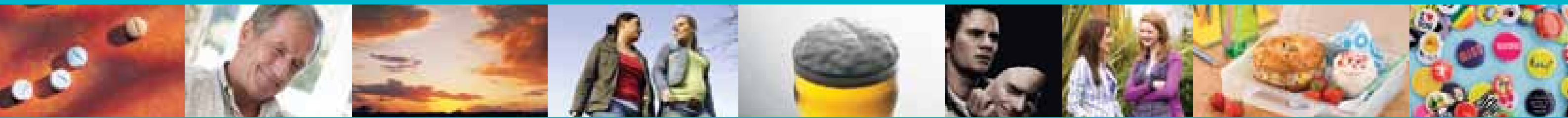
2009 2010



ANNUAL REPORT

HSC Public Health Agency

Getting in touch

Public Health Agency Headquarters

Ormeau Avenue Unit
18 Ormeau Avenue
BELFAST
BT2 8HS
Tel: 028 9031 1611

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BELFAST
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Tel: 028 9032 1313

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182 Galgorm Road
BALLYMENA
BT42 1QB
Tel: 028 2531 1000

Southern Office

Tower Hill
ARMAGH
BT61 9DR
Tel: 028 3741 0041

Western Office

Gransha Park House
15 Gransha Park
Clooney Road
LONDONDERRY
BT47 6FN
Tel: 028 7186 0086

Media line:

Tel: 028 9031 1514
Media enquiries only

Normal business hours:

8.45am–5.00pm Monday–Friday

Website:

www.publichealth.hscni.net

Board

The board of the Public Health Agency (PHA) meets frequently throughout the year and members of the public may attend these meetings. The dates, times and locations of these meetings are advertised in advance in the press and on our main corporate website www.publichealth.hscni.net

Using this report

This report highlights the broad range of work carried out by the PHA and shows how this work has contributed to meeting our objectives detailed in our Corporate plan 2009–2010. The online Portable Document Format (PDF) file of this report also has live web access to the relevant website.

This report is intended to be an overview of the year's main accomplishments.

For more detailed information on our work, please visit our corporate website at www.publichealth.hscni.net

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Other formats

Copies of this *Annual report* may be produced in alternative formats on request. A PDF file of this document is also available to download from our corporate website at: www.publichealth.hscni.net

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Chair's statement

My first statement to you as Chair of the PHA follows an exceptionally exciting and challenging period for health and wellbeing in Northern Ireland. We have all come a long way since the Health Minister, Michael McGimpsey, announced his plans for HSC reform under the RPA, which led to the creation of our organisation in April 2009.

Our business

Tackling health and social wellbeing inequalities, and promoting a shift across the health service to the prevention of illness, lay at the heart of the HSC reforms. The PHA was set up to provide a renewed and enhanced focus on public health by bringing together a wide range of public health functions under one organisation, with improved health and wellbeing as its core business.

It was also tasked with creating better inter-sectoral working, including enhanced partnership arrangements with local government to tackle the underlying causes of poor health and reduce health inequalities.

Shaping and developing

2009–2010 was fundamentally about shaping and developing our new organisation and setting longer-term directions. It was a year of transition and managing change, a year of harmonising inherited systems, a year of implementing a framework for design of the organisation and, most importantly, a year of laying down foundations for a fundamental shift in what we aim to do and how we do it.

Extensive portfolio of work

While establishing ourselves as the major regional organisation for health improvement and health protection, we had a busy and eventful first year, delivering an extensive portfolio of work across all key areas of public health and social wellbeing.

There was considerable coverage and exposure of the PHA's work throughout the year, not least in dealing with the first new pandemic virus of the 21st century – commonly referred to as swine flu. The PHA worked extremely hard, together with a range of other bodies throughout HSC, during the various stages of the pandemic to ensure a successful response.

Engaging and joint working

In other areas of work, we established engagement approaches to enable effective involvement of communities, groups and individuals in shaping the work of the PHA. Cluster level joint working arrangements between the PHA and seven district councils were put in place. On the operations side, we delivered on the information governance leaflet for all staff.

Vibrant community sector

An agency such as ours cannot function without a vibrant community and voluntary sector. Working collaboratively across disciplines and departments, maximising and making best use of available resources, we can make a difference.

My first year has been busy establishing links across Northern Ireland with a wide range of community and voluntary organisations working in some of our disadvantaged areas. Attending up to five meetings monthly, I was constantly impressed with the flexibility, energy and motivation I encountered.

Change, integration and commitment

Our achievements are all the more noteworthy when set in the context of considerable public sector change. The integration of staff and work from legacy organisations into the PHA presented many challenges and was a period of great anxiety and uncertainty. On behalf of the board I would like to congratulate the Chief Executive and staff for their dedication to quality, continued hard work and commitment.

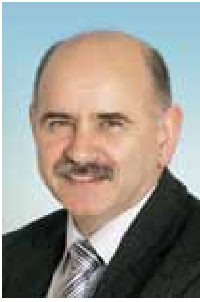
A personal word

I would also like to personally thank members of our board for their vision, dedication and support, and acknowledge our colleagues in the wider HSC family and in the DHSSPS for their assistance and advice. I look forward to working with you all to achieve our common vision for a healthier Northern Ireland.

Mary McMahon

Mary McMahon
Chair

Management commentary



I think it's fair to say that we all expected the first year of the PHA to throw up many challenges for all our staff. While much groundwork was undertaken to ensure as smooth a transition as possible into the new health and social care system, it was clear from the outset that considerable work would be necessary internally within each of the organisations to build capacity and develop strong relationships among the new bodies.

However, I do not believe that any of us could have anticipated just how much we would ask of our staff during this inaugural year, or the level of commitment, professionalism and teamwork that has been demonstrated right across the Agency.

We had barely been set up for three weeks when the swine flu issue emerged and I am immensely proud of the way staff pulled together to ensure a successful response to this while carrying out their normal day-to-day duties.

In addition to these 'new' pressures, staff have had to cope with substantial organisational change that has been slower to resolve than any of us would have anticipated or wished. Yet each of our areas has seen significant development during the year, setting in place strong foundations for the future of public health.

We have undertaken and supported a wide range of programmes and initiatives across all major health and social wellbeing areas in fulfilment of our commitments and core objectives detailed within our corporate plan for 2009/2010 – supporting the targets detailed by the Minister for Health as well as meeting the objectives identified in the original business cases for the PHA.

We cannot, however, achieve our aims in isolation and our commitment to working collaboratively cannot be emphasised enough. Working with the local community and voluntary sectors, and the statutory and private sectors, will continue to be central to all our work.

Within the area of health protection, for example, we saw substantial reorganisation and staff playing a key role with HSCB colleagues in implementing the strategic regional action plan for the prevention and control of HCAIs in Northern Ireland.

Within health improvement, a new PHA-funded 'one-stop shop' drop-in centre was opened in Banbridge, providing information, support and education to young people and their families affected or concerned by alcohol and drug misuse.

Another notable achievement has been the development of closer joint working with local government across Northern Ireland. The first initiative to launch under these new arrangements with local councils was the Belfast Health Development Unit in March, which will be followed by other launches as the initiatives roll out across Northern Ireland.

I applaud the commitment of everyone involved in setting up the unit, whose work will no doubt help to narrow the health gap between disadvantaged groups and communities, and improve health overall by addressing inequalities.

Within nursing and allied health professions, we made substantial headway in developing the area of Personal and Public Involvement, including a formal consultation scheme, to ensure service users and the public are involved in the commissioning, planning and delivery of our work.

Our high profile work through public information campaigns was recognised with a major mental health media award and the Northern Ireland "Maternity and Family Award" for normalising breastfeeding in the community. We continue to look at ways of providing information and resources, particularly for hard-to-reach groups, through the most effective methods and in particular through emerging and developing social media channels.

While we faced numerous challenges this year, everyone involved has responded with energy, enthusiasm and commitment, with a clear focus on making the health and wellbeing of our community better – thank you for all your hard work. Our board members helped lay the necessary foundations and I acknowledge their commitment, direction and work over the entire period.

As we enter a new financial year we focus on ensuring the right structures are in place to continue delivering a vision of HSC outcomes that are among the best in the world.

Dr Eddie Rooney
Chief Executive

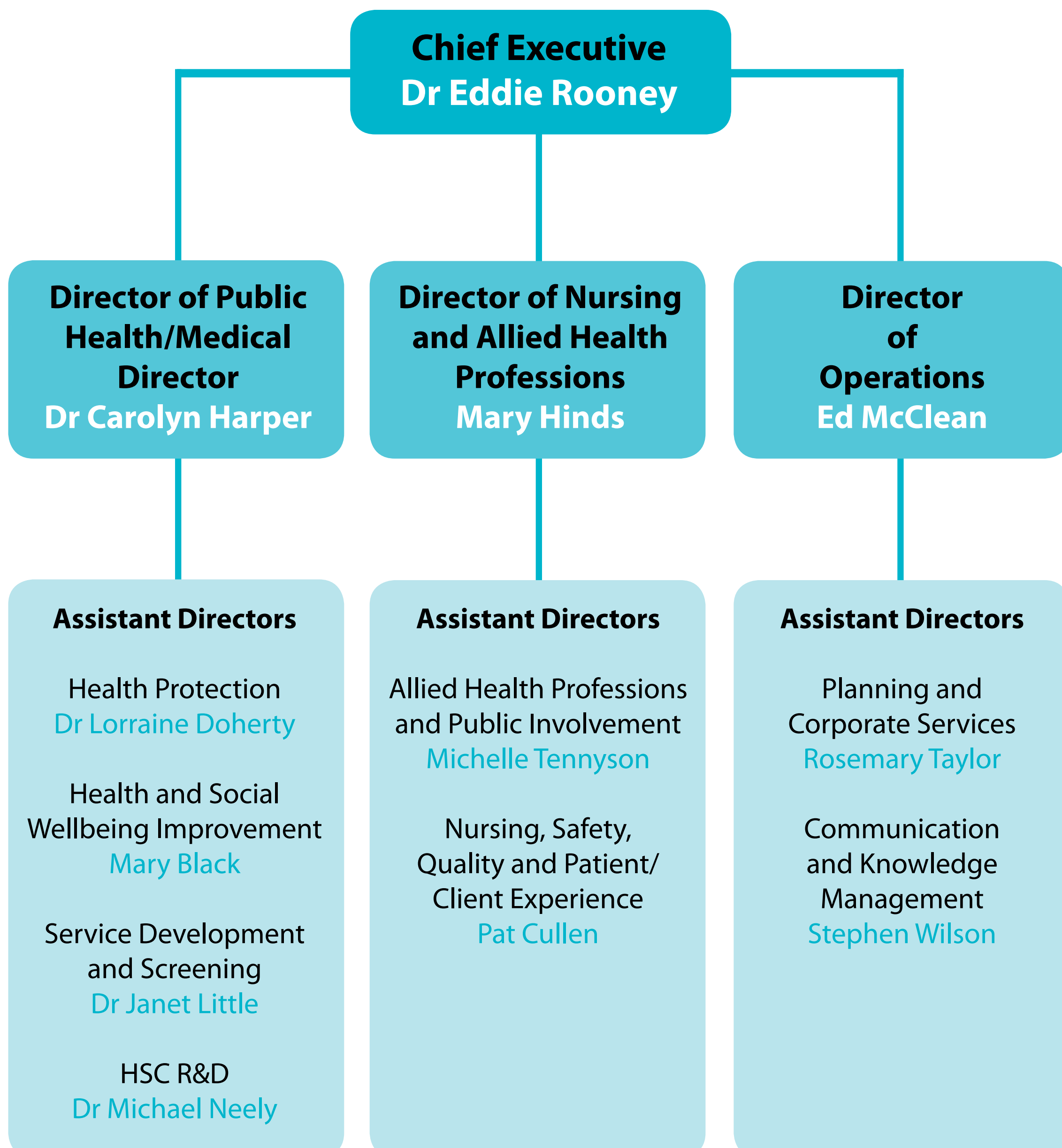
Directors' report

The PHA is an integral part of the HSC system, working with the HSCB, BSO and PCC. It drives the public health and social wellbeing agenda, bringing together a wide range of functions to give a renewed, enhanced and sustained focus on health protection and improving health and wellbeing outcomes.

The PHA is a multi-disciplinary, multi-professional body with a strong regional and local presence. It has four key functions:

- improvement of health and social wellbeing;
- health protection;
- public health support to commissioning and policy development;
- HSC research and development.

The following diagram highlights the organisational structure down to tier three and details the main areas of activity with those responsible.



Communication

From day one, the PHA was committed to ensuring that accessible and effective communication channels underpinned our work. We communicated emerging and key issues to all of our external stakeholders through regular updates on our new corporate website www.publichealth.hscni.net

Good internal communication was key in a year of uncertainty and change, and publication of a monthly e-bulletin aimed to keep all employees well informed about developments and achievements, particularly during roll-out of the new era.

In addition, a new PHA staff intranet site was developed and regular news and information added to keep everyone informed of internal developments. To reflect the organisational change and integration of staff from legacy bodies, a standard email address was also introduced and usage guidelines communicated.

Publication of our *Corporate plan* ensured staff were clear about the mission and strategic direction of the PHA and how we intend to fulfil our commitments. Management briefings were also conducted to ensure staff were kept up to date with progress on structures, and a consultation paper on restructuring was issued in consultation with trade unions.

Payroll

For a number of months after the new organisation came into effect, payroll arrangements reflected those of the legacy organisations until a single new system became operational.

Equality and human rights policies

The PHA has looked to build on the sound policies and programmes put in place by each of the legacy organisations. We are accountable for ensuring that we comply fully with our legal responsibilities, including Section 75 of the Northern Ireland Act 1998 and the Human Rights Act 1998.

During the year, advice, support, guidance and training on equality, human rights and diversity were provided to the PHA via the equality unit of the BSO.

Equality of opportunity

In accordance with Section 75 of the Northern Ireland Act 1998, the PHA recognised its obligations to promote equality of opportunity between:

- persons of different religious belief, political opinion, racial group, nationality, age, marital status or sexual orientation;
- men and women generally;
- persons with a disability and persons without;
- persons with dependants and persons without.

In developing our policies, we were required to examine or screen them for equality purposes to identify any that were likely to have a significant impact on equality of opportunity and/or good relations. Screening also covered issues in relation to the Human Rights Act 1998 and the Disability Discrimination Order 2006.

In light of this legislation, we developed a template and guidance for use by all staff to ensure consistency in approach. This also acts as the tool for documenting the outcomes of the screening and provided a paper trail of evidence for the PHA's screening report.

Records management

PHA staff were initially using existing file plans while a new standard filing plan was created. The new proposed system is being trialled to ensure continuity and cohesion across all locations and functions and will be rolled out once the trial has been completed and revised accordingly.

Business continuity

Communications detailing business continuity arrangements were sent to all staff, ensuring everyone was clear on what would happen from 1 April onwards, what everyone's role would be and who they should report to in light of any changes in line management.

Sick absence data

For the 2009–2010 financial year, the following sick leave days were recorded:

Total working days lost due to short-term sickness = 286 (0.71%)

Total working days lost due to long-term sickness = 714.8 (1.78%)

Total working days lost due to sickness = 1,000.8 (2.50%)

Freedom of Information

The PHA fulfilled its obligations under the Freedom of Information (FoI) Act 2000 by developing and circulating an information governance leaflet entitled *Information governance: what you need to know* to all staff. It outlined good practice and guidance on issues such as FoI, confidentiality and information security.

Information governance:
what you need to know

Information is a vital asset in enabling the Public Health Agency and its staff to carry out their work. This guide sets out good practice and guidance for staff on information governance. It covers:

- Data protection.
- Confidentiality.
- Freedom of information.
- Information quality assurance.
- Information security.
- Key contacts within the PHA.

Data protection

The data protection principles are:

Data-related incidents

There were no major data-related incidents reported during the year.

The theft of a laptop and Blackberry from an office in Towerhill, Armagh, was reported to the PSNI and treated internally as an adverse incident. Both devices were encrypted and hence the potential for data loss was minimised.

Follow-up work consisted of an immediate audit of all PHA offices, the provision of security equipment and advice where required, and the introduction of regular, out-of-hours office inspections to all localities.

Details of the incident were shared across all PHA/HSCB offices to aid organisation-wide learning.

Two laptops were also stolen from the Ormeau Avenue Unit premises. The PSNI was informed and investigations launched.

Both laptops were encrypted and no sensitive data accessible. Additional security measures were installed and communicated to staff.

The *Information governance* leaflet also covered the area of data protection.

Comments and complaints

The Public Health Agency received two complaints in 2009–2010.

These related to issues of communication and provision of service to the public and a general practitioner. In both cases the complaints were resolved.

A number of formal positive comments in recognition of our work were received.

If you wish to make a formal comment or complaint, please write to:

Edmond McClean
Director of Operations
Public Health Agency
Ormeau Avenue Unit
18 Ormeau Avenue
Belfast BT2 8HS.

Quality

The PHA campaign, 'Don't cover up your problems', won the 'Raising public awareness' category in the Mind Mental Health Media Awards during the year. The campaign was taken forward as part of the implementation of the Northern Ireland suicide prevention strategy and included TV, radio, outdoor and washroom advertising.

The PHA campaign targeted young men to raise awareness of mental health and encourage a positive attitude to seeking help.

At the NCT (formerly the National Childbirth Trust) Northern Ireland Maternity and Family Awards, the PHA won the award for 'Normalising breastfeeding in the community' for the 'Good for baby, good for mum' campaign and for the 'Breastfeeding awareness for schools' CD-ROM resource.

As part of our work to reduce and prevent HCAIs, a joint PHA/ HSCB HCAI prevention team was established to progress work in this area. Taking this work forward, the PHA is playing a key role in implementing the strategic regional action plan for the prevention and control of HCAIs in Northern Ireland, *Changing the culture 2010*.

Dr Eddie Rooney, Chief Executive, PHA, holding the award from the Mind Mental Health Media Awards, along with Health Minister, Michael McGimpsey and Liz Mayne, one of the awards judges.

At the awards, from left, Mary McMahon, Chair, PHA; Janet Calvert, Regional Breastfeeding Coordinator, PHA; Julie Neill, Health Development Officer, PHA; Margaret McCrory, Marketing Manager, PHA and Gail Werkmeister, NCT President.

Preparation of accounts

The PHA has prepared a set of accounts for the year ended 31 March 2010 in accordance with the relevant legislative requirements.

Summary financial statements are included in the 'Operating and financial review' section of this report from page 24.

The role of the Public Health Agency

Public health - Dr Carolyn Harper

The PHA was set up with the explicit agenda to:

- protect public health and improve the health and social wellbeing of people in Northern Ireland;
- reduce inequalities in health and social wellbeing through targeted, effective action.

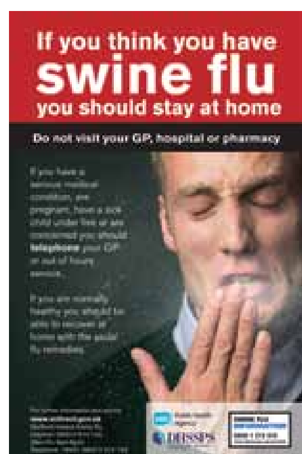
Broad range of activity

During the past year a broad range of activity was undertaken to help improve the health of the population of Northern Ireland. This was achieved through:

- prevention;
- early detection;
- high quality services;
- addressing inequalities;
- protecting health.

Pandemic response

Looking back on 2009–2010, it was, of course, dominated by the swine flu pandemic – declared by WHO on 1 June as the first flu pandemic for 40 years. The commitment and diligence of many people throughout HSC over the pandemic period resulted in a highly effective response and greatly enhanced preparedness for the future.



I wish to take this opportunity to thank every member of staff in the PHA who contributed to the pandemic response directly or indirectly. I also want to acknowledge the contribution of colleagues from the DHSSPS and other HSC bodies such as the HSCB, BSO, primary care practitioners, the five HSC trusts and NIAS. In addition, I would like to thank colleagues in local government, the UK border agency, the transport industry and many other individuals and organisations from all sectors who helped us tackle this major challenge.

Reducing the impact

Together we worked extremely hard in many areas to reduce the impact of pandemic flu on the public, as well as working with clinical staff on management of cases and their contacts.

These areas included:

- planning to manage predicted need for healthcare and support services, from caring for large numbers of people with uncomplicated flu to expanding intensive care capacity;
- planning for protection of HSC staff with comprehensive infection control measures and personal protective equipment;
- providing information, support and advice to the HSC and beyond, such as the education sector, councils, prisons, ports and airports;
- planning and implementing the pandemic flu immunisation programme, which included immunising pregnant women;
- communicating with staff and the public through media interviews, meetings, bulletins and leaflets;
- liaising with national groups such as HPA (UK) and colleagues in the NHS;
- surveillance and service pressure monitoring in close cooperation with the DHSSPS, HSCB, HPA (UK), all trusts and independent providers.

Activity in Northern Ireland

In Northern Ireland up to 17 February 2010, approximately 9% of the population were estimated to have had pandemic Influenza A(H1N1) 2009.

There were 1,367 laboratory confirmed cases, 577 hospitalised cases, and 50 intensive care admissions. The GP consultation rate during the peak week of the pandemic was 281 people per 100,000 population, greatly exceeding the Northern Ireland threshold for seasonal flu activity.

Protecting health – a frontline service

The health protection function provided by the PHA is a frontline acute response service of disease prevention and infection control, including outbreak management, emergency planning and environmental hazards.

In 2009–2010, the PHA established a single region-wide health protection service, building on the achievements of six legacy services including the CDSC, formerly part of HPA (UK).

We're maintaining our links with HPA (UK) and with health protection services in Scotland, Wales and the Republic of Ireland, making best use of specialist skills and integrating functions.

We are also linked into European and US centres as many health protection threats are global and require international cooperation.

During the year we responded to other specific threats to public health quickly and effectively, including multiple outbreaks of norovirus, clusters of *C. difficile* cases in nursing homes, cases of *E. coli* in nursery school children, and meningococcal disease.

In April we issued a boil water notice to people in the greater Belfast area and parts of counties Antrim and Down, and were part of a multi-agency response to a four-day tyre fire at Campsie.

Partnership working

A ministerial priority for public health protection is working with trusts to ensure PfA targets on HCAIs such as MRSA, MSSA and *C. difficile* are met.

In pursuance of this, we supported the HSCB and from April 2010 took a lead role in reducing HCAIs through partnership working with trusts, primary care and community care. Extension of the SSI surveillance programmes in trusts was also successfully implemented.

Improving user experience

We worked with the HSCB, trusts, primary care, and community and voluntary sectors to implement the cardiovascular and respiratory frameworks.

Patients, clients, carers and their wider families will be able to use these service frameworks to understand the standard of care they can expect to receive, thereby improving the user experience.

Early intervention

We also focused our efforts in the area of early intervention programmes to change the life expectancy of children and families. Intense support during early childhood enables children to maximise their potential, bringing better health and social outcomes for them.

A PHA seminar attended by representatives from across public sector organisations promoted discussion and debate on the early interventions/ infant mental health agenda.

Building on the early years intervention seminar looking at best practice and learning from others are, from left, Mary Gordon, founder of Roots of Empathy, Canada; Dr Carolyn Harper, Director of Public Health, PHA; Danny Broderick, Public Health and Clinical Coordination, South Australia; and Mary Black, Assistant Director, Health and Social Wellbeing Improvement, PHA.

Improving mental health and wellbeing

A key priority for the PHA in working with the DHSSPS, HSCB and trusts is to improve mental health and wellbeing and ensure high quality and effective care for those who need it. Through the Bamford taskforce, in partnership with the HSCB, the PHA continued to contribute towards improving mental health and wellbeing.

We also re-ran our award-winning campaign "Don't cover up your problems" as detailed under the quality section of the Directors' report. On-the-ground projects included the delivery of MHFA training to another 14 instructors, and the establishment of community response plans at district council level across the western area, guided by the regional suicide prevention strategy, to help prevent suicide clusters.

New MHFA instructors receiving their certificates from Mary McMahon, Chair, PHA.

Tackling inequalities through commissioning

Reducing inequalities through commissioning effective, accessible programmes and initiatives is also a priority for the PHA. In partnership with the HSCB and its LCGs, we advised on public health challenges and priorities and ensured formal inputs from key voluntary and community sector stakeholders, including local area partnerships, to put health inequalities at the heart of commissioning.

Tackling inequalities in health

Tackling health inequalities in our most vulnerable communities has been identified as a priority at ministerial level and part of our mandate is to allow the views of local government to influence health improvement programmes.

At a conference highlighting the challenging issue of health inequalities are, from left, Baroness May Blood; Health Minister, Michael McGimpsey; Mary Hinds, Director of Nursing and Allied Health Professions, PHA, and Barney McGahey, Chairman, Farset International.

Our key role in meeting our targets in this area saw joint working arrangements with local government put in place to harness the wide range of programmes and partnerships that exist to improve health and wellbeing.

One of the key objectives of HSC reform – and one of the key priorities for the PHA – is to strengthen intersectoral working, particularly between HSC and local government.

Joint Working

Introduction

Public health improvement staff from the PHA have been fully involved in shaping new working arrangements with local government and developing shared plans for taking this initiative forward.

The establishment of a Belfast health development unit was the first operational manifestation of the objective to allow the views of local government to influence health improvement programmes.

Action on alcohol and drug misuse

Tackling alcohol and drug misuse is a priority for the DHSSPS and it continues to be a key part of our work. In support of this, the PHA:

- launched a one stop shop information and support centre in Banbridge for young people and their families;
- hosted a NDACT "Drugs and alcohol, suicide and self-harm – cause or effect?" seminar;
- conducted media campaigns featuring issues such as links between breast cancer and alcohol, and highlighting the importance of talking to your child about alcohol;

- established a steering group and coordinator for the implementation of the *Hidden harm strategy*;
- developed a factsheet on legal highs in response to requests from parents and those working with young people.

Health Minister, Michael McGimpsey and Dr Eddie Rooney, Chief Executive, PHA, with speakers from the 'Drugs alcohol, suicide and self-harm – cause or effect?' seminar.

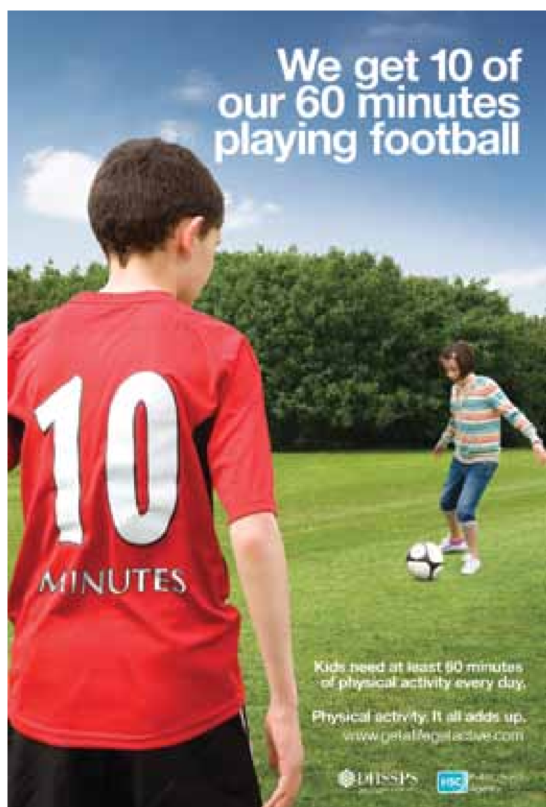
Action on smoking

Through multi-agency action with key partners, we continued important work in the area of smoking reduction. We hosted a workshop for the statutory and voluntary sectors to help shape future PHA practice on tobacco and to prioritise groups for attention – such as manual workers, pregnant women and young people. A range of speakers from across the PHA, DHSSPS and HSE took part.

A "Do you want to break free?" campaign was also launched to encourage smokers to quit and, in support of "No Smoking Day" in March, we promoted the help and support available to smokers using television, poster and press advertising.

Sexual health, physical activity and nutrition

Sexual health is identified as an area to be addressed under the Northern Ireland public health strategy, *Investing for health*. It is an important factor in good physical and mental health, and the increasing problem of sexually transmitted infections remains a challenge.



We continued to focus our efforts on obesity reduction and improved nutrition with a range of projects. A campaign "Physical activity: it all adds up!" was launched to encourage parents and carers to promote activity in children.

In a partnership between Safefood and Western IfH, an all-island resource focusing on "Field to fork" was developed and regional training was delivered to HE teachers on their role in promoting nutritional standards for school food.

Tackling fuel poverty

The importance the PHA puts on combating fuel poverty and reducing its impact on the health and wellbeing of householders was reflected in an investment of £780,000 in 2009–2010 for our fuel poverty programmes. The funding enabled a number of initiatives including distribution of "Keep warm" packs to vulnerable people, insulation measures, and implementation of local action plans.

A seminar we hosted on local fuel poverty in the northern area increased awareness among frontline staff across a range of sectors, local representatives and community stakeholders.

Working in partnership

We built on existing programmes and developed new initiatives and partnerships with local government, and community, voluntary and other organisations to address the wider determinants of health and social wellbeing, and target specific issues. We actively engaged with our stakeholders in informing and shaping programme development.

Among the many activities in 2009–2010 were:

- support for the regional HLC network in its development;
- agreement with DARD to assist the roll-out of its regional rural poverty programme;
- leverage of £800K INTERREG funding for a community allotment wellbeing project in the west;

At the funding announcement for PARC are, from left, Dr Michael McBride, Chief Medical Officer; Professor Frank Kee, Director of the Centre of Excellence for Public Health; Dr Carolyn Harper, Director of Public Health, PHA; and Dr Eddie Rooney, Chief Executive, PHA.

- work with the COE on the physical activity and rejuvenation of Connswater (PARC) study to evaluate the effects of the Connswater community greenway environmental project on local people;
- work with DSD on neighbourhood regeneration;
- managing a health improvement focus and programme for Travellers;
- launch by PHA's Belfast HAZ of a programme to improve the life chances of children and young people in north and west Belfast;
- input to Northern IfH Partnership's local health improvement plan.

Extending screening

In August we added another test to the range of newborn bloodspot screening or "heel prick" tests. The test recognises MCADD – an inherited metabolic disorder that can lead to serious illness, disability or even death in affected infants. Already, new cases have been detected and treated.

A new electronic data transfer system between general practices and the diabetic retinopathy screening centre was also introduced.

Information encouraging uptake

During the year the PHA provided information to both health professionals and the public to encourage the uptake of appropriate interventions that will protect and maintain health. Extensive work was undertaken to prepare for the launch of a bowel screening programme in Northern Ireland from April 2010 in a collaborative project involving the PHA, the HSCB trusts and the BSO, with support from NICaN.

Analysing a bowel cancer screening kit.

Securing safety and quality

Improving health through high quality services is a key aim of our Health Minister.

In partnership with the HSCB, we are developing the first joint commissioning plan. This aims to secure high quality, safe services while meeting patient and client needs. We also sought to bring professional leadership, evidence-based advice and expertise on the commissioning of services and with the HSC safety forum.

R&D essential role

HSC R&D division funded 24 new research studies in 2009–2010, representing a total commitment of £5.5million. The studies span the full spectrum of HSC R&D including public health, with a strong emphasis on research that sits close to the service and to the service user.

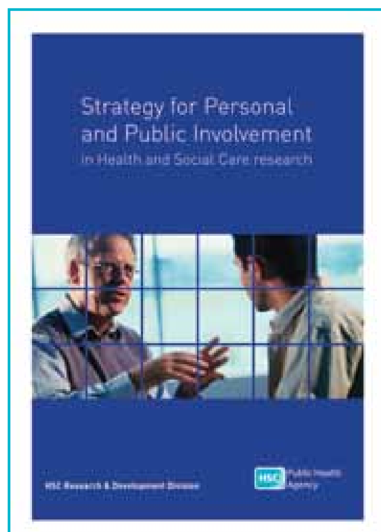
Commissioned research studies were funded in the areas of suicide prevention, acute lung injury, pharmacy prescribing and self-management of diabetes. Most of these are funded in partnership with other local or national stakeholders. Funding partnerships included a second US-Ireland R&D partnership award in the area of cystic fibrosis.

These awards are assessed in open competition by the prestigious US National Institutes of Health and represent collaboration between researchers in Ireland, Northern Ireland and the US. We continued our commitment to building HSC R&D capacity, awarding six doctoral fellowships, with projects ranging from dietary antioxidants and cardiovascular health to examining the uptake of domestic violence support services by violent men.

An important area of capacity deficit was addressed by the award of the first health economics fellowship in 2009–2010. This scheme operates Ireland-wide in partnership with the HRB in Dublin and the NCI in Washington.

The transfer of knowledge, generated by HSC R&D, into practice, policy or enterprise is gaining more emphasis. This year, HSC R&D evaluated the first set of applications under a new knowledge transfer scheme, making two awards in the areas of visual assessment for children with neurological disorders and e-learning for children with learning and developmental disabilities.

Throughout the year we worked to improve all aspects of HSC research infrastructure. The NICRN grew significantly, with over 6,000 patients recruited into 93 clinical trials in cancer, cardiovascular, critical care, dementia, diabetes, respiratory, stroke and vision.

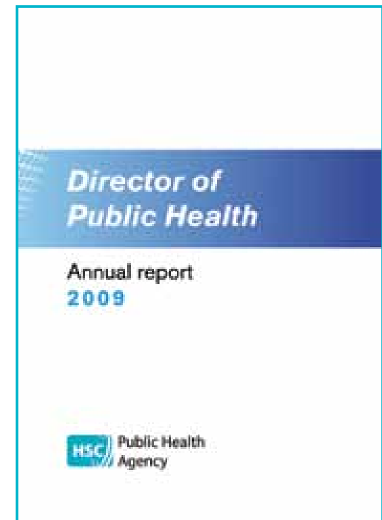


The HSC R&D Division also finalised a strategy for PPI in R&D, and has recruited a number of PPI representatives for involvement in HSC R&D division activities.

First steps

In this report I have presented just a snapshot of how the PHA has worked in its first year of operation to achieve its aim of improving health and wellbeing for everyone in Northern Ireland.

Our remit and results are too widespread to detail more fully here, but are outlined in more detail in my first *Director of Public Health Annual report*, available on the PHA website.



The examples outlined above are just a flavour of the work completed. Again, may I express sincere gratitude to all involved, in whatever capacity, in supporting the public health arena of work and in progressing our goals this past year.

We made a first step and a giant leap in establishing a regional unified public health service, building on the achievements of the legacy organisations, making best use of specialist skills, integrating functions, and strengthening strategic alliances.

Next year will bring further challenges, but also opportunities to build on this year and make a tangible difference to people's lives.

Nursing and Allied Health Professions - Mary Hinds

Expectations

"I have high ambitions and high demands for improvements in the services we deliver – because the people we serve deserve and expect no less." This expectation for service improvement by our Health Minister underpins our work in the areas of nursing, patient safety and quality, AHP and PPI.

Professionals transforming lives

The term nursing incorporates nursing, midwifery, health visiting, health care assistants and other support staff, while AHPs represent dietetics, occupational therapy, orthoptics, physiotherapy, podiatry, radiography, and speech and language therapy. All are key members of healthcare, providing interventions that help improve people's lives.

These professionals work with all age groups, across all programmes of care and in a range of surroundings including hospitals, people's homes, clinics, surgeries and schools. They work in partnership with HSC colleagues across primary, secondary and social care, the independent and voluntary sectors, and with other agencies such as DE and NIHE.

Making quality services safer

Our mandate here at the PHA is to lead in making the services provided by health and social care safer, where the experience of a patient and the quality of that service is just as important as the speed of access, and where citizens feel they have a say in the design and delivery of the services they receive.

Patient/client experience standards

The nursing and AHP directorate is leading on the implementation of the DHSSPS patient/client experience standards throughout the trusts. The PHA, in partnership with the trusts, has developed a range of methodologies for monitoring compliance against these standards and has begun testing these in designated areas within each trust.

The standards are being tested in acute medical wards, and acute inpatient and mental inpatient units. Plans are in place to include services provided for individuals with a learning disability.

The first composite monitoring report has been submitted by the PHA to the DHSSPS.

The PHA and HSCB have jointly revised the process for management and review of SAIs. The PHA with the DHSSPS has commenced arrangements for establishing a system. This will enable trusts to take necessary actions and learn from SAIs across the region.

Building capacity

Building on the work of our legacy organisations, we further supported and developed capacity in this area throughout 2009–2010. In the area of elective care reform, we achieved the 26 week and 13 week waiting time targets for treatment by AHPs for 2009 set by the Health Minister, and we are working towards his nine week maximum waiting time target.

Leading the way for AHPs

The PHA is also leading a regional AHP reform programme that aims to secure regional agreements on areas such as AHP treatment pathways and models of good practice. One of the key areas of focus is maximising the use of professional staff through a more effective combination of skills, using assistants and administrative staff.

H1N1 preparations

We established a regional AHP group to develop a regional guide to help HSC trusts respond to a potential H1N1 pandemic. Each of the seven professions agreed clinical priorities.

In other areas of clinical practice, we continued to lead in developing innovative and new services, and facilitate changes and modernisation. These included:

- implementation of the review of health visiting and community nursing;
- implementation of the *Bamford action plan for mental health and learning disability*;

- nursing/AHP representation on all LCGs;
- nursing /AHP involvement and support for service frameworks;
- AHP chair of the Northern Ireland lymphoedema network;
- service developments to enhance public health practitioners' skills in working with vulnerable children and families;
- autism training for all health visitors;
- introduction of a universal home visit for all children aged two years;
- development of a regional safeguarding nursing project;
- development of the DHSSPS 10 year quality strategy.

Engaging and developing

During August 2009 a series of workshops were held across Northern Ireland to engage with members of the nursing and midwifery community and other stakeholders in the development of a regional strategy for nursing and midwifery.

Through the five workshops, 150 participants were afforded the opportunity to contribute and shape this document under the four strategic themes of:

- developing person centred cultures;
- supporting learning and development;
- promoting safe and effective care;
- maximising resources for success.

This work, led by senior nurses, midwives and patient representatives, will build on the strategies developed by each of the trusts and is an opportunity to recognise the contribution made by the community of nursing and midwifery to the health and wellbeing of our population.

Professional development

The Health Minister launched a review into the contribution of health visitors and school nurses in Northern Ireland and has asked the PHA to take forward the implementation of the review.

In addition, work got underway to establish a professional forum for those nurses and midwives who are employed by the PHA and HSCB, both within and outside my directorate. The core purpose is to make sure everyone is up to date on professional/regulatory issues, from a policy, practice and professional regulation perspective.

Innovation for the future

The smooth handover from the DHSSPS to the PHA of the ECCH saw the continuation of a complex and challenging service design, procurement and implementation process in partnership with the five HSC trusts. The primary purpose of the ECCH is to improve the patient and client experience, providing better quality and more effective care.

Among its functions is to promote improvements in patient care through the use of healthcare technology and to fast track new products and innovation in HSC services. This past year saw the continuation of the remote telemonitoring pilots for people with severe chronic disease such as congestive heart failure, diabetes and COPD.

Meeting priorities

The PHA continued to work to meet PfA priorities in respect of compliance with patient safety and quality, and clinical and social care governance requirements, through full implementation of approved quality improvement plans, working in partnership with HSCB and trusts.

Effective public engagement

The DHSSPS is committed to a stakeholder-led service that is centred on the needs of patients, clients, carers and the wider population.

This is a policy reflected in *A healthier future* and reinforced by our Health Minister in his *Priorities for action*. Effective PPI is central to the delivery of safe, high quality services and is a key element of clinical and social care governance.

A key activity of the PHA is to build effective public engagement into our work – to establish coherent approaches to enable involvement of individuals, communities and other key stakeholders in shaping our work.

Personal and Public Involvement

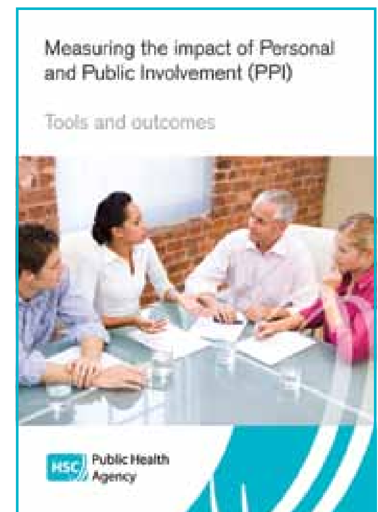
PPI is about people and communities influencing the planning, commissioning and delivery of health and social care services. It means actively engaging with service users and the public to discuss:

- their ideas, our plans;
- their experiences, our experiences;
- why services need to change;
- what people want from services;
- how to make the best use of resources;
- how to improve the quality and safety of services.

While the concept of PPI is not new, we have made considerable efforts during 2009–2010 to further embed PPI into our everyday work.

PPI consultation

The HSC (Reform) Act 2009 required the PHA, the HSCB, the DHSSPS, HSC trusts and special agencies to prepare a PPI consultation scheme for submission to the DHSSPS by the end of 2009. Our scheme was heavily influenced by the views of a variety of stakeholders obtained through a joint workshop with the HSCB and a series of one-to-one meetings. This is now with the DHSSPS for consideration in partnership with the PCC.



We continued to make progress on a number of issues identified by stakeholders as requiring action. The PHA hosted a workshop in January in partnership with the HSCB. This allowed the PHA to work with HSC colleagues on clarifying roles and responsibilities in relation to PPI, to establish a regional forum that helps organisations work in a more coordinated way, and to develop a regional PPI action plan.

We also piloted a series of two-day training events for senior, front line health and social care and voluntary/community sector staff in engaging with service users and the public.

Measuring the impact

In pursuance of action in our corporate plan, we commenced the development of a robust approach to assist the measurement of the impact of PPI, in particular ensuring full engagement and sensitivity to people and communities experiencing health and wellbeing inequalities. Ensuring PPI involvement in the R&D function of the PHA is also underway.

The stakeholder involvement e-network www.engage.hscni.net continues to be a key communication tool for information sharing and support among stakeholders.

Operations - Edmond McClean

The operations directorate of the PHA concerns processes, people and resources – all essential elements in developing a fit-for-purpose organisation that applies its skills and capabilities successfully, in partnership with others, to play a leading role in the new health structures.

Corporate plan

Our first corporate plan for 2009–2010 laid down a firm foundation on which to build and develop a strong organisation and infrastructure that manages resources effectively, efficiently and economically – in tandem with robust accountable governance. It set us on the right course and gave us a real sense of direction as we shaped our work practices and fulfilled our commitments.

Strategic development and governance

We inherited much good work and practice from the legacy organisations and this stood us in good stead as we began our journey of rolling out our organisation's development strategy. Development of an interim governance framework – which concerns accountabilities and responsibilities and how we are directed and controlled – was a core step in our working in 2009–2010.

This will form the basis of a holistic new governance framework and strategy for the PHA. Allied to this was initial work on the development of internal performance monitoring and reporting systems supporting the PHA across all its functions.

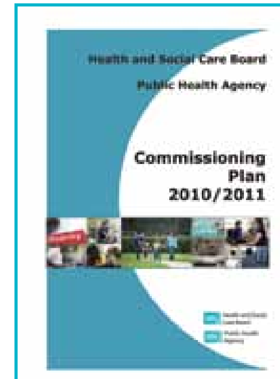
A suite of interim information governance policies were developed and an information governance leaflet produced and circulated to all staff outlining good practice and guidance on issues such as data protection and freedom of information.

Arrangements were put in place to establish the Chief Executive and Chair's offices, and to organise and provide support to the PHA board and its committees.

Commissioning

An important mechanism for the PHA in connecting regional policies and strategies to local action was the development of a joint commissioning plan covering the full PHA budget.

In partnership with the HSCB, we agreed a plan that focused on high quality, safe services consistent with meeting patient and client needs, had due regard to ministerial priorities and resources available, and strove to reduce inequalities.



Work began during the year to initiate a joint commissioning plan for 2010–2011, taking into account priorities such as the Northern Ireland Executive's PFG 2008–2011 and associated public service agreements, the ministerial PfA 2009–2010 as well as early guidance on PfA 2010–2011, and prevailing financial circumstances.

Risk management processes were established through the development of an interim corporate risk register and directorate risk registers. These will be reviewed regularly.

Performance monitoring

To support implementation of our corporate plan and timely reporting on DHSSPS performance targets, a web-based performance monitoring system was developed. This will be further refined and rolled out during 2010–2011.

Financial management

In fulfilment of our responsibility to achieve financial balance and live within our allocated resources through effective stewardship, we implemented financial management arrangements with the HSCB and BSO and will continue to examine and develop these to ensure that our strategic financial management requirements are met fully.

A major part of this was working closely with PHA programme managers, HSCB finance colleagues and DHSSPS policy and financial colleagues to provide a clear and detailed picture of commitments and expenditure against all the programme budgets, enabling the provision of timely information to support AMT decision making.

The PHA also led work in collaboration with the HSCB to review the range of processes used by the legacy organisations to fund voluntary and community organisations, resulting in a single regional process supported by standard documentation.

Interim controls assurance framework

An interim assurance framework, which operates to maintain and help provide reasonable assurance of the effectiveness of internal control across all areas of the PHA's activity, was approved by the board in October. This framework covers corporate control, safety and quality, finance, operational performance and service improvement. During 2010, it will be replaced by an overarching governance framework covering all domains of governance and related requirements placed upon it by the DHSSPS.

The following table details controls assurance standards compliance by the PHA during 2009–2010.

Figure 1: PHA controls assurance compliance 2009–2010

Standard	Progress expected by DHSSPS in 2009–2010	Position recorded by PHA in 2009–2010
Buildings, land, plant, and non-medical equipment	Substantive	Substantive
Emergency planning	Substantive	Substantive
Environmental management	Substantive	Substantive
Financial management	Substantive	Substantive
Fire safety	Substantive	Substantive
Governance	Substantive	Substantive
Health and safety	Substantive	Substantive
Human resources	Substantive	Substantive
ICT	Substantive	Substantive
Purchasing and supply	Substantive	Substantive
Records management	Substantive	Moderate
Research governance	Substantive	Substantive
Risk management	Substantive	Substantive
Security management	Substantive	Substantive
Waste management	Substantive	Substantive

Governance and audit committee

The interim framework will continue to be reviewed by the GAC and the board until a fully functioning system for monitoring the PHA's internal control system is implemented. The GAC held its first meeting in June. A subsequent meeting was held in October to approve the mid-year assurance statement and other relevant documents that support the internal control system.

Accommodation

The PHA was asked at its outset to consider options for a new headquarters for the organisation. A project team was established involving staff from the PHA, health estates and HSCB finance to develop a business case. The first stage of this work has been completed and considered by the PHA board and is now awaiting comment and guidance from DHSSPS.

At the same time the use of workspace across the PHA locations in Belfast city centre was reviewed, and some additional space leased to accommodate the new organisation and better support our functional needs.

A competent workforce

We continued the work started by our legacy bodies in growing a competent, confident workforce through planned training and support. Training in operational procedures and governance issues was organised for all PHA staff in partnership with the HSCB.

Workshops focusing on governance issues organised through the Beeches management centre facilitated the development of non-executive members of the board. Dedicated commissioner development training also took place.

To ensure close collaboration with all our health partners, regular meetings took place throughout the year at a senior level with all HSC organisations, including the chairs of the five LCGs, the assistant directors of commissioning and, in support of the partnership working with local government, the chief executives of all local council areas.

Staffing

Staffing structures are in place to tier 3 level, while tier 4 level and below still remain to be put in place. A number of staff have availed of the opportunity to take voluntary early retirement or voluntary redundancy packages.

Health intelligence

Responsibility for health intelligence also lies within this directorate. This function, encompassing knowledge management, facilitates the capture and use of knowledge for health and wellbeing improvement and protection, and the addressing of inequalities. Demands are increasing – reshaping and developing in light of our new organisation's needs.

Specialist support

We provide specialist support on information collation, analysis and appraisal, research and evaluation studies, and informatics. In addition, we are committed to testing and developing new and innovative practices and seeking greater understanding about the nature of health inequalities and the impact of action.

Health intelligence is a cross-cutting function across all divisions within the PHA. Our challenge this past year has been realigning this function to maximise the impact of high quality, relevant data by improving access to health information and intelligence across all HSC organisations in Northern Ireland.

A priority has also been to develop constructive and effective arrangements with the HSC data warehouse to access and shape services.

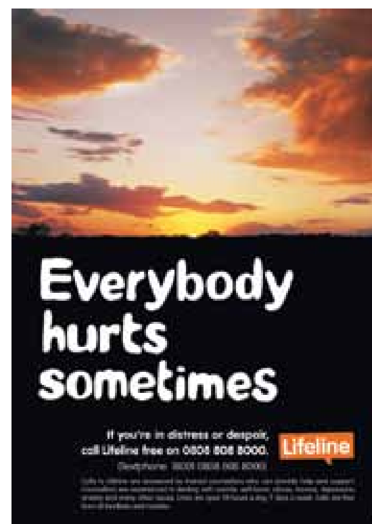
Building capacity

Much of our time in 2009–2010 has focused on servicing the demands of projects carried over from the legacy organisations. In pursuing our aim to further develop our knowledge and research capacity, work commenced on the development of a knowledge management framework in conjunction with the new COE for public health.

Building relationships

We have worked to build closer working relationships with key HSC, departmental, academic and local government partners to optimise the use of existing data sources and the commissioning of new research. We continued work on the development of an effective and efficient knowledge base that enables flexible, shared access to public health knowledge and helps influence the strategic agenda of other organisations and interests.

Important work



Key achievements this past year included the all-Ireland evaluation of applied suicide intervention skills training, evaluation of our regional suicide helpline Lifeline, and Food in Schools research.

Joint working with local government

The commitment to strengthening inter-sectoral working saw substantial progress made in joint working arrangements with local government. Almost all of the 26 local councils have indicated an interest in forming joint working arrangements with the PHA.

The work in developing the joint pilots is being led by a Steering Group comprising senior representatives from all committed geographic areas. Task groups have also been set up to develop a series of products to support the work of the joint teams in each locality. At time of writing, two joint working initiatives have been launched with more planned over the coming months.

Communications

The PHA's communications function – for both external and internal communications – also falls within the operations directorate. Accurate and relevant health information is essential if individuals are to make improvements to their health and we are committed to achieving high quality standards in all aspects of our communications practice.

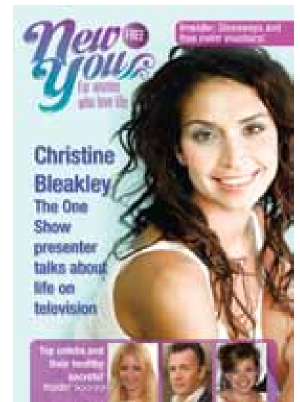
Fit-for-purpose systems

From the start it became apparent that the realisation of this new era relied in no small part on the need for fit-for-purpose communication systems to become a cornerstone in the strategic operation of the organisation. Our focus to date has included consolidation of legacy systems together with planning for the development of new bespoke systems.

A multi-disciplinary team

The communications demands facing the PHA to date have been both varied and challenging, requiring the full support of a multi-disciplinary team working across and supporting all areas of the organisation, and spanning the areas of publications development, design, website development, marketing, event management, public and media relations, and corporate communications.

Marketing and PR



Throughout the year our marketing and public relations function ran a number of major public information campaigns across a range of media to raise awareness and change attitudes, and help promote health choices and decision making, in the areas of smoking, alcohol, physical activity, sexual health and mental health.

The campaign "Reduce your drinking, reduce your risk of breast cancer" included television, radio, online and press advertising, and posters and leaflets. Washroom and phone kiosk posters and Facebook advertising were also used to promote the "Sex: don't just do it – think it through" campaign for young people. Alongside our usual promotion tools, we developed an activity log book for primary school children and a *New you* magazine for parents in support of our 'Physical activity: it all adds up!' campaign.

Campaign success

Our success in our campaign work was reflected in several awards that are detailed under the quality section of the Directors' report.

Publications support

On the publications and design side, we developed, produced and distributed over 160 resources for both the public and professionals in support of our work areas. This included the production of swine flu information for the general public, parents of young children, pregnant women, and health and social care workers.

Another major piece of work was the development and testing of information for the public, and for health professionals, to support the new bowel screening programme. The four leaflets for the public were translated into 10 regional and ethnic languages.

Electronic communications

Development of a corporate website www.publichealth.hscni.net to communicate messages to our external stakeholders and integrate content from our legacy systems was a priority for the new organisation. An intranet site was also rolled out as a communications channel for our staff.

Three new sites www.enjoyhealthyeating.info, www.hphlibrary.com and www.lifelinehelpline.info were introduced in support of nutrition, hospitals/health service and mental health work.

The www.breastfedbabies.org, www.getalifegetactive.com and www.mindingyourhead.info sites were also redeveloped.

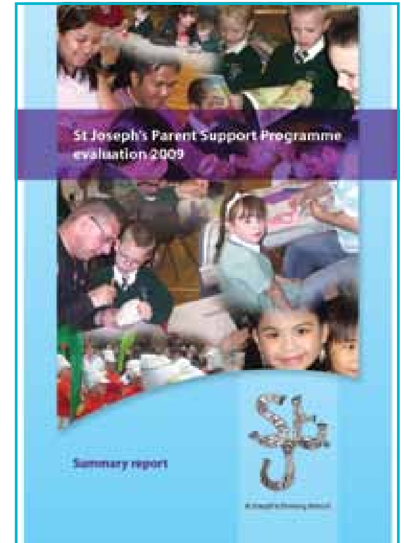
Event management

A number of conferences, seminars and training courses were organised by the PHA throughout the year on topics such as organ donation, healthcare associated infections, and healthy workplaces.

At the organ donor seminar held during the year are, from left, Dr Eddie Rooney, Chief Executive, Public Health Agency; Mr Chris Rudge, National Clinical Director for Transplantation, Department of Health, London; and Health Minister, Michael McGimpsey.

The staff involved in setting up the Belfast Health Development Unit, back row, from left, Suzanne Wylie, Beverley Smith, Caroline Bloomfield, Tom Crossan, Adele Keys, Margery Magee and Dr Leslie Boydell. Front row, from left, Mary Black, Elaine McCarthy, Valerie Brown, Elma Greer and Martina Smyth.

Communications support was also provided at partnership events such as the Farset health inequalities conference and at launches of the integrated services for children and young people programme, the St Joseph's primary school parent support programme evaluation report, and the Belfast Health Development Unit. We facilitated stakeholder engagement for issues such as suicide prevention, fuel poverty and community development work.



Shaping our future

Alongside the everyday communications activities, good progress has also been made, through various task and working groups, in developing the protocols that will shape future communications strategies. Important links have also been made to aid coordination with communications personnel across the HSC family in the DHSSPS, HSCB, and trusts.

Operating and financial review

Report from the Governance and Audit Committee (GAC)

The GAC was established to give assurance to the PHA board, based on an independent and objective review, that effective risk management and internal control arrangements are in place for finance, corporate governance and related areas.

The GAC comprises four non-executive directors of the PHA: Mrs J Erskine (Chair); Mr R Orr; Mr T Mahaffy; and Cllr S Nicholl. The committee is supported by: Mr E McClean, Director of Operations, PHA; Mr P Cummings, Director of Finance, HSCB; Mrs C McKeown, Head of Internal Audit, BSO; and their respective staff.

Representatives of the Northern Ireland Audit Office and PricewaterhouseCoopers attend as required.

The GAC decided at an early stage (in conjunction with the HSCB GAC) to recruit up to two independent lay advisors with expertise in finance and governance. Interviews have taken place and an announcement will be made shortly.

Meetings

The GAC met on the following dates during 2009–2010: 29 June 2009, 6 October 2009, 14 January 2010 and 4 March 2010.

GAC activities during 2009–2010

During 2009/10 the GAC:

- Noted the statement of assurance provided by the audit committee of the legacy Health Promotion Agency (HPA) and recommended the accounts and draft annual report of the legacy HPA to the PHA board for approval.
- Endorsed the process for developing an interim corporate risk register, directorate risk register, and a new corporate risk register. Approved a new risk assessment tool and subsequently approved the interim corporate risk register and new directorate risk registers.
- Approved the interim assurance framework.
- Had oversight of the process for self-assessment of compliance with controls assurance standards.
- Agreed the mid-year assurance statement and recommended its approval to the board.
- Self-assessed the GAC against the NAO audit committee self assessment checklist for submission to the DHSSPS, and approved an action plan arising from this.
- Approved a suite of interim information governance policies.
- Approved the internal audit workplan for 2010–2011 and considered the reports on each piece of work.
- Provided assurance to the board that the annual accounts would be prepared in accordance with the relevant statutory regulations.
- Reviewed the standing orders.

The GAC looks forward to continuing its work in 2010–2011, building on relationships with executive directors, PHA officers, and internal and external auditors to ensure robust governance across the PHA.

Julie Erskine
Chair of Governance and Audit Committee

Overview

These accounts have been prepared in a form determined by the DHSSPS based on guidance from the Department of Finance and Personnel's Financial Reporting Manual (FReM) and in accordance with the requirements of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

This summary financial statement does not contain sufficient information for a full understanding of the activities and performance of the PHA. For further information, the full accounts (including the statement of internal control), Annual Report and Auditor's Report for the year ended 31 March 2010 should be consulted.

Copies of the full accounts are available from:

Director of Finance
Health and Social Care Board
12–22 Linenhall Street
Belfast
BT2 8BS

NET EXPENDITURE ACCOUNT FOR YEAR ENDED 31ST MARCH 2010

	2010 £000s	Restated 2009 £000s
Expenditure		
Staff costs	(12,988)	(13,026)
Depreciation	(52)	(68)
Other expenditure	(29,865)	(44,266)
	(42,905)	(57,360)
Income		
Income from activities	-	419
Other income	392	874
	392	1,293
Net expenditure	**(42,513)**	**(56,067)**
Credit reversal of notional costs		
Cost of capital	(329)	(86)
Notional costs (audit fees)	26	24
Net expenditure for the financial year	**(42,816)**	**(56,129)**
Summary of Revenue		
Resource outturn		
Net expenditure	(42,513)	(56,067)
RRLs issued (to)		
Belfast HSC Trust	(9,795)	
South Eastern HSC Trust	(1,448)	
Southern HSC Trust	(6,824)	
Northern HSC Trust	(3,923)	
Western HSC Trust	(3,669)	
Total RRL issued	(25,659)	-*
Total commissioner resources utilised	(68,172)	(56,067)
RRLs received from		
DHSSPS (cash and non cash)	68,350	56,067
Surplus/deficit against RRL	**178**	**-**

* The equivalent of RRL's issued to Trusts in the financial year ended 31 March 2009 are included within Other Expenditure.

Revenue Resource Limit

Resulting from the introduction of the Non Departmental Public Body (NDPB) format of accounts, the Revenue Resource Limit (RRL) has been introduced as a means of setting a cash limit to the amount of funding to be drawn directly from the DHSSPS by the trust in relation to the costs of providing services to Agency residents. This RRL mechanism replaced the Service and Budget Agreement previously in place, which allowed for cash to be paid directly to the trusts by the legacy boards for the costs of services provided to the legacy Agency residents.

The memorandum below expresses the PHA 'Net Expenditure Account' in a traditional income and expenditure format.

SUMMARY FINANCIAL INFORMATION FOR YEAR ENDED 31ST MARCH 2010

	2010 £000s	Restated 2009 £000s
Income		
RRL received from DHSSPS	68,350	56,067
Other income	392	1,293
	68,742	57,360
Expenditure (including RRLs issued to Trusts)		
Staff costs	(12,988)	(13,026)
Depreciation	(52)	(68)
Expenditure	(55,524)	(44,266)
	(68,564)	(57,360)
Surplus/(deficit)	**178**	**-**

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2010

		2010 £000s		Restated 2009 £000s
NON-CURRENT ASSETS				
Property, plant and equipment		199		108
Intangible assets		3		6
TOTAL NON-CURRENT ASSETS		202		114
CURRENT ASSETS				
Inventories	-		2	
Trade and other receivables	710		485	
Other current assets	24		58	
Cash and cash equivalents	111		8,155	
TOTAL CURRENT ASSETS		845		8,700
TOTAL ASSETS		**1,047**		**8,814**
CURRENT LIABILITIES				
Trade and other payables		(16,754)		(11,931)
TOTAL CURRENT LIABILITIES		(16,754)		(11,931)
NON-CURRENT ASSETS PLUS/LESS NET CURRENT ASSETS/ LIABILITIES		**(15,707)**		**(3,117)**
ASSETS LESS LIABILITIES		**(15,707)**		**(3,117)**
RESERVES				
Revaluation reserve		23		21
General reserve		(15,730)		(3,138)
		(15,707)		**(3,117)**

I certify that the attached Financial Statements and Annual Report were approved by the board of Directors on:

Signed: **Date:** 1 June 2010

STATEMENT OF CASHFLOWS FOR THE YEAR ENDED 31 MARCH 2010

	2010 £000s	Restated 2009 £000s
Cashflows from operating activities		
Net expenditure after cost of capital and interest	(42,513)	(56,067)
Adjustments for non cash costs	(248)	21
(Increase)/decrease in trade & other receivables	(191)	20
(Increase)/decrease in inventories	2	2
Increase/(decrease) in trade payables	4,823	790
Less movement in payables relating to capital	-	(4)
Net cash outflow from operating activities	(38,127)	(55,238)
Cashflows from investing activities		
Purchase of property, plant and equipment	(144)	(9)
Purchase of intangible assets	-	-
Proceeds of disposal of property, plant and equipment	3	-
Proceeds on disposal of intangibles	-	-
Interest received	-	-
Net cash inflow/(Outflow) from investing activities	(141)	(9)
Cash flows from financing activities		
Grant in aid	30,224	54,806
Net financing	30,224	54,806
Net increase (decrease) in cash and cash equivalents in the period	(8,044)	(441)
Cash and cash equivalents at the beginning of the period	8,155	8,596
Cash and cash equivalents at the end of the period	**111**	**8,155**

Management board

The Management board responsible for setting the direction of the PHA is made up of the following individuals:

Executive members:

Dr Eddie Rooney (Chief Executive)
Dr Carolyn Harper
Edmond McClean
Mary Hinds

Non-executive members:

Mary McMahon (Chairperson)
Julie Erskine
Dr Jeremy Harbison
Miriam Karp
Thomas Mahaffy
Cllr Cathal Mullaghan
Cllr Stephen Nicholl
Ronnie Orr

Equal opportunities

The PHA has in place an equal opportunities policy to promote and provide equality between persons of different genders, marital or family status, religious belief or political opinion, age, disability, race or ethnic origin, nationality or sexual orientation, between persons with a disability and persons without, between persons with dependents and persons without, between men and women generally, and irrespective of staff organisation membership. This policy applies to recruitment, promotion, training, transfer and other benefits and facilities.

Public sector payment policy – measure of compliance

The Department requires that the PHA pays its non-HSC trade creditors in accordance with the CBI prompt payment policy and government accounting rules. The PHA's payment policy is consistent with the CBI prompt payment codes and government accounting rules and its measure of compliance is:

	2010 number	2009 number
Total bills paid	6,821	7,180
Total bills paid within 30 day target	6,371	6,866
% of bills paid within 30 day target	**93.4%**	**95.6%**

Related party transactions

During the year, none of the board members, members of key management staff or other related parties has undertaken any material transactions with the PHA.

Directors' interests

Details of company directorships or other significant interests held by directors, where those directors are likely to do business, or are possibly seeking to do business with the PHA where this may conflict with their managerial responsibilities, are held on a central register. A copy is available from Edmond McClean, PHA Director of Operations.

Charitable donations

The PHA did not make any charitable donations during the financial year.

Post balance sheet events

There are no post balance sheet events that have a material impact on the accounts.

Sickness absence information

The percentage figure for sickness absence for the 2009–2010 year is 2.5%. Further information is detailed within the Directors' report section.

Personal data-related incidents

There were no major personal data related incidents requiring disclosure.

Audit services

The PHA's statutory audit was performed by PricewaterhouseCoopers on behalf of the Northern Ireland Audit Office. The audit fee for 2009–2010 was £26k.

Statement on disclosure of audit information

All directors can confirm that they are not aware of any relevant audit information of which the PHA's auditors are unaware.

Staff numbers

The average number of whole time equivalent persons employed during the year was:

	2010			2009
	Total no.	**Permanently employed staff no.**	**Others no.**	**Total no.**
Health commissioning improvement and protection	**247**	221	26	235

Remuneration report for the year ended 31 March 2010 (audited)

Scope of the report

Article 242B and schedule 7A of the Companies (NI) Order 1986, as interpreted for the public sector, requires HSC bodies to prepare a remuneration report containing information about directors' remuneration. The remuneration report summarises the remuneration policy of the PHA and particularly its application in connection with senior executives. The report also describes how the PHA applies the principles of good corporate governance in relation to senior managers' remuneration in accordance with HSS (SM) 3/2001 issued by the DHSSPS.

Remuneration committee

The board of the PHA, as set out in its standing orders, has delegated certain functions to the remuneration committee. The membership of this committee is as follows:

Members

Mary McMahon (Chair)
Dr Jeremy Harbison
Miriam Karp
Cllr Cathal Mullaghan

During the 2009–2010 year the committee met on one occasion to agree its terms of reference.

Remuneration policy

1. The membership of the remuneration committee for the PHA consists of the Chair and at least two of its non-executives.

2. The policy on remuneration of the PHA senior executives for current and future financial years is the application of terms and conditions of employment as provided and determined by the DHSSPS.

3. Performance of senior executives is assessed using a performance management system that comprises individual appraisal and review. Their performance is then considered by the remuneration committee and judgements are made to their banding in line with the departmental contract against the achievement of regional organisation and personal objectives.

4. The relevant importance of the appropriate proportion of remuneration is set by the DHSSPS under the performance management arrangements for senior executives.

5. In relation to the policy on duration of contracts, all contracts of senior executives in the PHA are permanent and contain a notice period of three months.

Service contracts

Senior executives in the year 2009–2010 were on DHSSPS senior executive contracts, which are detailed and contained within the circular HSS (SM) 2/2001.

Directors

Dr Eddie Rooney, Chief Executive, appointed 01 April 2009.
Dr Carolyn Harper, Director of Public Health/Medical Director, appointed 01 April 2009.
Edmond McClean, Director of Operations, appointed 01 April 2009.
Mary Hinds, Director of Nursing and Allied Health Professionals, appointed 18 May 2009.

Non-executive directors

The Non-executive directors were appointed for a period of four years, with effect from 1 April 2009.

Chair	Mary McMahon
Non-executive director	Julie Erskine
Non-executive director	Dr Jeremy Harbison
Non-executive director	Miriam Karp
Non-executive director	Thomas Mahaffy
Non-executive director	Councillor Cathal Mullaghan
Non-executive director	Councillor Stephen Nicholl
Non-executive director	Ronnie Orr

No other persons served at board director level during 2009–2010.

A notice period of three months is provided by either party except in the event of dismissal. There is nothing to prevent either party waiving the right to notice or from accepting payment in lieu of notice.

Retirement age

Currently, employees are required to retire at age 65 although employees can ask to work beyond this age in accordance with Equality (Age) Regulations (NI) 2006.

Premature retirement costs

Section 16 of the Agenda for Change terms and conditions handbook (issued 14 February 2007 under cover of the Department's Guidance Circular HSS AfC (4) 2007, sets out the arrangements for early retirement on the grounds of redundancy and in the interest of this service. Further circulars have been issued by the Department – AfC (6) 2007 and HSS AfC (5) 2008 set out changes to the timescale for operation of the transitional protection under these arrangements.

Under section 16 of the Agenda for Change terms and conditions handbook, individuals who were members of the HPSS superannuation scheme prior to 1 October 2006, are over 50 years of age and have at least five years membership of the HPSS superannuation scheme, qualify for transitional protection. Staff who qualify for transitional protection are entitled to receive what they would have received by way of pension and redundancy payment had they taken redundancy retirement on 30 September 2006.

This includes enhancement of up to 10 years additional service (reduced by the number of years between September 2006 and the actual date of retirement) and a lump sum redundancy payment of up to 30 weeks pay (reduced by 30% for each year of additional service over 6 2/3 years). Alternatively, staff made redundant who are members of the HSS pensions scheme, have at least two years' continuous service and two years' qualifying membership, and have reached the minimum age (currently 50 years) can opt to retire early without a reduction in their pension as a alternative to a lump sum redundancy payment of up to 24 months pay.

In this case, the cost of the early pension payment is taken from the lump sum redundancy payment; however, if the redundancy payment is not sufficient to meet the early pension payment cost, the employer is required to meet the additional costs.

Salary (Audited)

The salary and the value of any taxable benefits in kind of the most senior members of the PHA were as follows:

	2009–2010	
Name	**Salary, including performance pay £000s**	**Benefits in kind (Rounded to nearest £100)**
Non-executive members		
M McMahon	30-35	-
J Erskine	5-10	-
J Harbison	5-10	-
M Karp	5-10	-
T Mahaffy	5-10	-
C Mullaghan	5-10	-
S Nicholl	5-10	-
R Orr	5-10	-
Executive members		
E P Rooney	115-120	100
C Harper	130-135	100
E McClean	75-80	-
M Hinds	85-90	-

Pensions (Audited)

The pension entitlements of the most senior members of the PHA were as follows:

	2009–2010				
Name	Real increase in pension and related lump sum at age 60 £'000	Total accrued pension at age 60 and related lump sum £'000	CETV at 31/3/09	CETV at 31/3/10	Real increase in CETV £'000
Non-executive members					
M McMahon	-	-	-	-	-
J Erskine	-	-	-	-	-
J Harbison	-	-	-	-	-
M Karp	-	-	-	-	-
T Mahaffy	-	-	-	-	-
C Mullaghan	-	-	-	-	-
S Nicholl	-	-	-	-	-
R Orr	-	-	-	-	-
Executive members					
E P Rooney	*See note below				
C Harper	0-2.5 pension 0-2.5 lump sum	20-25 pension 60-65 lump sum	317	353	9
E McClean	0-2.5 pension 5-7.5 lump sum	15-20 pension 45-50 lump sum	266	326	35
M Hinds	*See note below				

* E P Rooney and M Hinds joined the scheme during the 2009–2010 financial year. BSO's Superannuation Branch has indicated that due to the fact that they have not completed a full year in the scheme, it was not possible to calculate their pension entitlements.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the HSC pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer.
It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (Including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Statement of the Comptroller and Auditor General to the Northern Ireland Assembly

I have examined the summary financial statement for the year ended 31 March 2010 as set out at pages 26 to 28.

Respective responsibilities of the Public Health Agency, Chief Executive and Auditor

The Public Health Agency and Chief Executive are responsible for preparing the summary financial statement.

My responsibility is to report to you my opinion on the consistency of the summary financial statement within the Annual Report with the full annual financial statements, and its compliance with the relevant requirements of the Health and Social Care (Reform) Act (Northern Ireland) 2009 and Department of Health, Social Services and Public Safety directions made thereunder.

I also read the other information contained in the Annual Report, and consider the implications for my certificate if I become aware of any apparent misstatements or material inconsistencies with the summary financial statement. The other information comprises the Operating and financial review.

Basis of audit opinions

I conducted my work in accordance with Bulletin 2008/03 'The auditors' statement on the summary financial statement in the United Kingdom' issued by the Auditing Practices Board. My report on the Public Health Agency full annual financial statements describes the basis of my audit opinions on those financial statements and the part of the Remuneration Report to be audited.

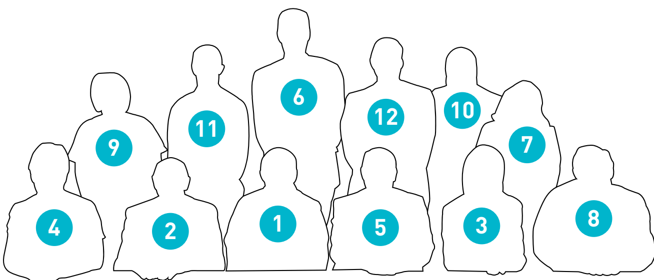
Opinion

In my opinion, the summary financial statement is consistent with the full annual financial statements of the Public Health Agency for the year ended 31 March 2010 and complies with the applicable requirements of the Health and Social Care (Reform) Act (Northern Ireland) 2009 and Department of Health, Social Services and Public Safety directions made thereunder.

KJ Donnelly
Comptroller and Auditor General
Northern Ireland Audit Office
106 University Street
Belfast
BT7 1EU

18 June 2010

PHA board



1 Mary McMahon

Mary is the PHA's Chair and is a self-employed Social Policy Researcher. She was previously coordinator with the Belfast Traveller Support Group and is a member of Amnesty International (Mid-Down branch), the Committee on the Administration of Justice and also the United Nations Children's Fund (UNICEF). She is a Belfast Harbour Commissioner.

2 Dr Eddie Rooney

Dr Rooney is Chief Executive of the PHA and was formerly Deputy Secretary in the Department of Education where his responsibilities included leading policy on the RPA. He transferred to the Office of the First Minister and Deputy First Minister as Equality Director in 2008.

3 Dr Carolyn Harper

Dr Harper is the PHA's Director of Public Health and Medical Director. She was previously Deputy Chief Medical Officer in the DHSSPS. She trained in general practice before moving into public health and also worked as Director of Quality Improvement for the Quality Improvement Organisation in California.

4 Mary Hinds

Mary Hinds is the PHA's Director of Nursing and Allied Professions. She was previously Director of the Royal College of Nursing (RCN) in Northern Ireland. Prior to joining the RCN, she was Director of Nursing at the Mater Hospital in Belfast.

5 Edmond McClean

Edmond McClean is the PHA's Director of Operations. He was previously lead Director supporting the initial development of Belfast and East LCGs. From 1997 to 2007 he was Director of Strategic Planning and Commissioning with the Northern Health and Social Services Board. This role also involved leading equality and human rights functions, Investing for Health and Northern Neighbourhoods Health Action Zones initiatives.

6 Paul Cummings

Paul Cummings is Director of Finance, HSCB. Paul, or a deputy, will attend all Agency board meetings and have attendance and speaking rights.

7 Julie Erskine

Julie Erskine is a member of the Northern Ireland Social Care Council and a member of the Northern Ireland Local Government Officers' Superannuation Committee. She has worked in the healthcare service industry for over 25 years and held the position of Operations Director and Support Services Director within a Belfast-based private healthcare company.

8 Dr Jeremy Harbison

Dr Harbison is a retired civil servant. He is a Pro Chancellor of the University of Ulster and a Trustee of the Community Foundation for Northern Ireland. He is Chair of the Northern Ireland Social Care Council and a Commissioner of the Northern Ireland Legal Services Commission.

9 Miriam Karp

Miriam Karp is a member of the Northern Ireland Social Care Council, a member of the Statutory Committee (Conduct committee) of the Northern Ireland Pharmaceutical Society, a Council Member of the Northern Ireland General Teaching Council, a member of the Social Care Institute Of Excellence (SCIE) Partners' Council and a consultant for Arthritis Care UK and the National Cancer Screening Programme in Ireland.

10 Councillor Stephen Nicholl

Stephen Nicholl is a locally elected representative member of Antrim Borough Council. He is employed as a Policy Advisor to Jim Nicholson MEP and was previously Secretary and Project Manager for the New Lodge Duncairn Community Health Partnership.

11 Thomas Mahaffy

Thomas Mahaffy is employed by UNISON as a Policy Officer with responsibility for partnerships, equality, human rights and social policy issues within Northern Ireland. He is a board member of the Northern Ireland Anti-Poverty Network and Human Rights Consortium.

12 Ronnie Orr

Ronnie Orr worked as a Social Services Officer with DHSSPS until 2009. He is currently a member of the Independent Monitoring Board for Hydebank Wood Prison and Young Offenders Centre.

Not pictured

Maeve Hully

Maeve Hully is Chief Executive of the Patient and Client Council (PCC). A representative from the PCC will attend all PHA board meetings.

Fionnuala McAndrew

Fionnuala McAndrew is Director of Social Care and Children, HSCB. Fionnuala, or a deputy, will attend all Agency board meetings and have attendance and speaking rights.

Councillor Cathal Mullaghan

Cathal Mullaghan is a locally-elected representative member of Belfast City Council. He is a board member of Libraries NI from 1 August 2009. He also sits on the Northern Ireland Local Government Association (NILGA).

Acronyms

AHP Allied Health Professions

AMT Agency Management Team

BSO Business Services Organisation

CDSC Communicable Disease Surveillance Centre

COE Centre of Excellence

COPD Chronic Obstructive Pulmonary Disease

DARD Department of Agriculture and Rural Development

DE Department of Education

DHSSPS Department of Health, Social Services and Public Safety

DSD Department for Social Development

ECCH European Centre for Connected Health

FoI Freedom of Information

GP General Practitioner

HAZ Health Action Zone

HCAI Healthcare Associated Infection

HE Home Economics

HLC Healthy Living Centre

HPA (UK) Health Protection Agency

HRB Health Research Board

HSC Health and Social Care

HSCB Health and Social Care Board

HSE Health Service Executive

IfH Investing for Health

INTERREG A community initiative that aims to stimulate interregional cooperation in the European Union

LCG Local Commissioning Group

MCADD Medium chain acyl dehydrogenase deficiency

MHFA Mental Health First Aid

MRSA Methicillin-resistant staphylococcus aureus

MSSA Methicillin-sensitive staphylococcus aureus

NCI National Cancer Institute

NCT National Childbirth Trust

NDACT Northern Drugs and Alcohol Coordination Team

NHS National Health Service

NIAS Northern Ireland Ambulance Service

NICaN Northern Ireland Cancer Network

NICRN Northern Ireland Clinical Research Network

NIHE Northern Ireland Housing Executive

NILGA Northern Ireland Local Government Association

PARC Physical Activity and Rejuvenation of Connswater

PCC Patient and Client Council

PfA Priorities for Action

PFG Programme for Government

PHA Public Health Agency

PPI Personal and Public Involvement

PSA Public Service Agreement

PSNI Police Service of Northern Ireland

R&D Research and Development

RAIL Regional Adverse Incident Learning

RPA Review of Public Administration

SAI Serious Adverse Incident

SSI Surgical Site Infection

US United States

WHO World Health Organization

Department of
Health, Social Services
and Public Safety
www.dhsspsni.gov.uk

AN ROINN
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin
an Fowk Siccar

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