.

52/15 CR32: Programme Budget Expenditure

Alderman Porter expressed his concern regarding future potential budget reductions and suggested that this uncertainty could be included in CR34. Mr McClean said that senior management continue to work closely with the department to minimise adverse risks and if more information became available it would be reflected in the risk register.

53/15 CR26: Lack of market testing for roll forward contracts and lack of staff capacity to appropriately procure services

In respond to a question regarding temporary additional capacity to support this work Mr McClean advised that the PHA Scrutiny Committee had approved an extension of this post for a limited period of time.

54/15 CR33: VOIP Telephone System

Mr McClean advised that the Business Continuity arrangements of VOIP telephone system downtime (Health Protection Duty Room) continue to be monitored following a recent power cut in Belfast.

55/15 Members approved the Corporate Risk Register as at 31 March 2015.

56/15 **Item 10 – Information Governance Update and Action Plan 2015/16**

Miss Taylor presented the action plan to members for noting. Members noted the updated action plan. It was noted that the plan contained the essential actions to ensure that the PHA met its legal and statutory requirements in respect of information governance.

58/15	**Item 11 – Data Protection/Confidentiality Policy** Miss Taylor presented the Data Protection/Confidentiality Policy. Member recommended the policy for PHA board approval.	**Miss Taylor**
59/15	**Item 12 - Gifts and Hospitality Policy** Miss Taylor presented the Gifts and Hospitality Policy for approval. Members recommended the policy for PHA board approval.	**Miss Taylor**
60/15	**Item 13 – Single Tender Actions for Goods and Services Procurement 2014/15** Mr McClean presented the report on STAs for Goods and Services Procurement 2014/15 for noting. He said that during this period 26 applications were submitted compared to 28 during 2013/14. He gave a brief analysis of the STA applications advising that of the 26 applications made, three did not require a rating and were subsequently withdrawn. Of the 23 applications given a risk status by PALs 19 were rated green, 1 rated green/amber, 1 rated amber and 2 were rated red. Members noted the report.	
61/15	**Item 14 – Audit Committee Self-Assessment Checklist** GAC approved the ACSA checklist for onward submission to the department once 2015/16 request is received.	
62/15	**Date and time of the next meeting** Date: 14 October 2015 at 9.30am Time: 9:30am Venue: PHA Conference Room 18 Ormeau Baths Belfast BT2 8HS	

HSC Public Health Agency

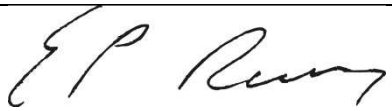
PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	15 October 2015
Title of Paper	Mid-Year Assurance Statement
Agenda Item	10
Reference	PHA/04/10/15

Summary

All arm's length bodies are required to submit a Mid-year Assurance Statement to the Department. Linda Devlin's letter of 15 September to the Chief Executive advised that the Mid-Year Assurance Statement template for 2015/16 should be completed and submitted no later than Friday, 16 October 2015.

The attached Mid-year Assurance Statement will be considered by the Governance and Audit Committee at its meeting of 14 October 2015, prior to the PHA Board meeting on 15 October 2015 in advance of the deadline of 16 October 2015.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	The Mid-Year Assurance Statement was approved by AMT on 29 September.
Recommendation / Resolution	For Approval
Director's Signature	
Title	Chief Executive
Date	6 October 2015

PUBLIC HEALTH AGENCY: MID-YEAR ASSURANCE STATEMENT

This statement concerns the condition of the system of internal governance in the *Public Health Agency as at 30 September 2015.*

The scope of my responsibilities as Accounting Officer for the Public Health Agency (PHA), the overall assurance and accountability arrangements surrounding my Accounting Officer role, the organization's business planning and risk management, and governance framework, remain as set out in the Governance Statement which I signed on *10 June 2015.* 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 the Remuneration Committees* 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 PHA 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 *10 June 2015.*

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 Public Health Agency's business plan as approved by the Department.

5. **Controls Assurance**

I confirm implementation of action plans arising from the year-end self-assessments of compliance with Controls Assurance Standards.

6. **External audit reports**

I confirm implementation of the external auditor's accepted recommendations. There were 2 priority 3 recommendations made relating to performance against the prompt payment target and the disclosure of a lease within the annual accounts. A range of actions have been taken internally within the PHA, HSCB finance and by BSO Shared Services to focus on prompt payment performance. The current performance (Aug 2015) is 90% by volume, however the target of 95% within 30 days remains challenging. The process to resolve the lease recommendation is ongoing, with PHA working with DHSSPS and DFP to resolve all business case requirements prior to completion.

7. **Internal audit**

I confirm implementation of the majority of accepted recommendations made by internal audit. Action is currently being taken to ensure the remaining recommendations are being fully implemented.

Internal Audit carried out a full review of the recommendations from the 2014/15 internal audits and provided a detailed progress report to the Governance and Audit Committee on 14 October 2015. A copy of this report is available if required. Of the 46 recommendations identified, 76% have been fully implemented, 22% (10 recommendations) partially implemented and 2% (one recommendation) have not yet been implemented.

The one recommendation that has not yet been implemented relates to the retendering of a service; this has been delayed due to staff absence.

Three reports have been finalised for 2015/16. Satisfactory assurance has been given in respect of PHA Risk Management, Procurement and Contract Management and Management of Health and Social Wellbeing Improvement Contracts.

8. RQIA and other reports

The RQIA Review of the Diabetic Eye Screening Programme was published in May 2015. A modernisation programme has been established and action plan developed. Progress will be reported by the PHA to the DHSSPS.

9. 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.

10. Internal Control Divergences

Update on prior year control issues which continue to be considered control issues:

Accommodation

The new agents for the Ormeau Baths facility are working well with the PHA, ensuring that any issues are dealt with promptly. PHA and PCC continue to be accommodated in Ormeau Baths.

During 2013/14 and early 2014/15 PHA staff worked with Health Estates to finalise the business case for new accommodation to resolve the continuing problems, especially in respect of 4th floor Linenhall Street and Alexander House with the number of staff significantly in excess of capacity, with consequent problems including noise, lack of meetings space and challenges regarding data confidentiality. While a few staff have been able to move to the desks in Ormeau Baths freed by the SBNI move to The Beeches, this has by no means resolved the problem. Rather, these issues continue to have a negative impact on PHA staff, resources and how the PHA carries out its business.

While significant progress was made towards implementation of the business case preferred option, the building was taken off the market at the last minute in August 2014. Advice was sought from DHSSPS Asset and Estate Management Branch (AEMB), with confirmation in January 2015 that PHA was not to be included in wider public sector acquisitions and moves within 2014/15. Therefore a new search for alternative accommodation is required along with the subsequent revision of the business case. This will also need to take account of the end of the lease for Ormeau Baths (February 2017). While the PHA will continue to work with the AEMB and DFP Health Projects along with Land and Property Services (LPS) and the other regional organisations (particularly HSCB and BSO), to progress this, it is recognised that PHA has very limited capacity or resources to assist with this.

The loss of the preferred option in August 2014 also resulted in the PHA being unable to vacate Alexander House as expected by the end of 2014/15, and therefore a renewed licence agreement is required. Advice was sought from AEMB and a Strategic Outline Case (SOC) was submitted to seek approval to renew the license to February 2017 (in line with the end date of the Ormeau Baths lease, to allow a fuller examination and business case for an accommodation solution for all PHA Belfast pressures). Following the receipt of queries from DHSSPS AEMB, the PHA

continues to seek advice from AEMB and is working with DFP Health Projects and LPS to address the queries and comments, to enable the SOC to be progressed and resubmitted as early as possible.

The PHA is also facing accommodation pressures in Omagh. As the lease for Anderson House was due to end July 2014, PHA initially submitted an SOC in February 2014 seeking approval to renew; PHA continues to work through queries from AEMB, seeking further advice from AEMB and working with LPS, DFP Health Projects and other HSC organisations, to progress the SOC, and reach a solution.

While the two SOCs have not yet been approved by the DHSSPS, PHA has not renewed either licence or lease. However, the PHA is required to provide accommodation for its staff and therefore cannot close either office until suitable accommodation is identified, approved and if necessary fitted out. The PHA continues to work with DHSSPS, LPS, DFP Health Projects, DLS and other HSC organisations as relevant, to resolve queries and obtain approval to renew the licence and lease or identify alternative suitable accommodation, as quickly as possible.

Management of Contracts with the Community and Voluntary Sector

The 2015/16 Internal Audit report on the management of health and social wellbeing improvement contracts provided satisfactory assurance on the system of internal controls over PHA's procurement and 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.

However, one priority one finding was identified in respect of the procurement of services. The audit acknowledged the improving position, with 12 tenders with an

annual value of £6.0m, awarded to date. For those contracts that have not been procured, contracts are being rolled forward in the interim period.

The PHA's Procurement Plan is a live document, and is continually revised to ensure that all contracts are included and the timelines set are achievable given the significant resources required to manage each Tender. Work is currently underway to develop the next phase of tenders. Progress against the Procurement Plan is monitored by the PHA Procurement Board.

PHA also continues to work closely with BSO Procurement and Logistics Service (PALS) and Directorate of Legal Services (DLS) to develop appropriate social care procurement processes and documentation. This work is overseen by the PHA Procurement Board.

It is recognised however that social care procurement is a new area for the wider HSC, and the PHA continues to work closely with colleagues in HSCB, BSO and the Trusts to develop and put in place appropriate and proportionate regional processes that meet the new procurement regulations.

Quality, Quantity and Financial Controls

PHA continues to face difficulties in commissioning and supporting services provided to the population of Northern Ireland in an environment where demand for these services continues to increase whilst the budget available for commissioning them remains constrained.

The PHA has taken action and continues to develop plans and associated efficiencies for 2015/16 which will contribute towards maintaining the integrity of the services that it currently commissions along with ensuring that additional priorities identified continue to be implemented and progressed. The PHA has also had a 15% reduction in the Management and Administration budget in 2015/16, but continues to project a full year breakeven position.

Business Services Transformation Project/Shared Services

The Governance Statement for 2014/15 had noted the on-going control issues relating to the delivery of Shared Services. During 2015/16 those issues have been largely been resolved in Accounts Payable and Receivable, which have moved to a business as usual status, with on-going monitoring and assurances being received by the PHA. However, the Internal Auditor has again provided a limited assurance in respect of the Payroll Shared Service, the HSCB Finance and PHA continues to raise the related issues with BSO at the Customer Forum and at Regional Forum to ensure that all control weaknesses identified are resolved satisfactorily.

Reduction in the PHA Management and Administration Budget

The 2015/16 allocation for PHA administration has been reduced by £2.8m, representing 15% of the administration budget. The reduction is recurrent and is part of the collective Departmental response to address the overall DHSSPS funding gap. While the PHA agreed a plan to manage the reduction in-year (2015/16) with the DHSSPS, and is confident that it will achieve a breakeven position, the reduction will have a significant and serious impact on PHA capacity to undertake its planned activities during the current year. The use of VES will be necessary to meet the required reductions in management and administration beyond this, with the attendant loss of skill and expertise.

The PHA will strive to make as many savings as possible in areas that will have the least negative impact on the essential work of the organisation. The PHA will continue to work closely with DHSSPS.

11. Mid-year assurance report from the Head of Internal Audit

I confirm that I have referred to the Mid-Year Assurance report from the Head of Internal Audit, which details the assurances the organisation has received from Internal Audit in the first six months of the year and reports on the accepted audit recommendations.

Signed 

CHIEF EXECUTIVE & ACCOUNTING OFFICER

15 October 2015

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	15 October 2015
Title of Paper	Review of Disability Action Plan 2013-18
Agenda Item	11
Reference	PHA/05/10/15

Summary

The attached paper presents the reviewed Disability Action Plan.

The review was triggered by feedback from the Equality Commission who, during 2014-15, had written to all HSC Organisations for the first time with advice on reviewing their Disability Action Plans. This advice centred on the need to:

- develop quantified performance indicators in the plan
- develop actions that relate the disability duties to specific functions of individual directorates and divisions - and that are owned by these and
- make actions more specific and measurable.

Accordingly, the Equality Unit engaged with divisions to undertake the review. This paper presents the reviewed Disability Action Plan as the outcome of the process.

Equality Screening / Equality Impact Assessment	Attached
Audit Trail	This update was considered by AMT on 6 October.
Recommendation / Resolution	For Noting
Director's Signature	
Title	Director of Operations
Date	6 October 2015

Disability Action Plan 2013-2018

Public Health Agency (PHA)

Reviewed August 2015

If you need this document in another format or language please get in touch with us. Our contact details are at the back of this document.

Introduction

The Public Health Agency has to follow the law which says that in our work we have to

- promote positive attitudes towards disabled people; and
- encourage participation by disabled people in public life.

The law also says that we have to develop a disability action plan. We have to send this plan to the Equality Commission. The plan needs to say what we will do in our work to make things better for people with disabilities.

As Andrew Dougal and Eddie Rooney– Chair & Chief Executive of the Public Health Agency – have stated we want to make sure we do this in a way that makes a difference to people with a disability. We will put in place what is necessary to do so. This includes people, time and money. Where it is right to do so, we will include actions from this plan in the yearly plans we develop for the organisation as a whole. These are called 'corporate' strategies or 'business' plans.

We will also put everything in place in the organisation to make sure that we do what we have to under the law. This includes making one person responsible overall for making sure we do what we say we are going to do in our plan.

We will make sure we let our staff know of what is in our plan. We will also train our staff and help them understand what they need to do.

The person in our organisation who is responsible for making sure that we do what we have promised to do is Ed McClean.

When you have any questions you can contact Ed McClean at:

Name: Ed McClean
Title: Director of Operations
Address: 4th floor (South), 12-22 Linenhall Street, Belfast, BT2 8BS
Telephone number: 03005550114 prefix with 18001 for Text Relay
Email: Edmond.mcclean@publichealth.hscni.net

How we will review this plan

Every year we will write up what we have done of those actions we said we would take. We will send this report to the Equality Commission. We will also publish this report on our website:

http://publichealth.hscni.net

We have a look at the plan every year to see whether we need to make any changes to it. If we need to, we write those changes into the plan. Before we make any big changes we talk to people who have a disability to see what they think.

After five years we will look at our plan again to see how we have done. We will also see what else we could do.

Whenever we develop or look at our plan we will invite people who have a disability to work with us.

Who is included in our plan?

Our plan relates to the following key areas:

- Physical disabilities;
- Sensory disabilities;
- Learning disabilities;
- Mental health disabilities; and,
- Other hidden disabilities.

It also covers people who are included in more than one of these areas. We have other equality laws that require us to promote equality of opportunity across a number of diverse categories. In our plans we need to also think about other factors such as caring responsibilities, age, gender, sexual orientation, ethnicity and marital status.

How we developed this plan

In starting off to develop this plan we looked at what we have done so far to make a difference for people who have a disability. We then read up on what the Equality Commission said would be good

to do. This was after they had looked at what other organisations have done.

All this helped us think about what else we could do to make a difference.

We thought it was important to involve people who have a disability in developing our plan. So we invited any of our staff who have a disability to be part of a small group to work on this. We also said that any of our staff who are interested could join.

We then invited disability groups to a meeting to find out what they thought about our ideas. We also asked them whether there was anything else we could do.

What we do

The Public Health Agency is part of health and social care in Northern Ireland. We were set up in April 2009.

We do things like:

- We find out what things people need to protect them from diseases and other hazards.
- We find out what services people in Northern Ireland need to keep healthy.
- We do not provide the services but work with other organisations that are called Trusts and other voluntary and private organisations that do so.
- We buy services from Trusts including, for example, hospital services.
- We organise and buy screening services. This is about finding out at an early stage whether a person is ill or is at risk of becoming ill.
- We try to make it easier for people to make healthier choices, for example in what they eat.
- We work with other organisations to try and reduce the big differences between different groups of people in Northern Ireland in how healthy and well they are.

- We develop and run campaigns for the general public in Northern Ireland on important health topics, for example on smoking.
- We develop websites on a number of health topics, for example on drugs, alcohol and smoking. Some sites are for specific groups such as young people or health professionals.
- We support research. We also buy and pay for research. We carry out some of the research ourselves.
- We make sure we learn from when something goes wrong in how health care is provided in Northern Ireland.
- We work with other organisations to improve the range and quality of services, for example for people of all ages with learning disabilities.
- We need to make sure services are good quality and check out that they are.
- We work with other health and social care organisations to improve how they engage with those who use their services, with carers and with the public.
- We also employ staff.
- We have to make sure that we obey the laws about employment, services, equality and rights.

How people can be involved in our work

There are a number of ways in which people can be involved in the work of the Public Health Agency. This includes:

- Focus groups in the development and evaluation of relevant public information campaigns, for example on flu or bowel cancer screening
- People with a disability and carers are involved in commissioning work on older people (represented on reference group)
- Neurological Conditions Network

- Reference group for regional guidance on the use of observations and therapeutic engagement

- HSC Research and Development: Evaluation Panels for research applications (such as in relation to learning disability and mental health needs).

What we have done up to now

This is some of what we have done already to promote positive attitudes towards disabled people and encourage the participation of disabled people in public life.

Promoting positive attitudes towards disabled people

- Images and photographs of events will include people with a disability whenever they participate in these

- For information targeted at people with a disability efforts are taken to include photographs of them

- Disability issues are covered in much of PHA's communication due to its remit (for example reports on PHA conferences such as on brain injuries)

- Mental Health training sessions for staff (pilots delivered in 2011-12, "Mood Matters" sessions delivered in 2012-13; six-week course "Life Skills" offered during 2012-13)

- The Equality Unit at the Business Services Organisation worked on our behalf on the development of an elearning resource on disability. This resource was launched in May 2011 and is now available to all Health and Social Care staff.

- The Equality Unit includes the disability duties in all Equality Awareness and Screening Training that it delivers to our staff.

- In Screening Training we look at how the disability duties can be considered in practice. Whenever staff take decisions they must write down what they have done or plan to do to promote the disability duties in their decision.

Encourage the participation of disabled people in public life

- At induction individuals are asked about their needs regarding fire safety and evacuation.

- We met with AdaptNI in December 2011 regarding their training programme 'In the Loop'. It supports people with a disability to make their voices heard on committees and in public life positions. We also talked to them about signposting people with a disability who they work with to public life opportunities in our organisation.

- Along with our partner organisations and led by the Equality Unit at the Business Services Organisation, we have put in place a process for publishing screening templates as soon as they are completed. A disability organisation had suggested that we do so. We do the same for publishing the quarterly screening reports. We ask people for their thoughts and suggestions on our screenings.

- When we evaluate training that the Equality Unit delivers we include a question on the needs of trainees with a disability. This helps us to find out whether we need to make any further adjustments.

- We include the disability duties in all Equality Awareness and Screening Training that the Equality Unit delivers.

- We let our staff, service users and the public know that they can ask for materials in other formats such as in large print or as a CD.

- HSC Research and Development: We have held consultation exercises with surviving patients and carers with cancer as part of Cancer Conference, in May 2015.

- HSC Research and Development: Personal and Public Involvement workshops held for research pharmacists at National pharmacy research Conference were co-facilitated by service users, in April 2015.

What we are going to do

In the table below we list all the actions that we will do. We also say when we will do them.

What we will do to promote positive attitudes towards disabled people and encourage the participation of disabled people in public life

(1) Communication

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
1. Work with disabled people to consider the diversity of images used and potential for portraying wider range of individuals when developing information materials including websites • Review best practice guidance • Develop comprehensive guidance and checklist for authors • Review information materials including website	Disabled people are portrayed in a positive manner	Checklist for authors Guidance for authors Review of information materials including website undertaken Annual Review of Progress to ECNI	Business Services Organisation's (BSO) Equality Unit Year 2 onwards
2. Assess and improve accessibility of website • Continue to undertake assessment against	Improved accessibility	Website accessibility of recognised standard.	Communications Year 3

recognised standard • Address any issues of inaccessibility			
3. Put in place contractual arrangements for the production of materials in alternative formats. • Undertake a scoping exercise by type of format based on current and best practice in UK • Where appropriate undertake tender exercise and put contracts in place	Accessible formats are more readily available	Contracts in place Arrangements are in place to support staff in procuring materials in alternative formats	BSO Equality Unit Year 3

4. Adopt Accessible Information policy and guidance.	Improved accessibility of information	Common wording relating to alternative formats for inclusion in documents. Protocol on how to deal with requests for alternative formats. For electronic communication, staff are supported to ensure that settings meet needs regarding accessible font size.	Agency Management Team (AMT) Year 2 BSO Information Technology Services (ITS) Year 2

(2) Awareness Raising and Training

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
5. Encourage staff to declare that they have a disability or care for a person with a disability through awareness raising and provide guidance to staff on the importance of monitoring. Prompt staff to keep up to date their personal equality monitoring records (via self-service on new Human Resources IT system)	More accurate data in place. Greater number of staff feel comfortable declaring they have a disability.	increase in completion of disability monitoring information by staff to 90% Prompt issued to staff on a regular basis.	PHA Year 2 onwards
6. Raise awareness of specific barriers faced by people with disabilities including through linking in with National Awareness Days or Weeks (such as Mind your Health Day).	Increased staff awareness of the range of disabilities and needs	Two annual Awareness Days profiled in collaboration with voluntary sector groups. Features run on Connect (PHA intranet). >50% of staff participating in the evaluation indicate that they know more about people	PHA Year 1 onwards BSO Equality Unit Year 3

		living with disabilities as a result of the awareness days.	
7. In collaboration with people with a disability review current guidance and produce revised guidance on support for staff with a disability.	Staff with a disability are supported and staff are empowered to provide support.	Guidance in place for staff with a disability on what support is available. Guidance promoted via websites, newsletters, emails by line managers and included in application packs.	PHA Year 3
8. **Mental Health and Learning Disability:** Raise awareness of carers supports and help identify need to support employees of PHA who also hold the role as carer to someone with a disability	Staff awareness and knowledge is strengthened	Awareness raising materials and correspondence circulated to staff Staff feedback	Assistant Director of Nursing, Safety Quality and Patient Experience (by Mar 2017)
9. In collaboration with disabled people design, deliver and evaluate training for staff and Board Members on disability equality and disability legislation.	Increased staff and Board Member awareness of the range of disabilities and needs.	25% of staff and Board Members have successfully completed the disability module of Discovering Diversity by end March 2016, 50% by end March 2017, 65% by end March 2018	PHA Year 2 onwards

• **Maternity Strategy:** Get a disability specialist midwife who is disabled to provide an update on best practice. • **Health Protection:** Invite speaker from external organisation (e.g. Disability Action, Mental Health Charity or RNIB) to attend Health Protection staff meeting.		All staff trained (general and bespoke) within 2 years through eLearning or interactive sessions and staff awareness initiatives delivered Training evaluation forms Meeting minutes	Assistant Director of Nursing, Safety Quality and Patient Experience (by Mar 2016) Assistant Director Health Protection (by Mar 2016)

(3) Getting people involved in our work, Participation and Engagement

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
10. Develop checklist and guidance for the involvement of people with a disability and their carers.	Greater accessibility and involvement for adults and children where relevant with disabilities. Barriers are removed.	Checklist in place and in use on involving people with a disability in meetings including payments of expenses.	BSO Equality Unit Year 3
11. Identify, provide and promote opportunities for more engagement for people with a disability in key work areas. • **10,000 Voices:** Proactively target disability groups to advise of the initiative and how they can become involved (issue press releases; send information leaflets and posters to groups) Facilitate their	Better engagement of people with a disability (adults and children where relevant) in key areas. People with a disability are encouraged and empowered to participate in public life.	Opportunities provided in key areas. Annual review of progress to ECNI Correspondence in relation to the initiative, how to get involved and contact details will regularly be sent to a list of disability organisations	Assistant Director of Nursing, Safety Quality and Patient Experience (by Mar 2016)

involvement (make surveys accessible to people with a disability) • **HSC Research & Development:** Disseminate specifically to relevant disability organisations information on 'OK TO ASK' Campaign being undertaken to encourage members of the public including those with disability to participate in research and clinical trials to mark Clinical Trials Day on May 20. • **HSC Research & Development:** Provide Personal and Public Involvement training to encourage and provide guidance to researchers on how to involve service users and		Correspondence circulated to list of disability organisations and via PCC newsletter Training materials provided to each participant and available on website	Assistant Director HSC Research and Development (annually from 2015-16 onwards) Assistant Director HSC Research and Development (by Mar 2017)

carers as partners in the research process and to raise awareness of research with service users including those with disability and members of the public. Training for researchers and service users and carers provided through workshops and master classes facilitated by researchers as well as service users with disabilities. Training materials provided to give guidance on how to involve and support service users and carers including those with special needs at training days and on website. • **HSC Research & Development:** Offer opportunities to		Meeting minutes evidence discussion held on introducing	Assistant Director HSC Research and Development

participate in funding panels for 2016 Doctoral Fellowship Scheme and the 2015 Enabling Awards Scheme and other opportunities as they arise.		equality monitoring forms for panel and steering group members	(by Mar 2016)
• **HSC Research & Development:** Offer opportunities to participate in project steering groups for particular research projects already funded e.g. awards made via the Bamford Research Programme; Dementia Research Programme and NIHR award on stroke prevention or in a consultation capacity.		Meeting minutes evidence discussion held on introducing equality monitoring forms for panel and steering group members	Assistant Director HSC Research and Development (by Mar 2017)
• **HSC Research & Development:** Involve carers and service users with		List of speakers	Assistant Director HSC Research

disability as speakers at annual social care conference in February 2016. • **HSC Research & Development:** Survivors of cancer and carers will deliver Building Research Partnership Course in 2 one day workshops to encourage research collaborations between researchers and service users to be held in April and October 2015. • **HSC Research & Development:** Train young people with mental health needs to collect data in a pilot study being run as part of a project funded under the Bamford Research programme and delivered		List of facilitators will demonstrate involvement of people with a disability Training manual available and provided to facilitators Young people named as co-researchers in research reports and presentations Briefing paper provided for Health Board, DHSSPSNI and other key stakeholders	and Development (by Feb 2016) Assistant Director HSC Research and Development (by Oct 2015) Assistant Director HSC Research and Development (by Mar 2017)

by QUB.		Report produced evaluating this initiative published in peer reviewed journal and disseminated at conferences	
• **Health Protection:** Liaise with disability organisations and involve them in the planning process for any HP events e.g. Health Protection Symposium 2016.		Minutes of meetings and correspondence with disability organisations	Assistant Director Health Protection (by Mar 2017)
• **Health Protection:** Ensure that active consideration is given to those with disabilities when organising local/regional Health Protection events e.g. PHA stand at the Balmoral Show (Health Protection are displaying Hand Hygiene related events on this stand)		Engagement with people with a disability	Assistant Director Health Protection (by Mar 2017)

• **Health Protection:** Liaise with Communications Team to ensure that internal/external events etc. are advertised. Ensure that Health Protection has access to e-mail circulation lists for disability organisations.		Correspondence circulated to list of disability organisations	Assistant Director Health Protection (by Mar 2016)
12. Explore scope and interest in the establishment of a forum for staff on disability (open to staff with a disability, carers of people with a disability and those with an interest, including trade unions). • Engage with HSC Trusts to establish current practice • Develop regional approach to complement current structures • Engage with staff	Better involvement of staff with a disability in decision-making.	Options paper Staff survey responses. HR Directors Forum Minutes Forum Terms of Reference.	Agency Management Team/BSO Equality Unit Year 2 onwards

• Put forum in place and promote to staff			
13. Nominate a champion at senior level.	Evidence of leadership at senior level.	Champion identified.	Agency Management Team Year 1
14. Develop a shadowing scheme for Board members and other key public life positions in engagement with the Public Appointments Unit and with people with a disability.	Develop capacity of people with a disability to participate in public life positions.	. Shadowing scheme terms of reference; people with a disability have participated.	Operations and Chief Executive's Office Year 5
15. Involve disabled people in delivery and review of this plan.	Better engagement by people with a disability (adults and children where relevant).	Feedback forms from engagement (and roundtable sessions, where appropriate)	BSO Equality Unit Year 5

(4) Recruitment and Retention

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
16. Explore the scope and options for identifying and promoting an advocate or specialist with role to support and advise staff on disability issues. • Explore best practice • Engage with staff • Identify advocate or specialist	Improved support for staff.	Scoping Report. Annual Review of Progress ECNI Staff Feedback	BSO Equality Unit Year 2
17. Offer mentoring opportunities for young adults and older adults with disabilities as appropriate. • Review best practice • Engage with disability organisations • Produce guidance • Identify mentors	People with a disability gain meaningful work experience.	Mentoring opportunities provided as appropriate and report to ECNI.	BSO Human Resources Year 2
18. Create and promote meaningful placement	People with a disability gain meaningful work experience.	Guidance paper. Provide increased number of	BSO Equality Unit

opportunities including for people with disabilities in line with good practice and making use of voluntary expertise in this area. Produce practical guidance on process and external support available. • Review best practice • Engage with disability organisations • Identify placements across all work areas • Undertake pilot • Evaluate pilot		placements. Placement participants feedback from evaluations Managers feedback from evaluations	BSO Human Resources Year 1 onwards
19. Encourage disabled people to apply for employment opportunities and remain in the workforce (for example attend career fairs, include welcoming statement and issue job adverts to local disability organisations and more flexible working arrangements and review	Greater numbers of people with a disability apply and remain in the PHA workforce.	Increase in disability marked on equal opportunities monitoring forms and HRPTS Information pack for applicants with a disability developed and in use.	PHA Year 3

job descriptions).			

The Equality Unit in the Business Services Organisation (BSO) will support staff in the implementation of this action plan.

Signed by:

Chair	Chief Executive
Date	Date

4th floor (South), 12-22 Linenhall Street, Belfast, BT2 8BS
Telephone: 03005550114
Textrelay: 18001 03005550114
You can also email us through our website on:
http://www.publichealth.hscni.net/contact-us

Reviewed August 2015

Screening undertaken in collaboration with organisations identified at the end of this screening template

Equality, Good Relations and Human Rights Screening

This organisation is required to consider the likely equality implications of any policies or decisions. In particular it is asked to consider:

What is the likely impact on equality of opportunity for those affected by this policy, for each of the section 75 equality categories? (minor, major or none)

Are there opportunities to better promote equality of opportunity for people within the Section 75 equality categories?

To what extent is the policy likely to impact on good relations between people of a different religious belief, political opinion or racial group? (minor, major or none)

Are there opportunities to better promote good relations between people of a different religious belief, political opinion or racial group?

See Guidance Notes for further information on the 'why' 'what' 'when', and 'who' in relation to screening, for background information on the relevant legislation and for help in answering the questions on this template.

For advice on screening please contact: staff in the Equality Unit Business Services Organisation, equality.unit@hscni.net or Telephone 028 9536 3961

As part of the audit trail documentation needs to be made available for all policies as decisions examined for equality and human rights implications. The screening template is a pro forma to document consideration of each screening question.

Equality, Good Relations and Human Rights SCREENING TEMPLATE

(1) Information about the Policy or Decision

1.1 Title of policy or decision

Disability Action Plan 2013 -2018 – reviewed August 2015

1.2 Description of policy or decision

- **what is it trying to achieve? (aims and objectives)**
- **how will this be achieved? (key elements)**
- **what are the key constraints? (for example financial, legislative or other)**

This Disability Action Plan for the period 2013-2018 represents our organisation's responsibilities under the Disability Discrimination Act (1995) as amended by the Disability Order 2006. This law requires us to carry out our functions giving due regard to two specific duties. These duties are: to promote positive attitudes towards disabled people and promote the participation by disabled people in public life.

The purpose of this action plan is to outline some key actions that we are going to deliver upon to make a difference to people with disabilities including staff and people who use our services, and where relevant, their carers.

In developing the action plan we paid particular attention to:

- Physical disabilities;
- Sensory disabilities;
- Learning disabilities;
- Mental health disabilities; and,
- Other hidden disabilities.

We also considered the equality categories as covered by Section 75 of the NI Act 1998

We have reviewed our plan and updated it accordingly. The review was triggered by feedback from the Equality Commission who, during 2014-15, had written to all HSC Organisations for the first time with advice on reviewing their

Disability Action Plans. This advice centred on the need to:

- develop quantified performance indicators in the plan
- develop actions that relate the disability duties to specific functions of individual directorates and service areas and that are owned by these and
- make actions more specific and measurable.

1.3 Main stakeholders affected (internal and external)

For example staff, actual or potential service users, other public sector organisations, voluntary and community groups, trade unions or professional organisations or private sector organisations or others

This plan is targeted at staff with a disability or staff with a particular experience of disability through being a carer.
It is also targeted at managers in health and social care.
The action plan is targeted at people with disabilities and their carers who use our services.
Third Party Organisations who provide services on behalf of health and social care including voluntary, community and the independent sector
Service users and carers
Voluntary and Community Organisations with particular interest in the Section 75 and Human Rights including advocacy organisations
Members of the public

1.4 Other policies or decisions with a bearing on this policy or decision

- **what are they?**
- **who owns them?**

This action plan relates specifically to the Disability Discrimination Order 2006 but in addition our Equality Scheme is important as is Equality Action Plan 2013-2018. These latter plans are important where issues in relation to disability are highlighted. In addition a wide range of health and social care human resources polices are relevant for people with a disability.

Legal requirements under the Human Rights Act 1998 and the European Convention on the Rights of People with Disabilities also have a bearing.

(2) Consideration of Equality and Good Relations Issues nd Evidence Used

2.1 Data Gathering

What information did you use to inform this equality screening? For example previous consultations, statistics, research, Equality Impact Assessments (EQIAs), complaints. Provide details of how you involved stakeholders, views of colleagues, service users, staff side or other stakeholders.

Working Groups within a number of Health and Social Care Organisations made up of staff with disabilities and those with an interest in disabilities including carers were active in its development.

Direct engagement with a range of community and voluntary groups representing disability was a useful resource in the identification of issues – Engagement Event November 2012.

Census 2011 data.

Research Reports.

In the development of the disability action plan information from a range of previous consultations and activity were considered where issues in relation to disability issues were raised.

Previous screening and equality impact assessment analysis where disability issues were highlighted.

Previous work in relation to organisations who developed first generation Disability Action Plans.

Engagement outcomes from work on Disability Action Plans.

Reports from various disability organisations for example RNIB, Action on Hearing Loss, Disability Action, Mencap, Carers Northern Ireland. Older Person's Organisations and Children and Young People's Organisations.

Report by Equality Commission on their review of first generation Disability Action Plans

2.2 Quantitative Data

Who is affected by the policy or decision? Please provide a statistical profile. Note if policy affects both staff and service users, please provide profile for both.

<table>
<tr><th>Category</th><th>What is the makeup of the affected group? (%) Are there any issue or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group?</th></tr>
<tr><td>Gender</td><td>18% of all people living in private households in NI have some degree of disability. When broken down this means that 21% of adults and 6% of children have a disability.
(Northern Ireland Statistics and Research Agency (NISRA) in its 2007) report on disability indicated that:

There is a higher prevalence of disability among adult females with 23% of females indicating that they had some degree of disability compared with 19% of adult males;

• Male prevalence rates are only higher than female rates amongst the youngest adults (16 to 25): 6% of males compared with 4% of females;
• 8% of boys aged 15 and under were found to have a disability, compared with 4% of girls of the same age.

Around 21% of all people living in private households within Northern Ireland have some degree of disability. Of this figure 12% indicated that they are limited a lot by their disability and 9% indicated that they are limited (by their disability) ‘a little’.
Figures from the Census 2011 show that there is a higher prevalence of females whose activities are ‘limited a lot’ – 13% of females compared to 11% of males due to their disability. However, this is to be expected given their longer life expectancy.

PHA staff data:
<table><tr><td>Male</td><td>22.96%</td></tr><tr><td>Female</td><td>77.04%</td></tr></table></td></tr>
<tr><td>Age</td><td>Northern Ireland Statistics and Research Agency (NISRA) in its 2007 report indicated that prevalence of disability increases with age: ranging from 5% among young adults to 67% among those</td></tr>
</table>

<table>
<tr><td></td><td>who are very old (85+);

As the population ages, so does the likelihood of having a disability that limits the day to day activities ‘a lot’. Figures from 2011 census of people who are limited a lot by their disability are as follows within the following categories;

Male

0-15 – 3%
16-44 – 5%
45 – 64 – 16%
65 and over – 33%

Female

0 – 15 – 2%
16 – 44 – 5%
45 – 64 – 17%
65 and over – 38%

Overall there are greater proportions of older people with a disability.

PHA staff data:

<table><tr><td>16-24</td><td>0.30%</td></tr><tr><td>25-29</td><td>6.34%</td></tr><tr><td>30-34</td><td>10.57%</td></tr><tr><td>35-39</td><td>15.71%</td></tr><tr><td>40-44</td><td>17.52%</td></tr><tr><td>45-49</td><td>16.01%</td></tr><tr><td>50-54</td><td>16.01%</td></tr><tr><td>55-59</td><td>14.20%</td></tr><tr><td>60-64</td><td>2.11%</td></tr><tr><td>>=65</td><td>1.21%</td></tr></table></td></tr>
<tr><td>Religion</td><td>Not available broken down by disability

PHA staff data
<table><tr><td>Perceived Protestant</td><td>6.95%</td></tr><tr><td>Protestant</td><td>39.88%</td></tr><tr><td>Perceived Roman</td><td>3.32%</td></tr></table></td></tr>
</table>

<table>
<tr><td></td><td>
<table>
<tr><td>Catholic</td><td></td></tr>
<tr><td>Roman Catholic</td><td>43.50%</td></tr>
<tr><td>Neither</td><td>1.81%</td></tr>
<tr><td>Perceived Neither</td><td>0.30%</td></tr>
<tr><td>Not assigned</td><td>4.23%</td></tr>
</table>
</td></tr>
<tr><td>Political Opinion</td><td>Not available broken down by disability

PHA staff data
<table>
<tr><td>Broadly Nationalist</td><td>0.30%</td></tr>
<tr><td>Other</td><td>2.72%</td></tr>
<tr><td>Broadly Unionist</td><td>0.60%</td></tr>
<tr><td>Not assigned</td><td>93.05%</td></tr>
<tr><td>Do not wish to answer</td><td>3.32%</td></tr>
</table>
</td></tr>
<tr><td>Marital Status</td><td>Not available broken down by disability

PHA staff data
<table>
<tr><td>Divorced</td><td>1.21%</td></tr>
<tr><td>Married/Civil Partnership</td><td>63.44%</td></tr>
<tr><td>Other</td><td>0.60%</td></tr>
<tr><td>Separated</td><td>1.51%</td></tr>
<tr><td>Single</td><td>21.45%</td></tr>
<tr><td>Unknown</td><td>11.48%</td></tr>
<tr><td>Widow/er</td><td>0.30%</td></tr>
</table>
</td></tr>
<tr><td>Dependant Status</td><td>Based on the most recent information from Carer’s Northern Ireland, the following facts relate to carers:
- 1 in every 8 adults is a carer
- 2% of 0-17 year olds are carers, based on the 2011 Census
- There are approximately 207,000 carers in Northern Ireland
- One quarter of all carers provide over 50 hours of care per week
- People providing high levels of care are twice as likely to be permanently sick or disabled than the average person

It may be concluded that a considerable share of people with a disability are carers themselves.

PHA staff data</td></tr>
</table>

	<table><tr><td>Yes</td><td>5.14%</td></tr><tr><td>Not assigned</td><td>91.54%</td></tr><tr><td>No</td><td>3.32%</td></tr></table>
Disability	The term disability covers a wide range and combination of conditions. Multiple needs are evident across sensory, physical and learning disability groups It is however estimated that between 17 – 21% of our population have a physical disability or sensory impairment, affecting 37% of households. 21% adults and 6% children have a disability 1 in 7 people in Northern Ireland have some form of hearing loss There are 5, 000 sign language users who use British Sign Language (BSL) or Irish Sign Language (ISL) (Source: Royal National Institute for Deaf People (2005), Deaf People Missing Out on Vital Services, RNID London There are 57, 000 blind people or people with significant visual impairment. In Northern Ireland there are approximately 16,500 persons with a learning disability. An indication of the extent of the disability is reflected in the sub-groupings that are traditionally used; - mild, moderate, severe and profound learning disabilities (Equality Commission NI, 2006). **http://www.equalityni.org/archive/tempdocs/LiteratureRev(F)l.doc** In Northern Ireland mental health needs are 25% higher than the rest of the UK. Over 10,000 people have the language disorder called aphasia. This usually affects both the understanding and production of spoken and written language The 2011 Census marked the first time that the question was included focusing on a request for type of disability to be stated. This question endeavoured to align the responses in so far as possible with the list of activities and disabilities that were used in the Northern Ireland Survey of Activity and Limitation Disability

(NISALD) 2009-2007.

The breakdown of the various long - term Disability Issues follows in the table below- as outlined in the 2011 Census.

Type of long – term condition	**Percentage of population with condition %**
Deafness or partial hearing loss	5.1
Blindness or partial sight loss	1.7
Communication Difficulty	1.6
Mobility of Dexterity Difficulty	11.4
Learning, intellectual, social or behavioural difficulty.	2.2
An emotional, psychological or mental health condition	5.8
Long – term pain or discomfort.	10.1
Shortness of breath or difficulty breathing	8.7
Frequent confusion or memory loss	2.0
A chronic illness (such as cancer, HIV, diabetes, heart disease or epilepsy).	6.5
Other condition	5.2
No Condition	68.6

Information on rare diseases provided by NI Rare Diseases Partnership www.nirdp.org.uk / info@nirdp.org.uk suggests 1 in 17 people is likely to be affected by a rare disease at some point in their lives; that is almost 106,000 people in Northern Ireland and approximately the population of Derry/Londonderry. Yet little information on rare disease in Northern Ireland is available for the effective planning and delivery of care and support.

A disease is “rare” if it affects fewer than 5 people per 10,000. There are over 6,000 rare diseases, with others being defined all the time. These range from the very rare to relatively well-recognised conditions such as Motor Neurone Disease, Spina Bifida, or Muscular Dystrophy. While each individual’s condition is rare, these are not minority issues.

<table>
<tr><td></td><td>PHA staff data<table><tr><td>No</td><td>86.71%</td></tr><tr><td>Not assigned</td><td>12.99%</td></tr><tr><td>Yes</td><td>0.30%</td></tr></table></td></tr>
<tr><td>Ethnicity</td><td>In the general population the 2011 Census indicated that 1.8% (32, 000) of the usual resident population belonged to minority ethnic groups, this figure has more than doubled since 2001 (0.8%).

This has implications for those who are from ethnic minorities or those from different racial backgrounds as they represent a greater proportion of the population since the 2011 census. Consequently assumptions have to be made in relation to an increase in the numbers with dual needs of disability and ethnicity.

(see also qualitative issues in section 2.4)

Figures from the 2011 Census provide the prevalance of disability among the following ethnic groups
Percentage of those whose disability limits their day to day activities a lot
All – 12%
Irish Traveller – 20%
White other – 12%
Chinese – 3%
Indian – 3%
Pakistani – 6%
Bangladeshi – 4%
Other Asian – 2%

Considering the 2011 Census figures for the ethnic composition of the General Population alongside those of People whose disability limits their day to day activities a lot, it shows that, with the exception of Irish Travellers, black and minority ethnic people are underrepresented amongst those with a disability when compared with their share amongst the general population.

White – 98.21% (1, 778, 449) – 99.40%
Chinese – 0.35% (6, 338) – 0.10%
Irish Traveller – 0.07% (1, 268) – 0.12%
Indian – 0.34% (6, 157) – 0.08%
Pakistani – 0.06% (1, 087) – 0.03%
Bangladeshi – 0.03% (543) – 0.01%</td></tr>
</table>

<table>
<tr><td></td><td>Other Asian – 0.28% (5, 070) – 0.03%
Black Caribbean – 0.02% (362) – 0.01%
Black African – 0.13% (2354) – 0.03%
Black Other – 0.05% (905) – 0.02%
Mixed – 0.33% (5976) – 0.10%
Other – 0.13% (2354) – 0.08%

PHA staff data

<table><tr><td>Not assigned</td><td>74.02%</td></tr><tr><td>White</td><td>25.98%</td></tr></table></td></tr>
<tr><td>Sexual Orientation</td><td>Not available by disability though if the general population shows figures between 7-10% of the population who are gay, lesbian or bisexual issue assumptions have to be made in relation to dual issues of sexual orientation and disability (see also qualitative issues in section 2.4)
This assumption is also supported by research in Northern Ireland on people with a disability who identify as lesbian, gay or bisexual - McClenahan, Simon (2013): Multiple identity; Multiple Exclusions and Human Rights: The Experiences of people with disabilities who identify as Lesbian, Gay, Bisexual and Transgender people living in Northern Ireland. Belfast: Disability Action.

PHA staff data

<table><tr><td>Do not wish to answer</td><td>1.81%</td></tr><tr><td>Not assigned</td><td>93.05%</td></tr><tr><td>Opposite sex</td><td>4.53%</td></tr><tr><td>same sex</td><td>0.60%</td></tr></table></td></tr>
</table>

2.3 **(a) Qualitative Data in relation to actions in action plan**

What are the different needs, experiences and priorities of each of the categories in relation to this policy or decision and what equality issues emerge from this? Note if policy affects both staff and service users, please discuss issues for both.

This section related specifically to the actions within our disability action plan which indicates what we will do to promote positive attitudes towards disabled people and encourage the participation of disabled people in public life

(1) Communication

Action Measure	**An identification of different needs, experiences and priorities of any of the equality categories in relation to this policy or decision and what equality issues emerge from this** **Specify the Section 75 equality categories where there are different needs** **Note if staff or service users**
1. Work with disabled people to consider the diversity of images used and potential for portraying wider range of individuals when developing information materials including websites	**A critical analysis of Media representation of disabled people.** In considering the importance of images one way of viewing this is to look outside of health and social care. Evidence suggests the media is an extremely important part of our everyday life and as an industry has been critical in the dissemination of information to the mass population. However the influence that the media holds over society has not always been used to society's benefit, particularly in relation to disability, where the media has continued to add to the discrimination of disabled people. This reinforcement can happen in a number

	of ways • The media reinforcement of impairment and the use of the medical model of disability. • The media's creation and underpinning use of disabled stereotypes. • The role of media influences: media organisations and their employees, political agendas, the intended audience and current societal trends. • The use of images, language and terminology related to disability. • The under-representation of disabled people in the media. • The effect of media on disabled people. It is important therefore that health and social care takes opportunities to challenge, or at least counter balance, this portrayal of disability. Given its role in planning, commissioning and delivering health and social care it is imperative that organisations present disability through the use of images and messages, using these sensitively in order to portray more positive messages. But the current coverage of disability is still an area that needs careful attention within health and social care. This work also needs to extend to ensuring that the multiple identities of people with disabilities for example as carers, across different age bands, as service users, as disabled men and women and children and those from minority ethnic groups are also portrayed culturally and sensitively. Health and social care also needs to look beyond images to review the key messages portrayed ensuring their positive portrayal in mainstream materials.
2. Assess and improve accessibility of website	Direct information concerning internet usage by disabled people in the UK is scarce. Disabled people are not included as a separate group in the regular surveys on internet usage that have been carried out by the Office of National

	Statistics (ONS). Research evidence over time on disabled people's attitudes to using the internet is scarce but what there is indicates positive attitudes. (Research conducted by Joseph Rowntree Trust 2004) There are some individual accounts of the difference that access to the internet has made in terms of choice and opportunities to be included in the social world. Cost is likely to be a greater disincentive for disabled than non-disabled people, as they generally have lower incomes, and may also have to purchase assistive devices as well as a computer. **Web accessibility** Accessibility has become a much greater issue for people with visual or motor impairments as computers are now able to handle intricate visual images – images which require subtle understanding by the computer. The WAI advocates that accessible web design benefits all users, non-disabled as well as disabled. For example, checkpoints that support web access for people with visual disabilities also help people accessing the web from mobile phones, hand-held devices, or car-based computers (when connection speed is too slow to support viewing images or video, or when a person's eyes are 'busy' with other tasks). Checkpoints such as captions support access for people with hearing impairments but also help people who are using the web in noisy environments. **Legal aspects of web accessibility** Government guidelines, and those of other organisations, have drawn attention to the relevance of Part III of the Disability Discrimination Act (DDA) to website

	accessibility making explicit reference to the provision of a website as a service which is subject to the Act. An accessible website as a 'reasonable adjustment' that might be made has not yet been tested in a UK court case. Comparison between disabled and non-disabled people in terms of use of the internet is complicated. Access to the internet, or even to services like the World Wide Web or email, by itself does not say anything about usefulness or usability. It might be that people with disabilities do manage to use the internet, but that they are not getting an equivalent experience out of it and so are being disadvantaged. However, the little evidence there is indicates that disabled people who do use the internet have positive attitudes towards it and this is supported by individual anecdotal accounts. There are however also issues to be considered in any future discussions about the use of websites. Evidence would also suggest that over reliance on the internet for the provision of information can cause difficulties for disabled people as a high proportion of all people who do not use the internet are disabled. Feedback from previous consultations emphasised the importance of decreasing reliance on websites for disseminating information. The recommendation is that organisations need to consider not just the WHO do we want to read this and WHAT we are disseminating but also HOW – where are we putting our information? How can we put it in the appropriate places to ensure accessibility to disabled people? Need to make use of Disability organisations and other voluntary organisations when designing websites. **Deaf or Hard of Hearing:** Persons with auditory impairments may have specific needs for content to be presented in a different format if they are sign language users. Likewise, designers have to take into consideration equivalent alternatives for auditory content and ensure that texts are not too complex and

	that they are easy to read.
3. Put in place contractual arrangements for the production of materials in alternative formats.	**Range of disabilities:** This action is very much a practical, operational arrangement but one that we feel has potential benefits across physical, sensory, physical and learning disability and literacy levels. Current lack of contractual arrangements for the production of information in accessible formats is a major curtailment for staff wishing to respond positively in the production of information appropriate for a range of needs. **Ethnic minorities:** In the contractual arrangements cognisance will also need to be taken of the additional complexities faced by people from minority ethnic groups who have disabilities, particularly those with sensory impairments. Currently minority ethnic individuals who also have sensory impairments face a multitude of barriers in accessing information due to limited arrangements. This is not a localized issue but one that will need more attention.
4. Adopt Accessible Information policy and guidance.	**Range of disabilities across service users and staff** **Learning disability:** People with a learning disability experience difficulties accessing written information from health and social care. Mainstream information provision is not in formats that suits their needs. **Parents who also have a learning disability:** According to a Social Care Institute of Excellence report (2007) entitled “Working together to support disabled parents” parents with learning disability and other disabilities are least likely to have information provided in a way that meets their particular needs. Information to be accessible needs to be in Easy Read or Makaton with use of appropriate symbols, pictures and language. Similarly if social care professionals do not adjust their communication style to meet the needs of

	people with a learning disability this can impact on people's access to services and increase anxiety levels. **Deaf or Hard of Hearing:** Inappropriate Communication Support for people with a hearing impairment also creates barriers. People who are deaf, hard of hearing or have a visual impairment encounter particular barriers when written information is the only format. Lack of availability of sign language interpreters or absence of up to date loop systems. Can cause problems. Deaf community need improved communication and access to public services. There need to be other options for sending out information on appointments such as email or texting or SMS. **Blind or partially sighted :**Those who are blind or partially sighted need information that does not rely on visual images **Other communication needs:** Over 10,000 people have the language disorder called aphasia. This usually affects both the understanding and production of spoken and written language and needs to be taken into account. Accessible communication needs to also cover language needs in relation to ethnicity based on the evidence of increased numbers of minority ethnic groups in Northern Ireland. Accessibility of information about services also needs to consider this dual need which may require translations and interpreting, where relevant.

(2) Awareness Raising and Training

Action Measure	An identification of different needs, experiences and priorities of any of the equality categories in relation to this policy or decision and what equality issues emerge from this. Specify the Section 75 equality categories where there are different needs Note if staff or service users
5. Encourage staff to declare that they have a disability or able to care for a person with a disability Provide guidance to staff on the importance of monitoring Improve quality of information in relation to percentage of staff with a disability from the Human Resources, Payment, Travel and Subsistence (HRPTS) system	**Disability**: **Staff:** Evidence from our local employment records indicates that the numbers of people declaring that they have a disability is low. This is in keeping with more general evidence which suggests under reporting of disability in employment. A range of issues can cause this, including for example, negative attitudes from others, fear of the perceived repercussions, fear of the perceived stigma, less than positive responses from unsympathetic managers or employers or previous negative experiences, lack of understanding of the benefits of doing so. Drawing on experience from England the Office for Disability Issues, Experiences and Expectations of Disabled People, July 2008 reported that: “Most barriers to work identified related to the need for support or understanding from a manager or colleagues (for example flexible working hours, flexibility to take time off sick, the need to manage stress or take breaks). Only one in 20 of those asked said that they required support to do the job.” This is evidence that this exists across the range of disabilities but qualitative evidence indicates that this is particularly pertinent in the context of those with

	mental health issues but also other hidden disabilities. There also needs to be attention given to barriers and fears by staff in declaring disabilities when other factors such as age or ethnicity are also added to the equation. The encouragement on declaration also needs to acknowledge the importance of choice and to ensure disabled employees can be as open about their disability as they want to be either to declare or not.
6. Raise awareness of specific barriers faced by people with disabilities including through linking in with National Awareness Days or Weeks (such as Mind your Health Day)	**Across disabled groups:** Negative attitudes or anticipation of negative attitudes can act as a barrier to people seeking support from social services. Parents with mental health problems, drug or alcohol or learning disabilities are reluctant to seek help for fear of having their children taken into care. (Working together to support disabled parents, Social Care Institute of Excellence (2007) **Multiple needs:** There is also a need to work with other community and voluntary groups such as black and minority ethnic groups, carers groups, and groups of and representing gay lesbian and bisexual and transgender issues.
7. In collaboration with people with a disability review current guidance and produce revised guidance on support for staff with a disability	The Equality and Human Rights Commission's first Triennial Review: *How Fair is Britain*? (2010) mapped progress on equality in Britain for people with protected characteristics. The report identified those issues most urgently in need of resolution and 'Closing the employment gap for disabled people' was identified as one of the top challenges facing society today. Similar issues are relevant in the Northern Ireland context. Over one in five adults in Britain today is disabled, yet only half are likely to be in work compared to four-fifths of non-disabled adults. High numbers of disabled people continue to be excluded from work opportunities that open the

	door to wealth, worth and wellbeing.
8. **Mental Health and Learning Disability:** Raise awareness of carers supports and help identify need to support employees of PHA who also hold the role as carer to someone with a disability	Staff who have caring responsibilities for a person with a disability may have particular needs in the workplace, such as for empathy and flexibility to respond to domestic emergencies. Likewise, they will benefit from information on support available in the community.
9. In collaboration with disabled people design, deliver and evaluate training for staff on disability equality.	People with disabilities face many barriers every day–from physical obstacles in buildings to systemic barriers in employment and civic programs. Yet, often, the most difficult barriers to overcome are attitudes other people carry regarding people with disabilities. Whether born from ignorance, fear, misunderstanding or hate, these attitudes keep people from appreciating and experiencing the full potential a person with a disability can achieve. The most pervasive negative attitude is focusing on a person's disability rather than on an individual's abilities. The disability equality training will need to take account therefore of the social model of disability developed by disabled people themselves.(See also action point below also for further expansion) Northern Ireland Rare Diseases Partnership (NIRDP) 2013 in responses to Equality Action Plans consultation exercise (2012-2013) suggested that the revision of Disability Awareness Training should include recognition of specific difficulties encountered by those who have a disability caused by rare disease and their families; including raising awareness of the isolation and stigma associated with rare disease, which impacts strongly on mental health.

(3) Getting people involved in our work, Participation and Engagement

Action Measure	**An identification of different needs, experiences and priorities of any of the equality categories in relation to this policy or decision and what equality issues emerge from this?** **Specify the Section 75 equality categories where there are different needs** **Note if staff or service users**
10. Develop checklist and guidance for the involvement of people with a disability and their carers.	**Across disabled groups:** The checklist and guidance will need to take account of the social model of disability which says that disability is caused by the way society is organised, rather than by a person's impairment or difference. It looks at ways of removing barriers that restrict life choices for disabled people. It also needs, where relevant, to address the needs of carers. When barriers are removed, disabled people can be independent and equal in society, and have choice and control over their own lives. Disabled people developed the social model of disability because the traditional medical model did not explain their personal experience of disability or help to develop more inclusive ways of living. The social model of disability says that disability is caused by the way society is organised. The medical model of disability says people are disabled by their impairments or difference. The checklist and guidance will need to consider a wide range of disabilities.
11. Identify, provide and promote opportunities for	Participation in work is a key tenet not only of equality but of a human rights based approach. Those with disabilities have faced barriers in decision making

more engagement for people with a disability in key work areas	processes. This affects all disabled people but there are issues in relation to sensory impairment and learning disability that create additional barriers.
12. Explore scope and interest in the establishment of a forum for staff on disability	**Across disabled groups: Staff:** In the United Kingdom over the last decade there has the growth of Disabled Employee Networks (DENs) across all sectors. According to Kate Nash Associates (2009) www.katenashassociates.com Disabled Employee Networks - a practical guide - "this is partly because organisations are becoming more disability and diversity confident but also because disabled people are becoming more comfortable about expressing their needs at work and feel more able to come together in networks of support. Disabled people are also increasingly aware of their economic influence as employees, as customers, as shareholders, as voters and as citizens. To become employers of choice for talented disabled people, organisations need to demonstrate a good track record in accommodating the needs of disabled employees in more sophisticated ways. Now the challenge is for employers to foster new thinking and practice, from and between employees of different sector strands, to build, as the Equality and Human Rights Commission suggest, "a Britain that is at ease with its diversity". **Multiple needs:** In this action it is important that the scope is widened .People are not one-dimensional. Given our multi-faceted identities, it is important for every employee network to embody the principal that all human difference is to be valued and all discrimination to be challenged. Networks make an important contribution to the organisation's ability to anticipate, accommodate and celebrate human difference.

	Any staff forum will need to be accessible to people with a range of disabilities, including sensory disabilities and learning disabilities who may have particular needs as to the way the forum operates.
13. Nominate a champion at senior level	**Multiple needs:** It is concluded that this particular proposal to nominate a Disability Champion has an important, and positive, impact for the disability protected equality category. In nominating a Disability Champion some of the other protected equality groups may feel disadvantaged. However the particular requirements of the disability duties are as such that such an initiative is considered good practice in promoting positive attitudes and in encouraging the participation of disabled people in public life. In addition the multiple identities of people with disabilities are acknowledged and will be promoted throughout. Should a need arise for a similar initiative for other groups arise consideration will be given to this.
14. Explore the scope for developing a shadowing scheme for Board and Council members and other key public life positions in engagement with the Public Appointments Unit and with people with a disability.	**Across disabled groups**: Work needs to commence on exploring the scope. As part of this initial dialogue it will be necessary to acknowledge the diversity of needs within disability and how a shadowing scheme could accommodate the range of needs over time including learning disability, mental health, physical disability and sensory impairment. Training initiatives will be key in delivery of this action
15. Involve disabled people in delivery and review of this plan	**Across disabled groups:** As part of the development of this part a range of staff with a disability were engaged in the process. In the process of review of the disability action plan it will be necessary to

	ensure that the process is made accessible including the provision of information in a range of alternative formats. This is particular important in relation to sensory impairments and learning disability. **Multiple needs:** Consideration needs to be also given as to how those with multiple needs including older and younger disabled people can be involved in a meaningful way.

(4) Recruitment and Retention

Action Measure	**An identification of different needs, experiences and priorities of any of the equality categories in relation to this policy or decision and what equality issues emerge from this.** **Specify the Section 75 equality categories where there are different needs** **Note if staff or service users**
16. Explore the feasibility of providing an advocacy or specialist service within workforce with role to support and advise staff on disability issues	**Staff with a range of disabilities:** The first few years of having a disability can be challenging in terms of making sense of how you may have to do life differently. For someone acquiring a disability or long-term health condition for the first time an advocate may be the first opportunity that the individual really has to speak about disability and how it affects them. An advocate or someone with specialist knowledge can offer an important opportunity to staff who are less inclined to be open to colleagues or their line manager. **Multiple needs:** Equally importantly as staff who have a long term disability changing needs in relation to, for example, their age or gender or their caring responsibilities may benefit from the support of someone who is a specialist in this issue or who has the skill and knowledge of knowing from where else to seek support.
17. Offer mentoring opportunities for young adults and older adults with disabilities as appropriate.	**Multiple needs:** This action relates specifically to disability and age in particular where consideration of differing needs of young adults and older adults need consideration in terms of appropriateness of mentoring opportunities. Multiple needs across the spectrum of disability will also need to be considered.
18. Create and promote	**Across disabled groups:** Though drawn from England, Wales and Scotland the

meaningful placement opportunities for people with disabilities in line with good practice and commitments of Section 75 equality duties, and making use of voluntary expertise in this area. Produce practical guidance on process and external support available	Equality and Human Rights Commission's first Triennial Review: *How Fair is Britain*? (2010) mapped progress on equality in Britain for people with protected characteristics. The report identified those issues most urgently in need of resolution and 'closing the employment gap for disabled people' was identified as one of the top challenges facing society today. Over one in five adults in Britain today is disabled, yet only half are likely to be in work compared to four-fifths of non-disabled adults. High numbers of disabled people continue to be excluded from work opportunities that open the door to wealth, worth and wellbeing. See report by Equality and Human Rights Commission http://www.equalityhumanrights.com/uploaded_files/Employers/wb_approved_lo.pdf The shift in recent years towards a high qualification, high skill economy to compete globally, has meant that the employment penalty for those with low or no skills has increased dramatically over time. It is estimated that the employment rate for disabled men without qualifications halved between the mid1970s to the early 2000s (EHRC, 2010). Disabled people with qualifications still face barriers to work. At every qualification level, disabled people are more than three times more likely than non-disabled people to be without a job but want to work (Palmer et al, 2005). Any placement scheme will need to take account of the range of disabilities, to ensure fair access to the scheme.
19. Encourage disabled people to apply for employment opportunities and remain in the workforce (for example attend career fairs, include welcoming	Similar issues as those identified under in Action Point 17. **Making a difference: opening up work** Previous research (Williams et al, 2008) has indicated that 27 per cent of disabled people who had left a job for reasons connected with their impairment felt they could

statement and issue job adverts to local disability organisations and more flexible working arrangements and review job descriptions)	have stayed with appropriate support, adjustments or adaptations – those at the top of the list were simple and low or no cost. Evidence from our research with individuals shows that a radical change in attitudes and practices is required to really improve the working lives of disabled people. http://www.equalityhumanrights.com/uploaded_files/Employers/wb_approved_lo.pdf

Category	***Needs and Experiences***
The detail of the plan is an attempt to address the issues raised via a number of sources including information on barriers facing people with disabilities which were collated in the development and responses to audits of inequalities and action plans carried out by organisations in 2010 and other research and information sources.	
Gender	Disabled people have often been represented as *without gender,* as *asexual.* In this way it may be assumed that for disabled people gender has little bearing. Yet the image of disability may be intensified by gender. **In the public arena :** • more women than men are classified as disabled • while disabled people are much more likely to live in poverty, women are likely to be poorer than men; • younger disabled women achieve lower educational outcomes than men; • disabled women are less likely to be in the paid workforce than either men with disabilities for non-disabled women, and in general have lower incomes from employment; • women are less likely to have access to rehabilitation, and to employment outcomes when they do receive rehabilitation; • the type of impairments are different for women and men, with women more likely to experience degenerative conditions, while men are more likely to experience injury-related events; • women are more likely to experience public spaces as intimidating and dangerous. **In the private and familial arena** • disabled women are more likely to be living on their own, or in their parental family than men; • disabled women are more likely to be divorced and less likely to marry than men with disabilities • women are more likely to face medical interventions to control their fertility; • women are more likely to experience sexual violence in relationships and in institutions. • women experience more extreme social categorisation

	than men McClenaghan (2013) underlines the experience of a double marginalisation of people with a disability who identify as trans. This includes reported experiences of feeling excluded within the disability sector at times on the one hand and a lack of accessibility to events organised in the trans (or, at times, jointly by the lesbian, gay and bisexual) sector on the other.
Age	It is widely recognised that disability increases with age and therefore the demand on our services will grow significantly in the next decade and beyond. Although people are living longer, they will experience more years of ill-health, more people will need help with everyday activities and these numbers are likely to double by 2025. (See DHSSPSNI Physical and Sensory Disability Strategy and Action Plan 2012 – 2015) Linked with gender the age distribution for women is different to men (older versus younger);
Religion	No particular needs have been identified on the basis of religion.
Political Opinion	No particular needs have been identified on the basis of political opinion.
Marital Status	No particular needs have been identified on the basis of marital status.
Dependent Status	There is limited information on disabled adults who care, particularly adults with learning disability who care for their children or who care for older parents. As parents get older there is evidence that the caring role gets reversed. Parents with a learning disability are least likely to have access to accessible information about services and support. For parents with a child with a disability there is a lack of available information for parents regarding their child's disability. (Working together to support disabled parents, Social Care Institute of Excellence 2007)
Disability	The diversity of disabilities including: • Physical disabilities; • Sensory disabilities;

	• Learning disabilities; • Mental health disabilities; and, • Other hidden disabilities. requires attention to be given to differential needs in relation to services and the provision of information in a range of accessible formats. A response in relation to Equality Action plans from Northern Ireland Rare Diseases Partnership (NIRDP) 2013 indicated that currently, while many individuals do receive good health and social care, those affected by rare disease are often marginalised and disadvantaged due simply to their condition being rare and largely misunderstood. Integration of care within other groups is to be commended; however there needs to be a much greater recognition that rare disease creates different needs, experiences, issues and priorities in relation to policy and service delivery decisions.
Ethnicity	In some cultures people view disability as a family curse. Perceptions and attitudes amongst service providers towards minority ethnic groups that "they try to take care of it themselves" or "they look after their own" can lead to lack of appropriate support or indeed the provision of inappropriate support. Staff need to be informed through training and support and through the provision of guidance as to the needs of people with disabilities from across ethnic groups. Language barriers requires that responses also include the provision of interpreting and translation services Department of Works and Pensions research on diversity and disability http://research.dwp.gov.uk/asd/asd5/summ2003-2004/188summ.pdf indicated that Black Caribbean and African disabled people more readily described experiences of discrimination and prejudice than those from the other groups. There are also additional barriers facing asylum seekers generally so additional needs may exist in relation to those who also have a disability.
Sexual Orientation	White lesbian and gay or transgendered disabled people more readily described experiences of discrimination and prejudice than those from the other groups. See Department of Works and Pensions research on diversity and disability http://research.dwp.gov.uk/asd/asd5/summ2003-

	2004/188summ.pdf McClenaghan (2013) underlines the experience of a double marginalisation of people with a disability who identify as lesbian, gay or bisexual. This includes reported experiences of feeling excluded within the disability sector at times on the one hand and a lack of accessibility to events organised in the lesbian, gay or bisexual sector on the other.

2.4 Multiple Identities

Are there any potential impacts of the policy or decision on people with multiple identities? For example; disabled minority ethnic people; disabled women; young Protestant men; and young lesbians, gay and bisexual people.

The Disability Plan relates to the following key areas:

- Physical disabilities;
- Sensory disabilities;
- Learning disabilities;
- Mental health disabilities; and,
- Other hidden disabilities.

It also recognises that people with disabilities are impacted by other factors such as caring responsibilities, age, gender, sexual orientation, ethnicity and marital status, religion and political opinion.

Department of Works and Pensions - carried out research on diversity and disability http://research.dwp.gov.uk/asd/asd5/summ2003-2004/188summ.pdf
People varied as to whether, and how, they felt they had experienced disadvantage resulting from their disability, gender, age, ethnicity or sexuality. The causes of such discrimination were widely assumed to be ignorance, fear and a lack of awareness on the part of those responsible.
Reactions were mixed around the concept of 'multiple' disadvantage. It had the most resonance for African, Caribbean and gay and lesbian disabled people. The extent to which people had felt able to overcome disadvantage was attributed to their access to personal, emotional, practical or financial resources.

2.5 Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to the policy or decision in order to promote equality of opportunity?

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
In developing the disability action plan staff with disabilities and staff who had caring responsibilities for people with disabilities were actively involved in its development This entire disability action plan has been developed as positive action, in order to make a difference to staff and service users with a disability. It offers commitments through a number of concise actions that have specified outcomes and precise timelines. By adopting this action plan we believe that we will be in a position to make tangible differences. In recognising the importance of accessibility the disability action plan includes a specific action for adaption and adoption of an accessible formats policy. Disability Awareness Days • Work to feature specific disabilities will take into consideration the need to include a range of age groups, ethnic groups and genders when testimonials and case studies are selected.	The actions within the plan are time specific with specific outcomes highlighted. In progressing actions cognisance will be taken of the wider section 75 equality categories that are also the key characteristics of people with disabilities. Monitoring of the action plan on an ongoing basis is key as is the involvement of people with disabilities as identified as one of the actions in the plan. The following elements of the plan will be subjected to a stand alone equality screening, and where appropriate, equality impact assessment: • Work Placements • Staff Forum • Disability Awareness Days • Checklist and guidance for the involvement of people with a disability and their carers.

• Information distributed to staff will take on board the needs of both staff with a particular disability and staff who are carers. Work Placements • We will work with a range of disability organisations to ensure opportunities are offered to people from a wide spectrum of disabilities, as well as different gender and age groups. Staff Forum • We will ensure that the way the forum operates allows people with a range of disabilities and from a range of age and ethnic backgrounds to be involved (for example, by providing information in accessible formats and choosing accessible venues).	

2.6 Good Relations

What changes to the policy or decision – if any – or what additional measures would you suggest to ensure that it promotes good relations? (refer to guidance notes for guidance on impact)

Group	***Impact***	***Suggestions***
Religion	N/A	
Political Opinion	N/A	
Ethnicity	N/A	

(3) SHOULD THE POLICY OR DECISION BE SUBJECT TO A FULL EQUALITY IMPACT ASSESSMENT?

A full equality impact assessment (EQIA) is usually confined to those policies or decisions considered to have major implications for equality of opportunity.

How would you categorise the impacts of this decision or policy? (refer to guidance notes for guidance on impact)

Please tick:

Major impact	
Minor impact	X
No further impact	

Do you consider that this policy or decision needs to be subjected to a full equality impact assessment?

Please tick:

No	

Please give reasons for your decisions.

The development of this Disability Action Plan is a statutory requirement in its own right. Actions identified all relate to good practice and positive action. We consider that the Plan takes account of the diverse needs of people with a disability and their carers identified to date, based on their multiple identities. Review of its implementation through agreed processes and through reports to Senior Management Team, Boards and the Equality Commission will keep this issue live and profiled.

(4) Consideration of Disability Duties

4.1 In what ways does the policy or decision encourage disabled people to participate in public life and what else could you do to do so?

How does the policy or decision currently encourage disabled people to participate in public life?	*What else could you do to encourage disabled people to participate in public life?*
This plan has been developed in accordance with the requirements of the Disability Discrimination Act (DDA) (1995) amended by the Disability Discrimination (NI) Order 2006 public authorities are required when carrying out their functions to give due regard to two specific duties, that of: • promoting positive attitudes towards disabled people; and, • encouraging participation by disabled people in public life. This action plan demonstrates a commitment to the fulfilment of these duties. A number of the actions relate specifically to this duty. Through action engagement in its development, implementation and review.	Implementation of the disability action plan

4.2 In what ways does the policy or decision promote positive attitudes towards disabled people and what else could you do to do so?

How does the policy or decision currently promote positive attitudes towards disabled people?	***What else could you do to promote positive attitudes towards disabled people?***
As above in relation to the legislative requirement. As above a number of the actions relate specifically to this duty Through action engagement in its development, implementation and review	Implementation of the disability action plan

(5) Consideration of Human Rights

5.1 Does the policy or decision affect anyone's Human Rights? Complete for each of the articles

ARTICLE	Yes/No
Article 2 – Right to life	
Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment	
Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour	
Article 5 – Right to liberty & security of person	
Article 6 – Right to a fair & public trial within a reasonable time	
Article 7 – Right to freedom from retrospective criminal law & no punishment without law	
Article 8 – Right to respect for private & family life, home and correspondence.	yes
Article 9 – Right to freedom of thought, conscience & religion	
Article 10 – Right to freedom of expression	
Article 11 – Right to freedom of assembly & association	
Article 12 – Right to marry & found a family	
Article 14 – Prohibition of discrimination in the enjoyment of the convention rights	yes
1st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property	
1st protocol Article 2 – Right of access to education	

If you have answered no to all of the above please move onto to move on to ***Question 6*** *on monitoring*

5.2 If you have answered yes to any of the Articles in 5.1, does the policy or decision interfere with any of these rights? If so, what is the interference and who does it impact upon?

List the Article Number	Interfered with? Yes/No	What is the interference and who does it impact upon?	Does this raise any legal issues?* Yes/No
	Not interference Cross cutting impact. The intent of the Disability Action Plan is the positive promotion of Human Rights.		No

** It is important to speak to your line manager on this and if necessary seek legal opinion to clarify this*

5.3 Outline any actions which could be taken to promote or raise awareness of human rights or to ensure compliance with the legislation in relation to the policy or decision.

Giving cognisance of human rights based approach in the implementation and monitoring arrangements associated with the disability action plan.

(6) Monitoring

6.1 What data will you collect in the future in order to monitor the effect of the policy or decision on any of the categories (for equality of opportunity and good relations, disability duties and human rights?

Equality & Good Relations	Disability Duties	Human Rights
On-going monitoring of the plan inclusive of people with disabilities Staff data to improve the information data set in relation to employment is key.	Monitoring data in relation to actions as specified within the plan	Monitoring data from review of the disability action plan to consider human rights issues.

Approved Lead Officer:	Rosemary Taylor
Position:	Assistant Director Planning and Operations
Policy/Decision Screened by:	Anne Basten, Equality Unit, Business Services Organisation
Signed: Date:	August 2015

Please note that having completed the screening you will need to ensure that a consultation on the outcome of screening is undertaken, in line with Equality Commission guidance.

Any request for this document in another format or language will be considered. Please contact us at **equality.unit@hscni.net** or on 028 9536 3961 or at BSO Equality Unit, 2 Franklin Street, Belfast BT2 8DQ

HSC Organisations involved in this screening exercise
Blood Transfusion Service
Business Services Organisation
Health and Social Care Board
NI Guardian Ad Litem Agency
Northern Ireland Medical and Dental Training Agency
NI Practice and Education Council for Nursing and Midwifery
Northern Ireland Social Care Council
Patient and Client Council
Public Health Agency
Regulation and Quality Improvement Authority
Safeguarding Board for Northern Ireland