PUBLIC HEALTH AGENCY
ANNUAL REPORT & ACCOUNTS
FOR THE YEAR ENDED 31 MARCH 2018

PUBLIC HEALTH AGENCY
ANNUAL REPORT & ACCOUNTS
FOR THE YEAR ENDED 31 MARCH 2018

Laid before the Northern Ireland Assembly
under Schedule 2, para 17(5) of the Reform Act for the Regional Agency, by the Department of Health

On 22 June 2018

Using this report

This report reflects progress by the Public Health Agency (PHA) in 2017/18 in delivering its corporate priorities and highlights examples of work undertaken to meet the targets as detailed in the PHA's *Annual business plan 2017–2018*. It shows how this work has contributed to meeting our wider objectives and fulfilling our statutory functions.

The full accounts of the PHA are contained within this combined document.

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

Other formats

Copies of this report may be produced in alternative formats upon request. A Portable Document Format (PDF) file of this document is also available to download from www.publichealth.hscni.net

Any enquiries regarding this document should be sent to us at:
Public Health Agency
12/22 Linenhall Street
Belfast
BT2 8BS

This publication is also available for download from our website at:
www.publichealth.hscni.net

ISBN: 978-1-874602-81-1

PUBLIC HEALTH AGENCY

ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2018

Getting in touch

Headquarters
4th floor
12–22 Linenhall Street
Belfast
BT2 8BS
Tel: 0300 555 0114 (Local call rate and included within inclusive call packages)

Northern Office
County Hall
182 Galgorm Road
Ballymena
BT42 1QB
Tel: 0300 555 0114 (Local call rate and included within inclusive call packages)

Southern Office
Tower Hill
Armagh
BT61 9DR
Tel: 0300 555 0114 (Local call rate and included within inclusive call packages)

Western Office
Gransha Park House
15 Gransha Park
Clooney Road
Londonderry
BT47 6FN
Tel: 0300 555 0114 (Local call rate and included within inclusive call packages)

Normal business hours:
9.00am–5.00pm Monday–Friday

PUBLIC HEALTH AGENCY

ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2018

Contents

PUBLIC HEALTH AGENCY

ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2018

PERFORMANCE REPORT

Overview

The Public Health Agency – our role, purpose and activities

The Public Health Agency (PHA) is the statutory body responsible for improving and protecting the health of our population and an integral part of the HSC system, working closely with the Health and Social Care Board (HSCB), local health Trusts, the Business Services Organisation (BSO) and the Patient Client Council (PCC).

Central to our main responsibilities is working in close partnership with individuals, groups and organisations from all sectors – community, voluntary and statutory.

The PHA was set up with the explicit agenda to:

- protect public health;
- improve the health and social wellbeing of people in Northern Ireland and work to reduce health inequalities between people in Northern Ireland;
- work with the Health and Social Care Board, providing professional input to the commissioning of health and social care services.

The PHA is a multi-disciplinary, multi-professional body with a strong regional and local presence.

During 2017/18, we continued to work and be guided by our purpose, vision and values. These were reviewed and updated as part of the development of the PHA Corporate Plan 2017–2021 and are therefore more representative of our vision for the future.

Our purpose

- protect and improve the health and social wellbeing of our population and reduce health inequalities through strong partnerships with individuals, communities and other key public, private and voluntary organisations.

Our vision

- all people and communities are enabled and supported in achieving their full health and wellbeing potential, and inequalities in health are reduced.

Our values

- we put individuals and communities at the heart of everything we do in improving their health and social wellbeing and reducing health inequalities;
- we act with openness and honesty and treat all with dignity, respect and compassion as we conduct our business;
- we work in partnership with individuals, communities and other public, private, community and voluntary organisations to improve the quality of life of those we serve;
- we listen to and involve individuals and communities;

- we value, develop and empower our staff and strive for excellence and innovation;
- we are evidence-led and outcomes-focused.

PUBLIC HEALTH AGENCY

ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2018

Overview from the Chief Executive and Chair

The Public Health Agency is the statutory body responsible for improving and protecting the health and wellbeing of the people of Northern Ireland and the last year has been an important and eventful period, albeit against a backdrop of reduced resources and staffing levels, and uncertainty regarding HSC reform and restructuring.

We have seen many notable achievements, successes and developments over the course of the year and, through this annual report for the 2017/18 financial year, we will highlight a small selection of these with a particular emphasis on fulfilment of PHA targets and goals, statutory requirements and Department of Health objectives.

Our *Business Plan* for 2017/18 contained some 86 key targets which cover every facet of our work and good progress has been made during the year against these, the achievement of which is monitored on a twice-yearly basis through Performance Management Reports to the PHA Board.

In November 2015, the then Minister outlined an end to the current way health and social care is commissioned and set out a requirement to strengthen accountability and authority within the system by streamlining structures, including the closure of the Health and Social Care Board (HSCB).

On the launch of *Health and Wellbeing 2026: Delivering Together* in October 2016, the then Minister confirmed the closure of the Board as part of a wider transformation agenda, setting out her intention to reduce bureaucracy to make decision-making more streamlined, and to plan and manage services in a way that promotes collaboration, integration and improvement in service delivery.

In January 2018, the Department of Health (DoH) confirmed that the HSCB would close and indicated that responsibility for HSCB functions and staff would move to the Department. This would be effected through a host organisation arrangement with a HSC body. Staff of the HSCB's Social Care and Children Directorate would however, transfer to the PHA. We look forward to welcoming these staff into the organisation in due course.

This additional responsibility for the PHA will bring new challenges and opportunities and, together, we will work with the Department of Health to implement these decisions and continue to promote the improvement and protection of health and wellbeing within a 'one system' ethos with a strong focus on transformation.

We must, however, acknowledge also that with the current political uncertainty in Northern Ireland any final decisions on operating models will be subject to business case approval and will require Ministerial consideration and legislation. This may therefore take some time.

It is also important at this time of change that we have a focused vision for the future. To this end, the PHA *Corporate Plan 2017–2021*, which was developed and

consulted on during 2016/17, was published in June 2017 following PHA Board and DoH approval in April and May 2017.

The plan sets out our strategic direction for the next four years and will help inform the shape and direction of a new PHA in line with then Minister O'Neill's vision set out in *Health and Wellbeing 2026: Delivering Together.*

As designated lead agency for the regional implementation of *Making Life Better* (MLB) we have been working over the course of the year with a range of stakeholders to implement MLB and to ensure strong alignment not only with our new Corporate Plan and *Delivering Together* but also with other key government policies and strategies including Department of Health (DoH) priorities, the *Draft Programme for Government Framework 2016–2021*, and local government-led Community Planning.

This whole-system, strategic framework for public health, launched in June 2014, builds on the earlier *Investing for Health* strategy which covered the years 2002–2012, and acknowledges that health and wellbeing are influenced by a broad range of social, environmental and economic factors.

We fully support the important collaborative and partnership approach championed by *Making Life Better* which recognises that many factors can affect an individual's health and wellbeing.

The health and social care sector alone cannot tackle the root causes of poor health and wellbeing and inequalities in health and so the whole-system approach is essential to the successful implementation of MLB.

We have also been building on the collaborative approach within the *Draft Programme for Government* and its subsequent delivery plans and continue to work closely with DoH and key partners in the ongoing development of the draft plans, ensuring close alignment with MLB.

As a statutory partner in Community Planning, the PHA has welcomed an increase in collaboration and partnership between the PHA and local councils. The past year has been no exception with continued close working, particularly regarding the development of community planning action plans.

While there are 11 separate Community Plans, each with different actions in response to differing local situations and factors, a number of common health and wellbeing themes have been identified across all:

- healthy lives (physical activity and healthy weight);
- mental health and wellbeing;
- age friendly;
- early years intervention.

We look forward to further supporting this process in each council area which will undoubtedly make a real, positive impact on people's lives.

We must also acknowledge all of our HSC partners who have worked in tandem with us to ensure *Making Life Better* and Community Planning are driven at a local level, based on local needs and shared outcomes.

Both Community Planning and the Northern Ireland Executive's *Draft Programme for Government Framework 2016–2021*, which has as its purpose to 'improve wellbeing for all by tackling disadvantage, and driving economic growth', draw heavily on outcomes-based accountability – which is a planning process that improves quality of life conditions in communities and improves outcomes for service users.

In line with this approach the PHA *Corporate Plan 2017–2021* is structured around long-term population outcomes with associated actions to help us achieve these outcomes. Over the period of this current plan we will therefore continue to further develop this approach, both with our staff and in working with our partners.

The reduction of health inequalities and ensuring a better quality of life for local people is a main aim of community planning and tackling health and wellbeing inequalities and promoting a shift towards prevention and early intervention are at the heart of our remit.

In general, the health of our population has been improving over time, as seen in increases in life expectancy, with average life expectancy now 78.3 years and 82.3 years for males and females respectively.

However, not everyone has had an equal chance of experiencing good health and wellbeing and too many people still die prematurely or live with preventable conditions which cause poor quality of life.

Poor mental health and a high level of suicide, obesity, an aging population, and associated increasing prevalence of dementia, healthcare associated infections, and drug resistance are just some of the many challenges facing us.

Another pressing issue is that of dental health, in particular child oral health and reducing the number of multiple extractions particularly in deprived communities. This matter will require the ongoing cooperation between the PHA and the Health and Social Care Board.

A new and improved bowel screening test which only requires one sample instead of three has been approved by the National Screening Centre for use throughout the United Kingdom. We are currently working with the DoH to secure funding. It is anticipated that this new test would considerably increase the numbers responding.

We are constantly looking to improve and develop all areas of the organisation and look to best practice both at home and abroad. Networks and collaboration nationally and internationally are encouraged and we regularly provide examples of our own high level of work to colleagues around the world.

One such example took place during the year when we welcomed a small delegation from the University of Malaya in Malaysia as part of a joint international research

programme between local organisations and the University. The visitors were looking at the possible development and transferability of the PHA's successful Be Cancer Aware public information campaign within Malaysia.

It was with regret that it was found necessary to discontinue several public media campaigns in Northern Ireland due to extensively reduced advertising budgets. However, it was possible to proceed in January 2018 with an already-planned campaign called #NotSorryMums urging a much greater number of Northern Ireland women to breastfeed.

Northern Ireland has one of the lowest rates of breastfeeding in the United Kingdom so the need for a change in how society perceives breastfeeding and how women are supported is essential. Special mention must go to the many women who helped to design and promote this message throughout the community.

The social media element of the campaign achieved great success with one Facebook post showing the TV ad reaching more than 1.2million people and the video being watched for over 150,000 minutes.

We were delighted to support during the year, as part of the local organising committee, the successful bid to host the 30th World Congress of the International Association for Suicide Prevention (IASP) to take place in Derry/L'Derry in 2019. The five day conference on the 17–21 September 2019 is expected to attract over 600 international delegates to the city which will have a major impact on raising awareness of this difficult issue and greatly contribute to the ongoing efforts to tackle suicide and provide help and guidance to those in need of support.

In recognition of the important joint campaign work we undertake with HSC partners we were delighted that the joint PHA/HSCB Stay Well This Winter campaign was shortlisted in two categories at the 2017 Chartered Institute of Public Relations Pride Awards. The campaign was shortlisted in both the Public Sector Campaign category and the Healthcare Campaign category.

Another great success worth mentioning was recognition among our colleagues within environmental health at the Chartered Institute of Environmental Health (CIEH) Excellence Awards where the PHA was shortlisted in the Best Environmental Health Project category for the 'It takes only seconds' home accident prevention blind cord safety video. The video was developed in association with local councils in Northern Ireland to encourage everyone to make their home blind cord safe. When launched on social media it was very successful, being viewed over four and a half million times.

The PHA commissions the Lifeline Crisis Response service, a key priority for the PHA in the fight against suicide and self-harm. Lifeline is a high-quality 24/7 telephone helpline service for people in distress or despair with follow-on counselling available for those who need it.

In autumn 2017 the PHA offered a contract extension to the then provider of this service for 12 months. That provider declined to accept the offer and in order to

secure the continuity of the Lifeline Crisis Response Service after expiry of the current contract, the PHA took immediate steps to secure an interim provider from 1 April 2018.

A range of procurement approaches available to us were deployed in order to secure a suitable service provider with experience in the field of mental health and helpline provision. These attempts were not successful in securing a non-statutory sector provider and in early February 2018 the PHA announced that the Lifeline service would move to Belfast Health and Social Care Trust for an interim period, with effect from 1 April 2018. Belfast Health and Social Care Trust will take the lead on behalf of the HSC in delivering this regional service. Under this arrangement, frontline staff who currently deliver the Lifeline service will transfer to Belfast Trust.

In delivering the Lifeline service, the PHA and the wider HSC will work to ensure that when anyone across Northern Ireland contacts Lifeline, they will receive the necessary level of support they require.

It was with great sadness that we learnt of the untimely passing of two of our colleagues during the year. Our thoughts and condolences are with the families of Anne Robinson and Lynne McGee.

Special acknowledgement and words of thanks must also go to Brian Coulter and Thomas Mahaffy, PHA non-executive directors, who both completed their terms as Board members at the end of the year. We thank them both for their extensive contribution to the work of the Agency Board.

A special mention must also go to Fionnuala McAndrew, Director of Social Care and Children within the Health and Social Care Board, who retired on 30 April 2018. Her sound counsel and expertise since 2009 will be much missed. We warmly extend to her every best wish in her retirement.

As we embark on a new financial year we acknowledge there is still much more to be achieved on all public health fronts but we welcome the challenges and look ahead to the upcoming year with confidence. With a highly professional and committed team and Board at the PHA, we are confident we can and will make a difference to the health of every individual in Northern Ireland.

The following report highlights the breadth of our work across all three directorates. It also acknowledges the challenges and the opportunities which lie ahead.

Valerie Watts
Chief Executive (Interim)

Date 11 June 2018

Andrew Dougal OBE
Chair

Date 11 June 2018

Performance Analysis

The PHA *Annual Business Plan 2017–2018*, sets out the key actions for year one of the PHA *Corporate Plan 2017–2021*, in the context of continuing constraints and uncertainties, especially in respect of organisational structures and budgets. Staff across the PHA, as well as Board members were engaged with, and contributed to, the content of the plan. A key strand running through the PHA *Annual Business Plan 2017–2018* was alignment with the *draft Programme for Government 2016 –2021*, *Making Life Better 2012–2023, Health and Wellbeing 2026: Delivering Together* and Community Planning.

The PHA *Annual Business Plan 2017–2018* contains 86 targets to take forward our five key outcomes:

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

Progress is reported to the PHA Board through twice yearly progress reports.

Performance against these targets has been of a high standard.

Figures, based on the position at 31 March 2018, report a total of 70 coded as green for achievability, 13 as amber, meaning they will be achieved, albeit with a short delay; and 3 as red.

The following narrative from each of the PHA's three Directorates, namely, the Directorate of Public Health; the Directorate of Nursing and Allied Health Professions; and, the Operations Directorate, details some of the activities undertaken during the year in fulfilment of organisational goals and to help achieve the above outcomes.

In addition, it looks at the future development of the organisation; environmental, social and community issues; and other relevant issues affecting organisational development.

PUBLIC HEALTH AGENCY

ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2018

DIRECTOR'S REPORT: PUBLIC HEALTH

In 2017/18, the Public Health Directorate continued to work in a challenging environment to achieve our corporate objectives and business goals to protect and improve the health and wellbeing of the people of Northern Ireland and reduce health inequalities. This requires collaborative effort across four key areas of work:

- Health Protection;
- Health and Social Wellbeing Improvement;
- Service Development and Screening; and
- HSC Research and Development.

It also requires good public health data and intelligence; as well as cross-sectoral collaboration with other government departments; public and private sector bodies; voluntary and community organisations; and, members of the public.

Such collaboration is vital in our work as the lead agency for the implementation of *Making Life Better*, the Northern Ireland Executive's strategic framework for public health. This work has been advanced through the action planning associated with the *Draft Programme for Government Framework 2016-21*. Much of this work is focused on prevention and early intervention programmes with the aim of increasing healthy life expectancy.

Hand in hand with that work, and in keeping with the Minister's 10 year vision for the transformation of the health and social care system *Health and Wellbeing in 2026: Delivering Together*, the Public Health Directorate continued its efforts to reduce health inequalities.

Indeed, the theme of the most recent Director of Public Health Annual Report for 2016, published on 8 June 2017, focussed on health inequalities. These are differences in health between different groups. Many of the inequalities we see are the result of social and economic factors. For example, even though life expectancy at birth continues to increase, people living in the most deprived areas do not live as long as those living in the least deprived areas of Northern Ireland. Such differences are unfair and require the organised efforts of society to address them.

The PHA is the lead employer for 10 junior doctors who are undertaking a specialist 5 year training programme in Public Health to become a Consultant in Public Health. The PHA and the other host training organisations, the Department of Health, Centre for Public Health at Queen's University and the Cancer Registry, are approved by the General Medical Council (GMC) as training locations. The training is led and delivered by consultants in the Public Health Directorate who have all recently achieved GMC recognition as approved supervisors. The quality of the training programme is closely monitored via a range of quality assurance activities. In November 2017, Northern Ireland Medical and Dental Training Agency (NIMDTA) carried out a visit to our training programme which received a provided a positive evaluation. Feedback from the trainees in GMC surveys is generally positive and compares very well with Public Health training provided in other parts of the UK.

Special achievements by trainees during 2017 include Dr Damien Bennett, Specialist Registrar in Public Health, who gained first place for his presentation at the Irish Faculty of Public Health's Scientific Meeting in December 2017.

The Directorate also supports the continuing professional development of all members of staff. Staff from a range of backgrounds are encouraged and supported to build their knowledge and skills in Public Health, including gaining Practitioner or other relevant status from the Faculty of Public Health.

The following report gives a sense of some of the important work the Directorate has undertaken over the last year, its key achievements, performance and outcomes and the impact it is having.

Health Protection

The Health Protection team within the Public Health Directorate continues to play a lead role in protecting the local population from infectious and environmental hazards through:

- the surveillance, prevention and control of infectious diseases;
- environmental health, emergency planning and response; and
- the public health response to chemical, radiation and poison exposures.

Delivery of immunisation programmes remains one of our biggest areas of work and Northern Ireland has some of the highest uptake rates for immunisation programmes in the UK and worldwide.

This has undoubtedly contributed to a reduction in the burden of infectious diseases in Northern Ireland. Our vaccine programmes protect the population throughout their lives; from birth and preschool, to school-aged children and young adolescents, through to working-age adults with pre-existing health conditions as well as pregnant women and the ageing population.

Though vaccine coverage is high overall, health inequalities mean that some groups of people and some areas in Northern Ireland are less likely than others to be vaccinated. The PHA is committed to maintaining and improving uptake rates of all immunisations. We work with general practitioners, health visitors and managers in the Child Health Information System to better understand the variation of preschool immunisation uptake across Northern Ireland and work together to improve coverage.

The Roma community often have low uptake of vaccines across Europe and so we are working with individuals from this community to better understand their knowledge, attitudes and barriers to vaccinations so that we can organise our vaccination programmes to better meet their needs.

The childhood vaccines protect again diphtheria; tetanus; whooping cough; and, polio; through to meningitis; measles; mumps; and, rubella. Vaccine against Group B

meningococcal disease is one of our most recent programmes and commenced on 1 September 2015.

Uptake of three doses of Meningitis B vaccine in infants up to two years of age was 94.1% in the third quarter of 2017 (October to December).

Latest figures available, for the financial year 2016/2017, show uptake of three doses of the five-in-one vaccine by 12 months of age was 97.0%. Uptake of one dose of MMR vaccine by two years was 95% and two MMR vaccines by five years of age was 92%.

Adolescents and young adults receive vaccines to protect against cervical cancer (the HPV vaccine) as well as meningitis and septicaemia. During 2016–2017, by the end of school year 10, 89.6% of girls had completed a course of HPV vaccine, and by the end of school year 12, 86.5% had received the new meningococcal ACWY vaccine. Figures for 2017/2018 are not yet available but a similar high uptake is envisaged.

Pregnant women are offered the flu and whooping cough (pertussis) vaccine to protect themselves and their new born babies. Uptake of the whooping cough vaccine in pregnancy is 72.3% as of November 2017.

Other individuals of working age (those under 65 years) receive protection for pneumococcal disease and influenza if they have medical conditions that put them at greater risk of disease.

Up to 12 March 2018, influenza vaccine uptake in Northern Ireland was 55.6% among those under 65 years in a clinical risk group.

Older people are offered the flu vaccine every year and the pneumococcal vaccine and shingles vaccine when they are 70 years of age.

Up to 12 March 2018, 71.5% of those aged 65 years and over had received the flu vaccine and from 1 October 2017 to 12 March 2018 uptake for 70 year olds of the shingles vaccine is 45.14%.

Meningococcal meningitis cluster

The following is a good example of work related to the monitoring and control of infectious diseases. It relates to a cluster of meningococcal meningitis in a high school during the peak of Storm Ophelia.

On 5 October 2017, the PHA's Health Protection Duty Room was notified of a probable case of meningococcal meningitis in an 11 year old female.

Chemoprophylaxis, the use of drugs to prevent disease, was arranged for household contacts in order to prevent any onward transmission and written information was provided for those at risk and to primary care colleagues. Microbiological testing subsequently confirmed the case to be serotype B meningococcus. On 12 October

the Duty Room was notified of a second probable case in an 11 year old female (one week later).

As before, chemoprophylaxis was arranged for household contacts and information provided. Further investigation revealed that the two cases attended the same class of a local high school.

According to the *Manual of infection control procedures*, the definition of a cluster of meningococcal disease is, "two or more confirmed or probable cases of meningococcal disease in the same preschool group, school, or college/university within a four week period".

A cluster of meningococcal disease was declared and an Outbreak Control Team (OCT) was convened on the same day to risk assess and implement control measures.

A total of 37 pupils and 17 teachers were identified at higher risk of meningococcal transmission because they spent all day together in one classroom with the cases. There were no other extracurricular or social links between the cases. Arrangements were made to offer chemoprophylaxis and two doses of vaccine, one month apart.
It can be logistically challenging to administer chemoprophylaxis and information to a risk group and Storm Ophelia made this even more complicated. As the school was closed, communication with parents of pupils was carried out by the headmaster through the school texting service. Arrangements were initially made with Trust school nursing teams and pharmacy to attend the school to provide chemoprophylaxis. However, due to adverse weather conditions, the school remained closed.

As an alternative, the next day public health nursing and medical staff spoke to parents of pupils and the teachers by telephone. The OCT is extremely grateful to local GPs in assisting public health with the prompt administration of chemoprophylaxis on the day. Arrangements were also made for the first dose of MenB vaccine to be administered the same week.

Within one week of declaring the cluster, the PHA, with the assistance of primary care, identified, phoned and administered chemoprophylaxis and the first dose of MenB vaccine to all contacts. Microbiological results subsequently confirmed both cases as indistinguishable serotype B meningococcus. There have been no further cases of meningococcal disease linked to the cluster.

Health and Social Wellbeing Improvement

Within the Health Improvement Division there has been a huge amount of work undertaken over the course of the last year to help improve the health and wellbeing of individuals and communities. This has included:

- enabling and encouraging healthy choices through, for example, promoting physical activity and reducing tobacco use and ensuring people are better informed about health matters and have access to relevant information;

- promoting and addressing issues associated with mental and emotional wellbeing through mental health promotion, drug and alcohol services and implementing *Protect Life 2 – A strategy for suicide prevention in the north of Ireland* and its associated action plan;

- addressing underlying determinants of health such as poverty and lack of educational opportunities through, for example, initiatives to support individuals and communities to maximise benefits and income and tackle fuel poverty and energy-efficiency at home.

There has also been a strong focus over the year on early interventions for families and children such as improving parenting skills and capacity and promoting breastfeeding.

Early Years

Good parenting and positive early life experiences are key factors in enabling the achievement of potential later-life outcomes including health and wellbeing. Important progress has been made over the last 12 months in the further development of a number of key interventions that have a critical role in addressing the PHA's health improvement theme to 'Give every child the best start in life'.

With regards to parenting support, the PHA has designed and implemented, in conjunction with the National Children's Bureau NI, the Incredible Years Coordination Programme. Working with over 80 delivery organisations, the PHA has introduced and increased the number of organisations that deliver the programme to the highest quality and fidelity standards. This action has led to improvement in the effectiveness and outcomes of the Incredible Years evidence-based programme which aims to reduce behaviour problems and increase problem solving skills, social competence and emotional regulation.

In addition, the PHA continues to focus on the development and implementation of other evidence-based parenting programmes such as Strengthening Families and the Solihull Parenting Programme.

A further programme, the Early Intervention Transformation Programme (EITP) which is a Northern Ireland Executive/Atlantic Philanthropies, Delivering Social Change signature programme, aims to improve outcomes for children and young people across Northern Ireland through embedding early intervention.

The universal workstream of EITP aims to equip all parents with the skills needed to give children the best start in life. During the year, the PHA agreed to design, implement and evaluate a new model of family support aimed at helping families with emerging vulnerabilities. In practice, this now means that through five Family Support Teams – the Early Intervention Support Service – over 700 families annually are being supported to address challenges and problems with over 50% of those supported, reporting improvements in four or more outcomes.

The programme is an excellent example of joint working with co-funding from Delivering Social Change; the Department of Health; Department of Education; Department of Justice; Department for Communities; Department for the Economy; and, the Atlantic Philanthropies. Information on other elements of the EITP programme can be found in the Nursing and Allied health Professions Director's section of this Annual report.

During 2017/18, the Agency has also worked with an extensive range of stakeholders to inform the development and implementation of an Infant Mental Health Framework and Plan. Informed by the latest emerging evidence and research about the extent to which brain and emotional capacity are dependent on experience and the environment, this Plan has three key priority themes which aim to increase focus on supporting 0–3 year olds. The themes include the use of evidence and policy; workforce development; and service development. A recent publication on joint policy and research with the NSPCC *Looking after infant mental health in Northern Ireland: our case for change* captures much of this important development.

Service Development and Screening

In the areas of Service Development and Screening, the PHA has led, and provided professional input to, a number of areas of work to support the objectives of the PHA as well as the Health and Social Care Board.

Service Development

The Service Development Division of the PHA provides public health advice to the Health and Social Care Board (HSCB) through input to commissioning teams and one or more Local Commissioning Groups. It also supports continuous improvement in safety and quality of services. Some examples of the work carried out by the Division during the year are detailed below.

Major trauma services

Major trauma causes serious injuries that can result in death or disability. National and international research has shown that improving the way trauma services are delivered can significantly reduce mortality.

During 2017, PHA medical, nursing and Allied Health Profession consultants worked as a team with HSCB commissioning colleagues to agree plans for service improvements in Northern Ireland. A major trauma network was set up, involving all six Trusts' Medical Directors and Directors of Acute Services, the Department of Health and HSCB/PHA members of staff.

The Clinical Advisory Subgroup also agreed standardised regional clinical protocols and patient record systems and organised specialised staff training. Data on key quality measures began to be collected and analysed to allow benchmarking of services and outcomes with England and Wales through the Trauma and Audit Research Network.

Work also got underway to agree additional staff and new ways of working at the Royal Victoria Hospital in the Belfast Trust which is Northern Ireland's Major Trauma Centre. As part of this, two extra Intensive Care Unit beds were opened in the summer of 2017 in tandem with the commencement of the Northern Ireland Helicopter Emergency Medical Service (HEMS) which aims to provide seriously injured patients with rapid care from a specialist doctor and paramedic team.

Critical care services

Critical care services are those required for the very sickest patients being looked after within hospitals. This is a regional service located in hospitals within each Trust. The services are supported by the Critical Care Network Northern Ireland (CCaNNI), which has a role to facilitate patient flow to available beds, standardise professional practice, improve the quality of critical care services and influence the strategic direction for critical care services. CCaNNI was set up ten years ago and has been very successful in achieving its aims during that time.

During 2017/18, the PHA and HSCB led a process to engage with, and seek the views of, CCaNNI members in respect of the future direction of the network.

Developing Eyecare Partnerships

The Developing Eyecare Partnerships Strategy, published by the Department of Health in 2012, was co-led by the PHA and HSCB over a five-year period ending in October 2017. Key achievements included:

- transformation of pathways for glaucoma, cataract and macular services;
- introduction of an acute eye scheme;
- improved IT integration for eyecare services;
- initiatives to promote good eye health and prevent sight loss –these included training for optometrists on smoking and sight loss, leaflets for employers and employees about preventing occupational eye injury, and development of a tool to assess vision in people at risk of falls;
- 10,000 MORE voices survey of peoples' experience of hospital eyecare services.

Myalgic Encephalopathy

Patients with Myalgic Encephalopathy (ME)/ Chronic Fatigue Syndrome (CFS) receive care from professionals working in primary care and hospital-based services. As a result of collaborative working between the PHA, HSCB, the Patient Client Council, patient representatives and support groups, a new post was agreed during the year for a physician with experience in ME/ Chronic Fatigue Syndrome to provide clinical leadership for the improvement of services across Northern Ireland. This development will also assist with implementation of the 2020 National Institute of Health and Care Excellence (NICE) guidance.

Breast Assessment

As a result of difficulties in recruiting and retaining specialist staff in a number of Trusts, particularly within radiology, there have been challenges in recent years in ensuring everyone requiring breast assessment is seen and assessed within appropriate timescales. To this end, the HSCB and PHA worked during the year with healthcare professionals and other stakeholders involved in delivering breast assessment services to determine how existing services could be redesigned to ensure more equitable and timely care.

Stroke

An extensive pre-consultation exercise on the modernisation of stroke services was completed by the PHA/HSCB during the 2017/18 year. A task and finish group was established, which includes PHA, HSCB, clinicians from the six Trusts, stroke survivors, charities and the Patient Client Council, to carefully consider the wide range of views and insights from that process. The group is finalising options to deliver a modernised stroke service across Northern Ireland to take account of the information collected in the pre-consultation and also the latest research and evidence to ensure optimal outcomes for stroke patients in Northern Ireland. A formal consultation on the modernisation of stroke services will be undertaken later in 2018.

Neonatal Services

About 8% of babies born in Northern Ireland need to be admitted to a neonatal unit for specialist care every year. The PHA works closely with local Trusts to improve services and ensure that every baby who needs it, gets the right care.

Child Death Review

Across the United Kingdom, rates of child death are higher than elsewhere in Europe. Whilst the number of child deaths has decreased in recent years, there is scope for further reductions in Northern Ireland. Surveillance and systematic review of all deaths is important to identify those factors that can be changed to prevent children dying in the future. During the year, the PHA played a lead role in the establishment of processes to ensure that the circumstances and care associated with every child death is carefully reviewed by an appropriate team of professionals. The PHA will continue to lead and support this important work moving forward.

Antenatal Anomaly Scanning

During 2017/18, the PHA worked with colleagues from the HSCB and all Trusts to improve the quality of the anomaly scan which is offered to all pregnant women. Often referred to as the twenty-week scan, the aim of this scan is to assess the baby's growth and development and identify structural anomalies before the baby is born. Detecting some anomalies before birth allows the delivery and neonatal care to be carefully planned and can improve outcomes.

The PHA has been leading a project to improve the quality of the scan, increase antenatal detection rates and improve the pathway for women and babies. The first phase of this project focused on improving the detection rates of structural heart conditions. A regional scanning protocol was agreed and all sonography staff who carry out the anomaly scan have had specialised training in foetal heart scanning. The group also developed a training day to help staff communicate better with families when the scan reveals abnormalities.

Regional and Trust leads are working together with the PHA and HSCB to introduce a quality assurance system. This will allow audit and review of scan quality to be carried out regularly so targeted training and support can be provided – ensuring that all pregnant women having scans can be assured about the quality of the scan, irrespective of where in Northern Ireland it is carried out.

Screening

Examples of this work are the Northern Ireland screening programmes which encompass the entire population, from birth through to older age.

All PHA screening programmes aim to achieve early diagnosis and treatment, thereby reducing morbidity and mortality. Most people invited for screening do attend and the numbers of attendees/responders and uptake rates for each of the screening programmes in Northern Ireland for 2016/17 (latest available figures) are shown in the table below. In total, there were 387,952 screening attendances during the year.

Screening programme	Description	Number of attendees / responders	Uptake rate 2016/17
Antenatal infection Screening	All pregnant women are offered screening for hepatitis B, HIV and syphilis infection as well as for non-immunity to rubella infection.	24,888	>99.97%
New-born blood spot Screening	All babies in Northern Ireland are offered screening for a range of rare conditions which can cause serious disability or death (e.g. Congenital hypothyroidism).	23,879	>99% (coverage)
New-born hearing Screening	All new-born infants are offered hearing screening, aiming to reduce the effects of permanent childhood hearing impairment on the development of speech and communication skills.	23,675	>98%
Diabetic eye screening programme	Everyone with diabetes (aged 12 and over) is invited to have photographs taken of the backs of their eyes once a year. This checks for early signs of damage to the retina caused by diabetes and aims to reduce sight loss through early identification and treatment.	45,845	69.2%
Cervical screening programme	All women aged 25 to 64 are invited to attend for a cervical (smear) test, which aims to prevent cervical cancer by detecting early pre-cancerous changes in the cells that line the cervix.	118,867	77% coverage in past 5 years

Breast screening programme	All women aged 50 to 70 are invited for screening mammography every three years. The aim of the programme is to reduce mortality from breast cancer.	63,127	77%
Abdominal Aortic Aneurysm (AAA) screening programme	In the year they turn 65; all eligible men are invited for a one-off ultrasound scan of their abdomen. The aim of the programme is to reduce mortality from ruptured abdominal aortic aneurysms (AAAs).	7,528	84%
Bowel cancer screening programme	This programme offers screening every two years to all men and women aged 60 to 74. If detected at a very early stage, bowel cancer treatment can be 90% successful.	80,143	59%
	Total screening attendances 2016/17	**387,952**	

The Agency's Population Screening teams have worked hard to quality assure and improve the population screening programmes. For example, the Northern Ireland Abdominal Aortic Aneurysm (AAA) Screening Programme, now in its fifth successful year of operation, has seen an encouraging increase in uptake from 83% (for the 2015/16 screening year) to 84% in 2016/17.

This follows another busy year of promotional activities in partnership with the health, community and voluntary sectors. Programme staff continue to work on identifying and addressing any potential barriers eligible men may face in accessing screening.

The Northern Ireland Breast Screening Programme continues to provide screening for breast cancer for eligible women aged 50 and over living in Northern Ireland and eligible women aged from 50 to 70, who are registered with a GP, are invited every three years for breast screening – see above table for figures. Women aged over 70 are not automatically invited for breast screening, but they are encouraged to self-refer.

A small number of women in Northern Ireland are part of the Surveillance Screening Programme for Women at Higher Risk of Breast Cancer and receive invitations for breast imaging starting at a younger age, and more frequently, in some cases using Magnetic Resonance Imaging (MRI) instead of, or as well as, mammography (low dose x-rays of the breast). These women will have been identified by clinicians as being at particularly higher risk of breast cancer, for example, due to their genetics.

Primary care practices have a key role in the delivery of the cervical screening programme and during 2017/18 the PHA collaborated with GP colleagues to develop and publish a new audit tool to support practices to monitor the quality of the cervical

screening service they provide. During the year, the first comprehensive patient satisfaction survey was also undertaken for the cervical screening programme. The findings have been largely positive and will be presented at local and national conferences over the coming months.

The Bowel Cancer Screening programme continues to go from strength to strength. While uptake is lower than that seen in other cancer screening programmes, this is largely due to the type of test which requires a participant to collect a sample of their bowel motion. Some people find this unpleasant and difficult to do. However, it should be noted that the uptake rate in Northern Ireland is comparable to elsewhere in the UK. The first full round of peer review quality assurance visits has now been completed across all Trusts, and the second round of visits commenced in December 2017 with a visit to the South Eastern Trust.

Planning work is also underway to consider how a new test kit can be introduced into the programme in Northern Ireland. This is a faecal immunochemical test (FIT) which has been shown to provide a more accurate screening test result and also achieve a higher uptake, as it requires just one stool sample to be collected. This compares to the current test kit which requires three samples.

The year has been a busy one for the Northern Ireland Diabetic Eye Screening Programme (NIDESP) programme with preparation for the introduction of surveillance clinics including the introduction of a number of pilot clinics, and the development of new supporting patient information. The Agency also carried out a pre-consultation exercise on proposals to change to the way the programme is delivered as part of a programme of modernisation. NIDESP is also continuing to address the remaining recommendations from the Regulation and Quality Improvement Authority (RQIA) review.

The Newborn Blood Spot Screening Programme (NBSP) is another important public health programme that makes a major contribution to the prevention of disability and death in our community, through early diagnosis and effective interventions for a range of inherited conditions. The NBSP in Northern Ireland currently offers screening for:

- Phenylketonuria (PKU);
- Congenital hypothyroidism (CHT);
- Cystic fibrosis (CF);
- Medium chain acyl- coA dehydrogenase deficiency (MCADD);
- Sickle cell disorders (SCD).

Plans are currently underway to procure new laboratory equipment and enhance the laboratory service to enable additional screening of selected inherited metabolic disorders. The expanded programme will test for the following new conditions:

- Glutaric aciduria type 1 (GA1);
- Isovaleric acidaemia (IVA);
- Maple syrup urine disease (MSUD);

- Homocystinuria (pyridoxine unresponsive) (HCU).

The most recently published national and regional reports show that the newborn blood spot screening programme in Northern Ireland is of high quality and is performing well against national standards. Key findings demonstrate that the programme, for example, had the highest level of coverage of any UK region in 2015/16 (latest figures), with 99.1% of 'born in and resident' babies having a conclusive test result recorded on the Child Health System (CHS) for PKU by 17 days of age, exceeding the UK core standard (of ≥95%) and similar to performance in 2014/15.

More than 99.9% of 'born and resident' babies during 2015/16 (latest figures) had a conclusive result recorded on the CHS for all conditions at the end of the reporting period.

Furthermore, Northern Ireland was the best performing UK region in relation to timely sample collection, with 98.4% of samples collected between 5–8 days of age, compliant with the UK core standard (of ≥95%) and similar to performance for 2014/15 (98.5%).

The programme also acknowledges that there are areas that could be improved upon. For example, the avoidable repeat rate for 2016/17 was 4.4%. While comparable to performance in other UK countries, the performance threshold and acceptable level based on UK standards, is set at ≤2.0%

For more Newborn Hearing Screening Programme (NHSP) figures, please see the above table.

HSC Research and Development

During 2017/18, the Health and Social Care Research and Development (HSC R&D) Division of the PHA continued to work on delivery of the third HSC R&D strategy *Research for Better Health and Social Care 2016–2025*.

A key part of the implementation plan has been a consultative review of the HSC R&D-funded core infrastructure, which was initiated in March 2017 and continued throughout 2017/18.

An initial survey during the year sought views from across the community of researchers including key stakeholders in the health, academic, community and commercial sectors and also personal and public involvement representatives.

The survey received a strong response and the results have been collated into a series of outcomes that are intended to work towards 'what good looks like' for those who work with, and as part of, the HSC R&D infrastructure.

More recently, in February 2018, the outcomes were shared with the research community at an interactive workshop where stakeholders were asked to suggest

options for action on how the goals might be achieved and what key performance indicators should be used to measure success.
Following on from the workshop, a proposed action plan will be shared for consultation and the R&D Division will then begin its implementation during 2018/19.

The findings of two further research studies commissioned in response to the Bamford Review, in mental health and learning disability, were launched during 2017/18, with attendance from a range of research users in the statutory and voluntary sectors, including commissioners and service users. Executive summaries of both projects are available on the HSC R&D website (www.research.hscni.net).

The findings of three research studies from Phase I of the Dementia Care Research Programme were presented as part of the Dementia Together NI Celebratory Event in November 2017. Topics included pain assessment and management; risk communication; and, advance care planning.

Outputs from these projects, including reports and booklets for health professionals and service users, were made available.

During the year links were established with the Palliative Care Programme Board to work towards formal dissemination of these materials through relevant service channels and a dialogue has been established between the Palliative Care Research Forum and the Programme Board to encourage future alignment of research and service priorities.

Important collaboration was instigated during the year with the HSC R&D Division joining two new and exciting funding consortia as a partner alongside the Research Councils and other health research funders.

The UK Prevention Research Partnership, a new initiative in prevention research, will support multidisciplinary research teams investigating the upstream and environmental determinants of health relevant to a range of non-communicable diseases.

This initiative will provide opportunities for researchers in public health to build collaborative projects to address this funding call. By harnessing health and biomedical data in the UK, the second initiative, Health Data Research UK, will develop and apply cutting-edge data science approaches in order to address the most pressing health research challenges facing the public.

A good example of work which progressed during 2017/18 within the R&D Division is the European funded INTERREG VA project, Cross-Border Healthcare Intervention Trials in Ireland Network (CHITIN), which recruited a dedicated team during the year to manage the project within the PHA.

Cross-Border Healthcare Intervention Trials in Ireland Network (CHITIN)

The CHITIN project is a unique cross-border partnership between the PHA and the Health Research Board in the Republic of Ireland to develop infrastructure and

deliver Healthcare Intervention Trials (HITs) to help prevent and cure illness and promote improved health and wellbeing.

The project is funded by the European Regional Development Fund and managed by the Special EU Programmes Body. Funds of €8.8m have been awarded which include a 15% contribution from the Department of Health in Northern Ireland and Health Service Executive in the Republic of Ireland.

It runs until 2021 and aims to provide increased opportunity for citizens to participate in HITs in Northern Ireland and the border counties of the Republic of Ireland with the intention of 'pump-priming' or stimulating future research projects in the area through the creation of, and investment in, a skilled research workforce.

Public health outcomes can be enhanced by evidence-based Health and Social Care (HSC) research including trials such as these which can investigate if a new intervention is safe, better than current practice or direct resources as to what works best.

In Ireland, citizens cannot equitably access HSC services in the most appropriate setting to their needs and opportunity for involvement in HITs is confined largely to cities, close to major hospitals, universities and centres of research. This is further exacerbated by the existence of a border.

The funded HITs include lifestyle interventions for healthy neurocognitive ageing; to improve mental health in at-risk young people; to tackle adolescent inactivity; and, to address obesity in pregnancy. Each of these aims to provide citizens and healthcare professionals in the region with greater breadth and reach of opportunity to deliver and participate in HSC research.

HIT teams form a network with support for mentoring, training and skills development. This should result in expanded capability and capacity for the planning and delivery of HITs beyond 2021, creating a legacy for future HSC research in the region.

DIRECTOR'S REPORT – NURSING AND ALLIED HEALTH PROFESSIONS

The PHA's Nursing and Allied Health Professions (AHP) Directorate is responsible for professional advice, support and assistance relating to all areas of nursing, midwifery, health visiting and allied health professions with particular leadership in midwifery supervision and public health nursing.

The Directorate has lead responsibility for a range of quality and safety issues including responsibility for the Health and Social Care Safety Forum, Personal and Public Involvement (PPI) and improving the patient and client experience.

The team continued to work throughout 2017/18 in fulfilment of its goals and objectives, helping to reduce inequalities whilst being guided by the voice of service users and staff and taking account of *Making Life Better* and *Health and Wellbeing 2026, Delivering Together.* The following report highlights some of the Directorate's key achievements and outcomes and the impact they are having.

The PHA continues to be at the forefront of innovative involvement practice. The Involvement Standards developed under the leadership of the PHA, are being used as a pathfinder for the development of UK-wide Involvement Standards for research.

During the year, the Regional Spirometry group was set up as a subgroup of the Respiratory Services Framework Forum, and chaired by PHA who has responsibility for implementation of the revised Respiratory Services Framework. Members of the group include respiratory physiologists; General Practice Nurses; the Association of the British Pharmaceutical Industry (ABPI); education providers; Allied Health Professionals (AHPs); Respiratory Specialist Nurses and the Royal College of Nursing (RCN).

The Regional Spirometry group took forward work on two programmes – a 12 week spirometry programme which has been RCN accredited and delivered by RCN since 2015 and a spirometry online programme developed by the Northern Ireland Centre for Pharmacy Learning and Development (NICPLD).

Separately, the Regional District Nursing Advisory Group chaired by the PHA has been working with other key stakeholders on a number of service development areas including:

- developing the Palliative Care Key Worker role (In Northern Ireland it is recognised that district nurses will typically be the keyworker in providing care and support for those with palliative and end of life care needs),
- agreeing a Key Performance Indicator for pressure ulcers,
- developing a Diabetes Competency Assessment Tool for district nursing
- providing expert advice to Phase 3 of the policy framework *Delivering Care: Nurse Staffing in Northern Ireland*.

Under the *Delivering Care: Nurse Staffing in Northern Ireland* framework, the following work has taken place:

- progress to implement Phase 1, Acute Medical and Surgical Wards, has been ongoing.
- Staffing models for Phase 2, Emergency Department; Phase 3, District Nursing; and Phase 4, Health Visiting; were approved and endorsed by the Chief Nursing Officer.
- Currently, Phase 5, Mental Health Nursing; Phase 6, Neo-Natal Nursing; and Phase 7, Primary Care Nursing; are being finalised.

Also under the *Delivering Care* portfolio, an all-Ireland collaboration is under way to develop and implement a range of measures and principles to provide consistent person-centred enhanced care in acute hospital settings. It is hoped this work will conclude in 2018/19.

In Prison Health, a multidisciplinary commissioning team, co-chaired by the PHA and HSCB, has been reconvened to oversee the planning, development, monitoring and service improvement of prison health care. A work plan has been progressed and key deliverables have been taken forward. The PHA continues to lead the delivery plan in partnership with the Department of Health, Department of Justice and other HSC organisations. The plan includes actions around transformation of the provision of healthcare in custody suites. A task and finish group was set up in December 2017 and is progressing work to address equality of healthcare for detained persons and ensure provision of the required governance and standards of care within the setting.

Under Project Retain, set up to help improve retention and recruitment of nursing staff, work has been taken forward during 2017/18 around older peoples care settings. This has included a range of training and development opportunities for nursing teams including students, trained staff and nursing assistants, working in designated older people's care environments in acute hospital settings to promote professional and personal development, team coaching, clinical skills updates, resilience and leadership.

During the year, the PHA, in partnership with HSC Trusts, developed the Individual Healthcare Plan for Type 1 diabetes and School Log Books. This individual healthcare plan is intended to be completed by the Diabetes Specialist Nurse for any child or young person with Type 1 diabetes in a school or Early Years setting.

It is recommended that the plan should be discussed and agreed annually between the Specialist Nurse, parent/carer and the school. It provides a summary of day-to-day care, including regular times for blood glucose monitoring and insulin administration, the level of supervision required, special dietary needs and adaptations required when exercising. It also includes action plans for hypoglycaemia and hyperglycaemia. School Log Books have also been developed and are to be used during school hours and help improve communication between the parent/carer and the school staff.

Personal and Public Involvement

The PHA has lead responsibility for taking forward the implementation of Personal and Public Involvement (PPI) across Health and Social Care.

There has been a significant upturn in demand for professional advice and guidance on involvement-related matters, in particular for a range of strategic, HSC-wide initiatives including requests from a number of the transformation work streams.

Notable achievements during 2017/18 have included supporting the DoH to develop a guide to co-production which will augment and build on key involvement mechanisms, structures and practices to ensure that the voice of service users, carers and the public is integral to the design, commissioning, development, delivery and evaluation of HSC services.

To further support the integration of PPI into all work across HSC, the PHA commissioned an innovative PPI Leadership Development programme which began in January 2018. The programme has been co-designed by HSC staff and service users and carers to enhance PPI leadership capacity; develop new networks of involvement leaders and support the development of individuals to their fullest leadership potential.

We also developed and launched the Engage website as a central resource for Involvement in HSC providing a wide range of information, guides and links to support embedding involvement into culture and practice. The site can be accessed at http://engage.hscni.net

EARLY YEARS

There is significant evidence to suggest that focusing efforts on the early years of an individual's development and health has significant impact on their long-term health and wellbeing as they become adults. To support this, the team was involved in a number of initiatives during the year including the following:

Transforming Universal Maternal and Early Years

Two early intervention programmes are being led by the children and families' nursing team in the PHA and one programme led by the Education Sector.

The first programme entitled, 'Getting Ready for Baby', lays the foundations for effective parenthood. Pregnant mothers and partners attend six group sessions. The pregnant mother receives all their care, advice and guidance at each session facilitated by midwives using the Solihull Antenatal Programme. During 2017, 24% of first-time parents attended a 'Getting Ready for Baby' group with parents reporting high levels of confidence and sensitive care-giving in their parenting role. There are early indications that health outcomes are also improving with 75% of mothers attending the group-based care attempting to breastfeed.

The second programme aims to develop and encourage parenting skills in the preschool years. As 92% of 3–4 year olds attend a preschool education setting, the programme allows health and education professionals to work together to improve preschool children outcomes and school readiness.

A health visitor is attached to each of the 793 preschool education settings. The health visitor contacts the preschool education setting each term to discuss any health and wellbeing issues and to offer health advice, guidance and information. A total of 50% of parents with preschool children were offered a health interview in the preschool setting in 2017/18. The parents complete a child development questionnaire prior to the interview where they can then discuss any health and wellbeing issues. There is also an opportunity for the preschool teacher to discuss any health and wellbeing issues about individual children with the health visitor.

A range of stakeholders and parents were involved in the co-production of both the Getting Ready for Baby and preschool programmes including development of a number of new materials, resources and assessment tools. New technologies have also been considered and a range of apps, short clips and websites are now being recommended to parents.

Safeguarding children and young people

The primary responsibility for safeguarding children and young people rests with their parents or carers. However those who work with children, young people or families, in whatever capacity, have a particular responsibility to promote their welfare and ensure they are safe. Nurses, midwives and allied health professionals play an essential part in ensuring that children and families receive the care, support and services they need to promote children's health and development.

A Safeguarding Board NI Case Management Review (CMR), undertaken in 2016, recommended a structured recording format be introduced in all maternity wards, neonatal intensive care units and paediatric wards where children are admitted and are deemed to be at risk of harm.

In response to this recommendation the Regional Nursing, Midwifery and Allied Health Professional Safeguarding Children Forum established a Task and Finish group to meet this recommendation. Representation was sought from each of the five Health and Social Care Trusts and professional groups including nursing, midwifery and allied health professionals.

Collectively structured recording documentation and agreed standards were designed and a useful aide-memoir to guide staff developed. This involved a high level of engaging and consulting with the wider frontline staff across the five Trust areas. Regional Guidance for Recording of Observations/Interactions between parent/care giver and children considered "at risk" or where there are safeguarding concerns has since been approved and disseminated to each of the Trusts for implementation.

This will serve to promote regionally consistent practice and assists Nurses, Midwives and AHP staff to work at a higher level to safeguard children in their care. This piece of work has effectively strengthened the child protection system and will keep children safer which is ultimately why CMR's are undertaken.

ADULTS

Work undertaken over the past year has focussed on addressing issues that impact on people of working age. Specific projects undertaken have helped to reduce inequalities so as to enable individuals to lead flourishing lives and to support those fighting disease and recovering from injury. Examples of this important work are detailed below.

Primary Care

During the year the PHA continued to progress implementation of the four recommendations set out in *Now and the Future: A General Practice Nursing Framework for Northern Ireland,* which was developed by the PHA in 2016.

1. Workforce Review

The workforce recommendations have been incorporated into *Delivering Care: Nurse Staffing in Northern Ireland* – the Northern Ireland policy for the nursing and midwifery workforce. Phase 7 focuses on primary care and is in the final stages of development. A regional steering group, chaired by the PHA, has been set up which oversees development and planning arrangement. This includes members from GP Federations, the Royal College of General Practitioners (RCGP), the Department of Health (DoH), the Health and Social Care Board (HSCB), the Royal College of Nursing (RCN) and the British Medical Association (BMA).

Five Advanced Nurse Practitioners took up posts in the Down Federation and this programme is expected to continue throughout 2018.

2. Education

In 2017, the PHA-funded and developed a bespoke foundation programme in partnership with the Clinical Education Centre for general practice nurses and healthcare assistants tailored to their identified training needs.

Courses were made available for general practice nurses via the RCN and the HSC Clinical Education Centre which also included a course on transformational leadership. It is planned that these regional education programmes, in partnership with education providers, will be rolled out in 2018.

A regional network for general practice nurses has been established across Northern Ireland to provide continuing professional development (CPD) and to consult on educational needs. Four network events took place across the region and focused on the management of long-term conditions.

Communication strategies for sharing correspondence, information on training and professional updates across the region were implemented and supported through the use of the primary care intranet, the PHA corporate website and use of social media channels.

During the year the PHA also hosted a number of important focus groups with nurses on topical issues including consultation on the Department of Health's future of general practice nursing which are feeding in to wider strategic actions.

3. Core Competency Framework

The PHA inputs into the Northern Ireland Practice and Education Council for Nursing (NIPEC) development of a career pathway to support the General Practice Nursing workforce in Northern Ireland. The insights gained will be used to help develop additional strategic actions. The pathway will also provide information on the diversity of roles and opportunities for career development in general practice for nurses already working in primary care or who may be considering this as a career.

4. Professional Governance

The PHA and RCN facilitated a number of activities designed to learn new ways of working, share experiences and help with problem solving. These will facilitate the involvement of general practice nurses following the implementation of new guidelines for Nursing and Midwifery Council (NMC) revalidation for nursing staff.

Mental Health

Important work was undertaken during the year stemming from the joint PHA/HSCB *Your Experience Matters* survey in 2012, assessing patients' experience of mental health services.

Each Trust has subsequently engaged in service improvement activities annually to help address particular issues identified as part of the survey. A key part of this improvement process has been the Implementing Recovery through Organisational Change Programme (ImROC) which focuses on staff and service users working together to ensure mental health services focus on recovery.

The recovery programme continues to go from strength to strength. All five HSC Trusts now fully embraced this new vision and have worked tirelessly over the last three years to ensure services are more recovery-focused. This work has made a difference to those using the Trust services, clinical practice, partnerships, leadership within the organisation and most importantly to the culture of the organisations.

The PHA continued to support HSC Trusts during the year by facilitating a regional workshop to celebrate success and engage key stakeholders in discussions around shaping the future of ImROC over the next three to five years. Following a second regional survey, a report entitled *You in mind – Your experience matters* was

launched during the year on 6 June 2017. It is encouraging to report that the findings demonstrate an improvement across all the survey questions.

Learning Disability

In response to the Regulation and Quality Improvement Authority's (RQIA) *Review of implementation of Guidelines and Audit Implementation Network (GAIN) - guidelines on caring for people with a learning disability in general hospital settings,* a Regional Hospital Passport (the "passport") for people with a learning disability was published by the PHA in May 2017.

The passport and guidance notes were informed by the learning disability health and wellbeing improvement group, representatives from HSC Trusts, education providers and people with a learning disability and their families and carers.

The purpose of the passport is to provide important information about the person with a learning disability that will help all staff in general hospital settings make reasonable adjustments in order to support safe and effective care whilst also improving their experience of care and treatment.

Since the launch in May 2017, copies of the passport and guidance notes have been distributed throughout Northern Ireland. Feedback on how the passport is being used has been received from a range of stakeholders including health care professionals working in the areas of learning disability and acute care settings.

Feedback has also been received from family carers on how the passport has proven beneficial when accessing services in general hospital settings and Emergency Departments.

The passport is available to download from the PHA website and following feedback from staff working with people with a learning disability and their carers, the passport is now available in an accessible format.

As part of the ongoing evaluation of the passport, the PHA awarded the Telling It Like It Is (TILII) organisation with a Personal and Public Involvement (PPI) award. TILII, which works with individuals who have a Learning Disability, is planning to engage with peers to develop an easy read evaluation tool that can be used as part of the wider evaluation.

Learning from Serious Adverse Incidents – a regional review of choking on food

Swallowing is one of the body's most complex actions involving the movement of food and fluids from the mouth to the stomach. Impairment can occur at any stage and result in an individual developing dysphagia, a condition where an individual has difficulty with some or all of the swallowing process; this can be either a long-term or short-term issue.

Swallowing difficulties can affect an individual physically, psychologically and socially and consequently their quality of life. It can lead to malnutrition, dehydration, chest infections and choking. Complications can be significant.

Whilst it is recognised that anyone can experience a choking episode, people with dysphagia have a higher risk of choking and the consequences can be fatal in all groups. Acknowledging that it is not possible to prevent all episodes of choking, reducing the risk of choking and improving the safety of individuals who have dysphagia, is essential.

In order to inform future regional safety work, a key area of focus during the 2017/18 year was a review of Adult SAIs and Adverse Incidents (AIs) relating to choking on food.
A multi-professional review team was established with representation from across the HSC. The aim of the review was to identify recurring themes, consider regional learning, highlight areas of good practice and to determine if regional actions are required to reduce/prevent reoccurrence of incidents relating to choking on food.

The themes identified through analysis of SAIs and AIs, reinforce a need for coordinated efforts to facilitate learning and inform future quality improvement work with an aim of prevention or reduction of risk of choking in future.

A number of key messages relating to the areas below are identified within the report:

- raising awareness;
- communication to staff delivering care directly;
- terminology;
- roles and responsibilities;
- education and training;
- reporting;
- support to staff.

A Regional Dysphagia Group, led by the PHA, has been established to take forward the next steps outlined in the thematic review as part of their core work plan.

The group's aim is to improve safety and quality of life of adults who have dysphagia through the identification and management of eating, drinking and swallowing difficulties. The multi-disciplinary group, founded on the principles of co-production, is made up of service users, carers, representatives from the statutory, independent and voluntary sectors and relevant professional groups.

OLDER PEOPLE

People who are older have a wealth of life experiences, skills and knowledge. They contribute significantly to society and the economy, yet this contribution is often overlooked.

Loneliness aide-memoire

Loneliness in older people is recognised as a public health issue which can affect their health and wellbeing.

A recent Age NI survey highlighted that:

- one-in-three older people in Northern Ireland said that they are lonely;
- 100,000 older people in Northern Ireland say that TV is their main form of company;
- 26,000 older people in Northern Ireland feel trapped in their own homes.

As a response, AHPs across Northern Ireland worked closely with Age NI during the year to develop an aide-memoire for health and social care staff to raise awareness of older people and loneliness and to make a difference by looking, listening and asking to see if they are lonely and signposting them to relevant agencies such as Age NI; the Silverline helpline for older people; and, Translink for practical advice on transport queries.

Some of the main reasons for loneliness include bereavement; retirement; living alone; lack of money; and, not having transport to get out and about. The aide-memoire encourages staff to notice these factors in their daily interactions with older people. It may be valuable for all health and social care staff in raising awareness of loneliness and to support them in taking appropriate action.

Dementia

The Delivering Social Change Dementia Services Signature Programme which was launched in 2014 by the Executive Office to transform the commissioning, design and delivery of dementia services for people in Northern Ireland drew to a close at the end of this financial year in March 2018.

The implementation of this programme was led jointly by the HSCB and the PHA in partnership with the Alzheimer's Society and with service user support from Dementia NI.

All of the set objectives were realised and in many instances exceeded expectations.

Achievements included the 'Still Me' awareness-raising campaign; the development of a Dementia Learning and Development Framework; the completion of Dementia Champions Training by over 260 staff; and, the recruitment of Dementia Navigators across all Health and Social Care Trusts.

For families and carers, Dementia Training for Informal Caregivers has been provided to over 2,000 people and innovative carer support schemes, enabling them to continue to provide care for their loved ones, have been piloted.

Training in delirium awareness has been delivered to over 2,500 hospital staff regionally. Over 40 staff have been trained as Delirium Trainers to enable workplace

training, complemented by an eLearning resource, to continue in other hospital environments.

Eleven booklets have been developed in total and cover information regarding the early stages of dementia right through to planning for the future. These include issues such as oral health care; communication; cognitive rehabilitation; sight loss; risk; and, moving into a care home.

The end of the project does not, however, signal the end of support in this area. Work will continue to further develop dementia care in hospitals, redesign memory services and implement a new regional dementia care pathway that will see the development of new roles for staff and offer people with a dementia a new community-based model of care.

DIRECTOR'S REPORT – OPERATIONS

The Operations Directorate provides expertise across a broad range of business activities that ensure the efficient running of the organisation. Specific areas within Operations include Communications, Health Intelligence, Planning, Governance and Operational Services.

Staff within the Directorate work closely with colleagues throughout the PHA and other bodies ensuring all of the PHA's work is underpinned by good communication, a strong evidence base, effective business processes and the management of resources.

Communications

Good communication is essential for any organisation to perform effectively. A central role of the Operations Directorate is to ensure that such communication is undertaken at all times through the dissemination of targeted messages and information, internally and externally, in a timely manner that is tailored to the requirements of each of our audiences.

We consistently look to ensure that the right messages are getting to the right target audiences through exploiting the most suitable mix of traditional and emerging communication channels. This is particularly relevant in today's fast-moving, technological and digital era.

Social media

During 2017/18, we continued to grow our social media presence.

This was enhanced by the use of infographics, video and photographs, enabling the extension of the reach of our messaging through social media channels. This has enabled us to get public health advice and information to ever-increasing numbers of people directly.

For example, an organic post in February 2018 promoting breastfeeding reached over 1.4 million people, which is reflective of how important a role social media channels play in the work of the PHA.

The increasing incorporation of rich media such as video and infographics into our social media channels has assisted in strengthening engagement with target audiences as they have enabled key messaging to be distilled into bitesize, engaging images or clips, which increased the likelihood of people sharing them on their own social media accounts and increasing the viral nature of the posts.

This has enabled the PHA to engage directly with the public on a range of important issues through third party support and this is an area that we will continue to prioritise going forward.

As a result of wider efforts to develop the use of social media, the two main channels used by the agency – Twitter and Facebook – both enjoyed a significant increase in follower numbers and saw significant levels of shares, including from high profile individuals and organisations.

Reflecting the success of video and images on the agency's existing social media channels, we went live with a third main channel – Instagram – in February 2018 to further enhance engagement using rich media content.

The number of Twitter followers rose from 7,338 on 1 April 2017 to 9,235 on 31 March 2018 and Facebook followers increased from 14,571 on 1 April 2017 to 18,982 on 31 March 2018.

Public relations

We undertook a sustained and effective programme of public relations activity around key programmes and issues during the course of the year which resulted in high levels of coverage and dissemination.

In fulfilment of our commitments under Protect Life, the Agency also continued the important work of proactively engaging with the media and journalism students to promote appropriate reporting of mental health issues and to raise awareness of sources of support for individuals or families experiencing mental health problems or for those at risk of suicide and/ or self-harm.

This work involved promoting the Samaritans and Irish Association of Suicidology Media Guidelines for reporting suicide with print and broadcast media in Northern Ireland and taking action on poor reporting of suicide by the media.

Public information campaigns

New mass media campaigns developed and implemented during 2017/18 included breastfeeding and dementia. There was also a continuation of the campaign *one in two* which highlighted that one in two smokers will die of a tobacco-related disease and aimed to motivate and encourage smokers to make a quit attempt.

Breastfeeding

The *#NotSorryMums* campaign launched on 31 January 2018 and aimed to increase awareness of the health benefits of breastfeeding and encourage a more supportive environment for breastfeeding mums. It ran throughout February and March 2018 and featured mass media advertising across multiple channels including TV, radio, outdoor, press and digital formats.

The campaign received very positive feedback particularly from breastfeeding mums and encouraged conversations on social media about breastfeeding in public places. An organic social media post featuring the TV ad received almost half a million views and reached over a million people. The website www.breastfedbabies.org was promoted on all advertising.

Dementia

A new phase of the dementia awareness campaign, *Still Me*, launched in September 2017 and ran until the end of December 2017. The new campaign featured a number of local people living with dementia who volunteered through the Alzheimer's Society or Dementia NI. Family and friends of the volunteers also featured in the campaign.

The campaign aims to raise awareness of the signs and symptoms of dementia, reduce stigma and fears about the condition, and encourage those experiencing signs or symptoms to seek help. It includes mass media advertising supported by public relations and social media activity and signposted to NI Direct website. It was developed in partnership with the DoH, The Executive Office and Atlantic Philanthropies as part of the Delivering Social Change Dementia Signature Project (DSCDSP).

Smoking

A continuation of the *one in two* campaign which aimed to motivate and encourage smokers to make a quit attempt ran in April and May 2017. The campaign features Gerry Collins who was diagnosed in 2013 with lung cancer as a result of smoking. The series of TV adverts featuring Gerry were produced by the Health Service Executive (HSE) in the Republic of Ireland as part of their 'Quit' campaign. Gerry Collins died in March 2014 before they were broadcast.

Gerry Collins said: "…if even one person stops smoking because of what we've done, then it will all be worth it for me."

The campaign evaluation results show awareness among smokers was extremely high (87%). However, more importantly the evaluation shows that almost one third of current smokers tried to change their smoking behaviour as a result of the campaign and 23% of smokers who quit when the campaign was running (in the previous 12 months) said it had encouraged them to quit. The survey also showed that 46% of recent ex-smokers (quit in the previous 12 months) said the campaign helped them stay quit.

The positive campaign results are reflected in the 2016/17 Health Survey for Northern Ireland which showed smoking prevalence fell by 2% and the percentage of the population who smoke is now 20%. The Gerry Collins campaign has contributed to the 2% decline in smoking in Northern Ireland. The PHA wishes to thank the HSE in the Republic of Ireland and, in particular, the Collins family for allowing the campaign to be adapted for Northern Ireland.

Website development

During 2017/18, work continued on the process of developing the Health and Wellbeing theme on NI Direct *(*www.nidirect.gov.uk) through the HSC Online project.

Two web content editors and a project support officer were recruited to support the development of the health conditions A-Z section, as well as migrate content

currently hosted on health topic sites. This work reflects the vision in the eHealth and Care Strategy of advocating the effective use of health and social care information as a key enabler for health promotion and health improvements in care management and wellbeing.

Maintenance and management of our websites continue in support of key areas of PHA work, and to further engage our audiences through social media and meet their expectations and needs.

Support materials and design

Demand for communications support from our editing and design function has continued to grow, with over 200 items produced following requests from health leads across directorates of the PHA. An area of growth was the use of infographics that communicate a clear message and simplify information for the general public. These were designed in-house for leaflets, reports and social media.

Mindful of our commitments to our equality scheme, the PHA in partnership with Belfast HSC Trust developed a new leaflet to promote physical activity for children and young people with a physical disability. The Regional Hospital Passport, for people with a learning disability in contact with general hospitals, was further developed with an interactive online version that can be readily updated by service users.

The range of leaflets on diabetic eye screening was extended to include a new leaflet on digital photography surveillance to highlight the new pathway, which will manage those who need closer monitoring, further tests or imaging or who are pregnant and have Type 1 or Type 2 diabetes. We also produced a new flyer on eye examination using ‘slit lamps’, a special kind of instrument used to examine the eyes in those for whom standard digital photography did not get a clear view of the back of the eyes.

We developed and delivered resources in support of a number of partnership projects including the Early Intervention Transformation Programme – a NI Executive/Atlantic Philanthropies *Delivering Social Change Signature Programme.* EITP aims to improve outcomes for children and young people across Northern Ireland through embedding early intervention approaches.

Our resources included three posters about getting ready to learn, and supplementary information on the age 3+ years health review which is carried out by health visitors in the preschool setting, and looks at a child’s social and emotional development. We also worked with speech and language therapists to produce two leaflets for parents to help babies and toddlers develop the skills to learn to talk.

Another important publication was the fourth Annual Quality Report of the HSCB and PHA which uses Quality 2020 as the strategic driver. It highlights the role of the HSCB and PHA in ensuring safe, high quality services and our commitment to putting patients, clients and their carers at the centre of our work. In helping to roll

out Personal and Public Involvement, we produced resources to help HSC staff undertake meaningful involvement with service users, carers and the public.

Internal communication

Work to develop and progress our internal communications activity, strategy and action plan continued which will ensure all PHA business is supported by efficient and effective internal communication systems and processes.

The delivery of internal communications within the PHA is undertaken within the context of wider government communications, particularly in accordance with current UK Government Communication Service (GCS) guidance and recommendations.

These recommendations focus on helping to inform and engage employees in a way which motivates them to maximise performance and to deliver organisational objectives.

Some of the key channels used to best inform and engage with PHA employees over the year are detailed below.

The corporate intranet site continued to be integral to internal communications during the year with regular updates and daily features being published on corporate issues as well as staff-related activities and achievements. To ensure best use of existing and developing technologies a new site will incorporate more dynamic content as well as social media feeds and video incorporation.

The PHA's weekly internal newsletter *inPHA* continued to help ensure all staff are kept up to date about important organisational news and developments as well as having a lighter, non-corporate side which includes staff news and achievements.

Health Intelligence

The PHA's Health Intelligence service brings together the latest data, information and evidence to underpin decision making, priorities and programmes. The health intelligence professionals bring understanding of the available epidemiological and demographic data, best practice and clinical guidance and work closely with a wide range of disciplines within and outside the PHA.

Much of what we do in these areas is in a supportive role and rarely published under the health intelligence name.

During 2017/18, the health intelligence function contributed to a range of reports, workshops and presentations on topics as diverse as cancer; dementia; breastfeeding; obesity; smoking; sexual health; and, mental health. Comprehensive briefs were produced on births, breastfeeding, and suicide as well as the yearly tobacco report.

Specific evaluations of effectiveness and outcomes were completed on major health improvement programmes including *Food in Schools*, the suicide prevention helpline and the sudden death protocols.

Evaluation work was undertaken on regional initiatives such as One Stop Shops; Therapeutic Horticulture; New Entrants services; the Choose to Lose weight management programme; the new physical exercise programme; the Strengthening Families programme; prison reader programmes; and, support to screening programmes.

Family Nurse Partnership projects in the HSC Trusts have been expanded with a resultant increase in the demand for more comprehensive information and reporting systems. Health Intelligence has taken the lead in developing this system and providing the required data analysis services. This includes providing information for Trust and regional-level annual reports and reviews.

The supporting tables around public health, specific tables on adult health for the Director of Public Health Annual Report and the Children's Health in Northern Ireland report, drawing data from Northern Ireland Child Health System (NICHS) and Northern Ireland Maternity Information System (NIMATs) to provide a regional and Trust-level statistical profile of births in Northern Ireland, were again produced and disseminated via the PHA website and made available to partner agencies.

The PHA also worked to develop or enhance performance and outcome measures and the reporting of these for regional strategies such as on obesity, breastfeeding and smoking or for the PHA's own performance framework and corporate plan. This includes early work on the Outcome Based Accountability approach and for the draft Programme for Government.

Following the publication of the *Making Life Better* Strategy, the PHA worked with the Northern Ireland Statistics and Research Agency (NISRA), Department of Health (DoH), colleagues in Health and Social Wellbeing Improvement (HSWBI) and the HSCB to reconfigure the Northern Ireland Neighbourhood Information Service (NINIS) web portal to make information available as widely as possible at as many geographical levels as is practical across the breadth of the determinants of health, for example, from poverty and social isolation to individual behaviour.

This is designed to support the wider public health agenda and the development of community planning with the new councils and was released at Trust level and then District Council level and now District Electoral Area level.

In addition, support has been provided to more detailed discussions with individual councils around outcome and performance measures for community planning.

Planning and Performance

As designated lead agency for the regional implementation of *Making Life Better* we have been working over the course of the year with a range of stakeholders to progress this, ensuring strong alignment with other key government policies and

strategies including the *Draft Programme for Government Framework 2016–21*, *Health and Wellbeing 2026: Delivering Together* and Community Planning.

During the year, work commenced with partners to refresh the regional MLB implementation arrangements to further enhance and strengthen collaboration across all sectors with a focus on delivery, local flexibility, innovation and shared outcomes.

As set out in the *PHA Corporate Plan 2017–2021*, the PHA is seeking to move to a more outcomes based approach. While recognising that we are still only at the beginning of this journey, the *Annual Business Plan 2017–2018* and the new Annual Business Plan for 2018/2019 identify, where possible, some of the anticipated impacts within the short and long term.

With the draft Programme for Government emphasising the importance of Outcomes Based Accountability (OBA) and our extensive work with local councils in developing community plans, we have continued to work to embed OBA as a core aspect of our work. This year has seen further training on OBA for senior staff, the development of performance accountability report cards and the use of OBA principles in business planning and reporting. We will continue to build on this work during 2018/19.

During 2017/18, the PHA continued to review, update and implement its Procurement Plan for the provision of health and wellbeing services. A £4.5m tender for the provision of Youth Engagement Services in eight locations across the region has now been completed and new contracts awarded.

Significant progress has also been made in planning for the re-tendering of services to be commissioned under *Protect Life 2: a draft strategy for suicide prevention in the north of Ireland*, which is currently being finalised by the DoH.

Subject to the new *Protect Life 2* strategy being approved, it is anticipated that new contracts will be awarded by 31 March 2019. Initial planning has also commenced on the re-tendering of contracts linked to developing healthier places, such as Healthy Living Centres.

Business Continuity Planning

During 2017/18, there was an increased focus on cyber security. This is an issue that is relevant to the entire HSC sector and one which the PHA cannot address on its own.

The PHA is represented on regional HSC cyber security groups where the aim is to ensure that the whole service is as resilient as possible in relation to potential cyber security incidents.

The PHA Business Continuity Plan was reviewed and tested during 2017/18 with a particular focus on cyber security. Continued steps were also taken to ensure that staff are aware of the existence of the plan, that they know what to do when an

incident occurs, and how to find out information should an incident occur when they are not in the office.

Information Requests and Data Incidents

- Freedom of Information (FOI) requests received from 1 April 2017 to 31 March 2018 = 52
- Environmental Information Regulations received from 1 April 2017 to 31 March 2018 = 4
- Subject Access Requests received from 1 April 2017 to 31 March 2018 = 4
- Open Data Requests received from 1 April 2017 to 31 March 2018 = 1
- No personal data protection incidents occurred during 2017/18.

Financial Performance Report

The HSCB Director of Finance supports the PHA in the delivery of its core functions, including Financial Planning, Financial Governance, Financial Management and Accounting Services.

Financial Planning

The PHA prepared a Financial Plan for 2017/18, taking into account the significant budgetary constraints and varied and mounting pressures on services. Political uncertainty caused delays in allocations being issued by DoH, and this Plan was formally approved by the PHA Board later than usual in August 2017.

Looking forward into 2018/19, the current financial context significantly limits the additional resources available for health and social care. There continues to be a risk that this will impact on the quality and safety of services, and the PHA along with the wider sector continues to take steps to mitigate this risk. In addition, a lack of political stability is continuing to create considerable uncertainty, adding more pressure to the HSC sector.

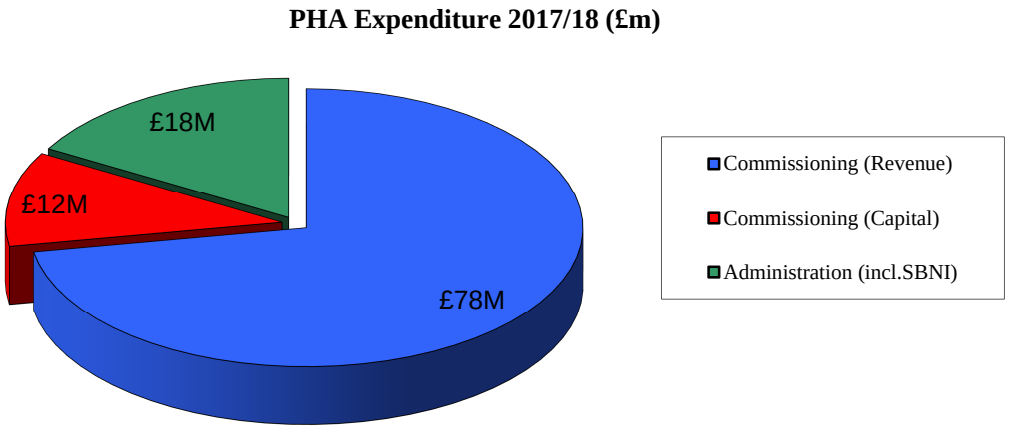
PHA Financial Management and Stability

The PHA received a revenue budget £96m revenue from the DoH in 2017/18, along with income from other sources of £1m, and has a statutory duty to breakeven within 0.25% of these resources. A further £12m capital funding was allocated to PHA in the year, and this was fully spent.

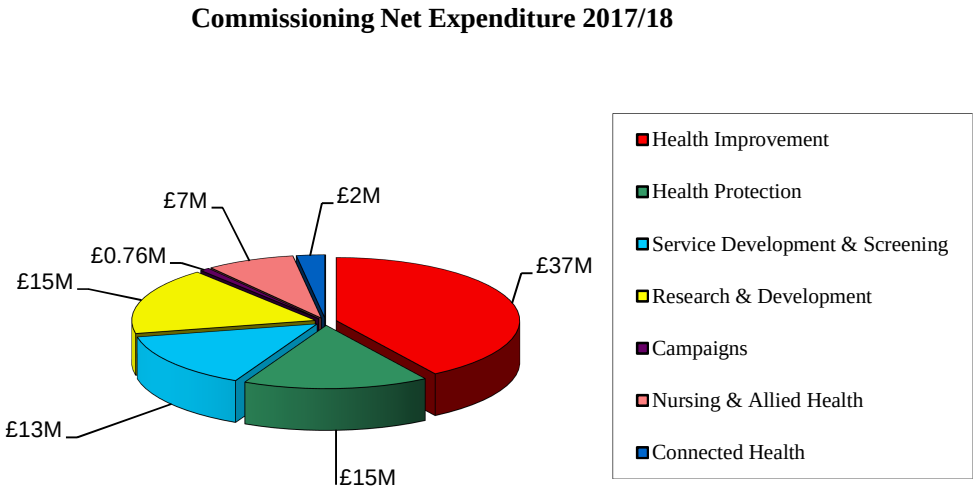
The financial statements presented in this Annual Report and Accounts report a small surplus of £140k, which is within the required breakeven threshold. This was achieved by significant and diligent effort on the part of PHA Budget holders, supported by the Finance Directorate (HSCB), managing the wide range of pressures and demands across both programme and Management and Administration budgets.

The following charts highlight how the PHA's revenue funds have been utilised during 2017/18.

a. PHA Net Expenditure by Area 2017/18



b. Programme Expenditure by Budget Area 2017/18



During the 2017/18 financial year, the PHA continued with the difficult task of managing to successfully deliver its many and complex functions with a decreasing budget (recurrent reduction of £0.4m since 2016/17). Delivery of these savings has created a significant and ongoing challenge for the PHA to ensure that core functions continue to be delivered to the standard that its stakeholders would expect.

The Centre for Connected Health and Social Care

The Centre for Connected Health and Social Care (CCHSC), located within the PHA, promotes the use of technology and innovation in the HSC system in Northern Ireland to drive improvements in health and social care.

The CCHSC continued during the year to contribute to improving health and wellbeing through a number of partnership activities.

CCHSC continued to work with HSCB on the implementation of the eHealth and Care Strategy, ensuring that the strategic aims of the PHA are fully reflected. To this end CCHSC reviewed progress of the strategy for 2016/17 and the development of implementation plans for 2017/18.

CCHSC has also been supporting work on the Encompass programme – the HSC-wide initiative that will introduce a digital integrated care record to Northern Ireland and has supported various engagement activities and helped develop the PPI model to support involvement of patients, carers and citizens.

Other key success during the year included delivering the eHealth and Data Analytics Dementia Pathfinder Programme of work and work around Telehealth and Telecare to ensure there is sufficient resource to allow for the smooth, safe exit from services provided under the Regional Remote Telemonitoring NI contract which has come to an end.

Work was progressed on HSC online, the Health Conditions A–Z, which will provide a comprehensive suite of health information, supporting people to make decisions in relation to their personal illness and chronic conditions.

CCHSC is a member of the DoH-led EU Engagement Forum set up to inform strategic directions and coordinate information about EU funding streams and networks and during the year worked with Trusts, HSCB, universities and industry to pursue both UK and EU funding opportunities.

Sunfrail – Impact and learnings from EU project on frailty

A good example of work undertaken by CCHSC during the year was with the Southern Health and Social Care Trust to examine the use of the Sunfrail Tool to improve the overall provision of services for older people in the community by ensuring the correct pathways are available at various stages of frailty and multimorbidity. The Trust used a 9-question tool to identify gaps in service provision/pathways for older people and recommendations for improvements.

Staff compiled a “Sunfrail directory” comprising Trust, community and voluntary sector services targeted at preventing, identifying or managing frailty. This directory was used to signpost older people to services available within their community in response to the alerts generated by the Sunfrail Tool.

A 1-day frailty training workshop was held involving staff conducting screening as well as those providing services. This enabled staff to gain a better understanding of: 1) frailty from the different bio-psycho-social domains, 2) relevance of services such as preventing falls through balancing classes, community pharmacist medication reviews, role of dementia navigators; and 3) how to use the tool in particular in a community setting.

Screeners began to use the tool to engage with older people in a number of community (Churches, social events, clubs) and GP settings. This helped to raise awareness of frailty in general and in some cases identify at an early stage, risk factors for frailty such as loneliness and decrease in physical activities. It also helped to promote existing services for older people such as falls prevention and balancing classes, walking groups and social clubs.

By August 2017, a total of 127 people had participated in the testing of the tool. A telephone follow-up conducted six weeks later with 26 people, showed more than half (58%) had taken up at least one of their Sunfrail care pathway recommendations.

Also, 20% of those with a sociological recommendation had taken up at least one action, 19% of those with a biological recommendations had taken up at least one action and 33% of those with an economic recommendation had taken up at least one action. Action taken by individuals included taking up bereavement counselling after consultation with GP, attending local falls clinic as a result of a bad neck break and successful application for a blue disability car badge.

The results of the project indicate that use of the Sunfrail tool in those aged over 65 years enables the identification of frailty risk alerts. The most frequent alerts detected in all settings were on functional decline, memory decline and polypharmacy items, particularly in community/primary care settings.

As the Sunfrail tool was tested on a target population with no evident sign of physical and cognitive disability, these alerts confirm the ability of the tool to increase the awareness on frailty risk factors in the population at low-medium risk of disability.

An international dissemination event was held in October 2017 in Portadown sharing results with HSC staff from Trusts, PHA, HSCB, DoH and the HSC Clinical Education Centre (CEC). Older people were also invited and participated in activities relevant to preventing or managing frailty. This event further reinforced the key message that frailty when identified early can be reversible, and that social interaction and physical activities can help mitigate against the risk of frailty.

Sustainability – environmental, social and community issues

The PHA is committed to protecting the environment and to sustainability, environmental, social and community issues.

It aims to understand the impact on the environment of its activities and to manage its operations in ways that are environmentally sustainable and economically feasible.

The PHA has had an *Environmental Policy* and *Waste Management Strategy and Policy* in place for several years now. These were reviewed during 2017/18.

These policies are designed to bring to the attention of all employees, suppliers and contractors, the PHA's position in regard to environmental issues and waste reduction (prevent/reuse/dispose) and demonstrate a desire to continually improve its performance in environmental sustainability and waste management.

The PHA also has a *Sustainable Development Strategy* in place. This strategy sets out the PHA's approach to sustainable development. It has been shaped around the priority areas contained within the former Office of the First Minister and Deputy First Minister's (OFMDFM) *Sustainable Development Strategy*.

The PHA is committed to the principles of sustainable development and will endeavour to integrate these into its daily activities.

The PHA will seek to increase awareness of sustainable development within the PHA generally, and to ensure that wherever possible, its overall business activities support the achievement of sustainable development objectives.

The PHA continues to support and implement a range of sustainability initiatives such as the Cycle to Work Scheme; Bus/Rail Translink Scheme (which encourages employees to use public transport and reduce their carbon footprint); the use of online-based systems for human resources, procurement, and invoice processing, moving away from paper-based systems; centralised printing devices for the production of printed material (which replaced printing equipment at each workstation); waste paper recycling and video and teleconferencing facilities to reduce travelling.

Equality

The PHA is fully committed to promoting equality of opportunity and good relations for all groupings under Section 75 of the Northern Ireland Act 1998. More information is available on the PHA's website at www.publichealth.hscni.net

The PHA has a range of policies in place that serve to advance this aim, including, on the employment side, the *Equality of Opportunity Policy*.

Tapestry – Disability Staff Network

This year, the staff network focused its resources on two areas in particular: developing a new streamlined process for making reasonable adjustments – a step-by-step flowchart for line managers on what to do once a member of staff declares that they have a disability – and developing a stand-alone website for the network.

Tapestry moreover linked up with key partners from the voluntary sector to learn more about existing employment support programmes. Presentations were received in relation to both Workable NI and Access to Work.

Together with regional partners across Health and Social Care (HSC) the PHA also engaged with Carers NI to learn more about good practice in supporting staff who provide care for family members.

Gender identity and expression – Employment Policy

Together with our partners we reviewed the outcome of the consultation we held on our draft Gender Identity and Expression Employment Policy. Taking all comments received into account, we finalised the policy and produced a consultation report. The policy was approved by the Agency Management Team in October 2017.

Work is currently under way to establish a regional task and finish group to support the implementation of the policy, including through the development of staff protocols.

Disability Work Placement

For the third year in a row, the PHA has offered to host a person under the Disability Work Placement Scheme. The Scheme is facilitated by the Equality Unit and the Health and Social Care Board jointly for the 11 regional HSC organisations.

One person started in December 2017 and has since left this placement to take up a paid position. Likewise, the person on placement in 2015/16 has since gained full-time paid employment with one of our partner organisations and one of the participants of the 2016/2017 scheme started working with the PHA in March 2018.

Looking forward – The continuing work of the PHA

In planning the PHA's work for 2018/19 and for the duration of the *Corporate Plan 2017–2021* and beyond, the PHA must take account of the wider environment within which it works. This includes looking at strategic, regulatory and legislative environments and at the various strategies, issues and statutory requirements which shape and influence the PHA's work.

The following list of influencing factors is by no means exhaustive but gives a broad representation of the environment within which the PHA works:

- Reform;
- Financial context;
- *Making Life Better*;
- Community planning;
- *Programme for Government*;
- DoH policy priorities;
- Partnership working;
- Personal and Public Involvement.

One of the main changing factors to the environment within which the PHA has been working and will continue to work is regarding reform of the HSC. With the closure of the Board as part of a wider transformation agenda and responsibility for HSCB functions and staff moving to the DoH there will obviously be changes in how the PHA works with the Department.

More changes will be evident internally with the planned transfer of the HSCB's Social Care and Children Directorate to the PHA, and with it additional responsibility and challenges to embed the function into the current structure as well as integrating the staff into the organisation.

The PHA has also started work this year to reshape the existing *Making Life Better* regional implementation structures to further enhance and strengthen collaboration across all sectors with a focus on delivery, local flexibility, innovation and shared outcomes. Building on many years of experience, the PHA fully supports *Making Life Better's* important collaborative and partnership approach which recognises that many factors can affect an individual's health. Reflecting on this, the PHA has started work with partners to refresh regional implementation arrangements to a more delivery-focussed structure that will further enhance and strengthen collaboration and encourage local flexibility.

The PHA will also continue to contribute to the important work of local councils, including the community planning processes and to work closely as action plans are finalised and implemented.

Important work with the DoH and key partners will also be core to the PHA's work over the coming year and years, as the ongoing development and implementation of the draft delivery plans for the draft Programme for Government Framework 2016–2021 plans takes place.

Valerie Watts

Chief Executive (Interim)

Date 11 June 2018

PUBLIC HEALTH AGENCY

ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2018

ACCOUNTABILITY REPORT

Corporate Governance Report

Directors' Report

PHA 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 at www.publichealth.hscni.net

Andrew Dougal OBE

Andrew Dougal took up the position as Chair of the PHA on 1 June 2015. He was previously Chief Executive of Northern Ireland Chest Heart and Stroke from 1983 and prior to that worked for 10 years in Education.

Over the last 30 years, he has been a Non-Executive Director of organisations spanning the private, public and voluntary sectors.

He is a former Trustee and Chair of the HR Committee of the UK Health Forum, a former Trustee and Treasurer of the World Heart Federation and a former Chair of the Chartered Institute of Personnel and Development in Northern Ireland

Valerie Watts

Valerie Watts took up post as interim Chief Executive of the PHA on 17 October 2016. She was appointed Chief Executive of the Health and Social Care Board in July 2014 and has over 30 years' public sector experience, beginning her career at the Royal Victoria Hospital where she oversaw competitive tendering for ancillary support services.

Most recently, she was Chief Executive of Aberdeen City Council (2011–2014) and former Town Clerk and Chief Executive of Derry City Council (2009–2011) where she was instrumental in securing the UK City of Culture for 2013 and developing a strategic economic master plan for the North West.

Edmond McClean

Edmond McClean was appointed Deputy Chief Executive of the PHA at the end of October 2016 and has continued as the PHA's Director of Operations heading the PHA's communications, governance, business planning and health intelligence functions.

His background includes lead Director supporting the initial development of Belfast and East Local Commissioning Groups from 2007 to 2009 and from 1997 to 2007 he was Director of Strategic Planning and Commissioning with the Northern Health and Social Services Board.

Councillor Billy Ashe

Billy Ashe is currently a Councillor for Mid and East Antrim Borough Council, of which he is a former mayor.

He was also previously mayor of Carrickfergus and Coordinator of a Carrickfergus-based community project.

Brian Coulter OBE

Brian completed his term as a PHA Board member on 31 March 2018. He has extensive experience in Healthcare Regulation as former Non-Executive Director of both the General Dental Council and the Human Tissue Authority.

He is past Chair of the General Optical Council, the Regulation and Quality Improvement Authority, the Northern Ireland Federation of Housing Associations, Parkview Special School Governors and the Eastern Health and Social Services Council.

He had a 23 year career in Health and Social Services followed by 18 years as Chief Executive of The Fold Group. His last employment was as Prisoner Ombudsman for Northern Ireland.

Les Drew

Les is a self-employed business consultant providing strategic advice regarding business improvement and change management.

Les was previously employed by Northern Ireland Electricity Networks (NIEN) as Head of Procurement. He has held a number of other senior management posts during his 39-year career including, Group Financial Controller; Governance and Risk Manager; Regulation Officer; and Information Technology Contract Manager.

He was a Non-Executive Director of the former South and East Belfast HSS Trust where he was Chair of the Audit Committee. He also served as a member of the Belfast HSC Trust for 8 years since its establishment on 1 April 2007.

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 Department of Health.

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.

Mary Hinds

Mary is the PHA's Director of Nursing and Allied Health 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.

Thomas Mahaffy

Thomas finished his term as a PHA Board member on 7 April 2018. He is also currently a Board member of the Northern Ireland Anti-Poverty Network, the Northern Ireland Human Rights Consortium, the Participation and Practice of Rights Project and convenes the Rights in Community Care Group.

He is employed by the trade union UNISON as Head of Organising and Development with responsibilities including union employer partnerships, equality, human rights and tackling health inequalities.

Dr Adrian Mairs

Dr Mairs is PHA's Acting Director of Public Health, covering Dr Harper's absence. He was previously Assistant Director of Public Health (Screening and Professional Standards).

He has trained in general practice and public health and worked in the DoH as a Senior Medical Officer and as a Consultant in Public Health in the legacy Northern Health and Social Services Board before joining the PHA in 2009.

Deepa Mann-Kler

Deepa Mann-Kler began her term as Board member on 1 March 2016. She is a Non-Executive Director with the Registers of Scotland. She served as a Non-Executive Director of the South Eastern Health and Social Care Trust for nine years; was an Independent Assessor with the Commissioner for Public Appointments and was Chair of the Crescent Arts Centre.

Her areas of expertise include corporate governance, risk management, communications, stakeholder engagement, research skills, strategic planning, ethics, equality and anti-discrimination. Deepa is CEO and Founder of NEON, a company creating software applications in health and wellbeing.

Alderman Paul Porter

Alderman Paul Porter has served as a Councillor from 2001 and was elected to the new Lisburn and Castlereagh City Council.

Over the past 15 years he has worked closely with community and voluntary organisations delivering major projects ranging from early intervention, youth programmes and special needs provision. During this time he has helped secure major capital investment for several community centres in the wider Lisburn area.

Paul Cummings

Paul Cummings is Director of Finance, HSCB. He has previously been a Director of Finance in the South Eastern, Mater and Ulster Community and Hospitals Trusts with over 30 years' experience in Health and Social Care and was the national chair of the Healthcare Financial Management Association in 2002/03, continuing to be an active member. Paul, or a deputy, will attend all PHA Board meetings and have attendance and speaking rights.

Fionnuala McAndrew

Fionnuala McAndrew initially trained as a teacher and moved into a social work career commencing in children's residential services. She has worked in a range of settings in local authorities in England and moved to Northern Ireland in 1996 to take up a post in the Southern Health and Social Care Board as Manager of the Registration and Inspection Unit, responsible for the registration of residential and nursing homes.

She was appointed Director of Social Care in the Southern Board in 2004 and became Director of Social Care and Children with the new Health and Social Care Board in April 2009.

Fionnuala McAndrew received an OBE in March 2012 for her services to healthcare in Northern Ireland.

Related party transactions

The PHA is an arm's length body of the Department of Health and as such the Department is a related party with which the PHA has had various material transactions during the year. In addition, the PHA has material transactions with HSC Trusts.

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

Register of 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 Deputy Chief Executive / Director of Operations, and on the PHA website at www.publichealth.hscni.net/lists-and-registers

Audit Services

The PHA's statutory audit was performed by ASM Chartered Accountants on behalf of the Northern Ireland Audit Office (NIAO) and the notional charge for the year ended 31 March 2018 was £16,000.

Statement on Disclosure of Audit Information

All Directors can confirm that they are not aware of any relevant audit information of which the external auditors are unaware. The Accounting Officer has taken all necessary steps to ensure that all relevant audit information which she is aware of has been passed to the external auditors.

STATEMENT OF ACCOUNTING OFFICER RESPONSIBILITIES

Under the Health and Social Care (Reform) Act (Northern Ireland) 2009, the DoH has directed the Public Health Agency to prepare for each financial year a statement of accounts in the form and on the basis set out in the HSC Manual of Accounts. The financial statements are prepared on an accruals basis and must provide a true and fair view of the state of affairs of the Public Health Agency, of its income and expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements the Accounting Officer is required to comply with the requirements of Government Financial Reporting Manual (FReM) and in particular to:

- Observe the HSC Manual of Accounts issued by DoH including relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in FReM have been followed, and disclose and explain any material departures in the financial statements.
- Prepare the financial statements on the going concern basis, unless it is inappropriate to presume that the Public Health Agency will continue in operation.
- Keep proper accounting records which disclose with reasonable accuracy at any time the financial position of the Public Health Agency.
- Pursue and demonstrate value for money in the services the Public Health Agency provides and in its use of public assets and the resources it controls.

The Permanent Secretary of the DoH, as Principal Accounting Officer for Health and Social Care Resources in Northern Ireland, has designated Mrs Valerie Watts as the Interim Accounting Officer for the Public Health Agency. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the PHA's assets, are set out in the Accountable Officer Memorandum, issued by DoH.

PUBLIC HEALTH AGENCY

ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2018

GOVERNANCE STATEMENT

1. Introduction / Scope of Responsibility

The Board of the Public Health Agency (PHA) is accountable for internal control. As Accounting Officer and Interim Chief Executive of the PHA, I have responsibility for maintaining a sound system of internal governance that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am responsible in accordance with the responsibilities assigned to me by the Department of Health (DoH).

As Accounting Officer, I exercise my responsibility by ensuring that an adequate system for the identification, assessment and management of risk is in place. I have in place a range of organisational controls, commensurate with officers' current assessment of risk, designed to ensure the efficient and effective discharge of PHA business in accordance with the law and Departmental direction. Every effort is made to ensure that the objectives of the PHA are pursued in accordance with the recognised and accepted standards of public administration.

A range of processes and systems (including SLAs, representation on PHA Board, Governance and Audit Committee and regular formal meetings between senior officers) are in place to support the close working between the PHA and its partner organisations, primarily the Health and Social Care Board (HSCB) and the Business Services Organisation (BSO), as they provide essential services to the PHA (including the finance function) and in taking forward the health and wellbeing agenda.

Systems are also in place to support the inter-relationship between the PHA and the DoH, through regular meetings and submitting regular reports.

2. Compliance with Corporate Governance Best Practice

The Board of the PHA applies the principles of good practice in Corporate Governance and continues to further strengthen its governance arrangements. The Board of the PHA does this by undertaking continuous assessment of its compliance with Corporate Governance best practice by internal and external audits and through the operation of the Governance and Audit Committee, with regular reports to the PHA Board.

The PHA Board has also completed a self-assessment against the DoH Arm's Length Bodies (ALB) Board Self-Assessment Toolkit. Overall this shows that the PHA Board functions well, and identifies progress from the previous year. An action plan has been developed to take forward further improvements.

Arrangements are in place for an annual declaration of interests by all PHA Board Members and staff; the register is publically available on the PHA website. Members are also required to declare any potential conflict of interests at Board or committee meetings, and withdraw from the meeting while the item is being discussed and voted on.

3. Governance Framework

The key organisational structures which support the delivery of good governance in the PHA are:

- PHA Board;
- Governance and Audit Committee; and
- Remuneration and Terms of Service Committee.

The PHA Board is comprised of a Non-Executive Chair, seven Non-Executive members, the Chief Executive and three Executive Directors. One Non-Executive Member stepped down in December 2016 and this vacancy has not yet been filled at 31 March 2018.

During 2017/18, the PHA Board met on nine occasions. The PHA Board meets regularly, usually monthly, with the exception of July. The Board sets the strategic direction for the PHA within the overall policies and priorities of the HSC, monitors performance against objectives, ensures effective financial stewardship, ensures that high standards of corporate governance are maintained, ensures systems are in place to appoint, appraise and remunerate senior executives, ensures effective public engagement and ensures that robust and effective arrangements are in place for clinical and social care governance and risk management. All meetings were quorate.

PHA Board Meeting Attendance Register 2017/18

Name	Meetings Attended	Meetings Contracted to Attend
A Dougal	9	9
V Watts	6	9
E McClean	9	9
C Harper (absent from January 2018)	5	8
A Mairs (Acting Director of Public Health from March 2018)	1	1
M Hinds	8	9
B Ashe	7	9
B Coulter	8	9
L Drew	8	9
T Mahaffy	6	9
D Mann-Kler	6	9
P Porter	6	9

The Governance and Audit Committee's (GAC) purpose is to give an assurance to the PHA Board and Accounting Officer on the adequacy and effectiveness of the PHA's system of internal control. The GAC has an integrated governance role encompassing financial governance, clinical and social care governance and organisational governance, all of which are underpinned by risk management systems. The GAC meets at least quarterly and currently comprises four Non-

Executive Directors supported by the PHA's Director of Operations and the HSCB's Director of Finance. Representatives from Internal and External Audit are also in attendance. During 2017/18 the GAC met on four occasions, and all meetings were quorate.

The Remuneration and Terms of Service Committee advises the PHA Board about appropriate remuneration and terms of service for the Chief Executive and other senior executives subject to the direction of the DoH. The Committee also oversees the proper functioning of performance appraisal systems, the appropriate contractual arrangements for all staff as well as monitoring a remuneration strategy that reflects national agreement and Departmental Policy and equality legislation. The Committee normally meets at least once every 6 months. During 2017/18, the Committee met on two occasions and each meeting was quorate.

4. Business Planning and Risk Management

Business planning and risk management is at the heart of governance arrangements to ensure that statutory obligations and ministerial priorities are properly reflected in the management of business at all levels within the organisation.

A new PHA *Corporate Plan 2017 – 2021*, setting out the PHA purpose, vision, values and strategic outcomes, was approved by the PHA Board on 20 April 2017 and by the DoH on 26 May 2017. The Annual Business Plan 2017/18, which sets out the corporate action plan for year one of the PHA Corporate Plan, taking account of DoH guidance and priorities, was approved by the PHA Board on 13 June 2017 and the DoH on 28 June 2017. Both documents were developed with input from the PHA Board and staff from all Directorates and engagement with external stakeholders.

The PHA's Risk Management Strategy and Policy explicitly outlines the PHA risk management process which is a 5 stage approach – risk identification, risk assessment, risk appetite, addressing risk and recording and reviewing risk, as follows:

Stage 1 - Risk Identification
Risks are identified in a number of ways and at all levels within the organisation (corporately, by Directorate and by individual staff members). Risks can present as external factors which impact on the organisation but which the organisation may have limited control over, or operational which concern the service provided and the resources/processes available and utilised.

Organisation risk is related to the PHA's objectives (as detailed in the Corporate Plan and Annual Business Plan). Each risk identified is correlated to at least one of the corporate objectives. Risks are also aligned with the relevant performance and assurance dimensions as identified in the DoH Framework Document.

Stage 2 - Risk Assessment
After risks are identified they are assessed to establish:

- the impact that the risk would have on the business should it occur; and
- the likelihood of the risk materialising.

The PHA is committed to adhering to best practice in the identification and treatment of risks. The AS/NZS 4360:2004 standard (adopted by DoH) which incorporates a "5x5" Risk Matrix has been used, along with a Risk Analysis Tools Impact Table which gives details of the impact definitions to be used when assessing each identified risk. As the licence for this standard expires in June 2018, the PHA is working with Trusts and other healthcare organisations to agree a regional replacement, which will adopt a similar approach.

Stage 3 - Risk Appetite
The PHA carefully considers its risk appetite, i.e. the extent of exposure to risk that is judged tolerable and justifiable. The PHA recognises that it is operating in an environment where safety, quality and viability are paramount and are of mutual benefit to service users, stakeholders and the organisation alike. Consequently, and subject to controls and assurances being in place, the PHA will generally accept manageable risks which are innovative and which predict clearly identifiable benefits, but not those where the risk of harm or adverse outcomes to service users, the PHA's business viability or reputation is significantly high and may outweigh any benefits to be gained. Risk appetite is built into the risk assessment process as outlined above.

Stage 4 - Addressing the Risk
Whilst there are four traditional responses to addressing risk (terminate, tolerate, transfer and treat), in practice within the PHA the vast majority of risks are managed via the "Treat" or "Tolerate" route, both of which are underpinned by the identification of an action plan to reduce and, if possible, eliminate the risk.

Stage 5 - Recording and Reviewing Risk
Within the PHA the risk management process is recorded and evidenced through the maintenance of Directorate and Corporate level Risk Registers.

To ensure the robustness of the PHA's system of internal control, fully functioning Risk Registers at both Directorate and Corporate levels are reviewed and updated on a quarterly basis, ensuring that risks are managed effectively and efficiently to meet PHA's corporate objectives and to continuously improve the quality of services.

Processes are established within each Directorate enabling risks to be identified, controls and/or gaps in controls highlighted and, where relevant, action to be taken to mitigate the risk. Directors and senior officers also identify risks which require to be escalated to the Corporate Risk Register.

The Director of Operations is the PHA Executive Board member with responsibility for risk management. The Corporate Risk Register is reviewed quarterly by the Agency Management Team (AMT) and Governance and Audit Committee (GAC).

The minutes of the GAC are brought to the following PHA Board meeting, and the Chair of the GAC also provides a verbal update on governance issues including risk. The Corporate Risk Register is brought to a PHA Board meeting at least annually.

During 2017/18, guidance and support was provided to staff who are actively involved in reviewing and co-ordinating the review of the Directorate and Corporate Risk Registers. A system has been established whereby the Senior Operations Manager meets with the planning and project managers supporting each Directorate and Division at the end of each quarter to ensure feedback and consistency in the review of the Risk Registers, and to share and learn from good practice.

All staff are required to complete the PHA risk management e-learning programme. In addition, staff have also been provided with other relevant training including fire, health, safety and security and fraud awareness.

All policies and procedures in respect of risk management and related areas are available to all staff through the PHA intranet (Connect) site.

Fraud

The Public Health Agency (PHA) takes a zero tolerance approach to fraud in order to protect and support our key public services. We have put in place an Anti-Fraud Policy and Fraud Response Plan to outline our approach to tackling fraud, define staff responsibilities and the actions to be taken in the event of suspected or perpetrated fraud, whether originating internally or externally to the organisation. Our Fraud Liaison Officer (FLO) promotes fraud awareness, co-ordinates investigations in conjunction with the BSO Counter Fraud and Probity Services team and provides advice to personnel on fraud reporting arrangements. All staff are provided with mandatory fraud awareness training in support of the Anti-Fraud Policy and Fraud Response plan, which are kept under review and updated as appropriate every five years.

5. Information Risk

The PHA has robust measures in place to manage and control information risks. The Director of Operations as Senior Information Risk Owner (SIRO) is the focus for the management of information risk at board level. The Director of Public Health as the Personal Data Guardian (PDG) has responsibility for ensuring that the PHA processes satisfy the highest practical standards for handling personal data. Assistant Directors as Information Asset Owners (IAOs) are responsible for managing and addressing risks associated with the information assets within their function and provide assurance to the SIRO on the management of those assets.

The PHA's Information Governance Steering Group (IGSG) has the primary role of leading the development and implementation of the Information Governance Framework across the organisation, including ensuring that action plans arising from Internal and External Audit reports and controls assurance standards assessments are progressed. The Group is chaired by the SIRO and membership includes all the

IAOs, PDG, a Non-Executive Board member and relevant governance staff. The IGSG meets quarterly, and provides a report to the GAC.

The PHA's Information Governance Strategy (incorporating the Information Governance Framework) 2015-2019 sets out the framework to ensure that the PHA meets its obligations in respect of information governance, embedding this at the heart of the organisation and driving forward improvements in information governance within the PHA. The Strategy covers the four year period from 2015 to 2019 and is supported by annual Action Plans setting out how it will be implemented. Alongside this a range of policies and procedures are in place, including Records Management, IT Security and Data Protection.

The PHA General Data Protection Regulation (GDPR) Action Plan sets out the key steps required to prepare for the introduction of GDPR in May 2018. Implementation progress reports are reviewed by the IGSG and GAC.

The PHA 'Connect' intranet site provides staff with easy access to the latest PHA policies, news and resources. Through the use of this site the PHA ensures that all staff have access to information governance policies and procedures. This has also been enhanced by the introduction of a MetaCompliance system ('iKnow') which can be used to send a 'pop-up' reminder to staff when they log in to their personal computers.

Information asset registers have been developed, and are kept under review. Information risks are assessed and control measures are identified and reviewed as required. Where appropriate information risks are incorporated in the Corporate or Directorate Risk Registers.

The HSC information governance e-learning programme, incorporating Freedom of Information, Data Protection, Records Management and IT Security continues to be rolled out to all staff. The SIRO and IAO's attend specialised training. Uptake of training is monitored by the IGSG.

6. Assurance

The Governance and Audit Committee provides an assurance to the Board of the PHA on the adequacy and effectiveness of the system of internal controls in operation within the PHA. It assists the PHA Board in the discharge of its functions by providing an independent and objective review of:

- all control systems;
- the information provided to the PHA Board;
- compliance with law, guidance and Code of Conduct and Code of Accountability; and
- governance processes within the PHA Board.

Internal and External Audit have a vital role in providing assurance on the effectiveness of the system of internal control. The GAC receives, reviews and monitors reports from Internal and External Audit. Internal and External Audit representatives are also in attendance at all GAC meetings.

The Chair of the GAC reports to the PHA Board on a regular basis on the work of the Committee.

The PHA Board also receives regular assurances through the financial and performance reports brought to it by the HSCB Director of Finance and PHA Director of Operations.

The PHA Assurance Framework which is reviewed twice yearly by the GAC and annually by the PHA Board, sets out a systematic and comprehensive reporting framework to the Board and its committees.

The PHA continues to ensure that data quality assurance processes are in place across the range of data coming to the PHA Board. Where gaps are identified, the PHA proactively seeks to address these, for example by the development and regular review of the Programme Expenditure Monitoring System (PEMS) to ensure comprehensive and robust information.
Information presented to the PHA Board to support decision making, is firstly presented to and approved by the Agency Management Team (AMT) and the Interim Chief Executive, as part of the quality assurance process. Relevant officers are also in attendance at Board meetings when appropriate, to ensure that members have the opportunity to challenge information presented.

PUBLIC HEALTH AGENCY

ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2018

Controls Assurance Standards

The PHA assessed its compliance with the applicable Controls Assurance Standards which were defined by the Department and against which a degree of progress was expected in 2017/18.

The PHA achieved the following levels of compliance for 2017/18:

Standard	DoH Expected Level of Compliance	PHA Level of Compliance	Verified by Internal Audit
Buildings, land, plant and non-medical equipment	75% - 99% (Substantive)	83%	-
Decontamination of medical devices	75% - 99% (Substantive)	N/A	-
Emergency Planning	75% - 99% (Substantive)	91%	-
Environmental Cleanliness	75% - 99% (Substantive)	N/A	-
Environment Management	75% - 99% (Substantive)	83%	-
Financial Management *(Core Standard)*	75% - 99% (Substantive)	88%	✓
Fire safety	75% - 99% (Substantive)	90%	✓
Fleet and Transport Management	75% - 99% (Substantive)	N/A	-
Food Hygiene	75% - 99% (Substantive)	N/A	-
Governance *(Core Standard)*	75% - 99% (Substantive)	89%	✓
Health & Safety	75% - 99% (Substantive)	90%	-
Human Resources	75% - 99% (Substantive)	86%	-
Infection Control	75% - 99% (Substantive)	N/A	-
Information Communication Technology	75% - 99% (Substantive)	89%	-
Management of Purchasing and Supply	75% - 99% (Substantive)	88%	-
Medical Devices and Equipment Management	75% - 99% (Substantive)	N/A	-
Medicines Management	75% - 99% (Substantive)	N/A	-
Information Management	75% - 99% (Substantive)	81%	-
Research Governance	75% - 99% (Substantive)	91%	-
Risk Management *(Core Standard)*	75% - 99% (Substantive)	88%	✓
Security Management	75% - 99% (Substantive)	88%	-
Waste Management	75% - 99% (Substantive)	87%	-

7. Sources of Independent Assurance

The PHA obtains Independent Assurance from the following sources:

- Internal Audit
- Regulation and Quality Improvement Authority (RQIA)

In addition, the PHA receives an opinion on regularity from the External Auditor in the Report to Those Charged with Governance.

Internal Audit

The PHA utilises an Internal Audit function which operates to defined standards and whose work is informed by an analysis of the risk to which the body is exposed and annual audit plans are based on this analysis.

In 2017/18 Internal Audit reviewed the following systems:

System reviewed	Assurance received
Financial Review	Satisfactory
Management of Contracts with Voluntary / Community Sector	Satisfactory – management of contracts; Limited – procurement of contracts
Risk Management	Satisfactory
Population Screening	Satisfactory – 3 out of 5 screening programmes reviewed; Limited – 2 out of 5 screening programmes reviewed
Research and Development	Limited

Internal audit also carried out the year end Controls Assurance verification and mid-year and end of year follow up reports.

In their annual report, the Internal Auditor reported that the PHA system of internal control was adequate and effective.

One priority one weaknesses in control was identified in the PHA Management of Health and Social Wellbeing Contracts Audit, relating to the procurement of health and social wellbeing improvement contracts. This has now been partially implemented.

One priority one weakness, with two recommendations, was identified in the Research and Development audit, in respect of governance and oversight of R&D activities. Both of the recommendations have been fully implemented.

The Internal Audit Follow Up report on previous Internal Audit Recommendations, issued on 31 March 2018, found that of the 40 recommendations with an implementation date of 31 March 2018 or earlier, 73% were fully implemented, and

27% were partially implemented. Work will continue during 2018/19 to address the 11 partially implemented recommendations.

RQIA

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

This system of assurance takes the form of a 6 monthly report which details the progress on implementation of RQIA recommendations. The most recent report, for the period ending 31 December 2017 was considered by the Agency Management Team on 13 March 2018.

External Audit

For the year ended 31 March 2017, the Comptroller and Auditor General gave an unqualified audit opinion on the financial statements and the regularity opinion of the PHA's accounts. A Report to Those Charged with Governance on additional matters did not identify any priority 1 or 2 issues.

8. Review of Effectiveness of the System of Internal Governance

As Accounting Officer, I have responsibility for the review of effectiveness of the system of internal governance. My review of the effectiveness of the system of internal governance is informed by the work of the Internal Auditors and the executive managers within the PHA who have responsibility for the development and maintenance of the internal control framework, and comments made by the External Auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governance and Audit Committee and a plan to address weaknesses and ensure continuous improvement to the system is in place.

9. Internal Governance Divergences

a) ***Update on prior year control issues which have now been resolved and are no longer considered to be control issues***

Business Services Transformation Project/Shared Services (Recruitment)

The audit assignment carried out during 2016/17 for Recruitment Shared Services resulted in a limited level of assurance being received from the Internal Auditor. For the 2017/18 audit of Recruitment Shared Services, Internal Audit has provided satisfactory assurance over the system of control with no significant issues to report.

b) ***Update on prior year control issues which continue to be considered control issues***

Business Services Transformation Project/Shared Services (Payroll)

The audit assignment carried out during 2016/17 for Payroll Shared Services resulted in an unacceptable level of assurance being received from the Internal Auditor. While the issues raised in this audit report had limited impact on the PHA, it was of some concern that progress on issues identified in prior years had not been made. As a result of the 2016/17 Payroll audit, an action plan was developed by BSO to attempt to address the control and system stability issues identified. Internal Audit has provided limited assurance for the 2017/18 audit of Payroll Shared Services. A number of key functions have not yet stabilised and significant control issues remain, including the resolution of known system issues.

Quality, Quantity and Financial Controls

While acknowledging the difficulties in commissioning and supporting services provided to the population of Northern Ireland in an environment where demand for these services continues to increase and the budget available for commissioning them remains constrained, the actions taken by the PHA during 2017/18 enabled it to maintain the integrity of existing services commissioned and to ensure that additional priorities were implemented and progressed, within budget.

The Northern Ireland Assembly was dissolved from 26 January 2017 with an election taking place on 2 March 2017, on which date Ministers ceased to hold office. An Executive was not formed following the 2 March 2017 election. As a consequence, the Northern Ireland Budget Act 2017 was progressed through Westminster, receiving Royal Assent on 16 November 2017, followed by the Northern Ireland Budget (Anticipation and Adjustments) Act 2018 which received Royal Assent on 28 March 2018. The authorisations, appropriations and limits in these Acts provide the authority for the 2017/18 financial year and a vote on account for the early months of the 2018/19 financial year as if they were Acts of the Northern Ireland Assembly.

Across the HSC sector it is expected that the significant financial challenges faced will intensify and extensive budget planning work to support the 2018/19 financial plan is ongoing between the PHA and Department of Health (DoH). However, as with other financial years the PHA remains committed to achieving financial break-even, and will continue to take appropriate actions and manage its budget to ensure the most effective service provision possible within budget constraints.

Management of Contracts with the Community and Voluntary Sector

The 2017/18 Internal Audit report on the management of health and social wellbeing improvement contracts provides satisfactory assurance on the system of internal controls over PHA's management of health and social wellbeing contracts, reflecting the significant work that has been undertaken by the PHA. Service level Agreements are in place, appropriate monitoring arrangements have been developed, payments

are only released on approval of previous progress returns and a procurement plan is in place, with action being taken against it during the year.

However, while Internal Audit acknowledged the improving position, a priority one finding remains in respect of the procurement of services. Although the PHA is continuing to implement the procurement plan, progress is slow due to a number of factors, including staff capacity and waiting for the new DoH Protect Life Strategy to enable mental health tenders to be progressed. That said, progress has been made during 2017/18, with the tender for the Youth Engagement Service (previously One Stop Shop) completed and new contracts awarded, market engagement being undertaken for the mental health tenders, and planning underway for the Healthy Places tenders. Procurement for the interim Lifeline Service model was initiated in November 2017, however no bids were received. Following significant work to identify solutions to ensure the continuity of this vital service from 1 April 2018, a decision was made, and approved by the DoH, to commission the interim service from the Belfast Health and Social Care Trust.

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. Progress against the Procurement Plan is monitored by the PHA Board.

PHA also continues to work closely with BSO Procurement and Logistics Services (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.

The PHA will continue to work closely with colleagues in HSCB, BSO, the HSC Trusts and the DoH, to develop and put in place appropriate and proportionate regional processes that meet the new procurement regulations.

Reduction in the PHA Management and Administration Budget

The 2015/16 management and administration allocation for the PHA was reduced by 15% (£2.8m). In order to meet this significant budget reduction, the PHA introduced a number of controls reducing goods and services expenditure, along with vacancy controls. However in order to achieve the savings required on a recurring basis it was necessary to avail of the Voluntary Exit Scheme (VES). This has resulted in a loss of knowledge and experience as well as reduced capacity.

In 2016/17 there was a further reduction of 10% (£1.6m) from the management and administration budget, followed by another reduction of 0.6% (£100k) in 2017/18.

While the PHA has taken measures to ensure that core and essential work is maintained, pressures are evident, especially as PHA responds to new and changing demands and needs.

The opening budget allocation for 2018/19 has now been received and includes a further reduction of £500k in the management and administration budget. This is

likely to have a negative impact on the work of the PHA. The PHA will continue to work closely with the DoH.

Campaigns Budget

One of the PHA core functions as set out in the Health and Social (Reform) Act (Northern Ireland) 2009 is "health promotion, including in particular enabling people in Northern Ireland to increase control over and improve their health and social wellbeing" (section 13 (2) (a)). In undertaking this function, the PHA may "provide information, advice and assistance" (section 13 (4) (f)). The running of evidence based social marketing campaigns has been a core element of how the PHA carries out this function. Since its establishment in 2009 the PHA has led on the development and commissioning of many campaigns aimed at informing the public about key health and wellbeing issues and providing the information and 'nudge' to take action to improve their health and wellbeing, for example mental health, obesity and tobacco control campaigns.

However as part of the 2017/18 budget reductions, the PHA campaigns budget of £1.195m was removed. While this reduction was non-recurring, it did have a significant impact on the PHA ability to raise public awareness on key health and wellbeing issues.

While the scale was much reduced in 2017/18, PHA did however, take all possible steps to raise public awareness, including running a Dementia campaign (funded through Atlantic Philanthropies), and obtaining approval to launch the Breastfeeding campaign (*#Not Sorry Mums*) in January 2018, given that the majority of planning and development work had already been completed in 2016/17. Key messages were also disseminated via other available communication channels, including PR, social media, and digital platforms.

There is a considerable lead in time to plan and develop campaigns prior to their launch and the financial constraints in 2017/18 have therefore also impacted on the ability of the PHA to begin to plan and develop campaigns that could run in 2018/19. The opening budget allocation for 2018/19 has now been received and includes a reduction of £1m from the campaigns budget.

No campaigns budget for a second year, or indeed a significantly reduced campaigns budget in 2018/19 will make it increasingly difficult to raise public awareness, and enable behavioural change on key health and wellbeing issues. The PHA will however look to other lower-cost and lower impact means of messaging during 2018/19 and will continue to seek to further develop a range of key partnerships that can help to disseminate priority public health communications.

c) Identification of new issues in the current year (including issues identified in the mid-year assurance statement) and anticipated future issues.

EU Exit

The Public Health Agency is actively scoping the potential impact of a 'no deal' outcome from the UK-EU negotiations on the services it provides, in line with the information provided by the Department. The process will continue to be refined as more clarity emerges on the detail of the final agreement.

Neurology Call Back

Due to concerns being raised in relation to the practice of a consultant neurologist at the Belfast Trust including work he undertook on behalf of other Trusts and in relation to his private practice, the HSCB and PHA have, at the direction of the DoH, established a regional Coordination Group (to include representatives for each of the five Trusts) to co-ordinate the work necessary to complete a call-back review. The PHA will work closely with the Trusts and independent providers to clarify their assessments of the numbers of past and present patients who may be affected, ensuring that a consistent approach is taken both during the review and reporting of outcomes to enable patients to be assessed and receive appropriate treatment and care where it is required.

The DoH has established an independent inquiry panel to examine how concerns about the clinician were communicated and responded to. The DoH has also directed RQIA to undertake an expert review of the records of deceased patients of the clinician who have died over the past ten years and to include patients who died before this if there is a concern.

Furthermore, the DoH has requested the RQIA to undertake a review of the governance of outpatient services in the Belfast Trust with a particular focus on neurology services.

The call back exercise should be completed by the end of July 2018. The Governance Review and Independent Inquiry are not planned to commence fully until the call back exercise is completed in order to avoid diverting resources away from ensuring the needs of patients are addressed.

10. Conclusion

The PHA has a rigorous system of accountability which I can rely on as Accounting Officer to form an opinion on the probity and use of public funds, as detailed in Managing Public Money NI (MPMNI).

Further to considering the accountability framework within the PHA and in conjunction with assurances given to me by the Head of Internal Audit, I am content that the PHA has operated a sound system of internal governance during the period 2017/18.

REMUNERATION AND STAFF REPORT

Remuneration Report

A committee of Non-Executive board members exists to advise the full Board on the remuneration and terms and conditions of service for Senior Executives employed by the Public Health Agency (PHA).

While the salary structure and the terms and conditions of service for Senior Executives is determined by the Department of Health (DoH), the Remuneration and Terms of Service Committee has a key role in assessing the performance of Senior Executives and, where permitted by DoH, agreeing the discretionary level of performance related pay.

DoH Circulars on the 2016/17 and 2017/18 Senior Executive pay awards had not been received by 31 March 2018. Any related payments, therefore have not been made to Executive Directors.

The 2015/16 Senior Executive's pay award was set out in DoH circular HSC(SE) 1/2016 and was paid in line with the Remuneration Committee's agreement on the classification of Executive Directors' performance, categorised against the standards of 'fully acceptable' or 'incomplete' as set out within the circular.

The salary, pension entitlement and the value of any taxable benefits in kind paid to both Executive and Non-Executive Directors is set out within this report. None of the Executive or Non-Executive Directors of the PHA received any other bonus or performance related pay in 2017/18. It should be noted that Non-Executive Directors do not receive pensionable remuneration and therefore there will be no entries in respect of pensions for Non-Executive members.

Non-Executive Directors are appointed by the DoH under the Public Appointments process and the duration of such contracts is normally for a term of 4 years. Details of newly appointed Non-Executive Directors or those leaving post have been detailed in the Senior Management Remuneration tables below.

Executive Directors are employed on a permanent contact unless otherwise stated in the following remuneration tables.

Early Retirement and Other Compensation Schemes

There were no early retirements or payments of compensation for other departures relating to current or past Senior Executives during 2017/18.

PUBLIC HEALTH AGENCY

ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2018

Membership of the Remuneration and Terms of Service Committee:

Mr Andrew Dougal - Chair
Councillor William Ashe – Non-Executive Director
Alderman Paul Porter – Non-Executive Director

The Committee is supported by the Director of Human Resources (BSO).

Senior Employee's Remuneration

The salary, pension entitlements, and the value of any taxable benefits in kind of the most senior members of the PHA were as follows, it should be noted that there were no bonuses paid to any Director during 2017/18 or 2016/17.

Non Executive Members (Table Audited)

	2017/18				2016/17			
Name	**Salary £000s**	**Benefits in Kind (to nearest £100)**	**Pension Benefits (to nearest £1,000)**	**Total £000s**	**Salary £000s**	**Benefits in Kind (to nearest £100)**	**Pension Benefits (to nearest £1,000)**	**Total £000s**
Mr Andrew Dougal (*Chair*)	30-35	-	-	30-35	30-35	-	-	30-35
Mrs Julie Erskine (Leaver 30th Nov 2016)	-	-	-	-	5-10	-	-	5-10
Mr Thomas Mahaffy	5-10	-	-	5-10	5-10	-	-	5-10
Alderman Paul Porter	5-10	-	-	5-10	5-10	-	-	5-10
Councillor William Ashe	5-10	-	-	5-10	5-10	-	-	5-10
Mr Brian Coulter (Leaver 31st Mar 2018)	5-10	-	-	5-10	5-10	-	-	5-10
Mr Leslie Drew	5-10	-	-	5-10	5-10	-	-	5-10
Ms Deepa Mann-Kler	5-10	100	-	5-10	5-10	-	-	5-10

Notes

Some non-executive members may have received benefits in kind below £50 – this will be rounded down to nil as specified in the 2nd column of the table above.

PUBLIC HEALTH AGENCY

ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2018

Executive Members (Table Audited)

	2017/18				2016/17			
Name	**Salary £000s**	**Benefits in Kind (to nearest £100)**	**Pension Benefits (to nearest £1,000)**	**Total £000s**	**Salary £000s**	**Benefits in Kind (to nearest £100)**	**Pension Benefits (to nearest £1,000)**	**Total £000s**
Dr Eddie Rooney *Chief Executive* (Retired 14th Oct 2016)	-	-	-	-	60-65	200	11,000	75-80
Dr Carolyn Harper *Director of Public Health* *	150-155	200	55,000	205-210	145-150	-	21,000	165-170
Dr Adrian Mairs *Acting Director of Public Health* (Started 28th Jan 2018) **	25-30 (115-120 FYE)	100	-	25-30	-	-	-	-
Mr Edmond McClean *Director of Operations / Deputy Chief Executive*	85-90	400	42,000	130-135	80-85	400	39,000	120-125
Mrs Mary Hinds *Director of Nursing & Allied Health Professionals*	100-105	-	11,000	110-115	100-105	-	13,000	115-120

Notes

Mrs Valerie Watts was appointed as Interim Chief Executive from 17/10/16 and has dual responsibility for the Public Health Agency and the Health and Social Care Board (HSCB). All remuneration has been reported under the post holder's substantive post in the HSCB.

* Absence of the Director of Public Health resulted in cover being required by an acting arrangement.

** No pension benefit shown as this is an annual calculation.

FYE – Full Year Equivalent

Median Salary (Table Audited)

The relationship between remuneration of the most highly paid director and the median remuneration of the workforce is set out below. There has been no significant change to the ratio when compared to 2016/17.

	2018	2017
Highest Earner's Total Remuneration (band in £000)	150-155	145-150
Median Salary (£)	35,224	34,875
Median Total Remuneration Ratio	**4.3**	**4.2**

Pensions of Senior Management (Table Audited)

	2017/18				
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 31/03/17 £000**	**CETV at 31/03/18 £000**	**Real increase in CETV £000**
Dr Carolyn Harper *Director of Public Health* (1a)	2.5-5.0 pension 7.5-10.0 lump sum	40-45 pension 130-135 lump sum	801	897	65
Dr Adrian Mairs *Acting Director of Public Health* (Started 28th Jan 2018) (2)	-	-	-	-	-
Mr Edmond McClean *Director of Operations / Deputy Chief Executive* (3)	0-2.5 pension 5-7.5 lump sum	25-30 pension 85-90 lump sum	-	-	-
Mrs Mary Hinds *Director of Nursing & Allied Health Professionals* (1b)	0.0-2.5 pension 2.5-5.0 lump sum	20-25 pension 60-65 lump sum	443	485	25

Notes

1) CETV at 31/03/17 has been adjusted by Pensions branch, based on the current framework prescribed by the Institute and Faculty of Actuaries as follows:

   (a) 795 to 801 (b) 439 to 443

2) This is an annual calculation so no figures are available for this financial year.

3) CETV calculation not applicable for this post holder.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, plus the real increase in any lump sum, less the contributions made by the individual. The real increases exclude increases due to inflation or any increase decrease due to transfer of pension rights.

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 a member's accrued benefits in 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 a member leaves the scheme and chooses to transfer their 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 disclosure applies.

The CETV figures 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 benefits 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 and framework 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 of 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.

Pension contributions deducted from individual employees are dependent on the level of remuneration receivable and are deducted using a scale applicable to the level of remuneration received by the employee.

Staff Report

Staff Costs (Table Audited)

PHA staff costs comprise:

	2018			2017
	Permanently employed staff	**Others**	**Total**	**Total**
	£000s	**£000s**	**£000s**	**£000s**
Wages and salaries	12,484	518	13,002	12,947
Social security costs	1,365	57	1,422	1,424
Other pension costs	1,824	76	1,900	1,894
Total staff costs reported in Statement of Comprehensive Net Expenditure	**15,673**	**651**	**16,324**	**16,265**
Less recoveries in respect of outward secondments			(203)	(342)
Total net costs			**16,121**	**15,923**

The PHA participates in the HSC Superannuation Scheme. Under this multi-employer defined benefit scheme both the PHA and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DoH. The PHA is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis.

Average Number of Persons Employed (Table Audited)

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

	2018			2017
	Permanently employed staff	**Others**	**Total**	**Total**
Commissioning of Health and Social Care	286	10	**296**	**299**
Less average staff number in respect of outward secondments	(3)	-	**(3)**	**(4)**
Total net average number of persons employed	**283**	**10**	**293**	**295**

Reporting of Early Retirement and other Compensation Schemes – Exit Packages (Table Audited)

Exit package cost band	Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages by cost band	
	2018	**2017**	**2018**	**2017**	**2018**	**2017**
<£10,000	0	0	0	0	0	**0**
£10,000 - £25,000	0	0	0	0	0	**0**
£25,001 - £50,000	0	0	0	0	0	**0**
£50,001 - £100,000	0	0	0	1	0	**1**
£100,001 - £150,000	0	0	0	0	0	**0**
Total number of exit packages by type	**0**	**0**	**0**	**1**	**0**	**1**
Total resource cost £000s	**£0**	**£0**	**£0**	**£61**	**£0**	**£61**

Redundancy and other departure costs have been paid in accordance with the provisions of the 2016/17 Voluntary Exit Scheme and the HSC Pension Scheme Regulations where appropriate. Exit costs are accounted for in full in the year in which the exit package is approved and agreed and are included as operating expenses at Note 3. Where early retirements have been agreed, the additional costs are met by the employing authority and not by the HSC pension scheme. Ill-health retirement costs are met by the pension scheme and are not included in the table.

Staff Benefits

The PHA had no staff benefits in 2017/18 or 2016/17.

Retirements due to ill-health

During 2017/18, there were no early retirement from the PHA agreed on the grounds of ill-health.

Staff Composition

The staff composition broken down by male/female and whole time equivalent (WTE) as at 31 March 2018 was as follows:

Gender	Headcount	Whole Time Equivalent
Female	244	226.0
Male	68	65.1
Grand Total	**312**	**291.1**

Staff Gender Breakdown within PHA 2017/18 Senior Management (excl. Board Members)*		
Gender	**Headcount**	**Whole Time Equivalent**
Female	25	23.3
Male	15	14.1
Grand Total	**40**	**37.4**

**Senior management is defined as staff in receipt of a basic WTE salary of greater than £67k inclusive of medical staff.*

Sickness Absence Data

The corporate cumulative annual absence level for the PHA for the period from 1 April 2017 – 31 March 2018 is 3.03% (2016/17 2.80%).

There were 16,841 hours lost due to sickness absence or the equivalent of 54 hours lost per employee. Based on a 7.5 hour working day, this is equal to 7.2 days per employee.

Staff Policies Applied During the Financial Year

During the year the PHA ensured internal policies gave full and fair consideration to applications for employment made by disabled persons having regard to their particular aptitudes and abilities. In this regard the PHA is fully committed to promoting equality of opportunity and good relations for all groupings under Section 75 of the Northern Ireland Act 1998.

The PHA has a range of policies in place that serve to advance this aim, including, on the employment side, the Equality of Opportunity Policy. More information is available on the PHA's website at www.publichealth.hscni.net

Where an employee has become disabled during the course of their employment with the PHA, the organisation works closely with Human Resources (BSO HR Shared Services) who are guided by advice from Occupational Health.

Subsequently, reasonable adjustments can be made to accommodate the employee such as reduced hours, work adjustments including possible redeployment, in line with relevant disability legislation. This legislation is incorporated into selection and recruitment training and induction training and is highlighted in relevant policies where necessary.

The PHA is fully committed to the ongoing training and development of all members of staff and through the performance appraisal system all staff are afforded this opportunity irrespective of ability/disability as well as having the same opportunities to progress through the organisation.

The PHA also participates in the Disability Placement Scheme which provides a six month placement for those with a disability wishing to return to the workplace. During their placement they receive support and guidance – for example, guidance on the completion of application forms when applying for future posts.

More information on the PHA's work regarding equality is available in this report under the section entitled 'Equality' as well as on the PHA's website www.publichealth.hscni.net.

Expenditure on Consultancy

The PHA had no expenditure on External Consultancy during 2017/18 (2016/17 - nil).

Off-Payroll Engagements

The PHA is required to disclose whether there were any staff or public sector appointees contracted through employment agencies or self-employed with a total cost of over £58,200 during the financial year, which were not paid through the PHA Payroll. There were no such 'off-payroll' engagements in 2017/18 or 2016/17.

ASSEMBLY ACCOUNTABILITY AND AUDIT REPORT

Funding Report

Regularity of Expenditure

The PHA has robust internal controls in place to support the regularity of expenditure. These are supported by procurement experts (BSO PaLS), annually reviewed Standing Orders, Standing Financial Instructions and Scheme of Delegated Authority and the dissemination of new guidance where appropriate. Expenditure and the governing controls are independently reviewed by Internal and External Audit and are self-assessed in controls assurance standards. During 2017/18, there has been no evidence of irregular expenditure occurring.

Losses and Special Payments

Type of loss and special payment		2017/18		2016/17
		Number of Cases	£	£
Cash losses				
	Cash Losses - Theft, fraud etc.	1	425	-
	Cash Losses – Overpayments of salaries, wages and allowances	-	-	480
Fruitless Payments				
	Late Payment of Commercial Debt	1	40	-
TOTAL		**2**	**465**	**480**

Special Payments

There were no other special payments or gifts made during the year (2016/17 – none).

Other Payments and Estimates

There were no other payments made during the year (2016/17- none).

Losses and Special Payments over £250,000

There were no losses or special payments greater than £250k during the year.

Remote Contingent Liabilities

In addition to contingent liabilities reported within the meaning of IAS37 shown in Note 21 of the Annual Accounts, the PHA also considers liabilities for which the likelihood of a transfer of economic benefit in settlement is too remote to meet the definition of contingent liability. As at 31 March 2018, the PHA is not aware of any remote contingent liabilities, and there were none in 2016/17.

Valerie Watts

Chief Executive (Interim)

Date 11 June 2018

PUBLIC HEALTH AGENCY

ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2018

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE NORTHERN IRELAND ASSEMBLY

Opinion on financial statements

I certify that I have audited the financial statements of the Public Health Agency for the year ended 31 March 2018 under the Health and Social Care (Reform) Act (Northern Ireland) 2009. The financial statements comprise the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Accountability Report that is described in that report as having been audited.

In my opinion the financial statements:

- give a true and fair view of the state of the Public Health Agency's affairs as at 31 March 2018 and of the Public Health Agency's net expenditure for the year then ended; and

- have been properly prepared in accordance with the Health and Social Care (Reform) Act (Northern Ireland) 2009 and Department of Health directions issued thereunder.

Opinion on regularity

In my opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Assembly and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis of opinions

I conducted my audit in accordance with International Standards on Auditing (UK) (ISAs) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'[1]. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of this certificate. My staff and I are independent of the Public Health Agency in accordance with the ethical requirements of the Financial Reporting Council's Revised Ethical Standard 2016, and have fulfilled our other ethical responsibilities in accordance with these requirements. I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my opinions.

Other Information

The Agency and the Accounting Officer are responsible for the other information included in the annual report. The other information comprises the information

[1] Reference to Practice Note 10 is to cover the basis for the regularity opinion.

included in the annual report other than the financial statements, the parts of the Accountability Report described in the report as having been audited, and my audit certificate and report. My opinion on the financial statements does not cover the other information and I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial statements, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit or otherwise appears to be materially misstated. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

Opinion on other matters

In my opinion:

- the parts of the Accountability Report to be audited have been properly prepared in accordance with Department of Health directions made under the Health and Social Care (Reform) Act (Northern Ireland) 2009; and

- the information given in the Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Responsibilities of the Agency and Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer Responsibilities, the Agency and the Accounting Officer are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Social Care (Reform) Act (Northern Ireland) 2009.

I am required to obtain evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of my responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my certificate.

In addition, I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Assembly and the financial transactions recorded in the financial statements conform to the authorities which govern them.

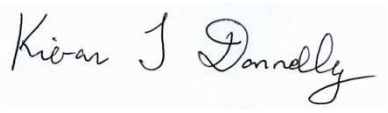
Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept; or
- the financial statements and the parts of the Accountability Report to be audited are not in agreement with the accounting records; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with the Department of Finance's guidance.

Report

I have no observations to make on these financial statements.



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

18 June 2018

PUBLIC HEALTH AGENCY

ANNUAL ACCOUNTS
FOR THE YEAR ENDED 31 MARCH 2018

PUBLIC HEALTH AGENCY

ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

FOREWORD

These accounts for the year ended 31 March 2018 have been prepared in a form determined by the Department of Health (DoH) based on guidance from the Department of Finance's Financial Reporting Manual (FReM) and in accordance with the requirements of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

PUBLIC HEALTH AGENCY

ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

CERTIFICATES OF DIRECTOR OF FINANCE, CHAIRMAN AND CHIEF EXECUTIVE

I certify that the annual accounts set out in the financial statements and notes to the accounts (pages 88 to 119) which I am required to prepare on behalf of the Public Health Agency have been compiled from and are in accordance with the accounts and financial records maintained by the Public Health Agency and with the accounting standards and policies for HSC bodies approved by the DoH.

Paul Cummings

Director of Finance

Date 11 June 2018

I certify that the annual accounts set out in the financial statements and notes to the accounts (pages 88 to 119) as prepared in accordance with the above requirements have been submitted to and duly approved by the Board.

Andrew Dougal

Chairman

Date 11 June 2018

Valerie Watts

Chief Executive (Interim)

Date 11 June 2018

PUBLIC HEALTH AGENCY

STATEMENT of COMPREHENSIVE NET EXPENDITURE for year ended 31 March 2018

This account summarises the expenditure and income generated and consumed on an accruals basis. It also includes other comprehensive income and expenditure, which includes changes to the values of non-current assets and other financial instruments that cannot yet be recognised as income or expenditure.

	NOTE	2018 £000	2017 £000
Income			
Income from activities	4.1	418	980
Other income (excluding interest)	4.2	778	679
Deferred income	4.3	0	0
Total operating income		1,196	1,659
Expenditure			
Staff costs	3	(16,324)	(16,265)
Purchase of goods and services	3	(49,038)	(50,800)
Depreciation, amortisation and impairment charges	3	(210)	(161)
Provision expense	3	10	(370)
Other expenditures	3	(2,677)	(3,060)
Total operating expenditure		(68,239)	(70,656)
Net Expenditure		**(67,043)**	**(68,997)**
Finance income	4.2	0	0
Finance expense	3	0	0
Net expenditure for the year		(67,043)	(68,997)
Revenue Resource Limits (RRLs) issued (to)			
Belfast Health & Social Care Trust		(14,251)	(13,769)
South Eastern Health & Social Care Trust		(4,612)	(4,427)
Southern Health & Social Care Trust		(6,435)	(6,324)
Northern Health & Social Care Trust		(8,579)	(8,281)
Western Health & Social Care Trust		(7,015)	(6,779)
NI Medical & Dental Training Agency		(148)	(132)
Total RRL issued		(41,040)	(39,712)
Total Commissioner resources utilised		(108,083)	(108,709)
Revenue Resource Limit (RRL) received from DoH	24.1	108,223	108,784
Surplus / (Deficit) against RRL		**140**	**75**

OTHER COMPREHENSIVE EXPENDITURE		2018 £000	2017 £000
Items that will not be reclassified to net operating costs		0	0
Net gain/(loss) on revaluation of property, plant and equipment	5.1/8/5.2/8	11	0
Net gain/(loss) on revaluation of intangibles	6.1/8/6.2/8	0	0
Net gain/(loss) on revaluation of financial instruments	7/8	0	0
Items that may be reclassified to net operating costs:			
Net gain/(loss) on revaluation of investments		0	0
TOTAL COMPREHENSIVE EXPENDITURE for the year ended 31 March		**(67,032)**	**(68,997)**

The notes on pages 92 to 119 form part of these accounts.

PUBLIC HEALTH AGENCY

STATEMENT of FINANCIAL POSITION as at year ended 31 March 2018

This statement presents the financial position of the Public Health Agency. It comprises three main components: assets owned or controlled; liabilities owed to other bodies; and equity, the remaining value of the entity.

	NOTE	2018 £000	£000	2017 £000	£000
Non Current Assets					
Property, plant and equipment	5.1/5.2	410		540	
Intangible assets	6.1/6.2	186		178	
Total Non Current Assets			596		718
Current Assets					
Inventories	10	0		0	
Trade and other receivables	12	574		493	
Other current assets	12	30		15	
Cash and cash equivalents	11	469		419	
Total Current Assets			1,073		927
Total Assets			**1,669**		**1,645**
Current Liabilities					
Trade and other payables	13	(6,981)		(6,987)	
Provisions	15	0		(375)	
Total Current Liabilities			(6,981)		(7,362)
Total assets less current liabilities			**(5,312)**		**(5,717)**
Non Current Liabilities					
Provisions	15	(364)		0	
Other payables > 1 yr	13	0		0	
Financial liabilities	7	0		0	
Total Non Current Liabilities			(364)		0
Total assets less total liabilities			**(5,676)**		**(5,717)**
Taxpayers' Equity and other reserves					
Revaluation reserve		47		36	
SoCNE reserve		(5,723)		(5,753)	
Total equity			**(5,676)**		**(5,717)**

The financial statements on pages 88 to 119 were approved by the Board on 11 June 2018 and were signed on its behalf by:

Signed  (Chairman) Date 11 June 2018

Signed  (Chief Executive - Interim) Date 11 June 2018

PUBLIC HEALTH AGENCY

STATEMENT of CASH FLOWS for the year ended 31 March 2018

The Statement of Cash Flows shows the changes in cash and cash equivalents of the Public Health Agency during the reporting period. The statement shows how the Public Health Agency generates and uses cash and cash equivalents by classifying cash flows as operating, investing and financing activities. The amount of net cash flows arising from operating activities is a key indicator of service costs and the extent to which these operations are funded by way of income from the recipients of services provided by the Public Health Agency. Investing activities represent the extent to which cash inflows and outflows have been made for resources which are intended to contribute to the Public Health Agency's future public service delivery.

	NOTE	2018 £000	2017 £000
Cash flows from operating activities			
Net surplus after interest/Net operating expenditure	SoCNE	(67,043)	(68,997)
Adjustments for non cash transactions	3	274	549
(Increase)/decrease in trade and other receivables	12	(97)	98
Increase/(decrease) in trade payables	13	(6)	(786)
Less movements in payables relating to items not passing through the NEA			
Movements in payables relating to the purchase of property, plant and equipment	13	88	1
Movements in payables relating to the purchase of intangibles	13	(12)	0
Use of provisions	15	(1)	0
Net cash inflow/(outflow) from operating activities		(66,797)	(69,135)
Cash flows from investing activities			
(Purchase of property, plant & equipment)	5	(159)	(309)
(Purchase of intangible assets)	6	(51)	(64)
Net cash outflow from investing activities		(210)	(373)
Cash flows from financing activities			
Grant in aid		67,057	69,617
Capital element of payments - finance leases and on balance sheet (SoFP) PFI and other service concession arrangements			
Net financing		67,057	69,617
Net increase (decrease) in cash & cash equivalents in the period		50	109
Cash & cash equivalents at the beginning of the period	11	419	310
Cash & cash equivalents at the end of the period	11	**469**	**419**

The notes on pages 92 to 119 form part of these accounts.

PUBLIC HEALTH AGENCY

STATEMENT of CHANGES in TAXPAYERS' EQUITY for year ended 31 March 2018

This statement shows the movement in the year on the different reserves held by the Public Health Agency, analysed into the SoCNE Reserve (i.e. that reserve that reflects a contribution from the Department of Health) and the Revaluation Reserve which reflects the change in asset values that have not been recognised as income or expenditure. The SoCNE Reserve represents the total assets less liabilities of the Public Health Agency, to the extent that the total is not represented by other reserves and financing items.

	NOTE	SoCNE Reserve £000	Revaluation Reserve £000	Total £000
Balance at 31 March 2016		**(6,389)**	**36**	**(6,353)**
Changes in Taxpayers' Equity 2016/17				
Grant from DoH		69,617	0	69,617
Other reserves movements including transfers		0	0	0
(Comprehensive expenditure for the year)		(68,997)	0	(68,997)
Transfer of asset ownership		0	0	0
Non cash charges - auditors remuneration	3	16	0	16
Balance at 31 March 2017		**(5,753)**	**36**	**(5,717)**
Changes in Taxpayers' Equity 2017/18				
Grant from DoH		67,057	0	67,057
Other reserves movements including transfers		0	0	0
(Comprehensive expenditure for the year)		(67,043)	11	(67,032)
Transfer of asset ownership		0	0	0
Non cash charges - auditors remuneration	3	16	0	16
Balance at 31 March 2018		**(5,723)**	**47**	**(5,676)**

The notes on pages 92 to 119 form part of these accounts.

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

NOTE 1 - STATEMENT OF ACCOUNTING POLICIES

1 Authority

These accounts have been prepared in a form determined by the Department of Health based on guidance from the Department of Finance's Financial Reporting Manual (FReM) and in accordance with the requirements of Article 90(2) (a) of the Health and Personal Social Services (Northern Ireland) Order 1972 No 1265 (NI 14) as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003 and the Health and Social Care (Reform) Act (Northern Ireland) 2009.

The accounting policies follow International Financial Reporting Standards (IFRS) to the extent that it is meaningful and appropriate to the Public Health Agency (PHA). Where a choice of accounting policy is permitted, the accounting policy which has been judged to be most appropriate to the particular circumstances of the PHA for the purpose of giving a true and fair view has been selected. The PHA's accounting policies have been applied consistently in dealing with items considered material in relation to the accounts, unless otherwise stated.

In addition, due to the manner in which the PHA is funded, the Statement of Financial Position will show a negative position. In line with the FReM, sponsored entities such as the PHA which show total net liabilities, should prepare financial statements on a going concern basis. The cash required to discharge these net liabilities will be requested from the Department when they fall due, and is shown in the Statement of Changes in Taxpayers' Equity.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

1.2 Currency and Rounding

These accounts are presented in UK Pounds sterling. The figures in the accounts are shown to the nearest £1,000.

1.3 Property, Plant and Equipment

Property, plant and equipment assets comprise Buildings, Plant & Machinery, Information Technology, and Furniture & Fittings.

Recognition

Property, plant and equipment must be capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the PHA;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or

- collectively, a number of items have a cost of at least £5,000 where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building or unit, irrespective of their individual or collective cost.

On initial recognition property, plant and equipment are measured at cost including any expenditure such as installation, directly attributable to bringing them into working condition. Items classified as "under construction" are recognised in the Statement of Financial Position to the extent that money has been paid or a liability has been incurred.

Valuation of Land and Buildings

The PHA does not hold any land, and the premises occupied by the PHA are held under lease arrangements.

Assets under Construction (AUC)

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Assets are revalued and depreciation commences when they are brought into use.

Short Life Assets

Short life assets are not indexed. Short life is defined as a useful life of up to and including 5 years. Short life assets are carried at depreciated historic cost as this is not considered to be materially different from fair value and are depreciated over their useful life.

Where estimated life of fixtures and equipment exceed 5 years, suitable indices will be applied each year and depreciation will be based on indexed amount.

Revaluation Reserve

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure.

1.4 Depreciation

No depreciation is provided on freehold land since land has unlimited or a very long established useful life. Items under construction are not depreciated until they are commissioned. Properties that are surplus to requirements and which meet the definition of "non-current assets held for sale" are also not depreciated.

Otherwise, depreciation is charged to write off the costs or valuation of property, plant and equipment and similarly, amortisation is applied to intangible non-current

assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. Assets held under finance leases are also depreciated over the lower of their estimated useful lives and the terms of the lease. The estimated useful life of an asset is the period over which the PHA expects to obtain economic benefits or service potential from the asset. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. The following asset lives have been used.

Asset Type	Asset Life
Leasehold property	Remaining period of lease
IT assets	3 – 10 years
Intangible assets	3 – 10 years
Other Equipment	3 – 15 years

1.5 Impairment loss

If there has been an impairment loss due to a general change in prices, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure within the Statement of Comprehensive Net Expenditure (SoCNE). If the impairment is due to the consumption of economic benefits the full amount of the impairment is charged to the SoCNE and an amount up to the value of the impairment in the revaluation reserve is transferred to the SoCNE Reserve. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited firstly to the SoCNE to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.6 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure which meets the definition of capital restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

The overall useful life of the PHA's buildings takes account of the fact that different components of those buildings have different useful lives. This ensures that depreciation is charged on those assets at the same rate as if separate components had been identified and depreciated at different rates.

1.7 Intangible assets

Intangible assets includes any of the following held - software, licences, trademarks, websites, development expenditure, Patents, Goodwill and intangible Assets under Construction. Software that is integral to the operating of hardware, for example an operating system is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example

application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the PHA's business or which arise from contractual or other legal rights. Intangible assets are considered to have a finite life.

They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the PHA where the cost of the asset can be measured reliably. All single items over £5,000 in value must be capitalised while intangible assets which fall within the grouped asset definition may be capitalised if the group is at least £5,000 in value. The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date of commencement of the intangible asset, until it is complete and ready for use.

Intangible assets acquired separately are initially recognised at fair value. Following initial recognition, intangible assets are carried at fair value by reference to an active market, and as no active market currently exists depreciated replacement cost has been used as fair value.

1.8 Non-current assets held for sale

The PHA had no non-current assets held for sale in either 2017/18 or 2016/17.

1.9 Inventories

The PHA had no inventories as at 31 March 2018 or 31 March 2017.

1.10 Income

Operating Income relates directly to the operating activities of the PHA and is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Grant in aid

Funding received from the DoH is accounted for as grant in aid and is reflected through the Statement of Comprehensive Net Expenditure Reserve.

1.11 Investments

The PHA did not hold any investments in either 2017/18 or 2016/17.

1.12 Other expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.14 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The PHA as lessee

The PHA held no finance leases during 2017/18 or 2016/17.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated. Leased land may be either an operating lease or a Finance lease depending on the conditions in the lease agreement and following the general guidance set out in IAS 17. Leased buildings are assessed as to whether they are operating or finance leases.

The PHA as lessor

The PHA did not have any lessor agreements in either 2017/18 or 2016/17.

1.15 Private Finance Initiative (PFI) transactions

The PHA had no PFI transactions during 2017/18 or 2016/17.

1.16 Financial instruments

- Financial assets

Financial assets are recognised on the Statement of Financial Position (SoFP) when the PHA becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred. Financial assets are initially recognised at fair value.

- Financial liabilities

Financial liabilities are recognised on the SoFP when the PHA becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are derecognised when the liability has been discharged; that is, the liability has been paid or has expired. Financial liabilities are initially recognised at fair value.

- Financial risk management

IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the relationship with the DoH, and the manner in which they are funded, financial instruments play a more limited role within HSC bodies in creating risk than would apply to a non-public sector body of a similar size, therefore the PHA is not exposed to the degree of financial risk faced by business entities.

The PHA has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the PHA in undertaking activities. Therefore the PHA is exposed to little credit, liquidity or market risk.

- Currency risk

The PHA is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The PHA has no overseas operations. The PHA therefore has low exposure to currency rate fluctuations.

- Interest rate risk

The PHA has limited powers to borrow or invest and therefore has low exposure to interest rate fluctuations.

- Credit and liquidity risk

Since the PHA receives the majority of its funding from the Department of Health, it has low exposure to credit risk and is not exposed to significant liquidity risks.

1.17 Provisions

In accordance with IAS 37, provisions are recognised when the PHA has a present legal or constructive obligation as a result of a past event, it is probable that the PHA

will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting year, taking into account the risks and uncertainties.

Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using DoF's discount rates of -2.42% (1-5 years), -1.85% (5-10 years), -1.56% (>10 years), in real terms.

The PHA has also disclosed the carrying amount at the beginning and end of the year, additional provisions made, amounts used during the year, unused amounts reversed during the year and increases in the discounted amount arising from the passage of time and the effect of any change in the discount rate.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the PHA has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the PHA develops a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it.

The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the PHA.

1.18 Contingencies

Where the time value of money is material, contingent liabilities which are required to be disclosed under IAS 37 are stated at discounted amounts and the amount reported to the Assembly separately noted. Contingent liabilities that are not required to be disclosed by IAS 37 are stated at the amounts reported to the Assembly. Under IAS 37, the PHA discloses contingent liabilities where there is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the PHA, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more

uncertain future events not wholly within the control of the PHA. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

The PHA had no contingencies as at 31 March 2018 or 31 March 2017.

1.19 Employee benefits

Short-term employee benefits

Under the requirements of IAS 19: Employee Benefits, staff costs must be recorded as an expense as soon as the organisation is obligated to pay them. This includes the cost of any untaken leave that has been earned at the year end. This cost has been calculated based on the balance remaining in the computerised leave system for all staff as at 31 March 2018. Untaken flexi leave is estimated to be immaterial to the PHA and has not been included.

Retirement benefit costs

Past and present employees are covered by the provisions of the HSC Pension Scheme. Under this multi-employer defined benefit scheme both the PHA and employees pay specified percentages of pay into the scheme and the liability to pay the benefit falls to the DoH. The PHA is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis. Further information regarding the HSC Pension Scheme can be found in the HSC Pension Scheme Statement in the Departmental Resource Account for the DoH.

The costs of early retirements are met by the PHA and charged to the Statement of Comprehensive Net Expenditure at the time the PHA commits itself to the retirement.

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the Statement of Financial Position date and updates it to reflect current conditions. The 2016 valuation for the HSC Pension Scheme updated to reflect current financial conditions (and a change in financial assumption methodology) will be used in the 2017/18 HSC Pension Scheme accounts.

1.20 Reserves

Statement of Comprehensive Net Expenditure Reserve

Accumulated surpluses are accounted for in the Statement of Comprehensive Net Expenditure Reserve.

Revaluation Reserve

The Revaluation Reserve reflects the unrealised balance of cumulative indexation and revaluation adjustments to assets.

1.21 Value Added Tax (VAT)

Where output VAT is charged or input VAT is recoverable, the amounts are stated net of VAT. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets.

1.22 Third party assets

The PHA had no third party assets in 2017/18 or 2016/17.

1.23 Government Grants

The PHA had no government grants in 2017/18 or 2016/17.

1.24 Losses and Special Payments

Losses and special payments are items that the Assembly would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the PHA not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.25 Accounting standards that have been issued but have not yet been adopted

Under IAS 8 there is a requirement to disclose those standards issued but not yet adopted.

Management consider that any other new accounting policies issued but not yet adopted are unlikely to have a significant impact on the accounts in the period of the initial application.

1.26 Changes in accounting policies/Prior year restatement

There were no changes in accounting policies during the year ended 31 March 2018. Due to changes in the template, there have been amendments to the layout and display of some figures.

1.27 Impact of implementation of ESA2010 on research and development expenditure

Following the introduction of the 2010 European System of Accounts (ESA10), there has been a change in the budgeting treatment (a change from the revenue budget to the capital budget) of research and development (R&D) expenditure. In order to reflect this new treatment which was implemented from 2016/17, additional disclosures have been included in the notes to the accounts.

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR YEAR ENDED 31 MARCH 2018

NOTE 2 - ANALYSIS of NET EXPENDITURE by SEGMENT

The PHA has identified 4 segments: Commissioning, Family Health Services (FHS), Administration, and Safeguarding Board NI - an independent body hosted by the PHA. Net expenditure is reported by segment as detailed below:

		2018	2017
Summary	**NOTE**	**£000**	**£000**
Commissioning	2.1	86,821	87,078
FHS	2.2	2,770	2,378
Agency Administration	2.3	17,825	18,584
Safeguarding Board NI	2.4	668	669
Total Commissioner Resources utilised		**108,084**	**108,709**

2.1 Commissioning

		2018	2017
Expenditure	**NOTE**	**£000**	**£000**
Belfast Health & Social Care Trust	SoCNE	14,251	13,769
South Eastern Health & Social Care Trust	SoCNE	4,612	4,427
Southern Health & Social Care Trust	SoCNE	6,435	6,324
Northern Health & Social Care Trust	SoCNE	8,579	8,281
Western Health & Social Care Trust	SoCNE	7,015	6,779
NI Medical & Dental Training Agency	SoCNE	148	132
Other	3.1/3.2	46,198	48,346
		87,239	88,058
Income			
Income from activities	4.1	418	980
Commissioning Net Expenditure		**86,821**	**87,078**

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR YEAR ENDED 31 MARCH 2018

NOTE 2 - ANALYSIS of NET EXPENDITURE by SEGMENT

2.2 FHS

FHS Net Expenditure	3.1	**2,770**	**2,378**

2.3 Agency Administration

		2018	2017
Expenditure	**NOTE**	**£000**	**£000**
Salaries and wages	3.2	15,925	15,861
Operating expenditure	3.2	2,404	2,853
Non-cash costs	3.3	274	549
		18,603	19,263
Income			
Staff secondment recoveries	4.2	203	342
Operating income	4.2	575	337
		778	679
Administration Net Expenditure		**17,825**	**18,584**

2.4 Safeguarding Board NI

Expenditure			
Salaries and wages	3.2	399	404
Operating expenditure	3.2	269	265
		668	669
Safeguarding Board NI Net Expenditure		**668**	**669**

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR YEAR ENDED 31 MARCH 2018

NOTE 3 EXPENDITURE

3.1 Commissioning:	**2018**	**2017**
	£000	**£000**
General Medical Services	2,770	2,378
Other providers of healthcare and personal social services	37,373	38,587
Capital grants to voluntary organisations	0	0
Research & development capital grants	8,825	9,759
Miscellaneous	0	0
Total Commissioning	**48,968**	**50,723**

3.2 Operating expenses are as follows:		
Staff costs[1]:		
Wages and salaries	13,002	12,947
Social security costs	1,422	1,424
Other pension costs	1,900	1,894
Supplies and services - general	70	75
Establishment	2,074	1,662
Transport	7	8
Premises	366	1,162
Rentals under operating leases	156	212
Total Operating Expenses	**18,997**	**19,384**

3.3 Non cash items:		
Depreciation	155	119
Amortisation	55	42
Loss on disposal of property, plant & equipment (including land)	58	1
Increase / Decrease in provisions (provision provided for in year less any release)	0	370
Cost of borrowing of provisions (unwinding of discount on provisions)	(10)	0
Auditors remuneration	16	16
Total non cash items	**274**	**549**
Total	**68,239**	**70,656**

Further detailed analysis of staff costs is located in the Staff Report within the Accountability Report.

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR YEAR ENDED 31 MARCH 2018

NOTE 4 - INCOME

4.1 Income from Activities	**2018**	**2017**
	£000	**£000**
R&D	418	980
Total	**418**	**980**

4.2 Other Operating Income	**2018**	**2017**
	£000	**£000**
Other income from non-patient services	573	337
Accommodation	2	0
Seconded staff	203	342
Total	**778**	**679**

4.3 Deferred income	**2018**	**2017**
	£000	**£000**
Research & development income released	0	0
Income released from conditional grants	0	0
Total	**0**	**0**

TOTAL INCOME	**1,196**	**1,659**

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR YEAR ENDED 31 MARCH 2018

NOTE 5.1 - Property, plant & equipment - year ended 31 March 2018

	Buildings (excluding dwellings) £000	Assets under Construction £000	Plant and Machinery (Equipment) £000	Information Technology (IT) £000	Furniture and Fittings £000	Total £000
Cost or Valuation						
At 1 April 2017	182	0	10	691	102	985
Indexation	13	0	0	0	0	13
Additions	6	0	0	65	0	71
Transfers	0	0	0	0	0	0
Disposals	0	0	(10)	(181)	(71)	(262)
At 31 March 2018	**201**	**0**	**0**	**575**	**31**	**807**
Depreciation						
At 1 April 2017	3	0	1	413	29	446
Indexation	2	0	0	0	0	2
Disposals	0	0	(1)	(174)	(29)	(204)
Provided during the year	49	0	0	99	7	155
At 31 March 2018	**52**	**0**	**0**	**338**	**7**	**397**
Carrying Amount						
At 31 March 2018	**149**	**0**	**0**	**237**	**24**	**410**
At 31 March 2017	**179**	**0**	**9**	**278**	**73**	**540**
Asset financing						
Owned	149	0	(0)	237	24	410
Carrying Amount						
At 31 March 2018	**149**	**0**	**0**	**237**	**24**	**410**

Any fall in value through negative indexation or revaluation is shown as an impairment.

The total amount of depreciation charged in the Statement of Comprehensive Net Expenditure Account in respect of assets held under finance leases and hire purchase contracts is £nil (2017 - £nil).

The fair value of assets funded from donations, government grants or lottery funding during the year was £nil (2017 - £nil).

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR YEAR ENDED 31 MARCH 2018

NOTE 5.2 - Property, plant & equipment - year ended 31 March 2017

	Buildings (excluding dwellings) £000	Assets under Construction £000	Plant and Machinery (Equipment) £000	Information Technology (IT) £000	Furniture and Fittings £000	Total £000
Cost or Valuation						
At 1 April 2016	0	0	10	706	72	788
Indexation	0	0	0	0	0	0
Additions	30	182	0	96	0	308
Transfers	152	(182)	0	0	30	0
Disposals	0	0	0	(111)	0	(111)
At 31 March 2017	**182**	**0**	**10**	**691**	**102**	**985**
Depreciation						
At 1 April 2016	0	0	0	415	21	436
Disposals	0	0	0	(110)	0	(110)
Provided during the year	3	0	1	108	8	119
At 31 March 2017	**3**	**0**	**1**	**413**	**29**	**445**
Carrying Amount						
At 31 March 2017	**179**	**0**	**9**	**278**	**73**	**540**
At 1 April 2016	**0**	**0**	**10**	**291**	**51**	**352**
Asset financing						
Owned	179	0	9	278	73	540
Carrying Amount						
At 31 March 2017	**179**	**0**	**9**	**278**	**73**	**540**

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR YEAR ENDED 31 MARCH 2018

NOTE 6.1 - Intangible assets - year ended 31 March 2018

	Software Licenses £000	Information Technology £000	Total £000
Cost or Valuation			
At 1 April 2017	62	212	274
Indexation	0	0	0
Additions	0	63	63
Disposals	0	0	0
At 31 March 2018	**62**	**275**	**337**
Amortisation			
At 1 April 2017	41	55	96
Indexation	0	0	0
Disposals	0	0	0
Provided during the year	12	43	55
At 31 March 2018	**53**	**98**	**151**
Carrying Amount			
At 31 March 2018	**9**	**177**	**186**
At 31 March 2017	**21**	**157**	**178**
Asset financing			
Owned	9	177	186
Carrying Amount			
At 31 March 2018	**9**	**177**	**186**

Any fall in value through negative indexation or revaluation is shown as an impairment.

The fair value of assets funded from donations, government grants or lottery funding during the year was £nil (2017 - £nil).

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR YEAR ENDED 31 MARCH 2018

NOTE 6.2 - Intangible assets - year ended 31 March 2017

	Software Licenses £000	Information Technology £000	Total £000
Cost or Valuation			
At 1 April 2016	62	148	210
Additions	0	64	64
At 31 March 2017	**62**	**212**	**274**
Amortisation			
At 1 April 2016	28	25	53
Provided during the year	13	30	43
At 31 March 2017	**41**	**55**	**96**
Carrying Amount			
At 31 March 2017	**21**	**157**	**178**
At 1 April 2016	**34**	**123**	**157**
Asset financing			
Owned	21	157	178
Carrying Amount			
At 31 March 2017	**21**	**157**	**178**

NOTE 7 - FINANCIAL INSTRUMENTS

As the cash requirements of PHA are met through Grant-in-Aid provided by the Department of Health, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with the PHA's expected purchase and usage requirements and the PHA is therefore exposed to little credit, liquidity or market risk.

NOTE 8 - IMPAIRMENTS

The PHA had no impairments in 2017/18 or 2016/17.

NOTE 9 - ASSETS CLASSIFIED AS HELD FOR SALE

Non current assets held for sale comprise non current assets that are held for resale rather than for continuing use within the business.

The PHA did not hold any assets classified as held for sale in 2017/18 or 2016/17.

NOTE 10 - INVENTORIES

The PHA did not hold any inventories as at 31 March 2018 or 31 March 2017.

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR YEAR ENDED 31 MARCH 2018

NOTE 11 - CASH AND CASH EQUIVALENTS

	2018	2017
	£000	£000
Balance at 1st April	419	310
Net change in cash and cash equivalents	50	109
Balance at 31st March	**469**	**419**

	2018	2017
The following balances at 31 March were held at	**£000**	**£000**
Commercial banks and cash in hand	469	419
Balance at 31st March	**469**	**419**

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR YEAR ENDED 31 MARCH 2018

NOTE 12 - TRADE RECEIVABLES, FINANCIAL AND OTHER ASSETS

	2018 £000	2017 £000
Amounts falling due within one year		
Trade receivables	243	158
VAT receivable	257	266
Other receivables - not relating to fixed assets	74	70
Trade and other receivables	**574**	**493**
Prepayments and accrued income	30	15
Accrued Income		
Current part of PFI and other service concession arrangements prepayment	0	0
Other current assets	**30**	**15**
Amounts falling due after more than one year		
Trade and other receivables	**0**	**0**
TOTAL TRADE AND OTHER RECEIVABLES	**574**	**493**
TOTAL OTHER CURRENT ASSETS	**30**	**15**
TOTAL INTANGIBLE CURRENT ASSETS	**0**	**0**
TOTAL RECEIVABLES AND OTHER CURRENT ASSETS	**604**	**508**

The balances are net of a provision for bad debts of £nil (2017 £nil).

NOTE 13 TRADE PAYABLES, FINANCIAL AND OTHER LIABILITIES

	2018 £000	2017 £000
Amounts falling due within one year		
Trade capital payables - property, plant and equipment	0	91
Trade capital payables - intangibles	58	46
Trade revenue payables	2,760	5,539
Payroll payables	692	335
BSO payables	2,325	357
Other payables	901	560
Accruals - relating to property, plant and equipment	3	0
Deferred Income	242	59
Trade and other payables	**6,981**	**6,987**
Other current liabilities	**0**	**0**
Total payables falling due within one year	**6,981**	**6,987**
Amounts falling due after more than one year		
Total non current other payables	**0**	**0**
TOTAL TRADE PAYABLES AND OTHER CURRENT LIABILITIES	**6,981**	**6,987**

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR YEAR ENDED 31 MARCH 2018

NOTE 14 - PROMPT PAYMENT POLICY

14.1 Public Sector Payment Policy - Measure of Compliance

The Department requires that PHA pay their non HSC trade creditors in accordance with applicable terms and appropriate Government Accounting guidance. The PHA's payment policy is consistent with applicable terms and appropriate Government Accounting guidance and its measure of compliance is:

	2018 Number	2018 Value £000s	2017 Number	2017 Value £000s
Total bills paid	5,828	57,184	5,903	58,348
Total bills paid within 30 day target or under agreed payment terms	5,381	56,636	5,560	56,564
% of bills paid within 30 day target or under agreed payment terms	**92.3%**	**99.0%**	**94.2%**	**96.9%**
Total bills paid within 10 day target	4,492	51,753	4,840	52,185
% of bills paid within 10 day target	**77.1%**	**90.5%**	**82.0%**	**89.4%**

14.2 The Late Payment of Commercial Debts Regulations 2002

	£
Amount of interest paid for payment(s) being late	40
Total	40

This is also reflected as a fruitless payment in the Assembly Accountability Report disclosure notes.

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR YEAR ENDED 31 MARCH 2018

NOTE 15 - PROVISIONS FOR LIABILITIES AND CHARGES 2018

	Other	2018
	£000	£000
Balance at 1 April 2017	375	375
Provided in year	0	0
(Provisions not required written back)	0	0
(Provisions utilised in the year)	(1)	(1)
Cost of borrowing (unwinding of discount)	(10)	(10)
At 31 March 2018	**364**	**364**

Comprehensive Net Expenditure Account charges	2018	2017
	£000	£000
Arising during the year	0	370
Reversed unused	0	0
Cost of borrowing (unwinding of discount)	(10)	0
Total charge within Operating expenses	**(10)**	**370**

Analysis of expected timing of discounted flows

	Other	2018
	£000	£000
Not later than one year	0	0
Later than one year and not later than five years	364	364
Later than five years	0	0
At 31 March 2018	**364**	**364**

Provisions have been made for 1 type of potential liability: Employer's and Occupier's Liability. For Employer's and Occupier's claims, the PHA has estimated an appropriate level of provision based on professional legal advice.

NOTE 15 - PROVISIONS FOR LIABILITIES AND CHARGES 2017

	Other £000	2017 £000
Balance at 1 April 2016	5	5
Provided in year	370	370
(Provisions not required written back)	0	0
(Provisions utilised in the year)	0	0
Cost of borrowing (unwinding of discount)	0	0
At 31 March 2017	**375**	**375**

Analysis of expected timing of discounted flows

	Other £000	2017 £000
Not later than one year	375	375
Later than one year and not later than five years	0	0
Later than five years	0	0
At 31 March 2017	**375**	**375**

NOTE 16 - CAPITAL COMMITMENTS

The PHA did not have any capital commitments as at 31 March 2018 or 31 March 2017.

NOTE 17 - COMMITMENTS UNDER LEASES

17.1 Finance Leases

The PHA had no finance leases in 2017/18 or 2016/17.

17.2 Operating Leases

Total future minimum lease payments under operating leases are given in the table below for each of the following periods.

Obligations under operating leases comprise	2018 £000	2017 £000
Buildings		
Not later than 1 year	106	106
Later than 1 year and not later than 5 years	278	381
Later than 5 years	0	0
	384	**487**

17.3 Commitments under Lessor Agreements

The PHA had no lessor obligations in either 2017/18 or 2016/17.

NOTE 18 - COMMITMENTS UNDER PFI CONTRACTS AND OTHER SERVICE CONCESSION ARRANGEMENTS

The PHA had no commitments under PFI or service concession arrangements in either 2017/18 or 2016/17.

NOTE 19 - OTHER FINANCIAL COMMITMENTS

The PHA did not have any other financial commitments at either 31 March 2018 or 31 March 2017.

NOTE 20 - FINANCIAL GUARANTEES, INDEMNITIES AND LETTERS OF COMFORT

Because of the relationships with HSC Commissioners, and the manner in which the PHA is funded, financial instruments play a more limited role within the PHA in creating risk than would apply to a non public sector body of a similar size, therefore the PHA is not exposed to the degree of financial risk faced by business entities. The PHA has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the PHA in undertaking activities. Therefore the PHA is exposed to little credit, liquidity or market risk.

The PHA did not have any financial instruments at either 31 March 2018 or 31 March 2017.

NOTE 21 - CONTINGENT LIABILITIES

The PHA did not have any unquantifiable contingent liabilities as at 31 March 2018 or 31 March 2017.

NOTE 22 - RELATED PARTY TRANSACTIONS

The PHA is an arms length body of the Department of Health and as such the Department is a related party with which the PHA has had various material transactions during the year. In addition, the PHA has material transactions with HSC Trusts.

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

NOTE 23 - THIRD PARTY ASSETS

The PHA had no third party assets in 2017/18 or 2016/17.

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR YEAR ENDED 31 MARCH 2018

NOTE 24 - FINANCIAL PERFORMANCE TARGETS

24.1 Revenue Resource Limit

The PHA is given a Revenue Resource Limit which it is not permitted to overspend.

The Revenue Resource Limit (RRL) for PHA is calculated as follows:

	2018 Total £000	2017 Total £000
DoH (excludes non cash)	95,571	96,006
Other Government Departments	486	0
Non cash RRL (from DoH)	274	549
Total agreed RRL	96,331	96,555
Adjustment for Research and Development under ESA10	11,892	12,229
Total Revenue Resource Limit to Statement of Comprehensive Net Expenditure	**108,223**	**108,784**

24.2 Capital Resource Limit

The PHA is given a Capital Resource Limit (CRL) which it is not permitted to overspend.

	2018 Total £000	2017 Total £000
Gross capital expenditure	134	372
Net capital expenditure	134	372
Capital Resource Limit	12,028	12,601
Adjustment for Research and Development under ESA10	(11,892)	(12,229)
Overspend/(Underspend) against CRL	**(2)**	**0**

24.3 Financial Performance Targets

The PHA is required to ensure that it breaks even on an annual basis by containing its net expenditure to within 0.25 % of RRL limits.

	2017/18 £000	2016/17 £000
Net Expenditure	(108,083)	(108,709)
RRL	108,223	108,784
Surplus / (Deficit) against RRL	140	75
Break Even cumulative position(opening)	1,275	1,201
Break Even cumulative position (closing)	**1,415**	**1,275**

Materiality Test:	2017/18 %	2016/17 %
Break Even in year position as % of RRL	0.13%	0.07%
Break Even cumulative position as % of RRL	1.30%	1.17%

The PHA has met its requirements to contain Net Resource Outturn to within +/- 0.25% of its agreed Revenue Resource Limit (RRL), as per DoH circular HSC(F) 21/2012.

NOTE 25 - EVENTS AFTER THE REPORTING PERIOD

There are no events after the reporting period having a material effect on the accounts.

DATE AUTHORISED FOR ISSUE

The Accounting Officer authorised these financial statements for issue on 18 June 2018.