HSC Public Health Agency

agenda

PHA Board Meeting

Date and Time 28 August 2024 at 1.30pm

Venue Conference Room, Tower Hill, Armagh

1 1.30	Welcome and Apologies	Chair
2 1.30	Declaration of Interests	Chair
3 1.30	Minutes of Previous Meeting held on 20 June 2024	Chair
4 1.35	Actions from Previous Meeting / Matters Arising	Chair
5 1.40	Reshape and Refresh Programme	Chair
6 1.50	Reports of New or Emerging Risks • Corporate Risk Register as at 30 June 2024 **[PHA/01/08/24]**	Chief Executive
7 2.00	Raising Concerns	Chief Executive
8 2.05	Updates from Committees: • Governance and Audit Committee **[PHA/02/08/24]** • Remuneration Committee • Planning, Performance and Resources Committee **[PHA/03/08/24]** • Screening Programme Board • Procurement Board • Information Governance Steering Group • Public Inquiries Programme Board	Committee Chairs
9 2.20	Operational Updates: • Chief Executive's and Executive Directors' Report	Chief Executive/ Executive Directors
	• Finance Report **[PHA/04/08/24]**	Ms Scott
10 2.40	Performance Management Report **[PHA/05/08/24] (For noting)**	Ms Scott
11 3.00	Draft Annual Progress Report 2023-24 to the Equality Commission on Implementation of Section 75 and the Duties under the Disability Discrimination Order **[PHA/06/08/24] (For approval)**	Ms Scott

12 3.20	Complaints and Claims Report **[PHA/07/08/24] (For noting)**	Chief Executive
13 3.25	ALB Self-Assessment **[PHA/08/08/24] (For approval)**	Chair
14 3.30	Partnership Agreement between Department of Health and Public Health Agency **[PHA/09/08/24] (For approval)**	Ms Scott
15 3.40	Information Management Systems in the Population Screening Programmes **[PHA/10/08/24] (For noting)**	Dr McClean
16 3.55	UK Covid-19 Inquiry - Module 1 Update Paper **[PHA/11/08/24] (For noting)**	Chief Executive
17 4.05	PPI Update Report **[PHA/12/08/24] (For noting)**	Ms Reid
18 4.20	Chair's Remarks	Chair
19 4.30	Any Other Business	Chair
20	Details of next meeting: *Friday 18 October 2024 at 10.00am* *Conference Rooms 1-3, 2nd Floor, 12/22 Linenhall Street, Belfast*	

HSC Public Health Agency

minutes

Title of Meeting	165th Meeting of the Public Health Agency Board
Date	20 June 2024 at 1.30pm
Venue	Meeting Room, County Hall, Ballymena

Present

Mr Colin Coffey	-	Chair
Mr Aidan Dawson	-	Chief Executive
Dr Joanne McClean	-	Director of Public Health
Ms Heather Reid	-	Interim Director of Nursing, Midwifery and Allied Health Professionals
Ms Leah Scott	-	Director of Finance and Corporate Services
Mr Craig Blaney	-	Non-Executive Director
Ms Anne Henderson	-	Non-Executive Director
Mr Robert Irvine	-	Non-Executive Director
Professor Nichola Rooney	-	Non-Executive Director
Mr Joseph Stewart	-	Non-Executive Director

In Attendance

Mr Robert Graham	-	Secretariat

Apologies

Mr John Patrick Clayton	-	Non-Executive Director
Dr Aideen Keaney	-	Director of Quality Improvement

70/24	**Item 1 – Welcome and Apologies**
70/24.1	The Chair welcomed everyone to the meeting. Apologies were noted from Mr John Patrick Clayton and Dr Aideen Keaney.
70/24.2	The Chair said that the session held before the meeting with Ms Gráinne Cushley regarding the Reshape and Refresh Programme had been useful and he would like a formal statement brought to the Board showing how PHA has embraced the recommendations of the EY review **(Action 1 – Chief Executive)**. He advised that at the recent Accountability Review meeting, the Permanent Secretary had indicated that he was pleased with the progress PHA has been making.
70/24.3	The Chair thanked Mr Maurice Meehan and Mr Paddy McEldowney for

the session they facilitated and said their presentation was excellent.

71/24 **Item 2 – Declaration of Interests**

71/24.1 The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.

72/24 **Item 3 – Minutes of previous meeting held on 16 May 2024**

72/24.1 The minutes of the Board meeting held on 16 May 2024 were **APPROVED** as an accurate record of that meeting.

72/24.2 The Chair said that he hoped that the minutes were clear in terms of PHA's position in relation to avian flu and the issues about the recruitment of public health consultants, as it is important that these are on record.

73/24 **Item 4 – Actions from Previous Meeting / Matters Arising**

73/24.1 An action log from the previous meeting was distributed in advance of the meeting.

73/24.2 Ms Henderson asked if a nominee had been agreed from among the Non-Executives for the Vaccine Programme Board. The Chair said that he was still reviewing the list of Boards that members sit on.

73/24.3 The Chair advised that the Raising Concerns policy is still being reviewed by the Department and he would like to be aware of the detail of that policy.

73/24.4 Ms Henderson said that she welcomed the update that was given with regard to screening programmes.

74/24 **Item 5 – Reshape and Refresh Programme**

74/24.1 The Chair said that he was adamant that this work will be completed by June 2025 and that timelines are adhered to. He added that he wished to place on record that Ms Cushley is doing an excellent job leading on this work with the support of the wider team.

75/24 **Item 6 – Reports of New or Emerging Risks**

75/24.1 The Chief Executive advised that there were no new risks. He informed members that the issue of recruiting public health consultants was discussed at the recent Accountability Review meeting and that PHA intends to write to the Department to request that all staff seconded are returned to PHA. He added that he wrote to the UK Health Security Agency (UKHSA) to request assistance and that he had spoken to Dame Jenny Harries who will formally respond, both from an UKHSA point of view and from a Department of Health in England perspective as

there may need to be a Department to Department conversation. He said that he wished to keep the Board informed that PHA is actively working on this issue. He added that Dr McClean has also spoken to Mr William Welfare in UKHSA.

76/24 **Item 7 – Raising Concerns**

76/24.1 The Chief Executive reported that there were no new concerns to be brought to the attention of the Board, noting the references earlier in the meeting to the recruitment of public health consultants and avian flu (H5N1).

77/24 **Item 8 – Updates from Board Committees**

Governance and Audit Committee ***[PHA/01/06/24]***

77/24.1 Mr Stewart advised that the minutes of the Committee meeting of 15 April have been shared with members, and that the Committee met on 13 June where it approved the Annual Report and Accounts which are being brought to the Board today. He said that the Committee had made some comments, including about the length of the Report. He added that the format of the Report was discussed at a meeting he had attended recently of Chairs of Audit Committees and Ms Brigitte Worth has undertaken to contact the Department of Finance to get clarity on this. He said that there was agreement that these reports need to be more meaningful and that management team should not be wasted on their preparation. With regard to the PHA Report, he said that more prominence needs to be given to the section on equality and diversity, and the section on Non-Executives needs to be more fulsome.

77/24.2 Mr Stewart said that where there are outstanding audit recommendations where the implementation date has been changed, there should be a narrative explaining why. The Chair added that if the date has to be changed again, that narrative should be added, and not replace the previous narrative.

77/24.3 Mr Stewart advised that Internal Audit had presented the report of an audit on Recruitment Shared Services which indicated that the system is not fit for purpose. The Chair asked if PHA should consider withdrawing, but Mr Stewart replied that Ms Scott thought that this was not possible. Mr Stewart said that this may be an issue that is worth raising at a future Accountability Review meeting and to find out if other organisations are saying the same. The Chair said that PHA needs to get an assurance in this area **(Action 2 – Chair)**.

77/24.4 Mr Stewart said that the Committee had looked at the Internal Audit HSC General Report where it was noted that the number of satisfactory audits has dropped year-on-year. He added that the number of Priority 1 recommendations has increased significantly, although not so much for PHA.

77/24.5 Mr Stewart reported that PHA received an unqualified audit opinion, but that due to the elections, the accounts will not be laid before the Assembly until 5 July. He advised that there were two Priority 2 findings within the draft Report to those Charged with Governance, the first of which related to outstanding payments from the Special EU Programmes Body (SEUPB). He said that PHA needs to get to the bottom of this matter. Ms Scott advised that she is writing to SEUPB regarding this. Mr Stewart reported that the second finding relates to Direct Award Contracts (DACs). The Chair said that PHA needs a plan to get away from the use of DACs. Mr Stewart agreed, and added that PHA needs to resolve the outstanding audit recommendations. The Chair said that while he did not wish to overburden Directors, this is an area that needs looked at due to the number of limited audits. He added that while Internal and External Audit are pointing out weaknesses, he sees these as a learning opportunity.

Remuneration Committee

77/24.6 The Chair noted that the Remuneration Committee has not met since the last Board meeting.

Planning, Performance and Resources Committee ***[PHA/01/05/24]***

77/24.7 The Chair noted that the Planning, Performance and Resources Committee has not met since the last Board meeting.

Screening Programme Board

77/24.8 The Chair noted that the Screening Programme Board has not met since the last Board meeting.

Procurement Board

77/24.9 Ms Henderson advised that she had attended a meeting of the Procurement Board which was chaired by Ms Scott for the first time, and that the meeting covered a range of issues.

77/24.10 Ms Scott reported that PALS had been in attendance at the meeting and had raised an issue regarding their capacity which means that PHA may not be able to deliver on its Procurement Plan. She said that she would be taking this forward. She added that PALS had delivered a presentation on changes in procurement legislation, which will see more of a focus on contract management and KPIs, but may result in longer procurement times. She said that PHA has around 533 contracts with a value of £40m and of these, a considerable proportion are with the community and voluntary sector and making the legislation more complicated means it will be less likely that they can comply. Mr Blaney agreed saying that this has been raised with him at community level and it may get to the stage where it is not worth their while applying. The Chair asked if this is a Department of Health or Department of Finance

directive, but Ms Scott advised that it is legislation.

77/24.11 Mr Irvine advised that the Northern Ireland Fire and Rescue Service (NIFRS) had experienced the same issue with PALS and that they had been mandated to use Shared Services by the Permanent Secretary, but because PALS could not deliver, NIFRS set up their own in-house service. Ms Scott said that PHA should not be averse to looking at that. The Chair advised that he had a meeting scheduled soon with the Chief Fire Officer.

Information Governance Steering Group

77/24.12 The Chair noted that the that the Information Governance Steering Group has not met since the last Board meeting.

Public Inquiries Programme Board

77/24.13 Professor Rooney advised that the Urology Inquiry has now completed and that with regard to the Muckamore Inquiry, submissions have been made by the previous PHA Directors of Nursing and that she had had the opportunity to read the submission made by Mr Rodney Morton. She noted that one of the issues made was the reference to the number of times the Board sought clarity about PHA's role with regard to Serious Adverse Incidents (SAIs).

77/24.14 Professor Rooney said that as part of the COVID Inquiry all organisations will be required to publish how they will be implementing the recommendations. She noted that PHA had indicated that it has had not the capacity to look at recommendations from other Inquiries. The Chief Executive acknowledged this, and pointed out that the Executive team is a small one. He added that PHA has looked at the reports, and that it did ask the Department if PHA was required to have a representative sit on its Public Inquiries Board but was advised that PHA was not needed. He advised that PHA will be informed if there are any issues that are particular to PHA. With regard to SAIs, he advised that the process is being reviewed.

77/24.15 Professor Rooney commented that if PHA is not going to take forward this work, then the minute of the Inquiries Programme Board should be amended. The Chair asked if it would be possible for Ms Cushley to look at this because some of the recommendations may align to elements of the Reshape and Refresh programme. Professor Rooney said that the Board needs an assurance. Ms Reid commented that any recommendations in relation to governance and proper understanding of roles and responsibilities should be picked up by the Reshape and Refresh Programme. With regard to the safety and quality agenda, she agreed that PHA needs to know what its role is.

77/24.16 The Chair asked if a short paper could be prepared on all of this. The Chief Executive undertook to take this forward **(Action 3 – Chief**

Executive).

78/24 **Item 9 – Operational Updates**

Chief Executive's and Executive Directors' Report

78/24.1 Professor Rooney sought clarity on the input the Health Improvement team is providing to a request from the Department regarding health inequalities. The Chief Executive replied that PHA is drafting a paper for the Minister as he is keen to have a flagship "launch" in the autumn and is looking for ideas about where and how there can be an effort to redress health inequalities.

78/24.2 Professor Rooney asked about Advanced Care Planning and noted that PHA is not taking this work forward in the absence of funding. Ms Reid advised that PHA has received a response from the Department indicating that it fully appreciates PHA's position. She added that this initiative will be placed on a list of areas for consideration. She explained that PHA had helped to develop the policy, but implementation will cost significantly more.

78/24.3 Professor Rooney asked about cervical screening. Dr McClean advised that there continue to be challenges in this area. She said that for the invasive cancer audit, there is a misunderstanding around what this is. She explained that correspondence has been sent to Trusts outlining what their role is, but they are currently behind on this work so PHA is following up to ensure that the Trusts catch up. She said that Trusts are under pressure as they are currently dealing with this backlog, implementing primary HPV and assisting the Southern Trust.

78/24.4 Dr McClean advised that there are currently three laboratories with small teams and shortly there will be a move to reduce this to one. She said that the review of slides in the Southern Trust should be completed by the end of August. Professor Rooney asked about the "Ladies with Letters" group, and Dr McClean replied that this is a small group and PHA has been engaging with them. She reiterated that the review will be completed soon and that to date, most of the reviews have concurred with the initial findings. She explained that once this review is completed and services are consolidated onto one site, it will be easier to manage this programme. She advised that PHA had approached NHS England about carrying out a review and she has followed up on this again.

78/24.5 Mr Blaney sought clarity on whether any individual whose slides found an abnormality would be fast-tracked and Dr McClean confirmed that this would be the case, and that the individuals would go straight to colposcopy. Mr Blaney asked that if a similar event were to happen again, would PHA be in a better position to scan the slides quicker, perhaps using AI. Dr McClean said that she did not have an answer for that, but noted that there is an interest in using AI in breast screening.

78/24.6 Ms Henderson said that it has been useful to see the update reports and to document that PHA has been following up to get this independent review undertaken.

79/24 Item 10 – PHA Annual Report and Accounts 2023/24 [PHA/02/06/24]

79/24.1 Ms Scott said that members will have previously seen the first section of the Annual Report. She advised that the figures in the Report have now been audited and that the accounts were completed in partnership with SPPG. She thanked Ms Tracey McCaig and her team, particularly Ms Caren Crockett for their help in putting the Report together.

79/24.2 Ms Scott advised that the Report contains the performance report, the accountability report and the financial statements. She confirmed that PHA received an unqualified audit opinion and that the auditor's certificate will be included. She proposed that the Annual Report and Accounts are put forward for laying before the Assembly.

79/24.3 Ms Scott said that some amendments have been made to the Report following comments by Governance and Audit Committee members.

79/24.4 The Chair reiterated that there needs to be a plan for dealing with Priority 1 audit recommendations and outstanding recommendations. Ms Scott noted that PHA received a satisfactory audit opinion from Internal Audit, but notwithstanding that there are outstanding audit recommendations which she said will be picked up as part of quarterly accountability meetings with Directors. The Chair noted that 80% of previous audit recommendations have been fully implemented so he sought to ensure that the remainder are given the right level of priority.

79/24.5 Ms Henderson commented that within the performance management section there should be exception reports brought to the Board on those areas that were rated "red" and how this will be addressed. Ms Scott explained that this relates to last year's Business Plan and these would have been brought through the Planning, Performance and Resources (PPR) Committee on a quarterly basis. The Chief Executive added that a commitment was made that, for any actions brought forward from the previous year that were rated "red", there will be a plan for how these will be delivered.

79/24.6 The Chair asked for clarity on the section around safety and quality alerts and governance. Ms Reid explained that previously HSCB and PHA would have had joint responsibility in assuring the Department that responses on assurance matters were implemented, but now that SPPG is part of the Department it no longer wishes to see these responses and now PHA is determining whether it wishes to see them. She acknowledged that the wording of the section is a little unclear. The Chair said that the Report should reflect what is currently happening.

79/24.7 The Chair asked whether PHA has a system of internal governance, and

	if the statement in the Report is accurate. The Chief Executive confirmed that it is correct, and noted that there has been discussion today about governance and how the Reshape and Refresh programme will look at outstanding governance issues.
79/24.8	Ms Scott said that the accounts outline that PHA had a total revenue of £146m, of which £51m was issued to Trusts, compared to £59.5m the previous year. She advised that PHA had £28.6m of staff costs and £62.6m was spent on goods and services. She reported that PHA received £2.3m of income, mainly through research and development.
79/24.9	Ms Scott advised that the figures in the accounts have been audited. She noted a change in the balance sheet which showed the transfer of the Vaccine Management System (VMS) from SPPG of around £4m. in relation to provisions, she noted that a judgement relating to overtime and holiday pay is due and this was may create a small increase. She explained that this will not be a material change but will be referenced in the PHA's Report to those Charged with Governance.
79/24.10	Ms Scott reported that there were three issues raised in PHA's draft Report to those Charged with Governance which related to SEUPB, DACs and contracts.
79/24.11	Ms Scott said that she would recommend this Annual Report and Accounts to the Board for approval.
79/24.12	The Chair acknowledged the work of Mr Stephen Bailie in Ms Scott's team. Ms Scott said that the new finance team is beginning to take shape following some recent appointments.
79/24.13	The Board **APPROVED** the Annual Report and Accounts.
80/24	**Item 11 – PHA Financial Plan 2024/25 [PHA/03/06/24]**
80/24.1	Ms Scott presented the PHA Financial Plan for 2024/25. She outlined that PHA will receive £130m of funding, £99.2m for commissioning, £30.6m for administration and £0.9m that is ringfenced. She explained that there is £1.2m of savings which has not been netted off.
80/24.2	Ms Scott went through the Plan outlining the spend for each programme area. Within R&D, she noted that the £3.2m contribution to the National Institute for Health Research has been reinstated. She explained that £352k has been set aside for campaign relating to organ donation, but added that there needs to be clarity about what that looks like in the context of other budgets. She said that the next section sets out the management and administration budget, but noted that PHA has limited oversight of the £809k budget for SBNI.
80/24.3	Ms Scott advised that there is a list of unfunded pressures, each with proposals for how they could be funded. She said that the next table

outlines potential slippage, and added that she plans to carry out an in-depth review of the management and administration budget.

80/24.4 Ms Scott said that she is recommending this budget for approval. She noted that there is limited scope within it, but felt that it is a reasonable settlement for PHA and that it is deliverable.

80/24.5 The Chair advised that he and Ms Henderson had met with Ms Scott to review this as it was not possible to arrange a meeting of the PPR Committee in advance of the Board meeting. He said that there is an assumption that there will be slippage but agreed that it is a good budget for PHA. He noted that there needs to be a list of projects in the event that there is slippage.

80/24.6 The Chair said that there had been a discussion about the cost of the Reshape and Refresh programme, and that there is likely to be an impact this year of £400k - £500k, but there is a number of assumptions in that, particularly around when the new Deputy Directors will be appointed.

80/24.7 The Chair commented that this budget will need to be monitored from September onwards. He noted that, following PHA's view that savings can be made from vaccinations, the Department has provided PHA with funding for vaccinations so this shows the faith the Department has in PHA.

80/24.8 Ms Henderson said that there was a thorough approach in developing this Plan. She noted the assumptions in relation to the Reshape and Refresh programme, vaccinations, slippage in the management and administration budget and campaigns. She asked why there is a reference to Diabetic Eye Screening in the list of unfunded pressures as she felt this should be funded recurrently, but Dr McClean explained that would relate to a particular element of the programme. Dr McClean added that PHA does not have good capacity in commissioning and that is an area that is being looked at.

80/24.9 In relation to vaccines and campaigns, Professor Rooney made the point that if PHA is going to be in charge of vaccination programmes, then it cannot do that effectively without campaigns. Dr McClean said that this has been raised with the Department and PHA was permitted to use a small amount of funding for the recent MMR campaign. She suggested that there may be an opportunity to review this with the new Minister. Professor Rooney said that PHA needs a Plan B. The Chair advised that Local Councils are keen to work with PHA to get messaging out. Mr Stewart proposed that the Chair should write to the Minister about the blanket ban on campaigns and the impact that this is having an organisation that is responsible for public health and have this on record **(Action 4 – Chair)**. The Chief Executive agreed that campaigns are important.

80/24.10 Mr Blaney said that he had attended the Nurse of the Year awards event where PHA had one winner and one runner-up and suggested that these staff should receive a letter from the Board **(Action 5 – Chair)**. Ms Reid advised that she and the Chief Executive had discussed the possibility of the staff coming to the Board to present their work.

80/24.11 The Chair said that, as chair of the PPR Committee, he would happy to recommend this Plan for approval, acknowledging that there are assumptions in it and that PHA may struggle to spend all of the money. The Chief Executive advised that there are already ongoing discussions around that.

80/24.12 The Board **APPROVED** the Financial Plan.

81/24 Item 12 – PHA Corporate Plan 2025/30 [PHA/04/06/24]

81/24.1 Ms Scott explained that this paper outlines how PHA aims to have a new Corporate Plan developed by March 2025. She said that it gives a sense of the scale of what needs to be achieved over the coming months and she is seeking the commitment and buy-in of the Board. She added that PHA will bring in additional support for the engagement element.

81/24.2 Ms Scott noted that there is a proposal within the paper for a Non-Executive to be part of the oversight group. It was agreed that this would be Professor Rooney.

81/24.3 The Board noted the paper on the development of the PHA Corporate Plan 2025/30.

82/24 Item 13 – Population Screening Programmes [PHA/05/06/24]

82/24.1 The Chair advised that this paper would be deferred until the next meeting.

82/24.2 Dr McClean explained that the paper relates to information systems to support screening programme and while she had received a draft paper, further work needed to be done on it and it needs to be discussed by the Agency Management Team (AMT) before it is brought to the Board. She explained that an assessment has been carried out, but the issue is more around the development of Encompass. She advised that the Chief Executive will be chairing a Digital Oversight Board which look at both screening programmes and the Child Health System.

82/24.3 Mr Stewart said that he would be keen that this paper is brought to the August Board meeting as there are ongoing issues which are highlighted on the Corporate Risk Register. The Chief Executive agreed that the paper should be brought to the August Board meeting and that if it is available sooner, it will be shared with members.

83/24	**Item 14 – Items for Noting**
83/24.1	There were no items listed for noting.
84/24	**Item 15 – Chair's Remarks**
84/24.1	The Chair said that he wished to recognise the contribution of Mr Andrew Dougal, the previous PHA Chair, who passed away on Monday. He acknowledged the contribution of Mr Dougal, both to the PHA and to Northern Ireland Chest, Heart and Stroke, which he had turned from a small charity into a large organisation. He also acknowledged Mr Dougal's work in other sectors, including the arts.
84/24.2	The Chair advised that he had met with PHA's Sponsor Branch where he had discussed the Partnership Agreement and the Board Self-Assessment. He reported that he had informed them that he no longer wished to use the ALB Self-Assessment tool as it was not fit for purpose and should be a tool to allow the Board to develop. He advised that Sponsor Branch has undertaken to liaise with the Department of Finance to confirm if PHA is required to complete this tool and that they are open to the idea of using a different one. He added that there is an assessment tool that he will revise and share with members.
84/24.3	The Chair noted that the process of NED appraisals has commenced and that in addition, he wishes to have a review where members review him and he would wish to use that information to improve Board effectiveness.
84/24.4	The Chair reported that he held more meetings with Local Council Chief Executives, and that they are keen to work with PHA.
85/24	**Item 16 – Any Other Business**
85/24.1	There was no other business.
86/24	**Item 17 – Details of Next Meeting**
	Wednesday 28 August 2024 at 1.30pm
	Conference Room, Tower Hill, Armagh
	Signed by Chair:
	Date:

HSC Public Health Agency

item 6

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	28 August 2024
Title of paper	Corporate Risk Register as at 30 June 2024
Reference	PHA/01/08/24
Prepared by	Karen Braithwaite
Lead Director	Leah Scott

Recommendation For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to bring the Corporate Risk Register, as at 30 June 2024, to the Board for noting.

2 Background Information

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

To support these assurances, a process has been established to undertake a review of both directorate and corporate risk registers on a quarterly basis i.e. the end of each financial quarter.

The attached Corporate Risk Register reflects the review as at 30 June 2024 and has been carried out in conjunction with individual directorate register reviews for the same period.

The Corporate Risk Register was approved by the Agency Management Team at its meeting on 17 July 2024, and by the Governance and Audit Committee at its meeting on 8 August 2024.

3 Outcome

Three new risks have been added this quarter:

- Corporate Risk 73 – Financial Planning Context 25/26
- Corporate Risk 74 – Impact of the introduction of a new HSC system wide planning, delivery, performance monitoring and governance system on the PHA
- Corporate Risk 75 – Pandemic Preparedness

Three risks have been removed this quarter:

- Corporate Risk 60 - Impact of Migration of HSCB on PHA
- Corporate Risk 68 - Information Governance
- Corporate Risk 72 - Financial Planning Context 24/25

4 Next Steps

The next review of the Corporate Risk Register will be undertaken after 30 September 2024.

PHA Corporate Risk Register

Date of Review:
30 June 2024

Introduction

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

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

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

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

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

Overview of Risk Register Review as at 30 June 2024

Number of new risks identified	3 CR73 Financial Planning Context 25/26 CR74 Impact of the introduction of a new HSC system wide planning, delivery, performance monitoring and governance system on the PHA CR75 Pandemic Preparedness
Number of risks removed from register	3 CR60 Impact of Migration of HSCB on PHA CR68 Information Govenrnance CR72 Financial Planning Context 24/25
Number of risks where overall rating has been reduced	0
Number of risks where overall rating has been increased	0

CONTENTS

Key:

Risk rating:

↑ increased from previous quarter

↓ decreased from previous quarter

→ remained the same as previous quarter

Control Effectiveness RAG Rating:
RED
AMBER
GREEN

Corporate Risk 39					
RISK AREA/CONTEXT: Cyber Security					
DESCRIPTION OF RISK: Information security across the HSC is of critical importance to delivery of care, protection of information assets and many related business processes. If a cyber incident should occur, without effective security and controls, HSC information, systems and infrastructure (including those used by the PHA, as well as Trusts providing services for the PHA) may become unreliable, not accessible when required (temporarily or permanently), or compromised by unauthorised 3rd parties including criminals. This could result in significant business disruption. It could also lead to unauthorised access to any of our systems or information, theft of information or finances, breach of statutory obligations, substantial fines and significant reputational damage. Whilst the BSO is primarily responsible for managing this system wide risk as IT lead for HSC, the Agency has a key responsibility to safeguard against any actions by its staff that could compromise IT security.				**DATE RISK ADDED:** June 2017 **REVISED:** June 2024 **CLOSED:** N/A	
LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension					
LINK TO ANNUAL BUSINESS PLAN 2024/25: Corporate Objective 5 Our Organisation Works Effectively					
GRADING	**LIKELIHOOD**	**IMPACT**		**RISK GRADE**	
Current	Possible	Major		**HIGH**	
Target	Possible	Moderate		MEDIUM	
LEAD OFFICER: Director of Operations					
Existing Controls	**1st, 2nd & 3rd lines of Assurance**	**Gaps in Controls and Gaps in Assurances**	**Control Effectiveness RAG rating (RED)**	**Action Plan/Comments/ Timescale**	**Review Date**
Technical Infrastructure: • HSC security hardware (eg firewalls); • HSC security software (threat detection, antivirus, email & web filtering); • Server/client patching;	1st and 2nd line Technical risks assessments and penetration tests; 1st and 2nd line Reports to GAC/PHA board on reported incidents as appropriate.	Gaps in Assurance: • Level of corporate recognition and ownership of cyber security threat as a service delivery risk. • An HSC Cyber Gap analysis (ISO 27001) was carried out. (external carried out by DXC) -		BSO ITS provides PHA IT services. PHA will continue to work with BSO ITS, DHCNI and through the HSC Cyber Scurity Programme Board. Work has continued in a number of priority work streams including Incident response and third party management. Further	Sept 2024

• 3rd party Secure Remote Access; • Data & system backups **Policy, Process:** • Regional & local ICT/information security policies; • Data protection policy; • Change Control Processes; • User Account Management processes; • Disaster Recovery Plans; • Emergency Planning & Service/Business Continuity Plans; • Corporate Risk Management Framework, processes & monitoring; • Regional & local incident management & reporting policies & procedures; **User Behaviours – influenced through:** • Induction/ Annual Appraisal • Mandatory Training; • HR Disciplinary Policy; • Contract of employment; • 3rd party contracts/data access agreements • Metacompliance monthly training now operational	1st & 2nd line PHA represented on cyber programme board 1st & 2nd line External security review carried out by ANSEC (external security company) 3rd line Internal Audit/BSO ITS self-assessment against 10 Steps towards NCSC; 3rd line: An HSC Cyber Gap analysis (ISO 27001) was carried out (externally carried out by DXC)	need to work through the recommendations • External security review carried out by ANSEC (ext security co) <u>Gap in Controls</u>: – • programme not delivered yet. • SoC sent to DoH for consideration which shows gaps: A SIEM (security incident management system) Privleged accounts management (PAM) • ~~Lack of resources (can't move forward with programme until funding available)~~ • BSO led Cyber strategic plan developed for implementation over next 4 years to deliver outputs of the cyber secrutiy strategy, however funding via DHCNI not yet secured.	cyber projects are being undertaken to enhance capabilities across the region, under 3 key work streams:. • Communications and culture which contains Cyber training for all staff, Senior Teams, ICT, Department specific • Strategy and Policy, the development and implementation of HSC wide Cyber Security policies, standards and processes and Supplier Management • Technical and Infrastructure including a HSC Network Security Review, Implementation of Network Discovery and vulnerability Management Tools and Incident Response management See below for update on key projects ongoing under these workstreams Debrief of full HSC-wide cyber incident response test – Incident test report tabled at cyber programme board (6 Oct 23) and agreed to take forward a review of current incident response plan and recommendations from report – ongoing (approx six month	

~~PHA BCP tested and updated February 2018 with a focus on cyber security update~~ PHA member of the Regional HSC Cyber Security Business Continuity Group BSO cyber project manager co-ordinating regional cyber security work. Regional cyber security programme board (BSO representing PHA) taking forward actions arising from DXC report and recommendations Ongoing work being taken forward and overseen by the Regional Cyber Security Programme Board. ~~Internal Audit of 'user behaviour' relating to cyber security (conducted January 2020) provided satisfactory assurance.~~ A regional cyber Incident Response Plan has been developed to effectively manage a cyber incident within the HSC. ~~A desktop testing exercise of the process took place on 21/6/19 with all HSC ICT~~			timescale) ~~Review end June 2024.~~ Review of Incident response plan now completed with finalisation due early July 2024. Training programme for Board members will continue to be delivered in consultation with Regional Cyber Security Programme Board) Update from Cyber Security Progamme Board – revised training being planned for roll-out with ALB Board members and senior teams. ~~Ceased temporarily due to retirement of trainer - due to re-commence with new trainer May 2024.~~ Now re-commenced May 2024 and ongoing roll-out planned. Review Sept 2024 Targetted training and 'all users' training (Metacompliance) to be provided. New schedule to run April 24 – March 25. Revised (June 24) HSC cyber elearning material ~~current review planned for completion in Feb 2024 with relaunch in April 2024~~. due to be launched July 2024	

~~organisations and local incident response colleagues.~~ Cyber Incident Response Action Plan finalised and launched A baseline audit against ISO27001 across all ICT Departments and Internal audits against NSCS Cyber Essentials 10 steps have been completed and recommendations accepted ~~Regional IT Security/cyber security training was refreshed and launched in September 2020.~~ Several Business Cases have been approved and implemented re ongoing resource funding for Cyber staff across HSC this includes: (i) Cyber Resource for one year (ii) Tactical Business Case for resource to implement the tactical recommendations from the network security review. PHA Business Continuity Plan test carried out 13 March 2023				

Full HSC-wide cyber incident response test - Incident response plan completed on 1 June 2023 Targetted training and 'all users' training (Metacompliance) provided during years 2022/23 (May-Mar) and 2023/24 (Apr-Mar) HSC cyber elearning material current review completed June 2024 including Management review of compliance.				

Corporate Risk 55

RISK AREA/CONTEXT: Shortage of Staff / Skill mix required to discharge full range of public health statutory responsibilities ~~Public Health Agency Staffing Issues~~

DESCRIPTION OF RISK:

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

The Public Health Agency does not currently have the appropriate retained staffing capacity / skill mix in order to be able to safely and sustainably discharge all of its statutory responsibilities pertaining to protecting and improving the health of the population of Northern Ireland. In particular, it is currently unable to fill Public Health Consultant positions due to the unavailability of suitably qualified people in the labour market. Whilst this has been managed to date through use of Retire & Return as well as some reprofiling of skill mix this is not sustainable in the medium to longer term. There is therefore a risk that the absence of core public health services in key areas such as Health Protection and preventing the transmission of communicable diseases could directly impact the health of the population.

Outside of the Consultant roles, with effect from 26th April 2024, posts at Band 8 are only being filled on a temporary basis through internal trawls as a precautionary step in light of planned organisational change programme Reshape Refresh. This will naturaly bring a level of instability whilst the change programme unfolds.

A number of specific staffing-related risks have been identified in the organisation including:

- A number of consultant in public health posts are vacant and attempts to fill them have been unsuccessful. Following recent retirements and leavers the position within the Health Protection service has become acute.
- Existing posts at Band 8 ~~that are~~ which become vacant are being filled by temporary appointments with backfilling of posts creating knock on effect in vacancies.

DATE RISK ADDED:
June 2020

REVISED:

August 2020 - HSCQI Risk added.

June 2022 - Merged.

September 2023 - Updated to cover all Directorate risks.

March 2024 - Updated to detail specifc high impact staffing risks at March 2024

June 2024 – Redrafted to reflect core risk.

CLOSED:

N/A

~~• The ongoing reshape and refresh review programme is likely to further delay the ability to progress with permanent appointments at Tier 3 and below promptly as newly agreed structures need to be worked through involving management of change process implementation.~~ ~~• The HSCQI Directorate is unable to fulfil it's core function due to staffing limitations~~	

LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension and Operational Performance and Service Improvement Dimension

LINK TO ANNUAL BUSINESS PLAN 2024/25: Potentially all corporate objectives; particularly corporate objectives 4 (working together to ensure high quality services) and 5 (our organisation works effectively).

GRADING	LIKELIHOOD	IMPACT	RISK GRADE
Current	Likely	Major	**HIGH**
Target	Possible	Moderate	**MEDIUM**

LEAD OFFICER: All Directors

Existing Controls	1st, 2nd & 3rd lines of Assurance	Gaps in Controls and Gaps in Assurances	Control Effectiveness RAG rating	Action Plan/Comments/ Timescale	Review Date
Interim leadership arrangements have been put in place in health protection to ensure safe high quality health protection service being provided. This has involved re-deployment of staff from other parts of the directorate to support health protection function including acute response, surveillance and governance.	1st & 2nd line: • Reports to CEx and AMT. • Updates to GAC via Corporate Risk register • Briefings provided to PHA Board. 3rd line: • Vacancy updates provided to Sponsor Branch via Ground clearance process.	**Gap in Controls** • Ability to recruit to consultant posts and other key posts is very constrained currently due to a number of external factors including availability of suitably qualified professionals and market forces • ~~Reshape and Refresh – the change management programme will take a~~		Reshape and Refresh – Management of Change: • Level 2 Job Descriptions (Director level) drawn up and moving through job evaluation process - review June 24 • Level 3 Job descriptions under development and will be included in job evaluation process by end of June 24	~~June 2024~~ Sept 2024

3 Deputy Director posts appointed since April 23 to support DPH in providing leadership across the directorate. These will focus on • Governance and standards • Training and workforce • Epidemiology and public health science Locum consultant in place to support health protection. Consultants on retire and return are providing support to the service. Consultant posts are advertised on a rolling basis. PH Directorate are developing a refreshed JD to facilitate a wider campaign approach ~~Consultant posts have been advertised. Most recent offer made in October 2023. No candidates on waiting list. HR developing new process for recruitment of PH consultants~~ Public health specialist/consultant workforce report developed and	• Ongoing engagement with HSCQI Leadership Alliance and Network. • Link with DOH Safety and Quality Standards branch.	~~prolonged period of time and is dependent on support resources (outwith of PHA management) being available to facilitate implementation. This is an additional gap in control at organisational level.~~ **Gaps in Assurance:** • Deficits in the PHA workforce across a range of functions compromising the performance of the organisation and ability to deliver statutory functions. **HSCQI** **Gaps in assurance:** • Unable to respond with agility to requests from the system. Prioritisation given to strategic areas of work as determined by the HSCQI Leadership Alliance. **Gaps in control:** • Funded Staffing levels are insufficient to build a reliable	Continue advertisement of Consultant Posts and upskilling nursing workforce (increase numbers undertaking masters in public health - ongoing Develop action plan to ensure the recommendations from workforce plan are implemented – Establish strong consultant led multidisciplinary teams in health protection and across directorate to make best use of skills of all staff – ensuring specialised skills of consultants are used to best effect. Reform of Acute response service - ongoing Training and development of a resilient workforce under a delegation framework to support emergency response and emerging situations has been completed. A business case for recurring funding to employ a resilience workforce is in progress – by Sept 24 ~~Recruitment for Band 3 administrative support staff within the Public Health Directorate – by June 24~~	

approved by AMT in January 2023. The report includes a number of recommendations to increase the supply of specialist and consultant public health staff who are registered with a certificate of completion of training or equivalent. Working with HR to implement a number of steps with individuals in relation to long term sick and absenteeism due to work related stress. £1.8M investment from DoH secured to enhance health protection staffing. Recruitment to the posts created largely complete – some posts still to be recruited on a permanent basis. Bank staff list created following the closure of contact tracing service. Staff from the bank have received training and are able to provide support to acute health protection service both in hours and out of hours. Introduction of SpR rota for acute response (Delegated		and responsive HSCQI infrastructure for NI HSC services.	• ~~Recruitment being progressed.~~ **HSCQI** • ~~PHA CEO has approved the recruitment of a temp 8C Assistant Director for 18 months via management of change process. HSCQI Director in regular communication with HR lead for PHA and CEO, PHA in relation to 8c post. JD was matched at 8B, resubmitted and rescheduled for discussion at matching meeting July 2024.~~ • ~~HSCQI clinical lead redeployed to Public Health Directorate since September 2023. Director HSCQI and PHA CEO keep this under review.~~ • ~~Ongoing discussions around funding/temporary funding between Director HSCQI, CEO PHA, DOH Safety and Quality Standards branch, and chair of HSCQI Leadership Alliance.~~	

responsibility to release Consultant capacity. Redeployments across admin team to provide cover for key areas. Admin support arrangements were reviewed during 2023 and a new post to support the business is in recruitment process. ~~Review of administrative support arrangements agreed with unions and commenced in January 2023 and report shared~~ **HSCQI** • On-going monitoring and prioritising of HSCQI work. • Ongoing Director review of existing HSCQI Directorate structures and support arrangements. • Prioritisation of Regional HSCQI Improvement Programmes and training. Learning System, scale and spread activity and other programmes of work. • ~~Discussions ongoing between Director of HSCQI, PHA CEO and DoH Safety and Quality~~			NMAHP • ~~Band 4 PA to Director – permanent recruitment to be completed by end April~~ • Vacant senior posts held until R&R process progressed. Resulting impact on capacity.	

~~Standards branch, and HSCQI Leadership Alliance re workload and capacity and funding.~~ • ~~A number of temporary funded posts have been extended. (HSCQI)~~ • ~~Permanent band 4 personal assistant post filled effective from 8th April 2024.~~ • ~~PHA CEO has approved the recruitment of a temp 8C Assistant Director for 18 months via management of change process and temp band 4 programme support administrator for 12 months. Temp band 4 post filled from 29th April 2024.~~ • ~~Temp Q2020 project manager in post Temp post extended for 12 months from March 2024~~ Nursing, Midwifery & AHP (NMAHP) • Temporary post for Interim Director of Nursing and AHP in position ~~has been appointed.~~ • ~~Band 3 admin posts recruited across directorate.~~				

• ~~Temporary backfill posts in position approved and appointed for lead AHP (currently on secondment) and Early years lead. Impact on lower band capacity, senior posts not recruited to resulting in capacity issues and potential support issues to ICS and new commissioning structures)~~ • ~~Band 4 PA to Director of NMAHP now permanently recruited.~~ • Admin review has been carried out, findings to be confirmed in July. Operations • ~~Director of Finance and Corporate Services in post as of end of Mar 24~~ Reshape and Refresh • Management of change process designed (end of Mar 24)				

Corporate Risk 59

RISK AREA/CONTEXT: Quality Assurance and Commissioning of Screening

DESCRIPTION OF RISK:
The commissioning and quality assurance of population screening programmes is a core PHA function.

Screening programmes are delivered within complex systems, involve a number of organisations and are supported by a range of bespoke IT systems. As well as maintaining the core PHA functions associated with the programmes, the PHA is increasingly leading on complex change and development projects for the screening programmes in response to policy changes or the impact of wider HSC IT or service changes.

There is a risk that PHA will not have the systems, capacity and/or digital expertise to manage and maintain comprehensive and robust provision of all of these functions for all screening programmes. This may result in a failure to deliver safe and effective screening programmes to the population, an inability to monitor, identify and respond to concerns regarding quality and performance, adversely impact public confidence in participating in screening programmes and negatively impact the reputation of the PHA.

~~However, a range of issues and concerns constitute actual and potential risks to the sustained provision of the ability to properly provide sustained provision of these functions and public confidence in particular screening programmes. This includes:~~

~~**Cervical Screening Cytology review in Southern Trust –** A precautionary slide review is being undertaken in the Southern Trust of approx. 17,000 women following a report by the Royal College of Pathologists. The PHA is co-chairing the response to this report, alongside the Trust. There is a risk to both public confidence in the cervical screening programme and an associated risk of reputational damage to the PHA through adverse criticism both within mainstream media and online.~~

~~**Screening programme IT systems** - The IT systems under-pinning individual screening programmes are becoming outdated, with some at risk of losing functionality over the medium term 3-5yrs. This will compromise the safe delivery of these programmes. There is no joined up, cross organisation strategic plan for maintenance and development of screening IT systems, with instead a piecemeal approach taken as and when needed. In particular:~~

DATE RISK ADDED:
November 2020

REVISED:
Dec 2023 - Risks revised (CR61 closed and integrated into CR 59)
June 2024

CLOSED:
N/A

- Breast Screening Select requires to be implemented in NI as a matter of urgency to ensure the continued functioning of the breast screening programme
- The cervical screening programme is operationalized across 3 different IT systems with limited integration. The cervical screening call recall functionality on NHAIS (a 30 year old system) is not included in the core project for replacing NHAIS with the new Digital Identity Service and will have limited maintainance support when England redecommission NHAIS. The current IT provision does not adequately support necessary changes to the programme or the flexibile ability to extract data for quality assurance and monitoring purposes (of process or outcomes).
- The roll out of Encompass and other regional IT developments (such as NIDIS and LIMS) will impact on interfaces with existing screening systems. For example, the Newborn Hearing Screening Programme (NHSP) relies on an interface between the demographic feed (currently the Child Health System) and Smart4Hearing (the IT system underpinning the programme). When the Child Health System is switched off in May/June 2025, as this service moves into Encompass, the NHSP will not be able to continue to function unless a new interface is developed.
- The contract for the IT system for the AAA Screening Programme is due for renewal in April 2025. Northern Ireland is not included in the procurement process being taken forward by England. PHA is awaiting a further update from England in terms of how they will be proceeding to inform any local actions. A further arrangement with the English provider or an alternative solution will be required, otherwise this programme will no longer be able to function.
- Impact of Encompass and new laboratory systems on interfaces and functionality and reporting within screening programmes risk a reduction in ability to adequately monitor and quality assure services.

Screening programme governance, risk management and control framework: Recent Internal audits have identified a number of findings and recommendations pertaining to the assurance framework for screening systems. Whilst many of these are being addressed sucessfullly(eg. Introduction of HPV testing in cervical screening) test to support quality assurance in cervical screening, additional resources are required to ensure full implementation and appropriate mitigation of potential risks.

Quality Assurance (QA): The QA functions and structures in the time critical antenatal and newborn screening programmes are underdeveloped and represent a specific risk to these programmes, including failure to monitor, identify and respond to underperformance issues..

PHA Staffing - staffing within individual screening programmes is relatively small-scale (and particularly therefore vulnerable during a pro-longed absence/illness). Taking a whole team perspective, there is limited resilience in terms of technical competencies, specifically, in terms of Information analysis and IT systems (see CR55 above).

~~This presents a risk of the PHA team not being fully able to monitor, identify and respond to underperformance within a screening programme.~~	

LINK TO ASSURANCE FRAMEWORK: Safety and Quality Dimension			
LINK TO ANNUAL BUSINESS PLAN 2024/25: Corporate Objectives 1 – 4			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
Current	Likely	Major	**HIGH**
Target	Possible	Major	**MEDIUM**
LEAD OFFICER: Director of Public Health			

Existing Controls	**1st, 2nd & 3rd lines of Assurance**	**Gaps in Controls and Gaps in Assurances**	**Control Effectiveness RAG rating**	**Action Plan/Comments/ Timescale**	**Review Date**
Screening Programme Board re-established to provide broader oversight (at CEx/Director level across regional organisations) **IT systems** • Project structure for implementation of Breast Screening Select has been established, business case approved and implementation ongoing. • Processes are in place within each programme	**1st and 2 line assurance** • Reports to AMT and briefing/updates to PHA Board; • Report on screening internal audit follow-up to GAC. • ~~Quarterly performance monitoring meetings with BSO for bowel and cervical screening~~ • Quality assurance site visits re-established in breast and cervical ~~cancer~~ screening programmes. • Desktop QA reviews in bowel screening	Gaps in Controls: • Commissioning and delivery of screening programmes is a HSC wide system based approach (ie. a number of partners). PHA relies upon each part of the system having appropriate controls in place • Funding insufficient to meet delivery needs within some screening programmes • Funded staffing levels in PHA are insufficient to provide a robust and responsive QA		**Southern Trust Cervical Cytology Review**: Ongoing support to the cytology review in Southern Trust including co-chairing the Steering and Operational Groups, development and maintainance of an Information system to manage all affected patients through the process and public messaging. Review to complete Sept/Oct 24. • ~~A programmed series of messaging to media/ public is ongoing underway on work being taken forward to ensure~~	~~June~~ Sept 2024

to attempt to manage any identified current risk – manual processes / reporting /monitoring/failsafe systems. • Technical review of screening IT systems completed by BSO ITS **Screening programmes –** ~~programme-specific restoration plans (post COVID-19) have been implemented and screening programmes are now back on stream.~~ Consultant screening group providing cross-programme ~~regional~~ oversight; regular updates provided to CMO Sponsorship ~~meetings~~ branch. Ongoing monitoring of uptake, activity and capacity within each programme with escalation of risks and concerns as required. Baseline screening budget reviewed and recurrent inescalpable funding needs ~~for full recovery~~ have been highlighted ~~in the 3 year investment priorities.~~	• Ongoing meetings between the Encompass team and screening leads to ensure intregrity of interfaces is mainitained with Encompass going live. • PHA CEX represented on encompass Programme Board • A programmed series of messaging to media/ public is ongoing to ensure that public confidence is maintained in the cervical screening programmes as a result of the Southern Trust Review. • Separate workstream established within the NIDIS project to extend the scope to replace the NHAIS functionality for cervical screening. **3rd line assurance:** • Regular updates provided to CMO group through sponsorship arrangements • Reporting to regular meetings of the ~~to~~ DoH Cervical Screening	infrastructure for all programmes • ~~Difficulties in recruiting to Public Health consultant posts~~ • Limited technical and information governance expertise available to support the screening programmes • ~~insufficient technical and information governance expertise available to support the screening programmes~~ <u>Gaps in Assurances</u>: • Limited resources (staffing, financial and technical) particularly to establish and support an enhanced QA structure for the newborn and antenatal screening programmes. • Limitations to core QA work as prioritisation given to responding to significant and urgent issues	~~that public confidence is maintained in the service~~ **IT systems:** • ~~Ongoing meetings between with the Encompass team and with screening leads programme teams to ensure intregrity of interfaces is mainitained with Encompass going live.~~ ~~Screening workshop planned with Epic team in April 2024~~ • ~~Manual data sharing for cervical screening has gone live with Wales. Discussions are ongoing with England to develop processes to minimise risks in preparation for when their new system is launched. July 2024~~ • ~~Separate workstream to be established within the NIDIS project to extend the scope to replace the NHAIS functionality.~~ • Ongoing pressures in Diabetic eye, call recall functions of bowel, and cervical screening programmes continue to be a feature.Need for additional recurrent funding continue to	

Programme specific issues: • Cytology revew – PHA staff in membership of Southern Trust Cervical Cytology Review Steering group and subgroups, advising on the delivery and assurance of the review programme. • Quarterly performance management meetings established with BSO for bowel and cervical screening delivery - with review of progress against audit action plan and SLA. **Staffing** – approval received to redirect programme monies to PHA staffing budget and 2xband 7 appointed in 2023/24	Oversight and Assurance Group	• Absence of cross organisation strategic approach to screening IT systems	to be raised as inescapable for 2024/25. June 2024 • ~~Ongoing large project work to support programme changes – primary HPV implementation, Breast screening select implementation.~~ • A Screening Digitial Modernisation Programme to be established and led by PHA. October 2024 • A digital directorate to be established as part of Reshape and Reform organisational restructure. Date TBC	

Corporate Risk 64					
RISK AREA/CONTEXT: Cyber Security (compromise of HSC network due to cyber-attack on a supplier or partner organisation)					
DESCRIPTION OF RISK: There is a risk to the HSC network and organisations in the event of a cyber-attack on a supplier or partner organisation resulting in the compromise of the HSC network and systems or the disablement of ICT connections and services to protect the HSC and its data. The risks and consequent impacts ~~and residual risk~~ include ~~on~~ the ability of the HSC to continue to deliver services to patients/service users/clients and therefore, potential harm to patients/service users/clients, compromise or loss of personal and organisational information, and loss of public confidence.				**DATE RISK ADDED:** September 2021 **REVISED:** June 2024 **CLOSED:** N/A	
LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension					
LINK TO ANNUAL BUSINESS PLAN 2024/25: Corporate Objective 5 Our Organisation Works Effectively					
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**		
Current	Likely	Major	**HIGH**		
Target	Possible	Moderate	MEDIUM		
LEAD OFFICER: Director of Operations					
Existing Controls	**1st, 2nd & 3rd lines of Assurance**	**Gaps in Controls and Gaps in Assurances**	**Control Effectiveness RAG rating (RED)**	**Action Plan/Comments/ Timescale**	**Review Date**
BSO Cybersecurity Strategy, Programme & Workplan (via Regional Cyber Security Progamme Board) Information Governance Team support & advisory services	1st & 2nd line: Technical risks assessments and penetration tests; 1st & 2nd line: HSC SIRO Forum for shared learning and collaborative action planning and delivery;	Gaps in Control: • Business continuity plans to be up to date in relation to a cyber incident, implemented and regular testing • Develop and test an Information Governance		PHA Business Continuity Plan, ~~exercise testing against the impact of a cyber incident was held on 13 March 2023. PHA Business Continuity Plan reviewed and updated following the exercise and~~ approved by AMT August 2023, now being	~~June 2024~~ Sept 2024

Info Gov Advisory Group (regional) Corporate Risk Management framework PHA BCP tested and updated February 2018 with a focus on cyber security PHA member of the Regional HSC Cyber Security Business Continuity Group Regional cyber security programme board led by programme manager – PHA representation on board Cyber Incident Response Action Plan finalised and launched Regional IT Security/cyber security training was refreshed and launched in September 2020. Information Governance Team support & advisory services Info Gov Advisory Group (regional) available Cyber Incident Response Supplier on Retainer contract established to provide further cyber incident preparedness	1st & 2nd line: IGAG oversight 1st & 2nd line: Reports to GAC/PHA board on reported incidents as appropriate. 1st & 2nd line: HSC Supplier framework developed for contractors who provide any service to HSC (approved by SIRO as part of Programme Board). Worked with PALS, Legal & CPD. 3rd line: IA report on 3rd party suppliers undertaken 2022	emergency plan in response to a Cyber attack • ICT Security and data protection clauses in all contracts. Partner organisations to meet security and IG standards of the HSC being addressed via supplier framework for new contracts going forward • Legal binding agreements are in place where contracts not required • Review existing contracts for Security and Data Protection clauses <u>Gaps in Assurance</u>: • PHA does not have in-house ICT systems expertise and is reliant on BSO partner to provide expert analysis of cyber related issues with PHA contracted orgs. • ~~Business Continuity Plan Test carried out annually~~	revised starting with ~~. Work also underway to review~~ Business Impact Analysis reports ~~and~~ to develop/document Directorate Level Plans (~~due for~~ 1st review June 2024 with roll-out across all Directorates due June-Sept 24) With the QUB and other cyber incidents, HSC SIROs are commissioning, through the Information Governance Advisory Group, a Regional IG Task & Finish Group to address the risks/review data flows from HSC/Partner organisations and issues associated with data loss by a partner organisation. Proposal considered at IGAG 27/5/21. This action currently with DHCNI for decision/funding, etc. Ongoing – lack of funding is holding up progress. Review again ~~June 2024~~ September 2024 Development and testing of IG emergency plan in response to cyber attack being led by IGAG. Currently with DHCNI to support financially. IGAG regularly seek input from DoH/DHCNI. – Currently not happening – no funding identified by DHCNI and no one identified to take it forward. Agreed to keep on risk register as an action and review in	

support in the event of an incident. HSC Supplier framework – to include Security and IG clauses, risk assessment and security management plans, approved by Cyber Security Programme Board in June 2022 now being implemented. Report to PHA IGSG at March 24 meeting re review of new and existing contracts in line with UK GDPR (working wih Cyber Security colleagues, PaLS and DLS as appropriate) and IG awareness raising re data sharing and other IG documentation to be considered/completed as required.			6 months if there has been any change. (Review Sept 24). Assistant IG Manager appointed to support Service Leads in a review of new and existing contracts in line with UK GDPR (working wih Cyber Security colleagues, PaLS and DLS as appropriate). IG awareness raising ongoing across PHA in relation to data sharing and other IG documentation to be considered/completed as required (ongoing) Standing item at PHA IGSG agenda – further update will be given at next meeting (~~June~~ Sept 2024; June mtg dedicated to IAR workshop)	

Corporate Risk 71			
RISK AREA/CONTEXT: Public Inquiries - Reputational damage to the PHA as a result of criticism received from any of the statutory public inquiries that the Agency is actively engaging with. This risk encompasses the ability of the PHA to respond to the requests made of it by each Public Inquiry.			
DESCRIPTION OF RISK: There is a risk that the PHA may suffer reputational damage and loss of professional credibility if the outcome of any public inquiry results in criticism of the PHA. The PHAs ability to adequately respond to Public Inquiries in a timely and complete manner is critically important. Factors such as loss of corporate memory with many key members of staff no longer in PHA employment, capacity of current staff to devote the time required to input into responses, no dedicated Public Inquiries Team within PHA and no corporate document retrieval system to readily locate relevant files are relevant. There is also the risk of adverse impacts on other significant PHA deliverables, if key staff are required to reallocate their time to input into the work of ongoing Public Inquiries. There has been no dedicated support / increase in core funding for staff from DoH. The PHA is actively involved in ~~four~~ three open public inquiries alongside a requirement to review the work undertaken in respect of the now closed Hyponatraemia, ~~and~~ Neurology and Infected Blood Inquiries			**DATE RISK ADDED:** 30 April 2023 **REVISED:** June 2024 **CLOSED:** N/A
LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension			
LINK TO ANNUAL BUSINESS PLAN 2024/25: Corporate Objective 5 Our Organisation Works Effectively			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
Current	Likely	Major	**HIGH**
Target	Unlikely	Moderate	MEDIUM
LEAD OFFICER: ~~Director of Operations~~ Head of Chief Executive's Office and Strategic Engagment			

Existing Controls	1st, 2nd & 3rd lines of Assurance	Gaps in Controls and Gaps in Assurances	Control Effectiveness RAG rating (RED)	Action Plan/Comments/ Timescale	Review Date
A formal governance structure has now been put in place in relation to PI work within the Agency: - A PI Programme Management Board chaired by the CEXE - A PI Steering Group chaired by the Director of Operations which meets as required. These groups are supported by a dedicated Inquiries team aligned to the Operations Directorate who co-ordinate the day to day response. The Agency has dedicated legal support for its PI work through a named Solicitor Consultant financed by PHA.	1st & 2nd line: -Dedicated Inquiries team led by staff working at AfC Ba 8A level with access to a formal Steering Group chaired by Director of Operations. 1st & 2nd line - Dedicated input by DLS Solicitor Consultant - Fortnightly reporting to PI Programme Management Board chaired by CEXE and containing Director and NED representation. - Update reports and escalation pathway to PHA board as appropriate. 3rd line - None Identified	Gaps in Assurance: • The PI governance structure remains relatively new and it will take time for a level of corporate ownership and accountability to be established. This process will also need to be considered against wider structural change within the PHA. Gaps in Control: • No dedicated financial support from DoH (ie no increase in core funding) • Concerns that the current staff resource may be inadequate given the envisaged extent and longevity of PI work which will take place well into 2027. • Scoping the work of the Public Inquiries Team to be undertakenin relation to recommendations from now closed Inquiries. • PHA response will neccesiate successfully engaging with a number of		In the immediate term (~~April –~~ June - September) the Agency will continue to respond to the requests made of it - primarily in relation to the UK Covid-19 Inquiry. ~~This work will extend to the preparations necessary for the DPH module 2C attendance in May and the continued work up witness statements in respect of Modules 3 and 4. The Agency awaits the publication of the Infected Blood Inquiry during May 24.~~ This work will extend to the consideration of the impending recommendations from Module 1 of the Inquiry and the preparations required for the CEXE's evidence session in respect of Module 3. The Agency will also undertake a review exercise in respect of the now published final report of the Infected Blood Inquiry. Creation of long-term formal PI work plan. This will necessitate an agreement around longer term staff resourcing and lines of accountability within the new PHA structure.	~~June 2024~~ Sept 2024

		senior staff who have left the organisation. • Psychological impact for staff responding to Inquiries / reliving experiences remains a live issue under consideration.	To be Reviewed ~~June~~ September 24	

APPENDIX 1

RISKS ADDED TO CORPORATE RISK REGISTER AS AT 30 June 2024

Corporate Risk 73

RISK AREA/CONTEXT: Financial Planning Context 25/26
Finance / Operational Performance and Service Improvement Dimensons

DESCRIPTION OF RISK: In light of the current financial planning context, and the financial deficit facing the HSC sector in NI, there is a risk that PHA will be required to to deliver further savings against its current baseline budget. To achieve the savings, PHA will need to prioritise current investments.

There is therefore a risk that PHA to will be required to stop a significant number of existing contracts it has in place with Providers from March 2025 Without continued investment and growth it will not be possible to develop and deliver a Corporate Plan to deliver statutory requirements of Health Protection, Health improvement and tackle Health inequalities in NI.

DATE RISK ADDED: June 2024

REVIEWED:

CLOSED:

LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension

LINK TO ANNUAL BUSINESS PLAN 2024/25: Corporate Objective 5 Our Organisation Works Effectively

GRADING	LIKELIHOOD	IMPACT	RISK GRADE
Current	Likely	Major	HIGH
Target	Likely	Moderate	MEDIUM

LEAD OFFICER: Chief Executive

Existing Controls	1st, 2nd & 3rd lines of Assurance	Gaps in Controls and Gaps in Assurances	Control Effectiveness RAG rating	Action Plan/Comments/ Timescale	Review Date
PHA approach will be guided by AMT and PHA board direction Development of Financial plan in advance of agreement of budgets. Engagement at highest level with DOH officials including Perm Sec and Director of Health Engagement with Minister and SPAD on importance of PHA to the public health outcomes .	1st and 2nd line assurances AMT/ PHA board to be updated on budget position on a regular basis. PHA staff to continue to engage with DoH Finance and Policy colleagues to ensure impact of achieving additional savings is understood.	<u>Gaps in Controls</u> 24/25 budget not agreed by NI Executive. <u>Gaps in Assurances</u> One year budgets		Discussions on-going with DoH Finance colleagues to agree approach for achieving savings in 2024/25 PHA to develop draft financial plan for 25/26, based on available budget information - by May 2025	Sept 2024

Corporate Risk 74	
RISK AREA/CONTEXT: ICS: Impact of the introduction of a new HSC system wide planning, delivery, performance monitoring and governance system on the PHA.	
DESCRIPTION OF RISK: A new system for the planning, delivery and performance management of health and social care is being designed and implemented in Northern Ireland. Integrated Care System (ICS) is the overall title for this. The primary risk is that the design and implementation of this new system and consequent legislation does not fully recognise the importance of public health in the role of planning and delivering better health for the population of Northern Ireland. The delay in the full programme of legislative instruments may mean that the PHA is at risk of operating 'ultra vires' in relation to accountability arrangements at an operational level with regard to joing planning and commissioning teams.	**DATE RISK ADDED:** June 2024 **REVIEWED:** **CLOSED:**
LINK TO ASSURANCE FRAMEWORK: Safety and Quality Dimension	
LINK TO ANNUAL BUSINESS PLAN 2024/25: Potentially all corporate objectives; particularly corporate objectives 4 (working together to ensure high quality services) and 5 (our organisation works effectively).	

GRADING	LIKELIHOOD	IMPACT	RISK GRADE
Current	Possible	Moderate	**MEDIUM**
Target	Unlikely	Minor	**LOW**

LEAD OFFICER: Chief Executive

Existing Controls	1st, 2nd & 3rd lines of Assurance	Gaps in Controls and Gaps in Assurances	Control Effectiveness RAG rating (RED)	Action Plan/Comments/ Timescale	Review Date
The Agency Chair and Chief Executive sit on the group led by the permanent secretary tasked with the design elements of the new planning and governance approach.	1st and 2nd lines - PHA Multi Disciplinary SPTs - Multi Disciplinary Planning and Commissioning teams	Control gaps: - Clarity around PHA role and resourcing - PHA does not currently have the planning capacity to support the anticipated requirements of joint commissioning and Planning bodies.		- Joint PCT workshop with SPPG/ PHA taking place in August SPT governance arrangements to be further developed within Reshape and Refresh programme	Dec 2024

The Chief Executive sits on the regional project board for ICS and AIPBs The senior officers of the PHA are involved in the developing the SOPs for how the systems of governance of planning will run at SPPG and PHA level.	- Regular reporting into JAM (PHA/SPPG joint assurance meetings) 3rd line - Internal Audit programme - Reporting to PTEB	- This is being developed in parallel to the Reshape and Refresh programme. Assurance: - There is no legislative framework currently underpinning the Governance arrangements for the PHA - PHA ICS hub in place to oversee the exchange of information and development of appropriate actions -		

Corporate Risk 75			
RISK AREA/CONTEXT: Pandemic Preparedness			
DESCRIPTION OF RISK: A key responsibility of the PHA is to provide the NI public health response to a pandemic. An emerging infectious disease including newly recognised infectious agents could result in large numbers of people falling ill and the next pandemic. The novel pathogen causing the epidemic could emerge abroad, with no effective treatment or vaccine. The immediate and critical public health response in NI will be focused on detection of the infection, surveillance, public health management of cases including testing, isolation, contact tracing, vaccination and treatments (if available). This needs to be scalable and will require co-ordination and implementation of national guidance and a supporting communications plan. National Risk Register 2023. Key area of risk is the capacity of the organisation to deliver on its requirements for planning and response to a pandemic.			**DATE RISK ADDED:** June 2024 **REVIEWED:** **CLOSED:**
LINK TO ASSURANCE FRAMEWORK: Safety and Quality Dimension			
LINK TO ANNUAL BUSINESS PLAN 2024/25: Corporate Objective 5 Our Organisation Works Effectively			

GRADING	LIKELIHOOD	IMPACT	RISK GRADE
Current	Possible	Major	**HIGH**
Target	Possible	Moderate	**MEDIUM**

LEAD OFFICER: Director of Public Health

Existing Controls	1st, 2nd & 3rd lines of Assurance	Gaps in Controls and Gaps in Assurances	Control Effectiveness RAG rating (RED)	Action Plan/Comments/ Timescale	Review Date
Establishment of PHA; SPPG and BSO Joint Pandemic Planning Preparedness Group (June 2023)	• Submission of draft plans to DoH assurance group by end August 2024. • Preliminary identification of business needs • Preliminary identification of	• Resources (capital and human) required to deliver a surge response for the required time period. • Joint planning with RoI re border response for a pandemic including a 5 nations approach for the management of travel with respect to data		• Draft plans being developed with expected date for submission of end August 2024. Work ongoing with DoH and SPPG in relation to pandemic planning. • Directorate level business continuity plans to be	Sept 2024

Completion table top exercises; • All Ireland table top exercise for HPAI- June 2023 • PHA;SPPG;BSO Table Top exercise Establishment of NI Regional Pandemic Preparedness Planning Board – June 2024 PHA representation on UKHSA 4 Nations planning groups PHA represented as observers on RoI National co-ordinating Group for HPAI	areas of planning which will require additional resource. • Regular review, updating and testing of draft plans. • Update of PHA business continuity plans by end October 2024. .	sharing around passenger locator forms. • Review of data sharing agreements with respect to data sharing for pandemic response including border health security and travel (PLFS). • Ability to deliver a robust contact tracing service to meet the requirements of the specific guidance with respect modelling assumptions as reflected in the UK National Risk register (20230 and UKHSA modelling assumptions (currently being finalised). • Identification and funding of a digital solution for contact tracing. • Further testing of plans required once finalised	developed by end August 2024. • Training programme being delivered by emergency planning team. • Resources required being quantified as part of the planning and will be shared with DoH and business cases developed as required.	

APPENDIX 2

RISKS REMOVED FROM CORPORATE RISK REGISTER AS AT 30 June 2024

Corporate Risk 60					
RISK AREA/CONTEXT: Impact of Migration to SPPG on PHA					
DESCRIPTION OF RISK: ~~Further to closure of the HSC Board in March 2022, there is a risk that the public health influence into commissioning may be diluted, lack of clarity about roles and responsibilities of PHA staff. With the ICS work still at a development stage, there is a risk to public health as there is a vacuum in planning.~~				**DATE RISK ADDED:** December 2020 **REVIEWED:** June 2024 **CLOSED:** June 2024	
LINK TO ASSURANCE FRAMEWORK: Safety and Quality Dimension					
LINK TO ANNUAL BUSINESS PLAN 2024/25: Potentially all corporate objectives; particularly corporate objectives 4 (working together to ensure high quality services) and 5 (our organisation works effectively).					
GRADING	**LIKELIHOOD**	**IMPACT**		**RISK GRADE**	
Current	Possible	Moderate		**MEDIUM**	
Target	Unlikely	Minor		**LOW**	
LEAD OFFICER: Chief Executive					
Existing Controls	**1st, 2nd & 3rd lines of Assurance**	**Gaps in Controls and Gaps in Assurances**	**Control Effectiveness RAG rating**	**Action Plan/Comments/ Timescale**	**Review Date**
~~• PHA CX a member of the Oversight Board;~~ ~~• PHA staff are represented on a number of the migration workstreams;~~ ~~• Finance Task and Finish Group report submitted to HSCB Migration~~	~~1st and 2 line assurance – Reports to AMT and Board~~ ~~• LCGs will continue with PHA input as appropriate until September 2023. This will allow for discussion on appropriate~~	~~Gaps in Controls:~~ ~~• Uncertainty regarding the future arrangements (including responsibilities and roles).~~ ~~• Uncertainty regarding future input (& time commitment) from PHA staff;~~		~~• Continuing input of PHA staff into development of new planning model, function workstreams etc, to ensure that PHA is taken account of in the new arrangements. (ongoing – review September 2023);~~	~~June 2024~~

Governance Steering Group. • New hub and spoke model group established in PHA involving staff from across all directorates to look at how PHA contributes to the ICS work. This group meets on a monthly basis to update on key developments	planning models with PHA input as appropriate. • Correspondence from Interim Director of Finance to Chair and CEO providing assurance re. Finance Function. • Joint Assurance Meetings involving AMT and SPPG Directors in place and providing platform for issues to be raised. 3rd line assurance: • Revision of Framework document raised with Sponsorship branch and Perm Secretary during Accountability meetings. • PHA CEO in membership of monthly PTEB meeting receiving updates/inputs on progress of ICS/AIPBs	• Uncertainty regarding role of DPH and DNAHP on SPPG Heads of Service group • All AIPB planning teams to be established Gaps in Assurances: • Uncertainty around legislation, when other Trusts are going to pilot phase and PHA reps on IPBs yet to be confirmed.	• New hub and spoke model group established in PHA involving staff from across all directorates to look at how PHA contributes to the ICS work. This group meets on a monthly basis to update on key developments • Revisit need for review of HSCNI framework document by DoH as a priority for PHA to clarify roles re commissioning in the emergent ICS context • Joint working group established between PHA and SPPG to develop guidelines / principles for inputting to commissioning processes. • Arrangements for professional input to commissioning process agreed in principle with SPPG. Further workshops planned April 2024 to agree ToR and governance processes for decision making and escalation. • Cross directorate PHA team established to share learning, support and plan	

			~~input to joint commissioning teams.~~	

Corporate Risk 68			
RISK AREA/CONTEXT: Information Governance			
DESCRIPTION OF RISK: ~~Information governance data sharing arrangements not in place to facilitate health surveillance to function fully and meet the requirements of international health regulations law and stakeholders' requests including WHO and UKHSA. Reputational risk to organisation.~~			**DATE RISK ADDED:** Dec 2022 **REVIEWED:** June 2024 **CLOSED:** June 2024
LINK TO ASSURANCE FRAMEWORK: Safety and Quality Dimension			
LINK TO ANNUAL BUSINESS PLAN 2024/25: Corporate Objective 5 Our Organisation Works Effectively			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
Current	Almost Certain	Moderate	**HIGH**
Target	Possible	Moderate	**Medium**
LEAD OFFICER: Director of Public Health			

Existing Controls	1st, 2nd & 3rd lines of Assurance	Gaps in Controls and Gaps in Assurances	Control Effectiveness RAG rating (RED)	Action Plan/Comments/ Timescale	Review Date
~~Final version of the Four Nations Data Sharing Agreement signed and returned to UKHSA 20/07/23 Completed document with all nations signed awaited return to PHA~~ ~~Genomics / CLIMB COVID consortium agreement expired and PHA has not signed the proposed replacement agreement under legal advice. Correspondence between PHA's legal adviser and UKHSA is ongoing.~~	~~1st and 2nd line Preparation of reports for AMT and the Board~~ ~~3rd line Regular engagement with DLS to advise on risk and approach to take.~~	~~Gaps in Controls: Addenda for data sharing to be completed and agreed. Clarity is sought about in what circumstances the EU Exit Health Protection Regulations require/justify data sharing.~~ ~~Gaps in Assurances: Work with BSO DLS did not reach a definitive conclusion about the data sharing related to the International Health Regulations.~~		~~External support, Gartner, commissioned to support information governance work. Action plan in place for review work which is ongoing.~~ ~~Revised drafted MOU, DPIAs and DAAs will require DPO review and sign off. Capacity issue with increased use of PID within HPS raised at PHA IG steering group 16/02/24.~~ ~~Final version of the Four Nations Data Sharing Agreement signed by both parties. Application of the Data Sharing Framework Agreement to be completed through individual Framework Agreement Addendums. HIV draft awaiting sign off.~~ ~~CLIMB COVID DSA is with DLS Legal adviser for consideration and is not signed. Update request response from UKHSA awaited. Position paper to be developed for AMT consideration setting out the relative risk to PHA of providing information to WHO and recommendations for how to~~	~~June 2024~~

			~~progress. New date required for AMT presentation.~~	

Corporate Risk 72	
RISK AREA/CONTEXT: Financial Planning Context 24/25 Finance / Operational Performance and Service Improvement Dimentions	
DESCRIPTION OF RISK - Financial Planning Context 2024/25~~. In light of the current financial planning context for 2024/25, PHA has been asked by DoH to identify the implications of delivering further savings of 2% / 5% /10% against its baseline budget of £115m. To achieve the savings, PHA will need to prioritise current investments. This will require the PHA to potentially stop a significant number of existing contracts it has in place with Providers by March 2025. It will be difficult to manage contract termination processes and will likely result in significant negative public, media and political reaction.~~	**DATE RISK ADDED:** December 2023 **REVIEWED:** June 2024 **REMOVED:** June 2024 Based on the draft budget position notified to PHA by DoH, PHA has agreed a Investment Plan for 24/25 that does not require existing contracted services to be terminated.

LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension			
LINK TO ANNUAL BUSINESS PLAN 2024/25: Corporate Objective 5 Our Organisation Works Effectively			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
Current	~~Likely~~	~~Major~~	~~**HIGH**~~
Target	~~Likely~~	~~Moderate~~	~~**MEDIUM**~~
LEAD OFFICER: Chief Executive			

Existing Controls	1st, 2nd & 3rd lines of Assurance	Gaps in Controls and Gaps in Assurances	Control Effectiveness RAG rating	Action Plan/Comments/ Timescale	Review Date
~~PHA approach will be guided by AMT and PHA board direction~~ ~~PHA has developed an initial savings plan setting out the impacts of reducing the PHA budget by 2% 5% and 10%~~ ~~PHA has agreed a financial Plan setting out how it will deliver £5.3m savings from 2023/24~~ ~~PHA officers met with DoH DoF in February to discuss consequences of savings options on PHA core business~~	~~1st and 2nd line assurances~~ ~~AMT/ PHA board to be updated on budget position on a regular basis.~~ ~~PHA Board presented with options for realaising the Savings in January 2024 for approval~~ ~~PHA submission to DoH setting out options for delivering 2% /5% /10% savings, approved by PHA Board in January 2024~~ ~~PHA staff to continue to engage with DoH Finance and Policy colleagues to ensure impact of achieving~~	~~Gaps in Controls~~ ~~24/25 budget not agreed by NI Executive.~~ ~~Gaps in Assurances~~ • ~~Allocation letter confirming PHA budget for 24/25 still to be issued by DoH.~~ • ~~Transfer of PHA budget responsibility from SPPG to new PHA Finance Directorate from 19th March will need to be closely managed to ensure robust financial controls are maintained.~~		~~Discussions on-going with DoH Finance colleagues to agree approach for achieving savings in 2024/25~~ ~~PHA to develop draft financial plan for 24/25, based on available budget information – by June 2024~~	~~June 2024~~

	~~additional savings is understood.~~			

HSC Public Health Agency

minutes

Title of Meeting	Meeting of the Public Health Agency Governance and Audit Committee
Date	13 June 2024 at 10am
Venue	Fifth Meeting Room, 12/22 Linenhall Street, Belfast

Present

Mr Joseph Stewart	-	Chair
Mr John Patrick Clayton	-	Non-Executive Director

In Attendance

Ms Leah Scott	-	Director of Finance and Corporate Services
Mr Stephen Bailie	-	Head Accountant, PHA
Mr Stephen Murray	-	Interim Assistant Director of Planning and Business Services
Mr David Charles	-	Internal Audit, BSO
Mr Ryan Falls	-	Cavanagh Kelly
Mr Roger McCance	-	NIAO
Mr Robert Graham	-	Secretariat

Apologies

Mr Robert Irvine	-	Non-Executive Director

28/24	**Item 1 – Welcome and Apologies**
28/24.1	Mr Stewart welcomed everyone to the meeting. Apologies were noted from Mr Robert Irvine.
28/24	**Item 2 - Declaration of Interests**
28/24.1	Mr Stewart asked if anyone had interests to declare relevant to any items on the agenda.
28/24.2	Mr Clayton declared an interest in relation to Public Inquiries as Unison is engaging with the Inquiries.
29/24	**Item 3 – Minutes of previous meeting held on 15 April 2024**
29/24.1	The minutes of the previous meeting, held on 15 April 2024 were **approved** as an accurate record of that meeting, subject to additions proposed by Mr Clayton in paragraphs 18/24.19, 19/24.9 and 19/24.12.

30/24 **Item 4 – Matters Arising**

30/24.1 Mr Stewart noted that an action log had been circulated to members prior to the meeting, and that action 2 relating to recommendations in the Internal Audit on recruitment was still under consideration. He sought further clarity in relation to action 3 which concerned the Newborn Screening Programme.

30/24.2 Mr Murray explained a bid was made for funding to the Department, but was not prioritised. He said that PHA can continue to make a bid for the resources, but until that bid is successful, there is little more that PHA can do. Mr Charles commented that it would be Internal Audit's view that the recommendation should be implemented.

30/24.3 Mr Stewart noted that there was an action from the February meeting relating to the preparation for the PHA Board of a paper on IT systems for screening programmes, and that although a paper had been received, it did not provide the clarity required, therefore this action should remain open. Mr Graham advised that an updated paper is due to be brought to the Board next week.

30/24.4 Ms Scott sought clarity on the situation regarding the recommendation relating to the Newborn Screening Programme. Mr Stewart advised that there was a view that it was not possible to implement this recommendation. Mr Clayton noted that it was Internal Audit's view that the recommendation should not be closed so suggested that further narrative was required as to why there is a different view from management **(Action 1 – Ms Scott)**.

31/24 **Item 5 – Chair's Business**

31/24.1 Mr Stewart advised that he had attended a meeting of Chairs of HSC Audit Committees, convened by Mr Jim McCooe. He said that there was a presentation on the Encompass programme followed by a discussion on the financial situation facing the HSC. He added that there was little hope expressed about additional funding being available and that the other Chairs had said it would be difficult for their organisations to achieve a balanced budget. He advised that as there is now a Minister in place, the Permanent Secretary has a responsibility to achieve a balanced budget, but the Minister may wish to instigate a programme of spending.

31/24.2 Mr Stewart said that Mrs Catherine McKeown had presented the Internal Audit General Report for HSC and noted that the number of audits receiving limited assurance is on the increase.

31/24.3 Mr Stewart reported that frustration was expressed by the Audit Committee Chairs about the format of Annual Reports and the amount of management time spent producing these reports. It was agreed that the Director of Finance in the Department would speak to the

Department of Finance regarding this.

31/24.4 Mr Stewart advised that there will be a further meeting of this group before the end of the year.

32/24 Item 6 – Internal Audit

Internal Audit Progress Report [GAC/25/06/24]

32/24.1 Mr Charles advised that the Progress Report shows that Internal Audit has delivered 27% of its SLA in the first quarter, and that a draft report of the audit on the management vaccination programmes, is currently with management for comments and should be brought to the next meeting.

32/24.2 Members noted the Internal Audit Progress Report.

Shared Services Update [GAC/26/06/24]

32/24.3 Mr Charles explained that for a range of Shared Services, including payroll, payments, recruitment and income, Internal Audit carries out audits for BSO, but the findings are shared with client organisations. He advised that since the last meeting two reports have been completed, one for recruitment where a limited level of assurance was given, and one for payroll where a split level of assurance was given with elementary processes receiving a satisfactory level of assurance and a number of other processes receiving a limited level of assurance.

32/24.4 Mr Charles advised that there were four significant findings within the audit of recruitment which related to HRPTS and the eRecruitment system, KPIs, waiting list management and Access NI checks. In terms of the audit of payroll, he noted that the consequences of that limited assurance would not be as complex for PHA as they would be for Trusts. He said that the detailed reports of these audits will go the BSO Audit Committee and BSO will be responsible for taking forward any recommendations.

32/24.5 Mr Stewart commented that this audit is a case of history repeating itself as the systems are not fit for purpose and if this continues to be the case, then PHA should carry out its own recruitment in-house, and that this is something the Agency Management Team (AMT) should look at. Ms Scott replied that she did not think that PHA had the flexibility to bring this in-house, but added that PHA does have its own dedicated HR resource. She added that she would wish to drill down into the specifics and noted that BSO is currently in the process of getting the system upgraded. Mr Stewart said that PHA needs to ensure that as a customer of a Shared Service, it is getting an efficient service.

32/24.6 Mr Clayton queried whether the vacancy rate in BSO has an impact on the service that PHA receives. He expressed concern around the finding relating to Access NI checks. He added that there may be an

impact in terms of PHA being able to take forward the recommendations from its own audit on recruitment, and that there are issues for both BSO and in-house in PHA. Mr Charles commented that fundamentally, whether it is PHA or BSO, recruitment is difficult due to the complexities and challenges of the system. However, he added that there will be a new system called Equip, which will replace HRPTS, but he did not know the timeframe for its introduction. He also noted that carrying out recruitment exercise is a task that managers have to perform in addition to their day-to-day work and that there are many bottlenecks in the system, and that it is difficult to get information out of the system.

32/24.7 Members noted the Shared Services update.

Head of Internal Audit Annual Report [GAC/27/06/24]

32/24.8 Mr Charles presented the Head of Internal Audit Report and began by outlining that Internal Audit is an independent provider. He advised that during 2023/24, KPIs were largely met, although the KPI relating to receipt of management comments had fallen. He reported that five audits were completed, three of which were given a limited level of assurance and two of which were given a satisfactory level of assurance. He added that a total of nine significant findings were made.

32/24.9 Mr Charles reported that Internal Audit had undergone an external quality assurance exercise which found that it largely conformed to audit standards.

32/24.10 Mr Charles advised that the Head of Internal Audit is providing an overall satisfactory opinion for PHA, but noted that action is required to address some of the findings from the audits where there was limited assurance. Mr Stewart welcomed the overall satisfactory opinion and said that members will keep a close eye on those areas where limited assurance was given. Ms Scott said that she would wish to assure members that audit recommendations will form part of the agenda for the accountability meetings that will be held with Directors.

32/24.11 Members noted the Head of Internal Audit Annual Report.

Internal Audit General Annual Report for HSC 2023/24 [GAC/28/06/24]

32/24.12 Mr Charles said that this Report gives a consolidated view across the HSC and the main finding was that 49% of audits received a satisfactory level of assurance, while 37% were limited. He advised that some assurances were split between satisfactory and limited, with 59% deemed “above the line”. In terms of the number of Priority 1 recommendations, this has increased from 19 in 2021/22 to 45 in 2023/24. He added that most of these are in areas such as contract management and procurement, and corporate governance. He reported that 82% of outstanding Priority 1 and 2 recommendations were fully implemented, which is the highest level recorded. In terms of learning,

he outlined that there is a need for effective contract management, an improvement in compliance, an enhancement in business continuity planning and a focus on staff training. In terms of improvements, he advised that there has been a cessation in off-contract nursing agency usage and an improvement in compliance with Staff in Post checking processes.

32/24.13 Mr Charles gave an overview of the spread of assurances in each HSC organisation and the audit areas looked at. He noted that when it came to first time audits, two of PHA's three limited audits were in areas that had not been audited before. Moving onto the implementation of audit recommendations, he reiterated that this was one area of success. He highlighted the age of outstanding recommendations.

32/24.14 Mr Charles said that going forward, management needs to address the number of limited assurances and to ensure that there is a focus on implementing recommendations promptly.

32/24.15 Mr Stewart said that this is an interesting report which he will bring to the attention of the full Board **(Action 2 – Mr Stewart)**. He added that he was going to make similar points around the number of partially implemented recommendations and limited levels of assurance, but he hoped that the work that Ms Scott will commence will come to fruition.

32/24.16 Mr Clayton said that the trends with regard to the increase in the number of limited assurances and Priority 1 recommendations made him query how sighted PHA is in terms of Internal Audit reports on areas where PHA commissions services. Mr Charles advised that PHA would not ordinarily see those reports as there would not be a formal reporting mechanism back to PHA. He added that this could be picked up as part of the audit that will be carried out shortly on performance management. Mr Clayton noted that given the amount of work PHA does with external organisations, this would not come through as part of contract management arrangements. Mr Murray said that as part of PHA's contract management with Trusts, it would not ask for Internal Audit reports, but assurance would be provided to managers that services are operating to the standard that PHA is expecting. Mr Clayton noted that this goes to the heart about how PHA seeks assurance and used cervical screening as an example of area where PHA has a role in being assessed.

32/24.17 Mr Clayton asked if there was a way of seeing the trends in terms of the number of Priority 1 recommendations that PHA has received. Mr Charles referred to a graph showing that PHA has received four Priority 1 recommendations, two from 2022/23 and two in 2023/24. Mr Clayton asked if it was more likely to receive Priority 1 recommendations in a new area. Mr Charles commented that if an audit was carried out in an area that was previously had a satisfactory level of assurance, but it changed to a limited level of assurance, this would be a concern and Internal Audit would look to see if there has been a diminution of

controls. He added that PHA's audit programme is a risk-based one so targets risk-based areas for audit.

32/24.18 Ms Scott noted that for PHA, there is some duplication in that there is a number of recommendations around the same theme, e.g. the Corporate Plan. She said that it is fortunate that there is Internal Audit within health with a dedicated bespoke team that can look at a vast range of areas. She added that PHA needs to have an audit needs assessment. She queried whether the increase in the number of limited assurances and the number of Priority 1 recommendations is linked to the financial situation in that there is not the financial capacity to implement them. Mr Charles replied that there are some which fall into that category, but there are other reasons for the increases, for example staff retirement or financial constraints. He said that the tightening of resources means having to do more with less and possibly more risk. However, he noted that there are examples of pure non-compliance and said that a lack of funding cannot be a good enough reason for this.

32/24.19 Mr Stewart commented that PHA, along with other organisations, needs to take a good hard look at its activity and have a rationale for what it deems to be priority and what is not a priority. He added that if the Department will not fund new work, then PHA will have to stop funding other programmes. He said that there should be a focused piece of work looking at prioritisation, and that PHA needs to have a way of measuring its deliverables. He pointed out that the Annual Report tells people about the things that PHA does, but it does not tell how PHA has made a difference.

32/24.20 Mr Clayton said that with regard to the outstanding recommendation for newborn screening, the issue for PHA is about not having a quality assurance programme. Mr Murray noted that another issue is about making comparisons with the rest of the UK so there is a need to get the full picture. Mr Clayton said that this is an important programme and an infrastructure needs to be built around it.

32/24.21 Mr Charles said that organisations need to look at risk appetite, and how they define risks which are a "no go", and what risks they are prepared to tolerate. Mr Stewart thanked Mr Charles for facilitating the session on the 3 Lines Assurance Model which he said was appreciated by members.

32/24.22 Members noted the Head of Internal Audit Annual Report.

33/24 Item 7 – Finance

Annual Report and Accounts incorporating Governance Statement and Letter of Representation [GAC/29/06/24]

33/24.1 Ms Scott said that it is her aim to make the first part of the Annual Report more meaningful and to be a reflection of the journey PHA is on

and use it to showcase the work of the organisation. She advised that the accounts are in a standard format and have been audited by External Audit.

33/24.2 Ms Scott advised that the Report is broken down into three sections, the performance report, the accountability report and the financial statements.

33/24.3 Ms Scott said that the performance report forms a considerable part of the document and is split into sections. Mr Clayton asked about a reference to campaigns which had appeared in the previous iteration, but Ms Scott explained that this had been moved into the Governance Statement. Mr Clayton asked why the reference to PHA's equality and diversity work appeared where it did as it seems out of place. Ms Scott noted that it is not possible to include every element of PHA's work, but she would re-look at this section. She added that it will take time to ensure that the Report is aligned to the new Corporate Plan. Mr Stewart said that having the Corporate Plan will be key going forward.

33/24.4 Ms Scott advised that the accountability report follows a set template. She said that the governance report will show that PHA has received a satisfactory level of assurance, notwithstanding that there are outstanding audit recommendations and a number of new control issues. She noted that PHA does not have a balanced budget and there are staffing issues. Mr Stewart said that the section on public inquiries should have made reference to the need for additional resources as there are pressures on the public health directorate. Mr Clayton said that there needs to be clarity in terms of when the ALB self-assessment was completed as the narrative is not accurate. He noted the reference to the pause on campaigns and said that it is important that there is reference to how PHA looking at its own internal quality assurance processes with regard to screening. Ms Scott acknowledged that this is an area of public concern and noted that the review will have happened when next year's report is being prepared.

33/24.5 Mr Stewart said that the Board has previously noted its concerns about the fact that PHA hosts SBNI and while there is a reference to the unlawful expenditure, he queried whether more narrative is needed to outline that the PHA Chief Executive is the Accounting Officer for an organisation over which he has no control. He said that it is not clear that SBNI has its own Board and Chair and therefore this report should put PHA's concerns on record. Ms Scott advised that SBNI has now implemented additional and is having biannual accountability meetings. She added that there will greater emphasis on getting the MOU with SBNI revised and that the Department is also aware of the situation. She said that there is no issue with including some additional narrative. Mr Stewart said that it should be a matter of public record if the Board has a concern.

33/24.6 Mr McCance advised that if members felt that the narrative in the Report

did not meet their concerns, an extra line could be inserted. Mr Stewart said that while it is clear there are assurances in place, he reiterated that it is less than ideal that PHA is hosting an organisation over which it has no control. Ms Scott undertook to make the necessary changes **(Action 3 – Ms Scott)**.

33/24.7 Ms Scott said that the remuneration and staff report gives an overview of the demographic and remuneration profile of the organisation. She advised that the accountability report follows, which will include the statement from the Comptroller and Audit General. She added that she was delighted that PHA has received an unqualified audit opinion.

33/24.8 Mr Bailie took members through the accounts and began by reporting that PHA finished the year with a surplus of £80k. He noted that while Trust expenditure appears to be lower than last year, this is a presentational issue as R&D grants now appear in the Department's accounts. He explained that the increase in intangible assets is due to the cost of the Vaccine Management System (VMS).

33/24.9 Mr Bailie reported that the staffing costs have increased slightly, which is due to the tail end of some costs for contact tracing staff. He added that the amortisation increase is due to VMS. In the note on leases, he explained that while PHA does not own any properties, this cost relates to lease of Linum Chambers. He explained that in terms of trade receivables, the increased amount is due to monies owed by the Special EU Programmes Body (SEUPB), but the amount owed is reducing. He added that provision has been made for the pay award, and added that there is also £210k for additional provisions for senior executive pay.

33/24.10 Mr Bailie advised that PHA has achieved a break even position and that for capital funding, there was no surplus. He thanked the auditors for a smooth and expedient audit and said that he would recommend the Annual Report and Accounts for approval.

33/24.11 Mr Clayton sought clarity around expenditure on consultants and whether the use of EY for the Refresh and Reshape programme was classed as consultancy, but Mr Bailie replied that PHA has liaised with the Department regarding this as the work was classed as staff substitution.

33/24.12 Ms Scott noted on page 97 the reference to the wastage of vaccines under losses. Mr Stewart asked why this is now appearing in PHA's accounts if PHA has only recently taken over the overall management of vaccination programmes. Mr Murray explained that the funding has always been in PHA's budget. Mr Bailie added that as PHA spent the money, it is accountable for it. Ms Scott explained that there is always wastage as there can never not be enough vaccines. Mr Bailie pointed out that this only relates to the flu vaccine. Mr Clayton asked if PHA is more confident that this will be managed better through VMS. Mr Bailie advised that this should be the case and outlined that PHA has to order

vaccines 9 months in advance based on an expected uptake. Mr Stewart noted that PHA was not able to run a campaign this year. Ms Scott said that this is an area that AMT is looking at and there is a wish to run a campaign for pertussis.

33/24.13 Mr Stewart asked where the accrual is recorded for the cost of staff not taking annual leave. Mr Bailie explained that this is contained within the accounts and is sitting at around £300k.

33/24.14 Mr Stewart asked if members were content for the Annual Report and Accounts to be approved to go to the Board. Ms Scott paid tribute to the Finance team and the work of SPPG colleagues in compiling the accounts.

33/24.15 Subject to amendments, members **APPROVED** the draft Annual Report and Accounts which will be brought to the PHA Board meeting on 20 June.

34/24 Item 8 – External Auditor's Report to those Charged with Governance (Draft) [GAC/30/06/24]

34/24.1 Mr McCance thanked PHA and Cavanagh Kelly for their work during the audit to allow this report to be completed. He advised that PHA has been given an unqualified audit opinion. He noted that the report remains in draft.

34/24.2 Mr Falls gave an overview of the draft Report. He advised that following the audit there are no misstatements or adjustments required to the accounts. He noted that there was a loss identified, which related to vaccine stock and following a review, it was determined that this was caused by a significant drop in uptake.

34/24.3 Mr Falls advised that accounts will not be formally laid until 5 July due to the General Election. He noted that in Section 3 there was one significant risk identified, regarding management override of controls, but reported that no issues were noted during the work of the audit. He thanked the team for a smooth audit process.

34/24.4 Mr Falls said that there were no changes in the accounting policies.

34/24.5 Mr Falls reported that there are two Priority 2 findings and one Priority 3 finding. He said that the first Priority 1 finding relates to SEUPB and funding owed to PHA as part of a project. He noted that while the debt has reduced, £2.6m remains outstanding. He advised that the second finding relates to the number, and level, of Direct Award Contracts (DACs) and in particular, he noted that there is not a detailed rationale for why DACs are in place. He reported that the Priority 3 finding relates to the signing of employment contracts.

34/24.6 Mr Falls said that the appendices include the letter of representation,

which contains a reference to the provision for holiday pay and senior executive pay, the audit certificate and the update on the implementation of last year's recommendations.

34/24.7 Mr Clayton noted the recommendation around the money owed by SEUPB and expressed concern about the size of the debt. He noted that there was a discussion on this issue last year and that there was ongoing engagement. While appreciating that this is a complex matter, he asked if there is a particular reason for the delay and if the Board, as a whole, could get an idea of timescales for getting this matter resolved to determine if any further intervention is required. Mr Falls advised that PHA is not unique in this situation and that there is a process issue for SEUPB. Ms Scott said that there is a minimal risk to PHA and that she could provide an age profile of the debt **(Action 4 – Ms Scott)**.

34/24.8 Mr Stewart expressed concern around the number of DACs that PHA has, and he appreciated that the Chief Executive has put an increasing focus in this area. He welcomed that External Audit had reviewed this area and has highlighted that there is a greater number of DACs within health than other departments, which is a weakness in governance. He said that there is a sizeable amount of funding involved, and it is a matter that he would bring to the attention of the Board. He noted that the Chair has convened a meeting to look at what can be done in this area. Mr McCance agreed that there is an issue regarding DACs in the HSC and that there are challenges for BSO and PALS.

34/24.9 Members noted the draft Report to those Charged with Governance.

35/24 Item 9 – Any Other Business

32/24.1 There was no other business.

36/24 Item 10 - Annual meeting with Auditors (External and Internal) without Officers present

36/24.1 It was agreed that this meeting would be rescheduled to a time when all Non-Executives are able to attend **(Action 5 – Mr Graham)**.

37/24 Item 11 – Details of Next Meeting

Thursday 8 August 2024 at 10am

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

Signed by Chair:

Joseph Stewart

Date: 8 August 2024

HSC Public Health Agency

minutes

Title of Meeting	Meeting of the Planning, Performance and Resources Committee
Date	2 May 2024 at 10.00am
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

Present

Mr Colin Coffey	-	Chair
Mr Craig Blaney	-	Non-Executive Director
Ms Anne Henderson	-	Non-Executive Director

In Attendance

Mr Aidan Dawson	-	Chief Executive
Ms Leah Scott	-	Director of Finance and Corporate Services
Mr Stephen Murray	-	Interim Assistant Director of Planning and Business Services
Ms Karyn Patterson	-	HR Business Partner, BSO
Mr Robert Graham	-	Secretariat

Apologies

Professor Nichola Rooney	-	Non-Executive Director

10/24 **Item 1 – Welcome and Apologies**

10/24.1 The Chair welcomed everyone to the meeting. Apologies were noted from Professor Nichola Rooney.

11/24 **Item 2 – Declaration of Interests**

11/24.1 The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.

12/24 **Item 3 – Minutes of Previous Meeting held on 8 February 2024**

12/24.1 Members **APPROVED** the minutes of the meeting held on 8 February 2024.

13/24 **Item 4 – Matters Arising**

13/24.1 The Chair asked if members felt the terms of reference for the Committee were appropriate.

13/24.2 Ms Scott said that the concept of a PPR Committee is a good one but in terms of having a focus on those matters that may have an impact on governance, she noted that the Committee does not have any delegated authority and suggested that this should be reviewed so that the Committee can approve business. She added that there should be clarity round the administration of the meeting, but felt that it is meeting regularly enough. The Chair asked Ms Scott for her views on the scope of the Committee and Ms Scott replied that it is appropriate adding that she sees staffing as being a key issue. Ms Scott added that in terms of performance, this will be key as the new Corporate Plan begins to take shape and a financial performance framework evolves. She noted that the Committee also looks at finance, but said that is not to understate the role of the Governance and Audit Committee. She reiterated that without clarity on delegated authority, the Committee is simply a scrutiny committee.

13/24.3 Mr Blaney agreed that staffing will be an important area going forward as there are threats to the organisation in terms of not having sufficient staff and also retaining current staff while the Reshape and Refresh programme is being rolled out.

13/24.4 Ms Henderson said that she is also content with the scope of the Committee but added that there is a lot of work to be done in terms of reviewing the Performance Management reports and giving impetus to the Corporate Plan. She commented that the timing of meetings is important so that the Committee as it has an important role in highlighting issues to the Board. She said that the Committee is not well serviced and thought should be given to who should support the Committee.

13/24.5 Mr Murray commented that the Committee is still in its infancy. He noted that there had been a previous discussion around performance management and having the appropriate staff in attendance. The Chair said that this Committee's role is to provide scrutiny so that the Board can look at strategy. He added that its role is to give the Board assurance and highlight any issues. He said that the Chief Executive needs to be in attendance and he outlined that going forward, the Chief Executive intends to have quarterly accountability meetings with Directors and these should take place before this Committee meets so that members can receive the most up to date position on matters. He agreed that he and Ms Scott would look at the timing of these meetings going forward.

13/24.6 Ms Scott advised that the Performance Management Report had been presented to the Agency Management Team (AMT) on Wednesday and

there were some observations on the timing of the report giving that AMT has had little opportunity to input into the final report. The Chair said that while he did not wish to put more pressures onto the Executive Directors, he saw the role of this Committee as one of having a deeper look at certain issues.

At this point the Chief Executive joined the meeting.

13/24.7 The Chair welcomed the Chief Executive and summarising the discussion so far noted that members are content with the scope of the Committee but that the timing of meetings and the attendance need to be reviewed. Mr Blaney asked if the timeline of this Committee needs to fit in with that of the Governance and Audit Committee and if this committee would look at risk but the Chair said that this Committee will be looking at performance. The Chair asked the Chief Executive if he felt all Directors should be in attendance and the Chief Executive replied that he would see how today's meeting goes first.

13/24.8 The Chief Executive noted that he had only received the Performance Management Report at the same time as the Committee members and therefore did not feel well briefed. Ms Henderson commented that the Report is too long, but the Chief Executive said that going forward it will be much shorter. Ms Scott asked if the template that PHA uses is mandated by the Department, but Mr Murray said that the Report is in a format that PHA uses in order to capture all of the necessary information.

13/24.9 The Chair reiterated that he and Ms Scott would look at the timetable of meetings, determine whether it is appropriate for other Directors to attend, and look at the terms of reference **(Action 1 – Chair/Ms Scott)**.

13/24.10 Ms Henderson asked for an update on the action around a paper on the Strategic Planning Teams (SPTs). Mr Murray explained that as part of the organisational change the SPTs have been operating is shadow form. He added that there is a workshop taking place next Thursday to look at SPTs. Ms Henderson asked if a short report could be prepared for the Board outlining the different SPTs and who chairs them. She suggested that the Chairs of SPTs should come to the Board and asked what the timeline was for their implementation. The Chief Executive replied that the SPTs should be operational by the autumn and added that joint groups with SPPG have already been set up. The Chair noted that this will fit in with the timeline for the Reshape and Refresh programme.

13/24.11 Ms Henderson asked if the chair of the Mental Health SPT could present at the next Board meeting. The Chief Executive asked if he could take time to consider this further. The Chair said that the update on SPTs should be shared with the Board as well as the timeline for the Reshape and Refresh programme so that the Board can look to support this work **(Action 2 – Chief Executive)**.

14/24 **Item 5 – Planning**

PHA Corporate Plan 2025-2028 Proposed Development Plan

14/24.1 Mr Murray advised that this is a draft paper which has not yet been finally approved by AMT. He said that it outlines the background for why PHA needs to develop a Corporate Plan taking into consideration the timetable of the Northern Ireland Executive and Programme for Government. He said that the methodology is straightforward, but the key issue is getting the time to develop it and ensuring that it reflects the ongoing Reshape and Refresh programme. He added that there is a number of other papers that needs to be considered e.g. the Hussey Review and Making Life Better. He said the process for completing the Plan needs to be looked at as well as the mechanism for supporting it.

14/24.2 Ms Henderson said that she was pleased to see this timeline written down, but asked who the team is that will be supporting this work and how the deadline of April 2025 has been determined. The Chair explained that this timeline is not being driven by the Department, but by PHA, and in his view there should be a 5-year Plan. Ms Henderson agreed saying that public health outcomes are always longer term. She asked about resources for this work and if there is a stakeholder engagement plan. Ms Scott said that PHA cannot afford not to do this work and therefore resources must be found adding that a team will be constituted from across the organisation to include professional staff. Mr Murray added that there will be a project management element to this work.

14/24.3 Ms Scott said that she agreed that a 5-year timeline is workable, but Mr Murray noted that PHA will have to work with the Programme for Government timeline, but it could commence with a 5-year Plan. Mr Blaney asked if PHA can fund everything that it puts in its Plan. The Chair said that the PHA should still set targets even if they cannot be meet. He added that it is important that staff have a vision and noted that there has probably been more staff engagement over recent months than there has ever been before. The Chief Executive said that PHA does have a vision but added that the wider HSC system is currently in a state of flux so PHA is working in a vacuum. He noted that the recommendations from Module One of the COVID Inquiry may indicate a change of direction in terms of how public health is looked at on a national basis and the impact of the creation of the UK Health Security Agency (UKHSA).

14/24.4 Ms Henderson said that this paper gives confidence to the Committee that a process is in place and should be shared with the full Board with updates every 2 months thereafter.

14/24.5 The Chief Executive noted that the first draft of the Corporate Plan needs to be ready by February 2025 so it can inform the Business Plan. Mr Murray said that by February 2025 there will be a draft that will show

	the direction of travel. Ms Henderson asked if this paper could be updated. Mr Murray reiterated that this paper is a draft and has not yet been considered by AMT. The Chair said that members could agree with the principles within the paper and it could be brought to the Board in June.
14/24.6	The Chief Executive advised that there would need to be a discussion with Mr Peter Toogood regarding a 5-year plan.
14/24.7	The Chair noted that there is now some clarity beginning to form in terms of PHA's relationship with SPPG.
15/24	**Item 6 – Performance**
	Financial Outturn for 2023/24
15/24.1	Ms Scott advised that PHA's final accounts for 2023/24 are being prepared for submission to the Department and the Northern Ireland Audit Office on Friday. She reported that PHA will end the year with a surplus of £81k and that a programme of audit will now commence. The Chair commented that PHA needs to look at is savings plan for next year as he has a concern around vacancies.
	Overview of Budget Planning for 2024/25
15/24.2	Ms Scott said that this paper outlined a proposed timetable for completion of the PHA budget for 2024/25. She advised that the assumption is that it will be a flat line budget with no allowance for price inflation, which will have an impact on Trust baselines. She added that there is an assumption of £1.5m of funding for the Vaccine Management System (VMS) and for HPV, but there is ongoing dialogue with the Department around these matters.
15/24.3	Ms Scott advised that the vaccine team managed the budget but there are some matters regarding wastage which are ongoing. She added that Dr Joanne McClean is writing to the Department to ensure that there is more precise ordering of stock. The Chief Executive added that he has spoken to Mr Peter Toogood regarding this. The Chair suggested that Local Councils could help with improving uptake of vaccines.
15/24.4	Ms Henderson said that the paper was excellent and should be presented to the Board. She asked if there are any proposals to cut programme spend, but Ms Scott replied that at present there are not. Mr Murray said that pressures will be looked at as well as areas where there is usually a level of slippage, e.g. Nicotine Replacement Therapy. He agreed that PHA is not expecting to make any cuts. Ms Scott noted that there is a risk that PHA may under spend. Mr Murray said that the next 3 weeks will be key while PHA is awaiting its allocation letter.

15/24.5 The Chair asked if there is a timeline for the development of the costing for the Reshape and Refresh programme. Ms Scott advised that work on this has commenced but a number of assumptions have to be made. She added that only part of the implementation will take place this year so there will not be a full year impact. The Chief Executive advised that a number of staff will be on protected pay for 5-year period, but during that period there could be retirements. The Chair said that this information should be included within the Plan. The Chief Executive advised that as the digital directorate is developed, the surveillance and epidemiology functions should be enhanced which should result in greater investment in PHA's information systems. He added that the outcome of the COVID Inquiry should be used to focus on investment.

15/24.6 Ms Henderson noted that the present management and administration budget is £27m and asked if there a sense if this will increase or decrease. The Chief Executive said that he did not know at present. The Chair noted that the Reshape and Refresh programme is not a cost saving exercise.

15/24.7 Ms Henderson asked when a high level costing of the Reshape and Refresh programme will be available. The Chair noted that this should be available by 20 June.

Performance Management Report 2023/24

15/24.8 Ms Henderson said that there needs to be a plan to deal with the reduced uptake in vaccinations. The Chief Executive said that vaccination is a corner stone of public health and there has been a steady decline in uptake so PHA needs to maintain a focus in this area and set challenging targets. Ms Henderson asked if PHA has a plan and if this could be brought to the Board. The Chief Executive advised that he chairs a Vaccination Programme Board and that it has held its first meeting. Ms Henderson asked if a short update could be brought to the Board **(Action 3 – Chief Executive)**.

15/24.9 Ms Henderson said that action 3c relating to mental health should be rated "red" and that AMT should review this. She added that as the service is not in place a paper should be brought to the Board by the autumn. The Chief Executive said that he would like to have a further discussion regarding this with the responsible Director. Ms Henderson noted that there are a lot of contracts that need attention. Mr Murray advised that PHA is in a better position than it was previously in this area. He noted that there were issues with either relevant staff being off on long term sick leave, or being redeployed to other areas. The Chair asked if PHA could use SIB to assist, but Mr Murray explained that the work required is around developing a service profile and commissioning intention, rather than the process. Mr Murray said that he was confident that there is a clear understanding about what PHA needs to do. Ms Henderson reiterated that the target should be rated "red".

15/24.10 The Chair noted that the Report is lengthy and said that an update is needed on how some of the areas rated "red" are going to be resolved. The Chief Executive agreed that there needs to be a focus and in terms of the procurement issue, he said that having the finance team will help drive this work forward.

15/24.11 Ms Henderson commented that as the cancer prevention team is not yet in place, action 3e should also be rated "red". The Chief Executive advised that he had attended a number of meetings with SPPG to discuss this. He explained that work is ongoing to re-establish cancer frameworks, but it is challenging.

15/24.12 Ms Henderson asked for further detail about action 4c around the development of Standard Operating Procedures (SOPs). The Chief Executive explained that as more nurses are involved in health protection work there is a need to review some SOPs, but given the pressures on the Duty Room in dealing with measles and pertussis cases, there has not been the capacity to complete this work. He added that there needs to be a wider discussion about health protection in Northern Ireland given the increasing profile of UKHSA and advised that he will be raising this with Mr Peter Toogood at PHA's Accountability Review meeting.

15/24.13 Ms Henderson asked about the status of the backlog in screening and if there could be an update on that **(Action 4 – Chief Executive)**.

15/24.14 Members noted the Performance Management Report Parts A and B.

16/24 Item 7 – Resources

16/24.1 Ms Patterson delivered a presentation giving a summary report on HR-related work during 2023/24. She advised that during the year PHA's overall headcount increased by 3.7% with the number of temporary staff decreasing and the number of permanent staff increasing. She reported that 95% of staff had had an annual appraisal. She gave an overview of sickness absence trends for both short term and long-term sickness and of employee relations related work.

16/24.2 Ms Patterson advised that PHA has developed a People Plan for 2024-2025 which looks at the areas of culture, staff experience and workforce development. She added that a Skills and Development Framework has also been developed which aims to provide support to managers and staff and can be used as a tool for lifelong learning.

16/24.3 The Chair asked if staff have Personal Development Plans and Ms Patterson advised that is part of appraisals. The Chair asked who carries out appraisals and if they are trained. Ms Patterson replied that line managers carry out appraisals and they are trained. She added that the Skills Framework can be used in appraisal as it outlines the skills and competencies that are needed for particular roles. The Chair

	asked if the Framework is in use, but Ms Patterson explained that there will be a "soft launch" this year as using this Framework will represent a big change for staff. The Chair asked which comes front, the new structure or the new PDPs. Ms Patterson advised that the Framework can be used this year and that it can be updated if there is any feedback from staff.
16/24.4	Mr Blaney asked if exit interviews are carried out. Ms Patterson advised the option of exit interviews is available, but there is a limited uptake. She added that most staff departures are due to staff moving to another HSC organisation, or retiring. The Chair asked about the induction process. Ms Patterson explained that a new induction programme was brought to AMT recently. Ms Henderson commended the outcome on the appraisal process.
16/24.5	The Chair asked what success would look like for the new People Plan. Ms Patterson said that this is the start of a process and putting foundations in place. The Chair said that there is good commitment from staff. He asked if it would be helpful to hold a celebration event in 2025 and Ms Patterson advised that there will be such an event.
16/24.6	The Chair asked if staff are appraised against the values of the PHA and Ms Patterson confirmed that they were. The Chief Executive added that managers should be having regular meetings with their staff throughout the year which give an opportunity for staff to discuss themselves, their work and their future. Mr Murray noted that the appraisal process is more embedded in the organisation.
16/24.7	Ms Henderson asked if morale in PHA will be impacted by the findings of the COVID Inquiry and the Chief Executive said that he did know, but he anticipated that the first findings will be known by June. The Chair said that he felt that PHA would face criticism, but the Chief Executive felt that public health in general would be criticised.
16/24.8	The Chair said that there is a confidence in the PHA and that people understand that there are financial pressures. He added that it is a well-respected organisation and Mr Blaney echoed this.
16/24.9	Mr Blaney asked whether, when carrying out an appraisal, a line manager would be able to advise a staff member of any forthcoming promotion opportunities. The Chief Executive explained that PHA has a commitment to fair employment so it follows strict parameters. However, he noted that PHA is one part of a wider HSC system so there are opportunities. Mr Murray said that it is important that PHA is valued equally among HSC organisations as he did not feel that this is currently the case.
17/24	**Item 8 – Any Other Business**
17/24.1	There was no other business.

18/24 **Item 9 – Details of Next Meeting**

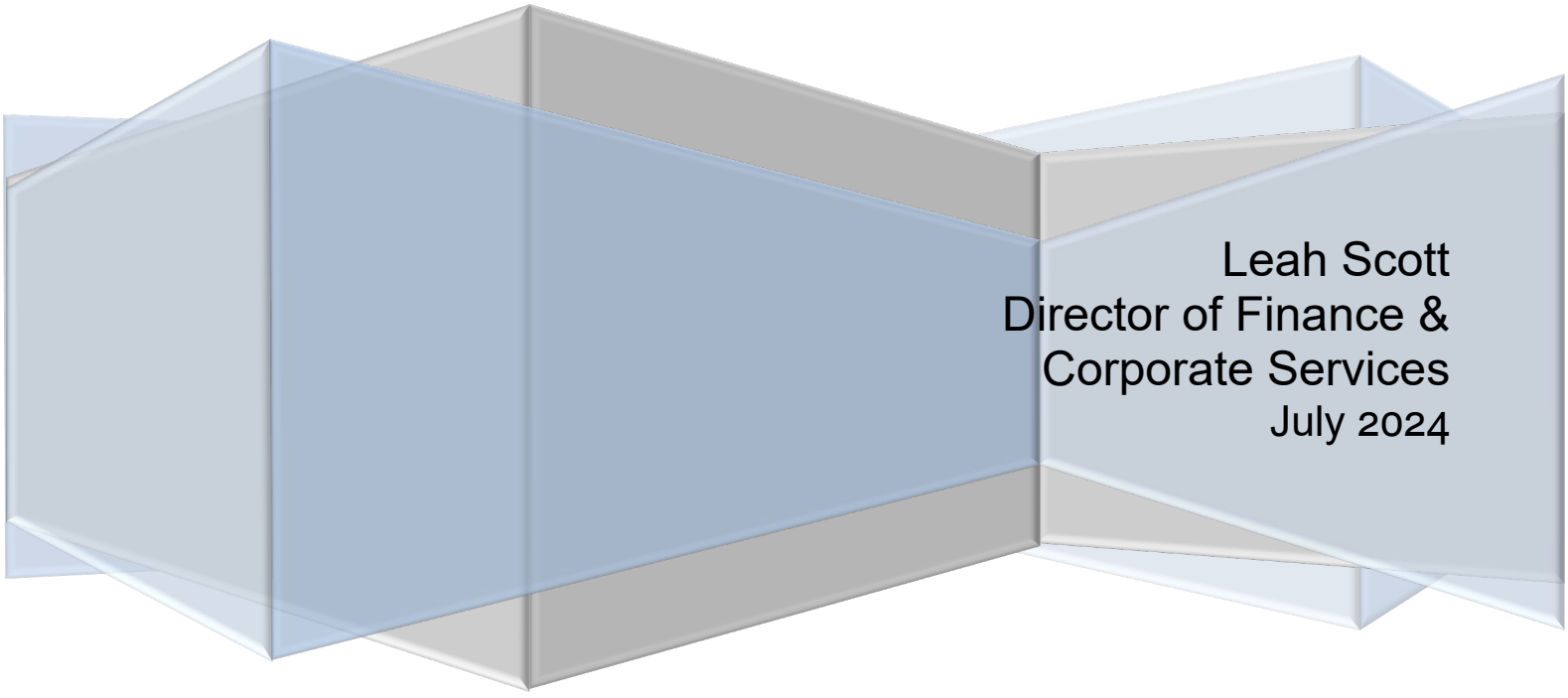
To be agreed

Signed by Chair:

Date: 19 August 2024

HSC Public Health Agency

Finance Report
June 2024



Leah Scott
Director of Finance &
Corporate Services
July 2024

Section A: Introduction/Background

1. The PHA Financial Plan for 2024/25 has set out the funds notified as available, risks and uncertainties for the financial year and summarised the opening budgets against the high-level reporting areas. It also outlined how the PHA would manage the overall funding available, in the context of cash releasing savings targets applied to the organisation. It received formal approval by the PHA Board in the June 2024 meeting.

2. The Financial Plan identified a number of areas of projected slippage and how this was to be used to address in-year pressures and priorities.

3. This executive summary report reflects the draft year-end position as at the end of June 2024 (month 3). Supplementary detail is provided in Annex A.

Section B: Update – Revenue position

4. The PHA has reported a year to date surplus at June 2024 of £0.2m (month 2, £0.2m) against the annual budget position for 2024/25.

5. In respect of the year to date surplus of £0.2m:

    - The annual budget for programme expenditure to Trusts of £45.1m has been profiled evenly for allocation, with £11.3m expenditure reflected as at month 3 and a nil variance to budget shown.
    - The remaining annual programme budget is £52.2m. This has reduced from £55.7m reported last month, a movement of £3.5m due to a £3.2m retraction in R&D, £1m funding reduction offset by an increase of £0.7m for National living wage and inflation. Programme expenditure of £8.7m has been recorded for the first three months of the financial year with an overspend of £0.2m reported. This budget is currently anticipated to achieve planned overspend of £0.8m by the end of the financial year which will be used to absorb the anticipated underspend in Administration budgets outlined below. Budget holders are required to continually keep all programme budgets under close review and report any expected slippage or pressures at an early stage.

- A year-to-date underspend of £0.3m is reported in the area of Management & Administration, primarily in the areas of Public Health and Operations, which reflects a high level of vacant posts in each area. The year-end underspend is expected to be approximately £0.8m.
- Most ringfenced funding has been mainstreamed in 2024/25, including all Transformation and Safe Staffing funding, leaving only the NI Protocol funding (£0.156m) as ringfenced and assumed ringfenced funding for COVID (£0.025m) and SBNI (£0.316m). A small variance is reported on this budget to date, however a breakeven position is forecast for the full year.

6. The month 3 position is summarised in the table below.

Table 2: PHA Summary financial position - June 24

	Annual Budget £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Variance £'000	Projected year end surplus / (deficit) £'000
Health Improvement	13,339	3,335	3,335	0	
Health Protection	8,672	2,168	2,168	0	
Service Development & Screening	15,370	3,843	3,843	0	
Nursing & AHP	7,674	1,919	1,919	0	
Centre for Connected Health	0	0	0	0	
Quality Improvement	25	6	6	0	
Other	0	0	0	0	
Programme expenditure - Trusts	**45,081**	**11,270**	**11,270**	**0**	**0**
Health Improvement	31,631	5,879	5,986	(106)	
Health Protection	16,116	2,065	2,092	(27)	
Service Development & Screening	3,217	293	294	(0)	
Research & Development	52	0	0	0	
Campaigns	662	157	230	(73)	
Nursing & AHP	444	125	50	76	
Quality Improvement	18	5	28	(24)	
Other	55	0	(3)	3	
Programme expenditure - PHA	**52,195**	**8,525**	**8,676**	**(151)**	**(770)**
Subtotal Programme expenditure	**97,276**	**19,795**	**19,946**	**(151)**	**(770)**
Public Health	17,589	4,390	4,170	220	
Nursing & AHP	6,269	1,563	1,384	179	
Operations	6,126	1,481	1,339	142	
Quality Improvement	755	188	186	3	
PHA Board	(189)	(304)	45	(349)	
Centre for Connected Health	458	112	61	51	
SBNI	883	216	185	31	
Subtotal Management & Admin	**31,891**	**7,646**	**7,369**	**276**	**770**
Trusts	0	0	0	0	
PHA Direct	0	0	0	0	
Subtotal Transformation	**0**	**0**	**0**	**0**	**0**
Trusts	0	0	0	0	
PHA Direct	497	137	99	37	
Other ringfenced	**497**	**137**	**99**	**37**	**0**
TOTAL	**129,664**	**27,578**	**27,416**	**162**	**0**

Note: Table may be subject to minor roundings.

7. As noted above, the projected year end position is breakeven (month 2, breakeven) and work will continue to identify measures to maintain this breakeven position.

Section C: Risks

8. The following significant assumptions, risks or uncertainties facing the organisation were outlined in the Financial Plan.

9. **Balance of savings still to be identified recurrently**: The 2023/24 opening allocation letter applied a £5.3m recurrent savings target to the PHA budget. While PHA has identified a recurrent source for £4.1m of the £5.3m savings target, there remain challenges in delivering the full requirement recurrently. The balance of £1.2m will be achieved non-recurrently from slippage on Administration budgets in 2024/25, as set out in the Financial Plan approved in June 2024 by PHA Board. Savings targets will continue to be monitored throughout the year with the identification of further recurrent savings plans finalised for 2024/25.

10. **EY Reshape & Refresh review and Management and Administration budgets**: The PHA is currently undergoing a significant review of its structures and processes, and the final proposed structure will not be available until later in the year. There is a risk in implementing the outcomes of this review in a savings context, and careful management will be required at all stages of this process.

11. **SEUPB / CHITIN income**: PHA receives income from EU partner organisations for the CHITIN R&D project. Claims are made on a quarterly basis, however PHA have experienced delays in receiving payment for claims. At 31 March 2024, the value of funding due was c£1.7m however, PHA had an equal and opposite creditor listed for monies due to other organisations. R&D staff are continuing to work closely with colleagues in partner organisations and the relevant funding body to ensure the expected full reimbursement of all claims.

12. **Demand led services:** There are a number of demand-led budgetary areas which are more difficult to predict funding requirements for, presenting challenges for the

financial management of the Agency's budget. For example, smoking cessation / Nicotine Replacement Therapy (NRT) and Vaccines. The financial position of these budgets are being carefully tracked.

13. **Funding not yet allocated**: At the start of the financial year there are a number of areas where funding is anticipated but has not yet been released to the PHA. These include Shingles vaccination funding (approx. £2.7m) and Pay awards for the 2024/25 financial year. No expenditure will be progressed for in these areas until allocations are approved and issued by DoH.

14. Due to the complex nature of Health & Social Care, there will undoubtedly be further challenges with financial impacts which will be presented going forward into the future. PHA will continue to monitor and manage these with DoH and Trust colleagues on an ongoing basis.

Section D: Update - Capital position

15. The PHA has a capital allocation (CRL) of £13.9m. This all relates to projects managed through the Research & Development (R&D) team. The overall summary position, as at June 2024, is reflected in **Table 3**, being a forecast breakeven position on capital funding.

16. R&D expenditure is managed through the R&D Division within PHA, and funds essential infrastructure for research such as information databanks, tissue banks, clinical research facilities, clinical trials units and research networks. The element relating to 'Trusts' is allocated throughout the financial year, and the allocation for 'Other Bodies' is used predominantly within universities – both allocations fund agreed projects that enable and support clinical and academic researchers.

17. CHITIN (Cross-border Healthcare Intervention Trials in Ireland Network) is a unique cross-border partnership between the Public Health Agency in Northern Ireland and the Health Research Board in the Republic of Ireland, to develop infrastructure and deliver Healthcare Intervention Trials (HITs). The CHITIN project is funded from the EU's INTERREG VA programme, and the funding for each financial year from the

Special EU Programmes Body (SEUPB) matches expenditure claims, ensuring a breakeven position. Activity on the CHITIN project has now ended, therefore no funding is shown in Table 3 below, however a number of claims remain outstanding and the R&D team continue to actively engage with SEUPB to ensure these are paid in full. Further information on delays experienced in the reimbursement of costs is provided in Section C, above.

Table 3: PHA Summary capital position – June 2024

Capital Summary	Total CRL £'000	Year to date spend £'000	Full year forecast £'000	Forecast Surplus / (Deficit) £'000
HSC R&D:				
R&D - Health ALBs	443	0	443	0
R&D - Trusts	7,453	0	7,453	0
R&D Other Bodies	4,336	586	4,336	0
R&D - Capital Receipts	(231)	0	(231)	0
Subtotal HSC R&D	**12,000**	**586**	**12,000**	**0**
CHITIN Project:				
CHITIN - Other Bodies	0	0	0	0
CHITIN - Trusts	0	0	0	0
CHITIN - Capital Receipts	0	0	0	0
Subtotal CHITIN	**0**	**0**	**0**	**0**
Other:				
Congenital Heart Disease Network	706	0	706	0
iReach Project	409	0	409	0
R&D - NICOLA	778	0	778	0
Subtotal Other	**1,893**	**0**	**1,893**	**0**
Total PHA Capital position	**13,893**	**586**	**13,893**	**0**

18. PHA has also received three other smaller capital allocations for the Congenital Heart Disease (CHD) Network (£0.7m), iReach Project (£0.4m) and NICOLA (£0.8m), all of which are managed through the PHA R&D team.

19. The capital position will continue to be kept under close review throughout the financial year.

Recommendation

20. The PHA Board are asked to note the PHA financial update as at June 2024.

Public Health Agency

Annex A - Finance Report

2024/25

Month 3 - June 2024

PHA Financial Report - Executive Summary

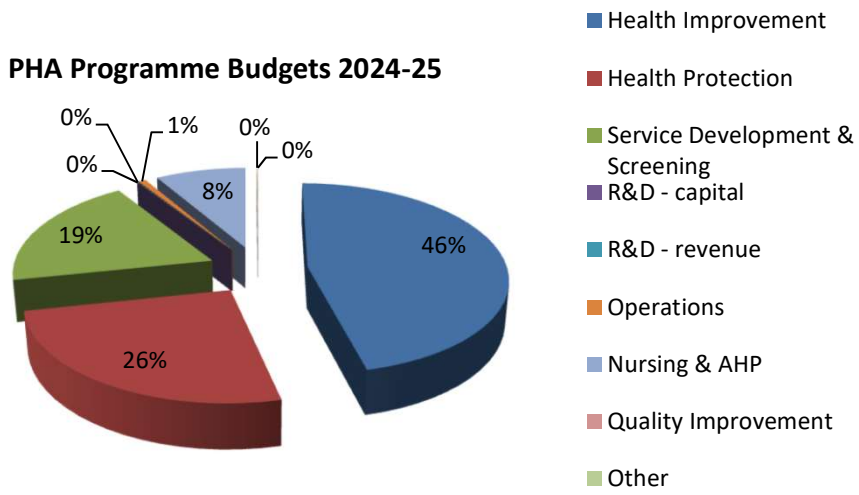
Year to Date Financial Position (page 2)

At the end of month 3, PHA is reporting an underspend of £0.2m against its profiled budget. This position is primarily a result of underspends within Adminstration budgets (page 6).

Budget managers continue to be encouraged to closely review their profiles and financial positions to ensure the PHA meets its breakeven obligations at year-end.

Programme Budgets (pages 3&4)

The chart below illustrates how the Programme budget is broken down across the main areas of expenditure.

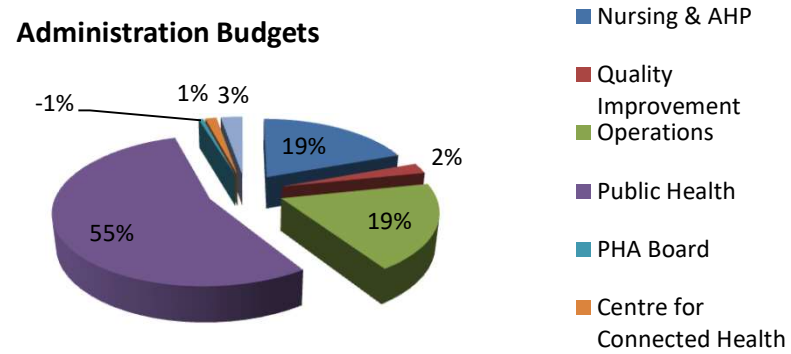


Administration Budgets (page 5)

The breakdown of the Administration budget by Directorate is shown in the chart below. Over half of the budget relates to the Directorate of Public Health.

A number of vacant posts remain within PHA, and this is creating slippage on the Administration budget which is offset by expenditure on the PHA Reshape and Refresh programme and other pressures noted in the Financial Plan.

Management will review the need for the recruitment of vacant posts to ensure business needs continue to be met.



Full Year Forecast Position & Risks (page 2)

PHA is currently forecasting a breakeven position for the full year.

Of the £5.3m savings target applied to PHA in 2023/24, £4.1m has been identified recurrently, and a balance of £1.2m is expected to be achieved non-recurrently in 2024/25 while a recurrent source is identified.

Public Health Agency
2024/25 Summary Position - June 2024

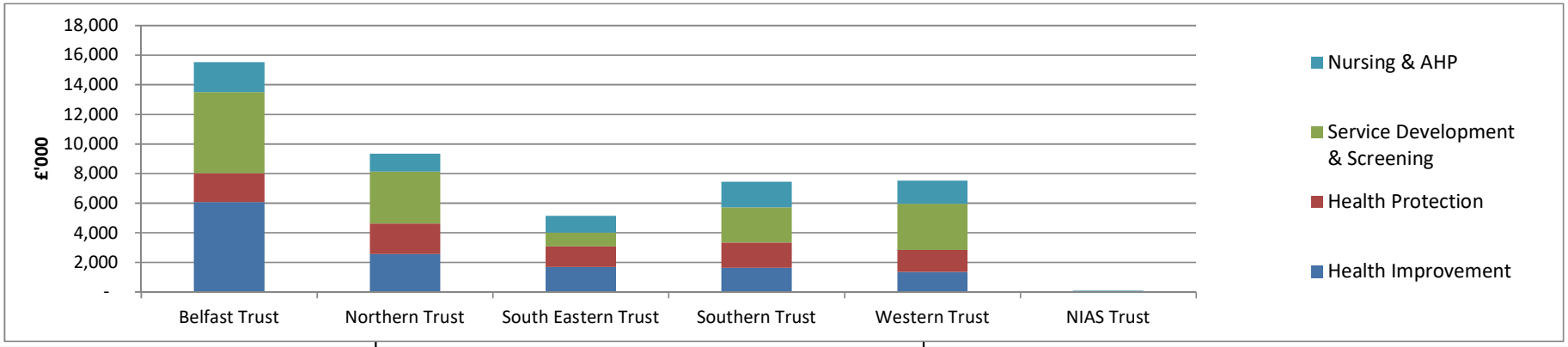
	Annual Budget					Year to Date				
	Programme		Ringfenced	Mgt &	Total	Programme		Ringfenced	Mgt &	Total
	Trust	PHA Direct	Trust & Direct	Admin		Trust	PHA Direct	Trust & Direct	Admin	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources										
Departmental Revenue Allocation	45,081	52,191	497	31,257	**129,026**	11,270	8,520	137	7,442	**27,370**
Assumed Retraction	-	-	-	-	**-**	-	-	-	-	**-**
Revenue Income from Other Sources	-	4	-	633	**637**	-	4	-	204	**208**
Total Available Resources	45,081	52,195	497	31,891	**129,664**	11,270	8,525	137	7,647	**27,578**
Expenditure										
Trusts	45,081	-	-	-	**45,081**	11,270	-	-	-	**11,270**
PHA Direct Programme *	-	52,965	497	-	**53,463**	-	8,676	99	-	**8,775**
PHA Administration	-	-	-	31,121	**31,121**	-	-		7,369	**7,369**
Total Proposed Budgets	45,081	52,965	497	31,121	**129,664**	11,270	8,676	99	7,369	**27,416**
Surplus/(Deficit) - Revenue	-	(770)	-	770	-	-	(151)	37	276	**162**
Cumulative variance (%)						***0.00%***	***-1.78%***	***27.29%***	***3.61%***	***0.59%***

Please note that a number of minor rounding's may appear throughout this report.
** PHA Direct Programme may include amounts which transfer to Trusts later in the year*

The year to date financial position for the PHA shows an underspend £0.2m, which is a result of an underspend on Management & Admin budgets being partially offset by a managed overspend on PHA Direct Programme expenditure.

The PHA is forecasting a breakeven position at year end, which includes the full absorption of the projected Management & Admin underspend.

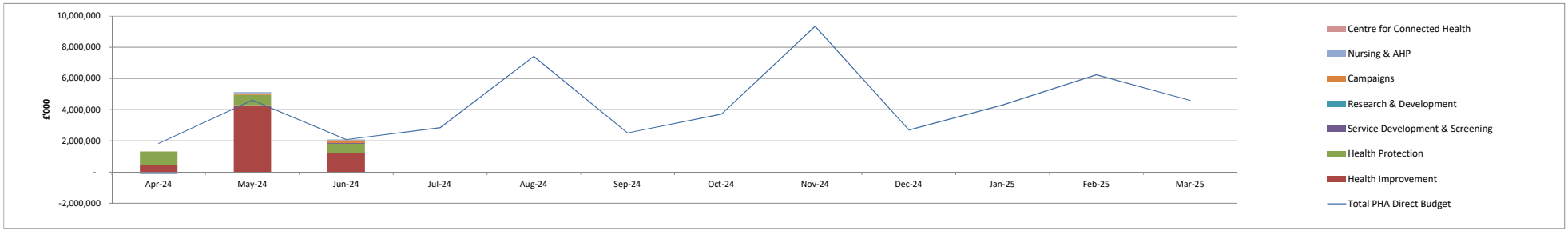
Programme Expenditure with Trusts



Current Trust RRLs	Belfast Trust	Northern Trust	South Eastern Trust	Southern Trust	Western Trust	NIAS Trust	Total Planned Expenditure	YTD Budget	YTD Expenditure	YTD Surplus / (Deficit)
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Health Improvement	6,073	2,575	1,689	1,638	1,364	-	**13,339**	3,335	3,335	-
Health Protection	1,955	2,059	1,390	1,714	1,483	70	**8,672**	2,168	2,168	-
Service Development & Screening	5,491	3,487	924	2,367	3,102	-	**15,370**	3,843	3,843	-
Nursing & AHP	1,999	1,218	1,141	1,716	1,570	30	**7,674**	1,919	1,919	-
Quality Improvement	25	-	-	-	-	-	**25**	6	6	-
Total current RRLs	**15,544**	**9,339**	**5,145**	**7,435**	**7,519**	**100**	**45,081**	**11,270**	**11,270**	-
Cumulative variance (%)										***0.00%***

The above table shows the current Trust allocations split by budget area. Budgets have been realigned in the current month and therefore a breakeven position is shown for the year to date.

PHA Direct Programme Expenditure



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total	YTD Budget	YTD Spend	Variance	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
Profiled Budget																	
Health Improvement	1,593	3,013	1,273	1,824	3,376	1,007	3,058	3,024	1,885	3,446	5,015	3,116	**31,631**	5,879	5,986	(106)	*-1.8%*
Health Protection	182	1,429	453	442	3,826	1,225	363	6,099	346	515	801	435	**16,116**	2,065	2,092	(27)	*-1.3%*
Service Development & Screening	0	150	143	452	138	209	247	179	371	284	287	756	**3,217**	293	294	(0)	*-0.1%*
Research & Development	-	-	-	-	-	-	-	-	-	-	52	-	**52**	-	-	-	*0.0%*
Campaigns	-	3	155	122	53	22	34	45	46	25	15	144	**662**	157	230	(73)	*-46.4%*
Nursing & AHP	59	11	55	0	0	47	7	1	54	0	70	140	**444**	125	50	76	*60.3%*
Centre for Connected Health	-	-	-	-	-	-	-	-	0	-	-	-	**-**	-	-	0	*0.0%*
Quality Improvement	2	2	2	2	2	2	2	2	2	2	2	2	**18**	5	28	(24)	*-520.7%*
Other	-	-	0	-	17	0	6	0	0	32	0	0	**55**	-	(3)	3	*100.0%*
Total PHA Direct Budget	**1,836**	**4,609**	**2,080**	**2,842**	**7,412**	**2,511**	**3,717**	**9,348**	**2,705**	**4,304**	**6,240**	**4,592**	**52,195**	**8,525**	**8,676**	**(151)**	
Cumulative variance (%)																***-1.78%***	
Actual Expenditure	**1,143**	**5,313**	**2,220**										**8,676**				
Variance	**693**	**(704)**	**(140)**										**(151)**				

The year-to-date position shows an overspend of approximately £0.2m against profile. A year-end overspend of c£0.8m is anticipated, and this is being managed closely in order to offset a forecast underspend in Administration budgets.

Whilst £4.1m of £5.3m savings target applied to PHA in 2023/24 has been achieved, the remaining £1.2m has been identified non-recurrently from Management & Administration budgets while a recurrent solution is identified.

Public Health Agency
2024/25 Ringfenced Position

	Annual Budget				Year to Date			
	Covid	NDNA	Other ringfenced	Total	Covid	NDNA	Other ringfenced	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources								
DoH Allocation	-	-	156	**156**	25	-	112	**137**
Assumed Allocation/(Retraction)	25	-	317	341	-	-	-	**-**
Total	25	-	473	**497**	25	-	112	**137**
Expenditure								
Trusts	-		-	**-**	-	-	-	**-**
PHA Direct	25	-	473	**497**	25	-	75	**99**
Total	25	-	473	**497**	25	-	75	**99**
Surplus/(Deficit)	**-**	**-**	**-**	**-**	**(0)**	**-**	**37**	**37**

PHA is assuming a small COVID allocation for the 2024/25 financial year relating to sessional vaccinators, and the Suicide Prevention funding formerly funded from NDNA budgets has been mainstreamed in 24/25.

Other ringfenced relates to NI Protocol funding and Fresh Start funding for SBNI. A breakeven position is expected on these budgets for the year.

PHA Administration

2024/25 Directorate Budgets

	Nursing & AHP £'000	Quality Improvement £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Annual Budget								
Salaries	6,057	742	4,780	17,343	875	408	616	**30,822**
Goods & Services	211	13	1,346	246	(1,063)	50	267	**1,069**
Total Budget	**6,269**	**755**	**6,126**	**17,589**	**(189)**	**458**	**883**	**31,891**
Budget profiled to date								
Salaries	1,514	186	1,195	4,334	86	102	154	**7,570**
Goods & Services	49	3	286	56	(390)	10	62	**76**
Total	**1,563**	**188**	**1,481**	**4,390**	**(304)**	**112**	**216**	**7,646**
Actual expenditure to date								
Salaries	1,337	182	973	4,039	42	62	143	**6,778**
Goods & Services	47	3	366	131	3	- 1	42	**591**
Total	**1,384**	**186**	**1,339**	**4,170**	**45**	**61**	**185**	**7,369**
Surplus/(Deficit) to date								
Salaries	177	3	222	295	44	40	11	**791**
Goods & Services	3	(0)	(80)	(75)	(393)	11	20	**(515)**
Surplus/(Deficit)	**179**	**3**	**142**	**220**	**(349)**	**51**	**31**	**276**
Cumulative variance (%)	*11.47%*	*1.49%*	*9.58%*	*5.00%*	*114.83%*	*45.55%*	*14.39%*	***3.61%***

PHA's administration budget is showing a year-to-date surplus of £0.3m, which is being generated by a number of vacancies, particularly within the Public Health and Nursing and AHP Directorates. Senior management continue to monitor the position closely in the context of the PHA's obligation to achieve a breakeven position for the financial year.

The full year surplus is currently forecast to be c£0.8m, and this is being managed by PHA through a managed deficit in Programme expenditure in the financial year.

Whilst £4.1m of £5.3m savings target applied to PHA in 2023/24 has been achieved, the remaining £1.2m has been identified non-recurrently from Management & Administration budgets while a recurrent solution is identified.

PHA Prompt Payment

Prompt Payment Statistics

	June 2024 Value	June 2024 Volume	Cumulative position as at June 2024 Value	Cumulative position as at June 2024 Volume
Total bills paid (relating to Prompt Payment target)	£3,102,546	535	£22,271,837	1,668
Total bills paid on time (within 30 days or under other agreed terms)	£3,002,398	530	£21,579,975	1,602
Percentage of bills paid on time	**96.8%**	**99.1%**	**96.9%**	**96.0%**

Prompt Payment performance for June shows that PHA achieved its target on value and volume. The year to date position shows that the PHA is achieving its target of 95% on value and volume. Prompt payment targets will continue to be monitored closely over the 2024/25 financial year.

The 10 day prompt payment performance remains very strong at 91.2% on volume for the year to date, which exceeds the 10 day DoH target for 2024/25 of 70%.

HSC Public Health Agency

item 10

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	28 August 2024
Title of paper	Performance Management Report
Reference	PHA/05/08/24
Prepared by	Stephen Murray / Rossa Keegan
Lead Director	Leah Scott

Recommendation For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to provide the PHA Board with a report on progress against the objectives set out in the PHA Annual Business Plan 2024/25.

2 Key Issues

This Report provides a summary of progress made, as at end of June 2024, on achieving the actions set out in the PHA Annual Business Plan 2024/25 (attached for ease of reference).

Of the 33 actions, 3 are currently rated Blue (Action completed). 25 are currently rated Green, 3 are currently rated Amber, 2 are currently rated Red

This summary report provides the BRAG status for each action, with further details provided on those actions currently rated Amber or Red.

A copy of the full performance report is embedded into the summary document, if further detail is required on those action rated as blue or green.

Attached as an addendum to the report is an update report on those actions that were not fully implemented from the ABP 2023/24. An update on progress made in delivering against these actions is provided and, where appropriate, a proposed approach suggested for continuing to ensure progress is monitored and reported on through established accountability structures in place.

The Performance Management Report was approved by the Agency Management Team at its meeting on 7 August 2024, and was considered by the Planning, Performance and Resources Committee at its meeting on 19 August 2024.

3 Next Steps

The next quarterly Performance Management Report update will be brought to the Board in November 2024.

HSC Public Health Agency

PERFORMANCE MANAGEMENT REPORT

Monitoring of KPIs Identified in

The Annual Business Plan 2024 – 2025

As at 30 June 2024

HSC Public Health Agency

This report provides an update on achievement of the actions in the PHA Annual Business Plan 2024-25.

The updates on progress toward achievement of the actions were provided by the Lead Officers responsible for each action.

There are a total of 33 actions across 5 Key Priorities in the Annual Business Plan. Each action has been given a BRAG status as follows:

BRAG Status:

	Action completed.
	Action on track for completion by target date.
	Significant risk of Action being delayed after target date.
	Critical risk of Action being significantly delayed/unable to be completed.

Of the 33 actions, 25 are currently rated Green, 3 are currently rated Amber, 2 are currently rated Red and 3 currently rated Blue.

This report will provide the BRAG status for each action with further details on those actions currently rated Amber or Red.

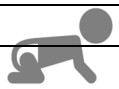
HSC Public Health Agency

Protecting Health

		Target
KPI 1	Provision of BBV screening through low threshold and inclusion services	Mar 25
KPI 2	Development of Northern Ireland One Health AMR Action Plan	Mar 25
KPI 3	Development of Surveillance Report & Risk Assessment	Mar 25
KPI 4	Outbreak Detection through statistical exceedance reporting	Oct 24
KPI 5	Appraisal of Flu Vaccination delivery programme	Mar 25

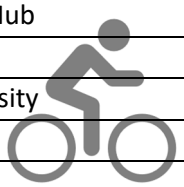
Starting Well

KPI 6	Pertussis & MMR Vaccination uptake rates	Mar 25
KPI 7	Replace and strengthen the existing Child Health System	Mar 25
KPI 8	Review unmet need and risk factors associated with Social Complexity in Pregnancy	Dec 24



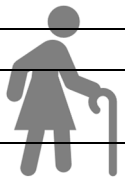
Living Well

KPI 9	Develop Health Inequalities Framework	Dec 24
KPI 10	Discovery exercise for the development of a NI Mental Health Hub	Sep 24
KPI 11	Commissioning – Alcohol and Drugs	Apr 25
KPI 12	Implementation phase 1 – 3 of a Whole Systems Approach Obesity	Mar 25
KPI 13	Reduce Smoking Prevalence across NI	Mar 25
KPI 14	Develop a Cancer Prevention Action Plan	Dec 24
KPI 15	Action plan to address Inequalities in participation in Screening Programmes	Mar 25



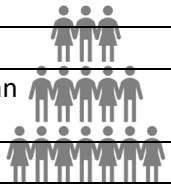
Aging Well

KPI 16	A new regionally agreed, evidence based Safer Mobility Model across NI completed	Mar 25
KPI 17	Care Homes Fall Pathway Initiative	Mar 25
KPI 18a	Level 1-3 Education and Training Tools for Advanced Care Planning Programme in place	Dec 24
KPI 18b	Implementation structures for the RESPECT programme in place	Dec 24
KPI 19	5% increase in uptake rate in Seasonal Flu Vaccination programme for Care Home Staff	Mar 25



Our Organisation and People

KPI 20	New PHA Corporate Plan developed	Mar 25
KPI 21	PHA Operational Structures/Operating Model implemented	Mar 25
KPI 22	Revised Business Continuity Plan developed	Dec 24
KPI 23	PHA procurements to be progressed in line with the agreed Procurement Plan for 2024/25	Mar 25
KPI 24	New Partnership Agreement in place with DoH	Dec 24
KPI 25	PHA Digital and Data Strategy approved and Implementation Plan developed	Sep 24
KPI 26	PHA Skills and Development Framework approved	Sep 24
KPI 27	Launch of new PHA People Plan	Jun 24
KPI 28	PHA R&D Office set up and Strategy issued for consultation	Mar 25
KPI 29	PHA Membership of each AIPB	Jan 25
KPI 30	PHA will achieve financial breakeven	Mar 25
KPI 31	Approach to Health Inequalities- Training delivered to all staff	Mar 25
KPI 32	PHA in membership / co-leading new SPPG/PHA commissioning teams	Sep 24



HSC Public Health Agency

As at end of June 2024 there were 5 KPIs identified with an Amber or Red BRAG status. Further details of these KPIs below.

For details on all the actions please click on the file here -> ABP Monitoring Template 24.25 V1.3

KPI	Description	Progress	Jun	Sep	Dec	Mar	Lead Director
KPI 12	Implementation phase 1 – 3 of a Whole Systems Approach Obesity in line with PHE/Leeds Beckett University methodology across early adopter sites, with 2 or 3 completed by March 2025	6 of 11 Councils have agreed to collaborate with PHA on developing and implementing a Whole System Approach (WSA) to Obesity within their Council areas. 2 Councils in ANDBC & BCC have successfully started the process embedding the WSA to Obesity within their community planning structures progressing through to phase 2 of the 6 phase approach and building a compelling narrative explaining why obesity matters locally and creating a shared understanding of how obesity is addressed at a local level, with both Councils soon to start phase 3. A 3rd Council in Derry & Strabane have started the process and are currently in phase 1 and agreeing the local governance and resource structures with 2 additional Councils due to start in September 2024 and January 2025.					Joanne McClean David Tumilty
	Further details if Amber/Red (Timescales, mitigating actions etc.)	Staff sickness and the need for external expertise to assist the process has caused some delays, both Ards & North Down and Belfast are likely be within phase 5 by March 2025.					

KPI	Description	Progress	Jun	Sep	Dec	Mar	Lead Director
		The new HI regional obesity team and PH registrars can offer additional staff capacity to the process. We are also procuring external expertise to assist with systems mapping and workshop planning and delivery for phases 3 & 4 with 2 sites in Belfast & Ards & North Down.					
KPI 18a	Level 1-3 Education and Training Tools for Advanced Care Planning Programme will be in place and quality assured by December 2024	This action cannot sit outside wider implementation of ACP. On request from the DoH, an options proposal has been submitted to outline resource required to progress this work.					Heather Reid Sandra Aitcheson / Sally Convery
	Further details if Amber/Red (Timescales, mitigating actions etc.)	Discussed at PHA /DoH ground clearing mtg. PHA Board updated. Currently awaiting a formal response from the DOH. Key stakeholders have been informed of position. Consider pausing the monitoring of actions 18a and b until further information available form DoH.					
KPI 18b	Implementation structures for the RESPECT programme will be in place and implementation underway including public messaging by December 2024	As above per 18a					All Directors Heather Reid
	Further details if Amber/Red (Timescales, mitigating actions etc.)	As above per 18a					
KPI 23	PHA procurements to be progressed in line with the agreed Procurement Plan for 2024/25 by March 2025 - (quarterly updates provided June/September/December)	Planned Tenders under Phase 1 of Drug and Alcohol, relating to Adult Step 2 services and Workforce Development are progressing and remain on track for completion by March 2025. The SHIP tender is currently being evaluated and remains on track to have new contracts in place by October 2024. The Shared Reader tender was completed on time but had to be stood down due to TUPE issues that came to light post evaluation of tenders received. New timelines have been set to					Leah Scott Stephen Murray

KPI	Description	Progress	Jun	Sep	Dec	Mar	Lead Director
		re-run the tender. The Raising Awareness and Promoting Informed Choice for Cancer Screening re-tender has been postponed to allow a wider review of the service to be completed. Planned tenders for Workplace health and The Elevate programme will not be completed within the planned timelines. This has been due to key staff having been off on significant periods of staff absence and also staff involved in these tenders now having to re-prioritise their time to take forward the Ministers 'Live better' Initiative					
	Further details if Amber/Red (Timescales, mitigating actions etc.)	• **Raise Awareness of Cancer Screening** – The existing contract with the provider has been extended using a DAC for a further year to 31 March 2025, to allow time for the review to be completed and a new model of service agreed that will most effectively help address inequalities across all screening programmes. • **Workplace Health** – It is likely that a DAC will be required to ensure the Service can continue until a new contract is in place. Revised timelines to be considered by DPH and agreed by Procurement Board in August. • **Elevate** – It is likely that the DAC currently in place will need to be extended to ensure the Service will continue until a new contract is in place. Revised timelines to be considered by DPH and agreed by procurement Board in August.					
KPI 25	PHA Digital and Data Strategy approved by Board and Implementation Plan developed by September 2024	A draft Strategy has been developed on data and digital. However, in moving this forward it has become obvious this needs to be further developed to include surveillance and intelligence. It will take longer now to complete this work.					CEO
	Further details if Amber/Red (Timescales, mitigating actions etc.)	We have established a workstream under the Refresh and Reshape programme to take this work forward. We have engaged EY (who facilitated R&R) to help us develop an agreed approach and consensus across the Agency on the way forward. We are drafting a job description for an Interim Director in this area.					

HSC Public Health Agency

Addendum 1

Roll-Forward Actions from 2023/24 PHA Annual Business Plan

<table>
<tr><th>Item</th><th>Description</th><th>Current Status</th><th>Proposed Approach for Future Monitoring.</th><th>Lead Director</th></tr>
<tr><td>1a</td><td>Vaccination

By December 2023, increase by 1% the uptake rates for pre-school immunisation (based on December 2022 position).</td><td>
<table>
<tr><th>COVER statistics</th><th>Q3 Oct-Dec 22 (%)</th><th>Q4 Jan-Mar 23 (%)</th><th>Q1 Apr-Jun 23 (%)</th><th>Q2 Jul-Sep 23 (%)</th><th>Q3 Oct-Dec 23 (%)</th><th>Q4 Jan-Mar 24 (%)</th><th>Diff %</th></tr>
<tr><td colspan="8">12 months</td></tr>
<tr><td>DTaP/IPV/Hib/HepB</td><td>92.5</td><td>92.4</td><td>91.6</td><td>92.5</td><td>92.0</td><td>91.0</td><td>-1.5</td></tr>
<tr><td>PCV</td><td>94.6</td><td>94.6</td><td>94</td><td>94.6</td><td>94.6</td><td>94.1</td><td>-0.5</td></tr>
<tr><td>Rotavirus</td><td>88.8</td><td>89.7</td><td>89.4</td><td>89.1</td><td>89.4</td><td>88.6</td><td>-0.2</td></tr>
<tr><td>MenB</td><td>92.8</td><td>92.6</td><td>91.7</td><td>92.4</td><td>91.9</td><td>91.2</td><td>-1.6</td></tr>
<tr><td colspan="8">24 months</td></tr>
<tr><td>DTaP/IPV/Hib/HepB</td><td>94.4</td><td>94.0</td><td>93.8</td><td>93.1</td><td>93.7</td><td>93.6</td><td>-0.8</td></tr>
<tr><td>MMR1</td><td>89.5</td><td>89.4</td><td>89.3</td><td>88.8</td><td>89.5</td><td>89.3</td><td>-0.2</td></tr>
<tr><td>PCV booster</td><td>90.2</td><td>91.8</td><td>89.8</td><td>89.1</td><td>89.7</td><td>89.4</td><td>-0.8</td></tr>
<tr><td>Hib/Men C</td><td>89.8</td><td>89.8</td><td>89.8</td><td>89</td><td>89.7</td><td>89.4</td><td>-0.4</td></tr>
<tr><td></td><td>89.0</td><td>89.2</td><td>88.6</td><td>88.1</td><td>88.7</td><td>88.3</td><td>-0.7</td></tr>
</table>
</td><td>Uptake rates will continue to be monitored through the Vaccine Management Board and updates on annual performance against all vaccine programmes reported to PHA Board.</td><td>Joanne McClean</td></tr>
</table>

Item	Description	Current Status	Proposed Approach for Future Monitoring.	Lead Director
		5 years DTaP/IPV/Hib/HepB: 94.0 / 93.6 / 94.4 / 94.4 / 94.7 / 94.8 / 0.8 DTaP/IPV/Hib/HepB (booster): 87.9 / 86.9 / 86.1 / 85.9 / 86.7 / 86.2 / -1.7 MMR1: 93.9 / 93.5 / 93.5 / 93.6 / 93.6 / 93.3 / -0.6 MMR2: 87.5 / 86.4 / 85.6 / 85.4 / 86.4 / 85.6 / -1.9 Hib/Men C booster: 93.3 / 92.9 / 93 / 93.1 / 93.0 / 92.4 / -0.9		
3c	Mental Health / Suicide prevention Draft PHA Mental Health, Emotional Wellbeing and Suicide Prevention commissioning framework developed by March 2024.	The Strategic Planning Team for MH & SP is currently reviewing commissioning priorities for key areas of service, in line with agreed procurement timelines. A PID has been developed and approved by the Procurement Board and a 3 year procurement plan in now in place. Protect Life 2, is currently being reviewed by the DoH which is likely to change some priorities which will need to be included in any future commissioning plans.	Progress will be kept under review by the Procurement Board and updates reported via PPR Committee	Joanne McClean
3e	Cancer Prevention Mutli- disciplinary working group to be established by May 2023 to develop an action plan for addressing primary and secondary cancer prevention in line with the 2022 cancer strategy by March 2024	Key PHA staff have collaborated and inputted to a DPH-led return to the Department of Health to report against the Regional Cancer Strategy, on behalf of the PHA (November 2023). There are a range of staff across the organisation working on this remit and formation of a structured MD Working Group will be taken forward in 2024/25 in line with the development of the Action Plan.	A Multi-disciplinary group to take forward the Action Plan will be established. CE will seek confirmation of progress via	Joanne McClean

Item	Description	Current Status	Proposed Approach for Future Monitoring.	Lead Director
			Director Accountability meeting	
4c	Health Protection Response All standard operating procedures for acute response to be reviewed and updated by March 2024.	All SOP's have now been reviewed and updated where required. The review of SOP's is a continuous process to ensure changes in local and national guidelines are adopted.	Action Closed	Joanne McClean
6c	Ensure PHA priorities relating to health protection, prevention and early intervention are reflected in draft AIPB plans	PHA Health Improvement Heads have attended DOH led Induction Workshop and process and timescale for Autumn 2024 convening of AIPB's (Southern, Belfast and SE (September 24) followed by Belfast and Northern (November 24). PHA will have key role in informing health protection, prevention and early intervention focussed initial draft Action Plans. PHA AIPB planning meetings ongoing to ensure preparations on required inputs e.g. population health profiles and related data.	PHA will be a strategic partner on each AIPB and will ensure that PHA priorities are reflected in any future plans developed. Board will be updated on AIPB priorities as plans are developed.	Joanne McClean Stephen Wilson
8e	Hybrid working pilot scheme to be fully implemented with evaluation undertaken which will feed into any future arrangements by March 2024	March – April 2024, through an online staff survey which attracted a 66% response rate and supplemented by staff focus group sessions which were attended by 17.6% of all staff (*who may or may not have submitted an online survey*). The Evaluation report was presented to AMT on 26th June 2024. Following on from AMT a next steps action plan is currently being devised with a view to having; • Communication to the organisation developed and agreed	Staff have been notified via the staff engagement session that hybrid working will continue. Guidance is	Robin Arbuthnot

Item	Description	Current Status	Proposed Approach for Future Monitoring.	Lead Director
		• Guidance developed for discussion with AMT • Final Scheme published	under development and will be finalised as soon as possible.	
10a	2% year on year increase in unprompted and prompted public awareness levels of PHA (including role and functions) established through quantitative/qualitative research programme as at March 2024.	Quantitative research undertaken during 23/24 confirmed that prompted brand awareness of PHA remains high, and unprompted awareness remains low. There has been no significant shift in awareness levels and it is unlikely that this will be progressed in the absence of core PHA Mass media led Campaigns. Public Engagement around the development of a new PHA corporate plan may provide some opportunities to improve awareness.	Subject to budget availability a repeat of the awareness tracker survey will be undertaken in year.	Stephen Wilson

HSC Public Health Agency

PHA Annual Business Plan

2024/25

Introduction

The Public Health Agency (PHA) Annual Business Plan sets out the key strategic actions that will be taken forward by PHA during 2024/25, in achieving the extant PHA Corporate Plan.

The Annual Business Plan identifies those key priorities that the Agency recognises will require particular focus to enable progress to be achieved both during 24/25 and in future years to protect and improve population health outcomes and reduce health inequalities. The Business Plan is underpinned by Directorate Business plans which encompass all core areas of work that are being progressed on an ongoing basis, meeting Ministerial priorities and outcomes set out in the Corporate Plan.

The Annual Business Plan is broken down under the following key priority areas that align with the PHA Corporate Plan 2017-21 (reviewed and rolled forward to 2023/24) and as reflected under the current Organisational Refresh and Reshape programme:

- Health Protection
- Starting Well
- Living Well
- Ageing Well
- Our Organisation and People

There is no doubt that 2024/25 will be a challenging year, as we strive to continue to meet our core commitments within a tight financial context and manage a period of significant organisational and system wide change. It will however also be a year of significant opportunity as PHA, under the Reshape and Refresh Programme, looks to evolve into a stronger organisation that will have the capacity and capability to provide the public health leadership and expertise to deal with and advise on the on-going wider public health and healthcare needs of the population. In this context of significant change it is important for the Agency and its stakeholders to have clarity around our strategic priorities and we will therefore take forward the development of a new Corporate Plan within 2024/25.

The PHA retains its responsibility for providing public health professional input to the Department of Health's Strategic Planning and Performance Group (SPPG) for the commissioning of health and social care services across Northern Ireland. In discharging our ongoing responsibilities in this domain we will continue to support the commissioning process and will work closely with colleagues in SPPG to take forward the planning, development and implementation of the new Integrated Care Planning System for NI

ensuring that the public health agenda and, in particular, addressing health inequalities, is appropriately reflected in any new plans developed.

Tackling our long established pattern of health inequalities - the unfair and avoidable differences in health outcomes both across the population and between different groups within society, is a complex and multifaceted challenge. At the core of the challenge is the need to address the wider social determinants of health and this requires the commitment and support of Government Departments, statutory bodies and Community and Voluntary Organisations.

As the lead public health body the Agency will continue to work with partners across Northern Ireland to tackle these inequalities and during 2024/25 we will specifically:

- target a greater level of investment towards population groups and communities, experiencing the highest health inequalities.
- focus preventative services on those groups experiencing poorest health, including the top 20% socio economically deprived populations
- Invest in health enhancing services, which provide opportunities for all and support our most vulnerable populations.
- Engage with service users, carers, their advocates and the wider public, enabling their voices to be heard

While not directly linked with the key actions and KPIs stated in this document, the Quality Improvement /HSCQI Directorate will support PHA priority areas of work by implementing the HSCQI Annual Workplan (as mandated by the HSCQI Leadership Alliance). Key areas of this plan that will support the PHA business plan will be via delivering regional improvement programmes, building regional quality improvement capacity and partnership working.

Accountability

The Annual Business plan will be monitored quarterly and update reports across all KPIs will be provided to PHA Board. AMT will be collectively responsible for ensuring the actions and associated KPIs are achieved. Where actions are not on target to deliver these will be considered by AMT and mitigating actions agreed to ensure maximum progress is made by March 2024.

1. PROTECTING HEALTH

Strategic Priority	Strategic Initiative	Outcome Measures (including timescales)	Lead Director
Protecting the health of the population	• We will improve the control and reduce the impact of infectious diseases. • We will explore and harness opportunities to protect and improve health, working with others taking a 'one health' approach which recognises the links between the environment, animal and human health. • We will deliver an effective communicable disease and AMR surveillance service which alerts us to changes in the incidence of infections so we can take action to protect public health. • We will support HSC partners in the control of infectious diseases, • We will lead the implementation of the Northern Ireland vaccination programmes • We will lead on the development of the PHA; SPPG and BSO Pandemic Preparedness Framework.	**KPI 1:** Implement the provision of BBV screening through low threshold and inclusion services to individuals at risk of hepatitis C, hepatitis B and HIV through injecting drug use or sharing drug taking paraphernalia, by **Mar 25** **KPI 2:** The public health component of a Northern Ireland One Health AMR Action Plan will be developed by **Mar 2025** (early draft agreed by **end of Dec 24)** **KPI 3:** Development of a unified, regular surveillance report and risk assessment for DoH and HSC system **by Mar 25** **KPI 4:** Establishment of outbreak detection through statistical exceedance reporting completed **by end of Oct 2024** **KPI 5:** Appraisal of flu vaccination delivery programme including development of options for programme management (including budget control) completed and agreed with DoH **by Mar 2025**. (Quarterly Progress checkpoint reports produced **June/ Sept/ Dec)**	Joanne McClean Joanne McClean Joanne McClean Joanne McClean Joanne McClean

2. STARTING WELL

Strategic Priority	Strategic Initiative	Outcome Measures (including timescales)	Lead Director
All Children and Young People Have the Best Start in Life	• We will support the provision and development of programmes that support children to: ○ Survive (reducing mortality, pre-conception and antenatal care), ○ Thrive (universal services, new born screening, nutrition and neurodevelopment, support for child development HCHF, vaccination, health care, wellbeing support etc) ○ Transform (poverty, safeguarding, social complexity and deprivation, family support, FNP etc)	**KPI 6:** Vaccine uptake rates for Pertussis and MMR stabilised with particular emphasis on those with the greatest risk of experiencing health inequalities by **Mar 2025** (quarterly updates provided **June/ Sept/ Dec)**	Joanne McClean
	• We will drive improvements in access to high quality data which will facilitate the development of outcome driven actions to support families and improve the health and wellbeing of mothers and children.	**KPI 7:** Develop an action plan, in partnership with Encompass, to replace and strengthen the existing child health system and its links to other key data systems by **March 2025** **KPI 8:** Review unmet need and risk factors associated with social complexity in pregnancy **by Dec 2024,**	Paul McWilliams / Stephen Wilson/ Leah Scott/ Heather Reid Heather Reid

3. LIVING WELL

Strategic Priority	Strategic Initiative	Outcome Measures (including timescales)	Lead Director
All Individuals and communities are equipped and enabled to live long and healthy lives	• We will review our existing investments and programmes of work and determine what changes are necessary to better target those individuals and communities experiencing the highest levels of health inequality • We will develop and implement with partners a range of coordinated actions across communities and a range of settings to improve mental health and wellbeing and reduce the level of suicide. • We will seek to influence and support healthy behaviours including reduction from alcohol and drug use, promote health weight and physical activity, reduce prevalence of smoking, improve sexual health and promote uptake of population screening programmes • We will support actions, focussed on early detection and treatment of illness, in particular cancer, respiratory and cardiovascular disease to optimise better health	**KPI 9:** Develop a framework to our approach for tackling health inequalities **by Dec 2024** **KPI 10:** Complete the Discovery exercise for the development of a NI Mental Health Hub **by Sept 2024** **KPI 11**: Approval of Commissioning Framework for Alcohol and Drugs Complete Phase 1 and commence Phase 2 of Regional Drugs & Alcohol Services Procurement **by Dec 2024** **KPI 12:** Implementation phase 1 – 3 of a Whole Systems Approach Obesity in line with PHE/Leeds Beckett University methodology across early adopter sites, with 2 or 3 completed by **Mar 2025** **KPI 13:** Continue to reduce smoking prevalence across NI by a minimum of 1% during 24/25. (i.e. from 14% to 13% **by March 2025**) **KPI 14:** Develop a cancer prevention action plan, including the actions outlined in the Cancer Strategy 2022 agreed **by Dec 2025** **KPI 15:** Action plan to address inequalities in participation in screening programmes developed **by March 2025**	All Directors Joanne McClean/Heather Reid Leah Scott Joanne McClean Joanne McClean Joanne McClean Joanne McClean

Strategic Priority	Strategic Initiative	Outcome Measures (including timescales)	Lead Director
	outcomes including those living with long term health conditions. • We will work with HSC Partners to ensure the delivery of high quality population screening programmes which reflect best practice standards.		

4. AGEING WELL

Strategic Priority	Strategic Initiative	Outcome Measures (including timescales)	Lead Director
All Older Adults (the Ageing Well community) are enabled to live healthier and more fulfilling lives	• We will work to support people to maintain their health as they age, so that they can lead active health lives for as long as possible delaying the onset of ill health and frailty • We will develop and implement multi agency healthy ageing programmes to engage with and improve the health and wellbeing of older people • We will promote appropriate intervention programmes within all settings to prevent, detect and manage ill health (including mental ill health) and its consequences • We will work to support people to make the best decisions around their care and treatment particularly at the end of life including the development of advance care plans through the RESPECT framework. • We will support programmes and initiatives that promote independence and self management	**KPI 16:** a new regionally agreed, evidence based safer mobility model across NI completed **by Mar 2025** **KPI 17:** all HSC care homes will have implemented the care homes fall pathway initiative - b**y Dec 2024** and a further 10% of the Independent care home sector will have adopted the pathway **by Mar 2025** **KPI 18**: i) Level 1-3 Education and Training Tools for Advanced Care Planning Programme will be in place and quality assured **by Dec 2024**. ii) Implementation structures for the RESPECT programme will be in place and implementation underway including public messaging by Dec 2024 **KPI 19:** a 5 % increase in uptake rate in seasonal flu vaccination programme for care home staff **by March 2025**	Heather Reid Heather Reid Heather Reid Joanne McClean

5. OUR ORGANISATION AND PEOPLE

Strategic Priority	Strategic Initiative	Outcome Measures (including timescales)	Lead Director
Our Organisation works effectively	• We will progress the implementation of the PHA Reshape and Refresh programme to ensure the organisation effectively delivers its core functions We will support our staff and their wellbeing, particularly during a period of organisational reform and restructuring • We will ensure appropriate resilience measures are in place across the organisation to enable a rapid and appropriate response to major public health incidents • We will make better use of data, research, evidence and health intelligence to inform our decision-making, influence external partner agendas and will further develop appropriate and robust data where required. • We will ensure high quality and appropriate governance arrangements and processes are in place to support the delivery of the PHA functions	**KPI 20:** New PHA Corporate Plan to be developed **by Mar 2025** **KPI 21:** New PHA Operational structures and operating model, implemented **by Mar 2025** (quarterly progress reports **June / Sept / Dec)** **KPI 22:** Revised Business Continuity plan developed and training rolled out **by Dec 24** **KPI 23:** PHA procurements to be progressed in line with the agreed Procurement Plan for 24/25 **by Mar 2025** (quarterly updates reported **June / Sept/ Dec)** **KPI 24:** New partnership Agreement in place with DoH **by Dec 2024** **KPI 25:** PHA Digital and Data Strategy approved by Board and Implementation Plan developed **by Sept 2024** **KPI 26:** PHA skills and development framework approved **by Sept 2024** **KPI 27:** Launch of new PHA People plan **by June 2024.** **KPI 28:** New PHA R&D office to be set up and HSC R&D Strategy to be issued for consultation by **Mar 2025**	CEO /All Directors CEO / All Directors Leah Scott Leah Scott Leah Scott CEO Leah Scott Leah Scott Joanne McClean/Leah Scott

Strategic Priority	Strategic Initiative	Outcome Measures (including timescales)	Lead Director
	• We will ensure we have the skills, opportunities and staffing capacity to deliver our functions	**KPI 29:** PHA will be in membership of each AIPB **by Jan 25.**	All Directors
	• We will work in partnership to communicate effectively with our stakeholders and target audiences and strengthen collaboration for improvements in population health and wellbeing	**KPI 30:** PHA will achieve financial breakeven position **at end of year**	All Directors
		KPI 31: An approach to health inequalities and associated training will be delivered to all staff across the organisation by March 2025	All Directors
	• We will work with SPPG and HSC partners to provide professional public health input to the commissioning of health services.	**KPI 32:** PHA in membership / co-leading new SPPG/PHA commissioning teams by **Sep 2024**.	All Directors

HSC Public Health Agency

item 11

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	28 August 2024
Title of paper	Draft Annual Progress Report 2023-24 to the Equality Commission on Implementation of Section 75 and the Duties under the Disability Discrimination Order
Reference	PHA/06/08/24
Prepared by	BSO Equality Unit & PHA Finance and Corporate Services (Corporate Governance) Department
Lead Director	Leah Scott

Recommendation For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is for the Board to note the contents of the PHA's Annual Progress Report and approve submission to the Equality Commission.

2 Key Issues

This Report follows a set template and is laid out as follows:

Chapter 1 – Summary Quantitative Report

Chapter 2 – Section 75 Progress Report

Chapter 3 – Equality and Disability Action Plan Progress Report

Chapter 4 – Updated Equality and Disability Action Plan

Chapter 5 – Equality and Human Rights Screening Report

Chapter 6 – Mitigation Report

This Report was approved by the Agency Management Team at its meeting on 21 August 2024.

3 Next Steps

Following approval the Report will be submitted to the Equality Commission.

Public Authority Statutory Equality, Good Relations and Disability Duties - Annual Progress Report 2023-24

Contact:

• Section 75 of the NI Act 1998 and Equality Scheme	Name: Leah Scott Telephone: 03005550114 Email: Leah.Scott@hscni.net
• Section 49A of the Disability Discrimination Act 1995 and Disability Action Plan	As above

(ECNI Q28):
Documents published relating to our Equality Scheme, including our most recent Five-Year-Review of Equality Scheme, can be found at:
http://www.publichealth.hscni.net/directorate-operations/planning-and-corporate-services/equality
Our Equality Scheme is due to be reviewed again by 31st March 2026.

Signature:

This report has been prepared adapting a template circulated by the Equality Commission. It presents our progress in fulfilling our statutory equality, good relations and disability duties. This report reflects progress made between April 2023 and March 2024.

Contents

Chapter 1: Summary Quantitative Report

(ECNI Q15,16,19)
Screening, EQIAs and Consultation

1. Number of policies screened (as recorded in screening reports). (see also Chapter 6) 2	**Screened in** 0	**Screened out with mitigation** 2	**Screened out without mitigation** 0	**Screening decision reviewed following concerns raised by consultees** No concerns raised by consultees on screenings published in 2023-24
2. Number of policies subjected to Equality Impact Assessment.	0			
3. Indicate the stage of progress of each EQIA.	Physical Activity Referral Scheme (PARS): A final draft version of the EQIA has been developed but further action has not been progressed due to staff capacity issues.			
4. Number of policy consultations conducted	1			
5. Number of policy consultations conducted with screening presented. (See also Chapter 2, Table 2)	1			

(ECNI Q24)
Training

6. Staff training undertaken during 2023-24. (See also Chapter 2, Q6)

Course	**No of Staff Trained**	**No of Board Members Trained**
Equality Screening Training	131	0
Equality Briefing (Agency Management Team)	6	0
Total	**137**	**0**

eLearning: 'Making a Difference' (mandatory equality awareness training)

Part 1 – All Staff	372
Part 2 – Line Managers	74

(ECNI Q27)
Complaints

7. **Number of complaints in relation to the Equality Scheme received during 2023-24**

0

Please provide detail of any complaints/grievances:

n/a

(ECNI Q7)
Equality Action Plan (see also Chapter 3)

8. **Within the 2023-24 reporting period, please indicate the number of:**

Actions completed:	2	Actions ongoing:	2	Actions not commenced (not proceeding):	1

(ECNI Part B Q1)
Disability Action Plan (see also Chapter 3)

9. **Within the 2023-24 reporting period, please indicate the number of:**

Actions completed:	5	Actions ongoing:	2	Actions to commence:	1

Chapter 2: Section 75 Progress Report

(ECNI Q1,3,3a,3b,23)

1. **In 2023-24, please provide examples of key policy/service delivery developments made by the public authority in this reporting period to better promote equality of opportunity and good relations; and the outcomes and improvements achieved. Please relate these to the implementation of your statutory equality and good relations duties and Equality Scheme where appropriate.**

During the reporting period, the PHA commenced work to develop good practice in further integrating equality considerations in procurement, with a particular focus on specifications relating to services and workforce development. Accessibility issues and the collection and use of equality monitoring data play a particular role herein.

This has been underpinned by direct engagement between Equality Commission and PHA staff in relation to the equality data and mainstreaming agendas. In this context, Commission staff together with BSO Equality Unit staff (who provide support services to the PHA) delivered a presentation to the PHA's Agency Management Team.

Table 1 below outlines examples of progress to better promote equality of opportunity and good relations.

Please note: Changes resulting directly from equality screenings are reported in Chapter 6, the Mitigation Report. Those due to the implementation of Equality and Disability Action Plans are reported in Chapter 3. In many other cases, it is not possible to ascribe developments to one single factor of Equality Scheme implementation. New initiatives are not necessarily an outcome of any equality screenings or Equality Impacts Assessments. As mainstreaming progresses and the promotion of equality becomes part of the organisational culture and way of working, the more difficult it becomes to ascribe activities and outcomes to the application of a specific element of Equality Scheme implementation. From this point of view, staff training and engagement and consultation are arguably the most important factors.

Table 1:

	Outline new developments or changes in policies or practices and the difference they have made for specific equality groupings.
Persons of different religious belief	**Directorate of Public Health** Health Protection Please see entry below (under 'disability') in relation to making an open and public offer of screening available for viral hepatitis in Belfast city centre, which improves access to tests and raises awareness of the condition and increases opportunity for case finding without any pre-conceived ideas of those who are presenting / engage with testing.

Persons of different political opinion	
Persons of different racial groups	**Directorate of Public Health** Health Protection Please see entry below (under 'disability') in relation to making an open and public offer of screening available for viral hepatitis in Belfast city centre, which improves access to tests and raises awareness of the condition and increases opportunity for case finding without any pre-conceived ideas of those who are presenting / engage with testing. Health Screening QR codes were added to 'The Facts', 'The Next Step' and Instructional leaflet during the latest reprint. The QR code is an additional resource which, when scanned, will directly link to translated versions of the three bowel cancer screening leaflets on the PHA website. **Directorate of Nursing, Midwifery and Allied Health Professions** Implementation of Continuity of Midwifery Carer (CoMC) in Northern Ireland CoMC is an evidence-based intervention that can significantly impact service users' choice, positive experiences, satisfaction and reduce clinical intervention rates. The model can also improve job satisfaction for midwifery staff through

	flexible working and better opportunities to build positive relationships with women and families. The establishment of a regional CoMC (NI) model of care will benefit users of maternity services across Northern Ireland and contribute to improved population health by: • providing safe, effective and compassionate midwifery care; • ensuring a consistent approach through the implementation of one regional CoMC (NI) model which is in line with national guidance and regulatory requirements; • supporting the implementation of NMC midwifery education and proficiency standards which will protect the public now and into the future; • ensuring midwives and managers have the knowledge, skills and confidence to provide the regional CoMC (NI) model of care across all settings; • offering a value for money service using a cost avoidance approach. There is strong evidence that CoMC, and the relationship it allows to develop between caregiver and receiver, leads to better outcomes and experience for the woman and baby. In Northern Ireland, roll out of CoMC teams has prioritised women who live in socially deprived areas and /or those women identified as most at risk during pregnancy. The evidence demonstrates that CoMC improves outcomes for women with social risk factors, and those from specific ethnic groups. It may also help avoid unconscious racial bias and circumstances that lead to harm for Black and Asian women. Based on the best evidence available, CoMC delivers safer and more personalised care:

	• The 2016 Cochrane review concluded that CoMC models save babies' lives, prevent preterm birth, reduce interventions and improve women's experiences and clinical outcomes. • The 2018 and 2020 Cochrane reviews concluded that CoMC prevents stillbirth and preterm birth. • Working in this way facilitates good personalised care and supports planning and continuous risk assessment. • Outcomes of CoMC models in comparison to other models are that: • 24% less likely to experience preterm birth • 16% less likely to experience a pregnancy loss overall • 19% less likely to experience a pregnancy loss before 24 weeks • 15% less likely to experience regional analgesia • 16% less likely to have an episiotomy • 10% less likely to experience instrumental vaginal birth • 7 times more likely to be attended at birth by a known midwife. Women also reported a higher level of satisfaction with: • information giving, advice and explanations • making an informed decision about place of birth and the preparation for labour and birth • decisions about intrapartum analgesia and feeling in control during labour and birth • Relational care improves women's experience and perceptions of quality of care.

Persons of different age	**Directorate of Nursing, Midwifery and Allied Health Professions** Please see entries below (under ‘gender and gender identities’ and under ‘disabilities’).
Persons with different marital status	
Persons of different sexual orientation	**Directorate of Public Health** Health Protection We undertook open public engagement and offer of mpox vaccination to raise awareness and reduce stigma of mpox and sexually transmitted infection during both the Belfast Pride and the Foyle Pride event. This served to increase accessibility of mpox vaccination to those who may be at greatest risk and raises awareness of the disease and risk factors for transmission. Health Screening The 'Promoting Informed Choice' for Breast Screening (and Very High Risk Breast Screening Surveillance) in facilitation with the Northern HSC Trust Engagement Officer hosted a Promoting Informed Choice Breast Screening Workshop with representatives of the LGBTQIA+ community to optimise uptake of breast imaging and reduce health inequalities by identifying and addressing any relevant general practice, organisational or population factors that impact on uptake.

Persons of different genders and gender identities	**Directorate of Public Health** Health Protection Please see entry above (under 'sexual orientation') in relation to open public engagement and offer of mpox vaccination during both the Belfast Pride and the Foyle Pride event, which served to increase accessibility of mpox vaccination to those who may be at greatest risk and raises awareness of the disease and risk factors for transmission. Health Screening The 'Promoting Informed Choice' for Breast Screening (and Very High Risk Breast Screening Surveillance) in facilitation with the Northern HSC Trust Engagement Officer hosted a Promoting Informed Choice Breast Screening Workshop with representatives of the LGBTQIA+ community to optimise uptake of breast imaging and reduce health inequalities by identifying and addressing any relevant general practice, organisational or population factors that impact on uptake. The workshop aimed to • develop collaborative working relations between members of the transgender & gender-diverse, non-binary and gender fluid community and NHSCT Breast Services. • identify ways to remove roadblocks to transgender & gender-diverse, non-binary and gender fluid service users attending Breast Screening appointments

	• understand the channels of communication to transgender & gender-diverse, non-binary and gender fluid service users • review current PHA Breast Screening material for transgender & gender-diverse, non-binary and gender fluid service users. **Directorate of Nursing, Midwifery and Allied Health Professions** We introduced Expectant Mother Risk Assessment and identification of need for breast feeding or breast milk expression facility in PHA buildings (Linenhall Street). This creates benefits relating to: • Preparation for motherhood - knowing that facility is available for return to work • Promotion of right to babies receiving breast milk on mother's return to work • Promotion of breast feeding and expression of breast milk for mothers with dependent children • Increasing breast feeding rates and maintenance in Northern Ireland.
Persons with and without a disability	**Directorate of Nursing, Midwifery and Allied Health Professions** Patient and Client Experience In 2023/2024, the PHA worked in partnership with the British Deaf Association and Signvideo to agree a mechanism for people who use sign language (BSL/ISL) to share their experience in their language and receive an accessible response from the specific service. This work included co-designed promotional material which was launched in March 2024. This change in practice supports

	the voice of sign language users to share their feedback through Care Opinion. This body of stories will inform all levels of the system, including commissioning and regional forums, to improve the experience of sign language (service users, families and carers). In recognition, the work received a Patient Experience National Network Award in 2024 for partnership working. Personal and Public Involvement The ReachDeckonto Engage website was installed, which facilitated increased accessibility for a range of people including those with disabilities and those who didn't have English as their first language. This encourages people to become more actively involved in HSC. Allied Health Professions Special School Partnership Pilot and Hearing Our Children's Voices Context and Background Special schools and Health partners are currently facing a number of significant pressures and challenges including: • an increasing demand for placements in special schools; • an increasing demand for post-16 opportunities in special schools; • a changing and more complex presentation of Children and Young People (CYP) with special educational needs; • a variation and inconsistency in the type of provision offered regionally; and

	• a need for enhanced working across the education and healthcare sector to help address CYP needs in a holistic manner. The Children's Services Co-operation Act 2016 has outlined that involvement, collaboration and partnership working improves outcomes for our children and places a duty on us to work better together across boundaries to achieve this. To this end, DE and DoH jointly funded a Partnership Lead post to work across Health and Education for CYP with Special Educational Needs and Disabilities and facilitate and enhance integrated working. This position also supports the opportunities across the Health and Education sector to harness the voices and experiences of CYP and their parents and carers to help inform the planning and provision of services. Special School Partnership Pilot This initiative aims to improve outcomes for Children with Special Educational Needs and Disability through creating and testing a model of Partnership and Engagement across Special Schools in N.I. Our Vision is that Special Schools become visible, vibrant and connected hubs within our local communities and that our places, spaces and services will be equipped to include our Children and Young People in all aspects of daily living to give them the best start in life, assist them to become progressively independent and optimize their educational, personal and life outcomes. Our aim is to lead collaboration and co-operation to increase visibility, connections and influence of Special schools across sectors, organisations and

	professions and provide space to hear the voice of our Children, Young People and their parents or support networks. The pilot currently engages 7 Special Schools in local partnerships across all 5 Trust with key stakeholders across sectors and professions, in a Hub and Spoke network model that supports effective engagement across a wide group of age-ranges of CYP with a range of complex disabilities alongside Special Educational Needs. Hearing Our Children's Voices This work has also proactively sought to test an innovative approach to hear the voices of over 70 Children and Young People with profound and complex disabilities about what is important to them at school, at home and in the community, through the medium of Art, Drama, Music and Play Therapies. Impact • Children from a range of ages and complex needs and disabilities who have been unable to engage in any activity for more than a few minutes have been engaging in therapy for 45-50mins • Through the therapies, children have been making daily choices rather than being passive recipients of care • Teachers have reported a positive impact in the classroom • Parents have reported a positive impact at home • Feedback obtained from CYP will provide important information on their needs that will support planning across the wider community sector.

	Directorate of Public Health Development of Regional Syringe Pump Guidance including Education and Training for Adults and Paediatrics in NI. This regional guidance document will support standardisation of Syringe Pump use including education and training across all care setting in NI, support good governance across all organisations, and will benefit all adults and paediatrics who require a syringe pump. Health Protection We held an open public engagement and testing event for hepatitis B and hepatitis C to raise awareness and reduce stigma of these blood borne viruses whilst extending the opportunity to test to the wider public. Making an open and public offer of screening available for viral hepatitis in Belfast city centre improves access to tests and raises awareness of the condition and increases opportunity for case finding without any pre-conceived ideas of those who are presenting / engage with testing. Health Screening We produced accessible Word versions of 'The Facts' and 'The Next Step' Bowel Cancer Screening Programme leaflets as well as the four AAA Screening Programme leaflets and made them available on the PHA website. The accessible word versions of the leaflets will give people with sensory

	impairments, such as reduced vision, information in a format they can use. The word version allows you to change the font size and can be used with a screen reader to speak the text. Specialist Screening Practitioners (SSP's) and members of BSO's call recall staff attended visual awareness training delivered by RNIB. The training will ensure that staff are aware of the challenges faced by people who have a visual impairment, and how they can support bowel cancer screening participants who have a visual impairment at any stage of the bowel cancer screening pathway. Likewise, AAA Screeners received training on visual awareness from RNIB and an introduction to sign language from a BSL teacher. **Directorate of Operations and Planning** We now use clear and straight forward language in press releases, social media posts and other materials to try to make public health information easy to understand and accessible. We also use alternative text on social media graphics to increase accessibility for people with sensory loss. We add subtitles by default to all video content for supporting accessibility and understanding of information, particularly for people with hearing loss. Further work on promoting equality for people with a disability in the workplace is reported on in detail in Chapter 3 (the Equality and Disability Action Plan – Progress Report 2023-24).

Persons with and without dependants	**Directorate of Public Health** Health Protection Please see entry above (under ‘disability’) in relation to making an open and public offer of screening available for viral hepatitis in Belfast city centre, which improves access to tests and raises awareness of the condition and increases opportunity for case finding without any pre-conceived ideas of those who are presenting / engage with testing. **Directorate of Nursing, Midwifery and Allied Health Professions** Please see entry above (under ‘gender and gender identities’).

(ECNI Q4,5,6)

2. During the 2023-24 reporting period

(a) were the Section 75 statutory duties integrated within…?

	Yes/No	Details
Job descriptions	Yes	For all new posts, the Job Description now includes the following: "Assist the organisation in fulfilling its statutory duties under Section 75 of the Northern Ireland Act 1998 to promote equality of opportunity and good relations and under the Disability Discrimination (Northern Ireland) Order 2006. Staff are also required to support the organisation in complying with its obligations under Human Rights Legislation."
Performance objectives for staff	Yes	All PHA staff have a performance objective to complete the 'Equality, Good Relations and Human Rights: Making a Difference' training module which outlines the Section 75 statutory duties.

(b) were objectives and targets relating to Section 75 integrated into…?

	Yes/No	Details
Corporate/strategic plans	Yes	The PHA Corporate Plan 2017-2021, rolled over into 2023-24, includes five key outcomes. Two of these relate directly to Section 75 groups: 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

Annual business plans	Yes	Against the Corporate Plan outcomes, a number of actions included in the Business Plan 2023-24 related to specific Section 75 groupings: Children and Young People • By December 2023, increase by 1% the uptake rates for pre-school immunisation (based on December 2022 position) • Complete the re-tender of the regional Early Intervention Support Service for families by June 2023 and expand service to increase number of families supported from 630 to 800 by March 2024 (subject to additional funding from DoH being allocated, as planned) Older Adults • Implement the 'Shingrix for All' vaccine programme with phased introduction from September 2024 • Implement the Regional Falls Pathway and Bundle for Care Homes in 10 % of care homes in each Trust area by March 2024

(ECNI Q11,12,17)

3. **Please provide any details and examples of good practice in consultation during the 2023-24 reporting period, on matters relevant (e.g. the development of a policy that has been screened in) to the need to promote equality of opportunity and/or the desirability of promoting good relations:**

Table 2

Policy publicly consulted on	**What equality document did you issue alongside the policy consultation document?**	**Which Section 75 groups did you consult with?**	**What consultation methods did you use?** **AND** **Which of these drew the greatest number of responses from consultees?**	**Please tell us about anything you feel worked particularly well / not so well in this consultation.**
Equality and Disability Action Plans 2023-28	☒ Screening template ☐ EQIA report ☐ none	Full Section 75 consultation list	Online questionnaire (greatest number of responses received)	Most of those who responded were either from professional organisations (such as the Royal Colleges) or staff members. Only very few Section 75 voluntary sector organisations engaged

			Free written comments Online events One-to-one meeting	with us, possibly reflecting their significantly reduced capacity to do so.

(ECNI Q21, 26)

4. In analysing monitoring information gathered, was any action taken to change/review any policies?

Table 3

Service or Policy	What equality monitoring information did you collect and analyse?	What action did you take as a result of this analysis to address any inequalities observed?	Which Section 75 equality groups benefited from these changes specifically?
Nursing, Midwifery and Allied Health Professions – 10,000 MORE Voices As part of 10,000 MORE Voices initiatives we review the Equality returns for specific projects - In 23/24 the main project was 'My Experience of Social Work' and 'My Experience of Primary Care	As standard across all 10,000 MORE Voices projects we explore - age, gender, place of birth, ethnic origin, sexuality, disability	The analysis did not identify any inequalities.	Not applicable

Multidisciplinary team' In 23/24 this was included in pilot processes for 'My life in a Care Home' and 'Experience about decisions about my care'.			
Operations and Planning – Health Intelligence • Mental health • Maternity and child health • Alcohol and drugs	• age • gender (also deprivation)	identification and significance testing of variation between inequalities demographics reported in research findings and research findings disseminated to stakeholders to inform their planning/implementation activities	(potential for benefits for age and gender as a result of stakeholders using research findings to inform their planning/implementation activities)

(ECNI Q22)

5. **Please provide any details or examples of where the monitoring of policies, during the 2023-24 reporting period, has shown changes to differential/adverse impacts previously assessed:**

There is no information to evidence that PHA undertook monitoring, during the 2023-24 reporting period, of policies previously screened or EQIAed.

Table 4

Policy previously screened or EQIAed	**What were the inequalities identified in the screening or EQIA?**	**Did the equality monitoring data you collected show that these inequalities had changed in 2023-24?** **(Please tick)**	**Please tell us more about these changes and why you think this has happened.**
-	**-**	☐ Yes ☐ No	**-**

(ECNI Q25)

6. **Please provide any examples of relevant training shown to have worked well, in that participants have achieved the necessary skills and knowledge to achieve the stated objectives:**

The PHA avails of the joint Section 75 training programme that is coordinated and delivered by the BSO Equality Unit for staff across all 11 partner organisations. The following statistics thus relate to the evaluations undertaken by all participants for the training.

Screening Training Evaluations

The figures in bold below represent the percentage of participants who selected 'Very Well' or 'Well'. Participants were asked: "Overall how well do you think the course met its aims":

- To develop an understanding of the statutory requirements for screening: 85%
- To develop an understanding of the benefits of screening: 88%
- To develop an understanding of the screening process: 77%
- To develop skills in practically carrying out screening: 63%

Lower self-assessment figures in relation to the fourth of these learning outcomes in comparison to the other outcomes are not entirely surprising. In the main, these skills are developed when staff undertake screenings and receive feedback and advice specific to an individual screening.

(ECNI Q29)

7. **Are there areas of the Equality Scheme arrangements (screening/consultation/training) your organisation anticipates will be focused upon in the next reporting period?**

During 2024-25 we will continue to focus on developing best practice in procurement with particular emphasis on specifications and contract management and drafting related resources for staff – in order to make our screenings more effective and efficient and to progress on the collection and use of equality monitoring data.

Appendix – Further Explanatory Notes

1 Consultation and Engagement

(ECNI Q10)
targeting – During the year, where relevant, we took a targeted approach to consultation in addition to issuing an initial notification of consultation.

(ECNI Q13)
awareness raising for consultees on Equality Scheme commitments – During the year, at the consultation events on our Equality and Disability Action Plans, we raised awareness of our commitments in relation to the Plans.

(ECNI Q14)
consultation list – During the year, we reviewed our consultation list.

2 Audit of Information Systems

(ECNI Q20)
We completed an audit of information systems at an early stage of our Equality Scheme implementation, in line with our Scheme commitments.

x

Equality and Disability Action Plans 2023-24

What we did

If you need this document in another format please get in touch with us. Our contact details are at the back of this document. Our Equality and Disability Action Plan 2023-28 can be found on our website at: Consultation: Equality and Disability Action Plans 2023-28 | HSC Public Health Agency (hscni.net) (Chapter 4)

Equality Action Plan 2023-24: What we will do to promote equality and good relations

Action 1: Lead Consultant and Project Manager in Screening (working with PALs and Operations). June 2023

What we will do: Cancer Screening

Raise awareness and promote informed choice in cancer screening, focusing on those communities and population groups who are less likely to participate in screening, including in particular people from ethnic minority backgrounds, people with a disability, and lesbian, gay and bisexual people

- Take forward a process to retender for the contract with an external organisation with community links to undertake this work.
- Once tender is awarded, manage contract and monitor progress to ensure targets are met and target groups reached. PMR, session impact data and equality data will be submitted quarterly and Annually. Contract review meetings will be undertaken quarterly.

What we are trying to achieve: Ethnicity, Disability, Sexual Orientation

Empower those from the above range of S75 groups and deprived areas across NI (whose uptake of screening invitations tends to be lower) to make an informed choice to participate in cancer screening.

To engage with those in the above S75 groups and deprived areas across NI to raise awareness of cancer signs and symptoms.

Performance Indicators and Targets:

The service provider will deliver 240 Cancer Screening Awareness Sessions annually, in an accessible manner, to participants in target groups and living in socially deprived areas across NI.

The annual average number of session attendees from target groups will be approx. 2,400. (N.B. targets would be revised in light of future waves of the pandemic.)

Increase session attendees' awareness of the Cancer Screening Programme by 40%

Increase session attendees' intention to attend cancer screening when next invited by 20%.

Increase session attendees' knowledge of cancer signs and symptoms by 20%.

What we did over the last year:

This action is no longer being taken forward. The existing contract with the provider has been extended for a further year to March 2025 to allow time for exploratory work to develop a wider action plan to address inequalities across all screening programmes.

Action 2: PHA Regional antenatal infection screening programme co-ordinator – data collected quarterly.

What we will do: Infectious diseases in pregnancy screening (IDPS): -

Ensure that all women from section 75 categories have access to IDPS early in pregnancy and that there is equality of access into clinical care for those screening positive for infections.

1. We will provide information leaflets about the IDPS programme in an accessible format in different languages.
2. We will liaise with community groups if necessary who can provide transport for women to clinic appointments if necessary.

3. We will monitor the programme to reduce potential inequalities within it especially for those women requiring referral to specialist services.

What we are trying to achieve: Persons from ethnic minority groups, asylum seekers and migrants.

1. We are trying to ensure that people from the above groups know how to access services and have the information they need in the appropriate language, in order to make an informed choice about IDPS screening.
2. We are trying to ensure that women who need to attend specialist services can access the service and attend appointments required for the health of themselves and their baby.

Performance Indicator and Target: (1) Quarterly statistics will be collected from each Trust to show performance against National standards and these will provide evidence of IDPS uptake and attendance at specialist appointments.

The target would be that performance against each standard would reach the acceptable level and hopefully achieve the achievable level (top level)

2. Audit in progress around women screened positive for hepatitis B- this will highlight inequalities of access amongst women attending specialist services.

What we did over the last year:

1. The annual data for the IDPS programmes shows that we have reached the achievable level for most of the standards and have reached the acceptable level for standard 6 – the review of women with hepatitis B by hepatology services within 6 wks.

2. A health equity audit has been completed for women diagnosed with hepatitis B, looking at their attendance at specialist services. Whilst this didn't show a statistically significant difference for the section 75 category of women specifically, it did show that there was slightly increased odds of a woman missing her hepatology appointment is she was: born outside the UK, didn't speak English or booked in a Trust area outside of Belfast.

Action 3: PHA Nursing and PHA Health Protection end March 2024.

What we will do: Health Improvement:

Refugees, Asylum seekers, Minority Ethnic & Migrant communities should have the opportunity of equal access to Health and Social Care services in Northern Ireland.

- Engage with SPPG & DoH to consider additional funding needs in the short term and to develop a regional *Northern Ireland New Entrants Service (NINES) which is consistent & effective across NI*
- *Submit a paper* to SPPG to highlight the issues to be addressed and develop a business case for the funding requirements.

What we are trying to achieve: Persons of different racial groups

Equal access for all Asylum Seekers, Minority Ethnic &Migrants to initial health assessments and associated screening across the Region

Performance Indicator and Target: (1) Written evidence of engagement and paper submission. (2) Formation of working group to address issues relating to capacity for NINES/allied services, membership to include PHA and SPPG commissioning/primary care.

What we did over the last year: (1) Written evidence of engagement and paper submission. Paper was submitted by the PHA Service Development and Screening Consultant. Business Cases were requested from each Trust and DoH, Commissioning and PHA were reviewing these. Funding comes in ad hoc.

(2) Written evidence of engagement and paper submission. Formation of working group to address issues relating to capacity for NINES/allied services, membership to include PHA and SPPG commissioning/primary care. This group was set up and meets on a monthly basis.

Action 4: PHA Health Improvement with support from Employment Equality Leads in all HSC organisations by March 2024

What we will do: HSC LGBTQ+ Staff Forum

Facilitate a minimum of 4 annual meetings the HSC LGBTQ+ Staff Forum.

Work in partnership with other HSC organisation promote membership of the HSC LGBTQ+ Staff Forum.

In partnership with members outline the key priorities for the HSC LGBTQ+ Staff Forum.

Participate in and contribute to Diversity Champions events with other LGBTQIA+ Staff Networks in NI.

What we are trying to achieve: Gender, Sexual Orientation. Provide an opportunity for HSC LGBTQ+ Staff to:

- have a space to have their voice heard in the HSC.
- be able to contribute to decision making that affects LGBTQ+ people.
- Provide a community were LGBTQ+ people can feel better supported, recognised and included by the HSC.
- take an active role in promoting inclusion and diversity in the HSC

Performance Indicator and Target: Population outcome: LGBTQ+ staff working in the HSC see the HSC values realised. Performance accountability:

- Promotion of the Staff forum in each HSC organisation
- Increase in HSC LGBTQ+ Staff Forum membership and in active participation.

What we did over the last year:

In 2023/24 the HSC LGBTQ+ staff forum:

- Held 4 HSC LGBTQ+ Staff Forum Network meetings
- Following promotion of the HSC LGTQ+ Staff Forum in HSC organisations membership increased from 34 on 1st April 2023 to 84 on 31st March 2024 (membership is currently 260 – Aug 24) .
- Coordinated 10 Sexual Orientation and Gender Identity awareness sessions for HSC staff. There were 186 staff from across HSC organisations attended.
- Over 70 HSC staff walked with the HSC LGBTQ+ Staff Forum in Belfast Pride 2023.
- Actively participated in two Diversity Champions events with other LGBTQIA+ Staff Networks.

Action 5: Lead by the PHA PPI Team, with guidance from BSO Equality colleagues, HSC partners and service users and carers

What we will do: Develop and introduce an equality specific section for all Involvement training commissioned / delivered by the PHA.

What we are trying to achieve: All S75 Groups**.** Aim to ensure best practice is followed in terms of equality issues, in respect of involvement matters in the PHA and to influence practice across the wider HSC

Performance Indicator and Target: Equality specific section developed for use in all Involvement training commissioned / delivered by the PHA. Increase in understanding of the rationale for embedding best practice in equality matters.

What we did over the last year: PHA is currently reviewing all PPI training available in the HSC, this will be completed by end of September 2024.

Equality Action Plan - Conclusions

- We completed 2 actions (#3,4)
- We did some work on 2 actions (#2,5) which are still in progress
- We didn't do any work on 1 action (#1) (action now not being taken forward)
- All of the actions in our action plan are at regional and/or at local level.
- Our action plan is a live document. If we make any big changes to our plan we will involve people in the Section 75 categories. We will tell the Equality Commission about any changes.

Disability Action Plan 2023 - 24: What we will do to promote positive attitudes towards disabled people and encourage the participation of disabled people in public life

Action 1 PHA Regional antenatal infection screening programme co-ordinator, (by early 2024 for 1 and 2 below; by end 2025 for 3 below)

What we will do: Service Development and Screening

Infectious diseases in pregnancy screening (IDPS) programme

Since people living with HIV are protected under the Disability Discrimination Act, it is important that we ensure that pregnant women screened positive for HIV are not discriminated against.

1.We will continue to encourage all staff involved in the care of pregnant women to attend HIV awareness training at least every 3 years.

2.The PHA will develop a regional power point training presentation on the IDPS, which includes HIV. This will ensure standardisation of training regionally.

3.The PHA will work with HSC Trusts to strengthen their internal quality assurance function within the IDPS programme so that assurances can be given that all staff are attending training as recommended i.e. three yearly.

What we are trying to achieve: Promoting positive attitudes and Encouraging participation in public life

(for 1. and 2.) To ensure equality of care for all pregnant women screened positive for HIV.

(for 3. Above) To ensure that Trusts take responsibility for ensuring that their staff are attending training in the IDPS programme.

Performance Indicator and Target: (for 1 and 2) Regional Power point training presentation for the IDPS programme developed.

(for 3) QA structures for the IDPS programme agreed and implemented. (will be resource dependent)

What we did over the last year: (for 1 and 2) This has been completed in conjunction with the Clinical Education Centre (CEC) who provide IDPS programme contemporary issues training for all midwives across N.Ireland

(for 3) Although funding is not available at present to implement the QA structure within the IDPS programme, we have tasked the Trusts to set up a local IDPS co-ordinating group, to provide a forum for internal quality assurance, programme governance and the opportunity to discuss operational issues. So far 3 out of the 5 Trusts have a group in operation

Action 2 Agency Management Team (AMT) with support from BSO Equality Unit. (end Mar 2028)

What we will do: Awareness Days

Raise awareness of the lived experience of people with specific disabilities and conditions.

What we are trying to achieve: Promoting positive attitudes:

Increased staff awareness of a range of disabilities and conditions.

Performance Indicator and Target: 2 awareness days profiled every year.

>50% of staff taking part in the evaluation indicate they know more about people living with disabilities and conditions as a result of the awareness days.

What we did over the last year: Disability Awareness Days

For our Stroke Awareness Day, we had two speakers (Annie Rea, Advanced Practitioner Occupational Therapist, and Claire Murphy, Speech and Language Therapist) from the Community Stroke Team in the South Eastern HSC Trust. They explained what a stroke is, signs and symptoms, as well as hidden effects. They also presented information on stroke and work and on caring for someone with a stroke, and signposted to further

advice and information. Nearly 50 staff and board members joined the call, some of whom also engaged in the Question and Answer session.
At our Awareness Days on Schizophrenia, Martina Doherty (Nurse Education Consultant from the BSO Clinical Education Centre) covered a wide range of issues including what schizophrenia is, myths and misconceptions, symptoms, spotting the signs, management and support, and how to help. She likewise responded to questions by attendees, many of whom focused on how to support a family member or friend who is unwilling to seek help. The session was chaired by Prof. Dorothy Whittington, a non-executive Director on the BSO Board and the BSO Disability Champion.
Following the sessions, we uploaded the presentation or a recording of the session to the Tapestry website for those unable to attend on the day.
Our survey on the Awareness Days at the end of the year suggested the following:
Strokes (out of 14 staff who attended a session on the day or accessed any of the materials)

- 14 staff felt they knew more about Strokes as a result;
- 8 indicated they knew more about supporting a friend or family member;
- 8 indicated they knew more about supporting a colleague.

Schizophrenia (out of 13 staff who attended a session on the day or accessed any of the materials)

- 10 felt they knew more about Schizophrenia;
- 11 indicated they knew more about supporting a friend or family member;
- 5 indicated they knew more about supporting a colleague.

Action 3: Agency Management Team (AMT) with support from BSO Equality Unit. (end Mar 2028)

What we will do: Placement Scheme

Create and promote meaningful placement opportunities for people with disabilities.

What we are trying to achieve: Promoting positive attitudes and Encouraging participation in public life:

People with a disability gain meaningful work experience.

People with a disability are successful in applying for paid employment after they have completed a placement.

Performance Indicator and Target: At least 3 placements in the PHA offered every year.
Feedback through annual evaluation of scheme indicates that placement meets expectations.
At least 1 placement participant every year is successful in applying for paid employment within 12 months of completing their placement.

What we did over the last year: During 2023-24, we took time to review the Disability Placement Scheme that we have been running for nearly 10 years. We also spoke to a number of voluntary sector organisations who run or are involved in running programmes for people with a disability that include work placements. We wanted to find out how other programmes work.

We have decided that we want to move away from running a cohort scheme where all participants start and finish at the same time. We think that giving greater flexibility as to when people start and how long placements last will allow more people to undertake placements with us.

Action 4 Agency Management Team (AMT) with support from BSO Equality Unit (end March 2028)

What we will do: Tapestry Network

Promote and encourage staff to participate in the disability staff network and support the network in the delivery of its priorities.

What we are trying to achieve: Encouraging participation in public life:

Staff with a disability feel more confident that their voice is heard in decision-making.

Staff with a disability feel better supported.

Performance Indicator and Target: Tapestry staff survey

Increase in Tapestry membership or in participation at meetings

What we did over the last year: During 2023-24, we made a conscious effort to raise the profile of the Network across all organisations. Over the month of November the network was on site in various locations across the region raising awareness and promoting the benefits of the Network. As well as corporate communications and posters, information and merchandise stands were set up and information shared over 6 half days in November. Over 200 staff engaged with the promotion and shared their experiences. In terms of the growth of the Network, as a result of the recent promotion, membership has grown by 60% and attendance at meetings has increased significantly in the last year.
As a result of this growth, it was decided that a formal Business Plan was needed. A Business Planning meeting was held with Tapestry members on 14th February. A new vision, objectives, and actions were developed as a result of the input on the day and these were shared and agreed with the wider network at the March 24 meeting.

Action 5: PHA PPI Team in collaboration with Tapestry, 3rd sector Advocacy organisations – ongoing during 2023-28

What we will do: Pro-actively use the Engage Website to promote & encourage involvement of service users and carers with a disability. Liaise with Tapestry, HSC partners, Disability Action & other advocacy groups, to identify ways in which the Engage website might be more effectively used to advance meaningful involvement of service users and carers in the work of the HSC.

What we are trying to achieve: Encouraging and facilitating participation in public life.

Help to inform HSC staff how they could support and encourage active involvement of service users and carers with a disability**.** Inform and encourage service users and carers with a disability to avail of involvement opportunities with the HSC.

Performance Indicator and Target: Production of a Guide targeted at informing staff about ways in which to support involvement of service users and carers with a disability.

Increasing numbers of service users and carers with a disability availing of HSC Involvement opportunities

What we did over the last year: After engagement with a number of advocates with people with disabilities, the Reachdeck tool has been installed on the engage website. One of the features of the tool is a read aloud function to support people who are blind or visually impaired.
As part of PPI/PCE Strategy there is planned collaboration with partners to develop the planned guide to support involvement of SUC with a disability TBC March 2025.

Action 6: PHA PPI Team working in collaboration with the DoH, HSC partners & the PCC by the end of 2024.

What we will do: Work with HSC partners to develop guidance and mechanisms to take forward remuneration of service users and carers in line with the policy direction laid down in the Co-Production Guide

What we are trying to achieve: Encouraging and facilitating participation in public life.

Helping to address barriers to participation by service users and carers, many of whom are living with a disability and who are less likely to get involved due to additional financial pressures and costs.

Performance Indicator and Target: Have in place guidance and mechanisms to facilitate remuneration of service users and carers in agreed, appropriate and defined circumstances.

Increasing numbers of service users and carers with a disability, availing of remunerated HSC Involvement opportunities

What we did over the last year: A paper has been jointly developed by PHA and PCC and submitted to DOH policy leads for their consideration.

Action 7: PHA Patient Client Experience Team working in collaboration with HSC partners and charitable partners (complete by the end of 2024)

What we will do: Work with HSC partners to develop mechanisms for feedback which are accessible to the wider population of Northern Ireland

What we are trying to achieve: Improve opportunity for people of NI to provide feedback on experiences across HSCNI

Performance Indicator and Target: All campaigns and promotion material will be supported by translation and adapted to encourage feedback from people with a disability

What we did over the last year: On target. We now have resources to support people with a Learning disability to share their experience, with training in Talking Mats and plans to collaborate with Cedar Foundation and Mencap – informed by NIPEC report there is a focus upon accessing the wider HSC services.
We have also developed specific promotional material for varying visual impairments and plan to work with dementia charities to engage people with dementia and their carers.

Disability Action Plan - Conclusions

- We completed 5 actions (#1(parts 1 and 2), 2, 4, 5).
- We did some work on 2 actions (#6,7) which are still in progress
- We didn't do any work on 1 action (#3).

- All of the actions in our action plan are at regional and at local level.
- Our action plan is a live document. If we make any big changes to our plan we will involve people with a disability. We will tell the Equality Commission about any changes.

Public Health Agency (PHA)
Equality and Disability Action Plans 2023-28

1. Equality Action Plan 2023-28: What we will do to promote equality and good relations

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
Service Development and Screening Support the implementation of an online booking system for diabetic eye screening. *	**Disability, Dependants, Age** The online booking system allows participants to select a date for screening more suitable to them via a link within their invitation letter. The objective of this system is to give more flexibility to individuals with caring responsibilities, young people and those of working age. It is also hoped that this in turn will reduce the number of clinic DNAs.	Usage of the system will need to be restricted until the programme has recovered sufficiently and has capacity to offer a variety of screening clinic slots online. The other impact will be the implementation of a low risk pathway in 2023/24, the effects of this new pathway will not be realised until 2025/26 as eligible patients will be moved in a phased approach over 2 years. The impact of the system will be reviewed by the Belfast HSC Trust along	The implementation and management of the booking system is the responsibility of the Belfast HSC Trust, however the PHA will support the implementation and the impact of the system will be kept under review by the NIDESP Operational Group (with PHA and Belfast HSC Trust membership) Aim to have full implementation by March 2026.

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
		with input from PHA Screening.	
Allied Health Professions Through partnership working with key stakeholders, both statutory and non-statutory to help to determine and plan for the predicted healthcare needs of children and young people with Special Educational Needs (SEN). **Specific action 1** – The development of a standardised regional pathway and process across the health and social care system for the identification of children with Special Educational Needs, advice and recommendations on the provision required to meet these needs and the intended outcome of this provision in meeting these needs.	**Disability, Age** Children and young people (CYP) with SEN will benefit from a standardised health statutory assessment process towards timely access to AHP support/recommendations within the educational setting.	Health services will more consistently meet KPI in respect of the submission of health reports for SEN statutory assessment process.	PHA AHP by Sept 2024 PHA AHP by Sept 2024

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
Specific action 2 - The development of an integrated model of support across the health and educational sector that can assist to meet the child and young person's needs holistically and which meets requirements within the Children's Services Co-operation Act (2015).	CYP will benefit from a holistic approach to addressing their AHP needs within the school environment, reducing duplication and enhancing consistent messaging.	Review of training programmes provided by health and education towards model with greater regional consistency and evidence of cross organisational partnership working.	PHA AHP by Sept 2024
Cancer Screening Raise awareness and promote informed choice in cancer screening, focusing on those communities and population groups who are less likely to participate in screening, including in particular people from ethnic minority backgrounds, people with a disability, and lesbian, gay and bisexual people • Take forward a process to retender for the contract with an external organisation with	**Ethnicity, Disability, Sexual Orientation** Empower those from the above range of S75 groups and deprived areas across NI (whose uptake of screening invitations tends to be lower) to make an informed choice to participate in cancer screening. To engage with those in the above S75 groups and deprived areas across NI to	The service provider will deliver 240 Cancer Screening Awareness Sessions annually, in an accessible manner, to participants in target groups and living in socially deprived areas across NI. The annual average number of session attendees from target groups will be approx.	Tender process led by Lead Consultant and Project Manager in Screening (working with PALs and Operations). Contract will be awarded to a service provider in Q1 2023/24, to undertake this work for the next 4 years (at a minimum).

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
community links to undertake this work. • Once tender is awarded, manage contract and monitor progress to ensure targets are met and target groups reached. PMR, session impact data and equality data will be submitted quarterly and Annually. Contract review meetings will be undertaken quarterly.	raise awareness of cancer signs and symptoms.	2,400. (N.B. targets would be revised in light of future waves of the pandemic.) Increase session attendees' awareness of the Cancer Screening Programme by 40% Increase session attendees' intention to attend cancer screening when next invited by 20%. Increase session attendees' knowledge of cancer signs and symptoms by 20%.	Contract management will be undertaken on an ongoing basis, by Project Manager in Screening with input from Lead Consultant and others as appropriate.

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
Infectious diseases in pregnancy screening (IDPS): - Ensure that all women from section 75 categories have access to IDPS early in pregnancy and that there is equality of access into clinical care for those screening positive for infections. 1. We will provide information leaflets about the IDPS programme in an accessible format in different languages. 2. We will liaise with community groups if necessary who can provide transport for women to clinic appointments if necessary. 3. We will monitor the programme to reduce potential inequalities within it especially for those women requiring referral to specialist services.	**Persons from ethnic minority groups, asylum seekers and migrants.** 1. We are trying to ensure that people from the above groups know how to access services and have the information they need in the appropriate language, in order to make an informed choice about IDPS screening. 2. We are trying to ensure that women who need to attend specialist services can access the service and attend appointments required for the health of themselves and their baby.	1.Quarterly statistics will be collected from each Trust to show performance against National standards and these will provide evidence of IDPS uptake and attendance at specialist appointments. The target would be that performance against each standard would reach the acceptable level and hopefully achieve the achievable level (top level) 2. Audit in progress around women screened positive for hepatitis B- this will highlight inequalities of access	PHA Regional antenatal infection screening programme co-ordinator–data collected quarterly.

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
		amongst women attending specialist services.	
Health Improvement Refugees, Asylum seekers, Minority Ethnic & Migrant communities should have the opportunity of equal access to Health and Social Care services in Northern Ireland. • Engage with SPPG & DoH to consider additional funding needs in the short term and to develop a regional Northern Ireland New Entrants Service (NINES) which is consistent & effective across NI • Submit a paper to SPPG to highlight the issues to be addressed and develop a business case for the funding requirements.	**Persons of different racial groups** Equal access for all Asylum Seekers, Minority Ethnic &Migrants to initial health assessments and associated screening across the Region	Written evidence of engagement and paper submission Formation of working group to address issues relating to capacity for NINES/allied services, membership to include PHA and SPPG commissioning/primary care	PHA Nursing and PHA Health Protection End March 2024

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
HSC LGBTQ+ Staff Forum Facilitate a minimum of 4 annual meetings the HSC LGBTQ+ Staff Forum. Work in partnership with other HSC organisation promote membership of the HSC LGBTQ+ Staff Forum. In partnership with members outline the key priorities for the HSC LGBTQ+ Staff Forum. Participate in and contribute to Diversity Champions events with other LGBTQIA+ Staff Networks in NI.	**Gender, Sexual Orientation** Provide an opportunity for HSC LGBTQ+ Staff to: • have a space to have their voice heard in the HSC. • be able to contribute to decision making that affects LGBTQ+ people. • Provide a community were LGBTQ+ people can feel better supported, recognised and included by the HSC. take an active role in promoting inclusion and diversity in the HSC	Population outcome: LGBTQ+ staff working in the HSC see the HSC values realised. Performance accountability: • Promotion of the Staff forum in each HSC organisation • Increase in HSC LGBTQ+ Staff Forum membership and in active participation. Production of a document outlining Staff Forums key priorities.	PHA Health Improvement with support from Employment Equality Leads in all HSC organisations by March 2024

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
Equality Monitoring Commitment to collect additional equality data and outline planned analysis to be carried out on specific data that will be collected.	**All S75 Groups** Gather additional information relating to S75 groups and explore how this can be used to inform wider decisions	Audit what information is currently gathered and develop plan to identify opportunities to collect additional data Identify data that allows further analysis to be carried out	PHA Health Improvement and Operations End Mar 2028
Equality Working Group Establish a PHA Equality Working Group	**All S75 Groups** Ensure Equality is considered at a strategic level within PHA Aim to change culture of organisation to ensure equality issues are being considered and addressed	Group established and meeting regularly – TOR agreed and action plan in place	PHA Planning and Operational Services End Mar 2028

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
Develop and introduce an equality specific section for all Involvement training commissioned / delivered by the PHA.	**All S75 Groups** Aim to ensure best practice is followed in terms of equality issues, in respect of involvement matters in the PHA and to influence practice across the wider HSC	Equality specific section developed for use in all Involvement training commissioned / delivered by the PHA. Increase in understanding of the rationale for embedding best practice in equality matters.	Lead by the PHA PPI Team, with guidance from BSO Equality colleagues, HSC partners and service users and carers

*Due to an ongoing post Covid recovery programme and the implementation of an extended screening interval in 2023/24, the availability of the online booking has had to be restricted to smaller groups, initially it is being used with those who have previously DNA'd. A review will then be carried out looking at functionality, and uptake amongst those targeted. Following this it is expected that availability will be extended to other groups within our eligible population, e.g. those newly diagnosed with diabetes, younger age groups etc.

2. Disability Action Plan 2023-28: What we will do to promote positive attitudes towards people with a disability and encourage the participation of people with a disability in public life

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
Service Development and Screening **Infectious diseases in pregnancy screening (IDPS) programme** Since people living with HIV are protected under the Disability Discrimination Act, it is important that we ensure that pregnant women screened positive for HIV are not discriminated against. 1.We will continue to encourage all staff involved in the care of pregnant women to attend HIV awareness training at least every 3 years. 2.The PHA will develop a regional power point training presentation on the IDPS, which includes HIV. This	**Promoting positive attitudes and Encouraging participation in public life** To ensure equality of care for all pregnant women screened positive for HIV.	Regional Power point training presentation for the IDPS programme developed.	PHA Regional antenatal infection screening programme co-ordinator, by early 2024.

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
will ensure standardisation of training regionally . 3.The PHA will work with HSC Trusts to strengthen their internal quality assurance function within the IDPS programme so that assurances can be given that all staff are attending training as recommended i.e. three yearly.	To ensure that Trusts take responsibility for ensuring that their staff are attending training in the IDPS programme.	QA structures for the IDPS programme agreed and implemented. (will be resource dependent)	PHA Consultant responsible for the IDPS programme and Regional antenatal infection screening programme co-ordinator by end 2025
Awareness Days Raise awareness of the lived experience of people with specific disabilities and conditions.	**Promoting positive attitudes:** Increased staff awareness of a range of disabilities and conditions.	2 awareness days profiled every year. >50% of staff taking part in the evaluation indicate they know more about people living with disabilities and conditions as a result of the awareness days.	Agency Management Team (AMT) with support from BSO Equality Unit. End Mar 2028

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
Placement Scheme Create and promote meaningful placement opportunities for people with disabilities.	**Promoting positive attitudes and Encouraging participation in public life:** People with a disability gain meaningful work experience. People with a disability are successful in applying for paid employment after they have completed a placement.	At least 3 placements in the PHA offered every year. Feedback through annual evaluation of scheme indicates that placement meets expectations. At least 1 placement participant every year is successful in applying for paid employment within 12 months of completing their placement.	Agency Management Team (AMT) with support from BSO Equality Unit. End Mar 2028
Tapestry Network Promote and encourage staff to participate in the disability staff network and support the network in the delivery of its priorities.	**Encouraging participation in public life:** Staff with a disability feel more confident that their voice is heard in decision-making. Staff with a disability feel better supported.	Tapestry staff survey Increase in Tapestry membership or in participation at meetings	Agency Management Team (AMT) with support from BSO Equality Unit End Mar 2028

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
Strategic Planning Teams Create and promote opportunities for people with disabilities to participate in PHA's strategic planning process to ensure the needs of people with disabilities are appropriately reflected when setting commissioning priorities.	**Encouraging participation in public life:** People with a disability are meaningfully involved in setting commissioning priorities initially in the following areas (to be regularly reviewed): • Mental Health • Older People • Alcohol and Drugs	Review current participation opportunities Develop and implement engagement plan	PHA Planning and Operational Services AD End Mar 2028
Providing information in signed video format Undertake an audit of PHA websites to: 1) identify key information to be made available in signed video format and 2) ensure relevant contact details are available and up to date in relation to requesting signed format versions.	**Encouraging participation in public life:** Ensure that content is accessible to people who are deaf	Complete audit to identify key information to be made available and where contact details are provided	PHA Planning and Operational Services End Mar 2028

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
Disability Training Plan Working together with Tapestry, we will co-produce, commission and deliver, and evaluate a training plan for staff on disability equality.	**Promoting positive attitudes:** Raise awareness of issues facing those with a disability and identify/develop suitable training and development opportunities	Engage with Tapestry to identify training required and explore how this can be implemented.	Agency Management Team (AMT) with support from BSO Equality Unit End Mar 2028
Pro-actively use the Engage Website to promote & encourage involvement of service users and carers with a disability. Liaise with Tapestry, HSC partners, Disability Action & other advocacy groups, to identify ways in which the Engage website might be more effectively used to advance meaningful involvement of service users and carers in the work of the HSC	**Encouraging and facilitating participation in public life.** Help to inform HSC staff how they could support and encourage active involvement of service users and carers with a disability**.** Inform and encourage service users and carers with a disability to avail of involvement opportunities with the HSC	Production of a Guide targeted at informing staff about ways in which to support involvement of service users and carers with a disability. Increasing numbers of service users and carers with a disability availing of HSC Involvement opportunities	PHA PPI Team in collaboration with Tapestry, 3rd sector Advocacy organisations – ongoing during 2023-28

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
Work with HSC partners to develop guidance and mechanisms to take forward remuneration of service users and carers in line with the policy direction laid down in the Co-Production Guide	**Encouraging and facilitating participation in public life**. Helping to address barriers to participation by service users and carers, many of whom are living with a disability and who are less likely to get involved due to additional financial pressures and costs.	Have in place guidance and mechanisms to facilitate remuneration of service users and carers in agreed, appropriate and defined circumstances. Increasing numbers of service users and carers with a disability, availing of remunerated HSC Involvement opportunities.	PHA PPI Team working in collaboration with the DoH, HSC partners & the PCC by the end of 2024.
Work with HSC partners to develop mechanisms for feedback which are accessible to the wider population of Northern Ireland	**Improve opportunity for people of NI to provide feedback on experiences across HSCNI**	All campaigns and promotion material will be supported by translation and adapted to encourage feedback from people with a disability	PHA PCE Team working in collaboration with HSC partners and charitable partners; Complete by the end of 2024

Equality and Human Rights Screening Report

April 2023 – March 2024

These screenings can be viewed on the BSO website under: Equality Screening - Business Services Organisation (BSO) Website (hscni.net)

Policy / Procedure	Policy Aims	Date	Screening Decision
Draft Equality and Disability Action Plans 2023-28	In line with our commitments under Section 75 of the Northern Ireland Act 1998 and our Equality Scheme, the Equality Action Plan 2023-28 identifies a number of key actions to promote equality. The purpose of the Disability Action Plan is to outline some key actions that we are going to deliver upon to make a difference to people with disabilities including staff and people who use our services, and where relevant, their carers - to promote positive attitudes towards disabled people and encourage the participation by disabled people in public life.	May-23	Screened out with mitigation
Self-Harm Intervention Programme (SHIP): Re-tender	Under the Protect Life Suicide Prevention Strategy for Northern Ireland, the PHA is tasked	Jan-24	Screened out with mitigation

	with commissioning services for people who self-harm. A Self-Harm Intervention Programme (SHIP) will be provided by Community and Voluntary sector organisations, targeting those with less complex problems that would otherwise be discharged from Health and Social Care Trusts with little or no support in place. It complements the mental health services provided by the Trusts.		

No concerns were raised by consultees on any of the screenings published in 2023-24.

Chapter 6: Mitigation Report

Equality and Human Rights Mitigation Report

April 2023 – March 2024

Equality and Disability Action Plans 2023-28

In developing the policy or decision what did you do or change to address the equality issues you identified?	*What do you intend to do in future to address the equality issues you identified?*
Informed Choice in cancer screening • The PHA commissions a service to raise awareness of and promote the three cancer screening programmes throughout Northern Ireland. The service is targeted at those impacted by health inequalities (Section 75 groups, including learning disability, along with those living in socially deprived areas). • The PHA worked with transgender groups to produce a regional screening transgender leaflet for cancer and AAA screening programmes. In final stages of drafting. • The PHA regularly runs social media campaigns to promote the 3 cancer screening programmes, tied to awareness raising events eg Cervical Screening Awareness Week. Training for those who work with women with HIV • All antenatal screening co-ordinators (ANSCs) are encouraged to complete the Infectious diseases in pregnancy training programme run by NHS England. For those ANSCs with caring responsibilities this is an	Diabetic eye screening • It is not currently possible to book an appointment online in another language. Patients are advised in the invitation letter that they can contact the Trust directly to make an appointment and also to advise if they require an interpreter to attend the appointment. The Trust currently do not provide letters or leaflets in other languages; it is an area that the Trust hope to address within the coming months. • Patients with a disability such as deafness are also advised in their invitation letter that they can contact the Trust by email (as an alternative means of communication regarding their needs). Children with special educational needs • The PHA continues to work in partnership with SPPG, DoH, EA and DE in the increased number of children and young people with Special Educational Needs who require placement in Special Schools to determine and deliver the AHP support to meet their needs across the section 75 categories. This

on-line training which can be accessed from home. • Currently none of the ANSCs have disabilities or are members of ethnic minority groups, however if this was the case provisions would be made to accommodate them and ensure that they could avail of the training via the use of interpreters or signers for the deaf if necessary. • The ANSCs are then tasked with providing training to the staff working in maternity services including HIV awareness training. Trusts would be responsible for ensuring that staff with disabilities or language problems could access the training. Awareness Days • Deaf: We arrange a Sign Language Interpreter for all our events. • Carers: We organise our Awareness Days on Tuesdays, Wednesdays and Thursdays, when most staff who work part-time are at work. We upload the presentation from the speakers and, whenever possible, record and upload the speaker's input onto the Tapestry website. That way, all staff can access the information at a time convenient to them.	includes developing a model of training to support educational staff to meet needs of CYP with disabilities that is age appropriate and meets their cognitive and cultural needs. Informed Choice in cancer screening • This commissioned service is due to go out to tender. The current service has been temporarily extended in the interim. Funding for this work going forward is uncertain. • To make information more accessible to those who do not have English as a first language, we will review our suite of available translated leaflets, adding leaflets in new languages, if required and providing translated versions of new leaflets. • We hope to undertake a review of the literature to further understand the barriers to screening and interventions to promote informed choice for those impacted by health inequalities. New entrants' services • BSO face to face foreign language Interpreting Services are available to all Patients/Clients who do not speak English proficiently when accessing Health and Social Care services in Northern Ireland

Work Placements • We work with a range of disability organisations to ensure opportunities are offered to people from a wide spectrum of disabilities, as well as different gender and age groups. • We ensure that reasonable adjustments are discussed and put in place before placements commence. • Some of the placements are offered on the basis of Hybrid Working. This means, working in an office some of the time and working from home some of the time, if preferred by the individual. • We have completed a separate equality screening for our Placement Scheme. We review this screening every year when we make changes to the Scheme. Tapestry Disability Staff Network • We ensure that the way the forum operates allows people with a range of disabilities and from a range of age and ethnic backgrounds to be involved (for example, by providing information in accessible formats; arranging for a Sign Language Interpreter to attend	Training for those who work with women with HIV • Trusts will be asked for assurance that all staff working in maternity services are able to access HIV awareness training. Strategic Planning Teams • In developing the SPT communication and engagement strategies we will identify meaningful approaches for engaging people with disabilities, recognising the differing needs depending on age, gender, ethnicity, caring responsibilities and sexual orientation.

all meetings; and by arranging meetings online). • Accessible formats and inclusiveness are integrated into the Terms of Reference. • Strict confidentiality provisions apply. • When we engage with Tapestry members we offer members to take part in a discussion at a meeting or to send their views to a dedicated email address for Tapestry. Only a small number of staff from the BSO Equality Unit, who facilitate the network, have access to this email address.	

Self-Harm Intervention Programme (SHIP): Re-tender

Category	***In developing the policy or decision what did you do or change to address the equality issues you identified?***	***What do you intend to do in future to address the equality issues you identified?***
All	In developing the specification, we recommended CPD programme includes: • Equality and diversity awareness • Human rights awareness • Emerging mental illness awareness • Substance use issues awareness	Monitor annual CPD programme. Have Equality and Diversity as standing item on • Contract Management meetings • Regional SHIP Network meetings

	• Disability and carers awareness • Understanding the needs of autistic clients (section 3.3.8)	
Gender	In developing the specification, we: • Included appendix 1 which outline the rates of self-harm by gender. • Used gender neutral language throughout • Included gender demographic information in our monitoring return, including options for non-binary, and prefer to self-describe • Require collection of Section 75 information (6.3.1) • Require staff to attend a sexual orientation and gender identity course (3.3.9.3)	Monitor gender of both referrals and clients and support persons with each provider and across the region. Identify areas for service improvement, for example if proportion of males declining the service is higher than the number of females. Or if number of males being referred to the service is lower than expected. Review Section 75 data on an annual basis to identify and required areas for action. Monitor staff training.
Age	In developing the specification, we: • Included appendix 1 which outline the rates of self-harm by age. • Included appendix 3 which outlines service usage by under and over 18 years. • Included eligibility criteria for clients outlines age profile for service (2.3)	Monitor age of both referrals and clients and support persons with each provider and across the region. Identify areas for service improvement, for example if proportion of those aged 60+ declining the service is higher than those aged 35-59 years. Or if number of under 18s being referred to the

	• Included criteria for support person(s) widened to 11+ years old to ensure inclusive of young carers/siblings (2.4) • Specified that staff working with children and young people have the necessary qualifications and skills as outlined by their professional body (3.2.4) • Included the requirement to offer evening and weekend appointments, important for those in education/employment (4.7.6) • Included mode of delivery to include face-to-face and remote to widen access for different age groups (4.8) • Included age demographic information in our monitoring return. • Require collection of Section 75 information (6.3.1)	service is lower than expected. Review Section 75 data on an annual basis to identify and required areas for action.
Religion	In developing the specification, we: • Require providers to offer online and blended delivery of the service, to support barriers to be overcome • Included the requirement for cultural competence training (3.3.9.3)	Review Section 75 data on an annual basis to identify and required areas for action. Monitor staff training. Monitor geographic locations that services are offered from.

	• Require providers to deliver services from geographic locations that consider religious sensitives (4.7.5) • Require collection of Section 75 information (6.3.1)	
Political Opinion	In developing the specification, we: • Require providers to offer online and blended delivery of the service, to support barriers to be overcome (4.3.5, 4.5.6, 4.8.3) • Require providers to deliver services from geographic locations that consider political sensitives (4.7.5) • Require collection of Section 75 information (6.3.1)	Review Section 75 data on an annual basis to identify and required areas for action. Monitor geographic locations that services are offered from.
Marital Status	In developing the specification, we: • Changed the language to 'support person' in recognition of the diverse family/friendship dynamics within Marital Status • Require collection of Section 75 information (6.3.1)	Review Section 75 data on an annual basis to identify and required areas for action.
Dependent Status	In developing the specification, we:	Review Section 75 data on an annual basis to identify and required areas for action.

	• Included the requirement to offer evening and weekend appointments, important for those with caring responsibilities (4.7.6) • Included mode of delivery to include face-to-face and remote to widen access for those with caring responsibilities (4.8) • Require collection of Section 75 information (6.3.1)	
Disability	In developing the specification, we: • Enhanced our eligibility criteria to provide clarity on provision of support for those with Mental illness, Personality Disorder, Neurodiversity. Learning Difficulties/Intellectual Disability, Alcohol or Substance use (2.3) • Require providers to make adjustments for service users with communication support needs (4.3.9, 4.4.1, 4.4.3) • Require premises to be accessible to all service users, including full participation of those service users with disabilities (4.7.2) • Included mode of delivery to include face-	Require Providers to confirm on an annual basis that premises are accessible to all. Review Section 75 data on an annual basis to identify and required areas for action.

	to-face and remote to widen access for those with disabilities (4.8) • Require collection of Section 75 information (6.3.1)	
Ethnicity	In developing the specification, we: • Included the requirement for cultural competence and trauma informed approaches training (3.3.9.3) • Included a requirement for Provider to utilise interpreter for engagement calls and written correspondence is translated when identified by referrer (4.3.8) • Included a requirement that if a client/support person requires an interpreter that this is provided (4.4.2 & 4.5.7) • Require providers to deliver services from geographic locations that consider prevalence of hate crimes (4.7.5) • Require collection of Section 75 information (6.3.1)	Monitor staff training. Monitor geographic locations that services are offered from. Review Section 75 data on an annual basis to identify and required areas for action.
Sexual Orientation	In developing the specification, we: • Require staff to attend a sexual orientation and	Monitor staff training. Monitor geographic locations that services are offered from.

	gender identity course (3.3.9.3) • Require providers to deliver services from geographic locations that consider prevalence of hate crimes (4.7.5) • Require collection of Section 75 information (6.3.1)	Review Section 75 data on an annual basis to identify and required areas for action.

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***

Public Health Agency

item 12

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	28 August 2024
Title of paper	Complaints and Claims Report
Reference	PHA/07/08/24
Prepared by	Alastair Ross / Catherine Collins
Lead Director	Aidan Dawson

Recommendation For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is for the Board to note the latest report on complaints and claims against the PHA.

2 Background Information

Following the receipt of an internal audit recommendation, the Agency now produces a quarterly Complaints Report to ensure that senior leaders within the PHA, at both Executive and Non-Executive level, are adequately briefed in respect of complaints handling.

The Complaints Report as at quarter 1 2024/25, has now been updated to include information in respect of claims management within the Agency - this being a further recommendation set out in the Internal Audit of Complaints and Claims Management within the PHA (2023).

3 Key Issues

During the first quarter of 2024/25, the PHA received no formal complaints and has closed one complaint.

4 Next Steps

The next Report will be brought to the Board in October 2024.

2024/2025
Complaints and Claims
Quarterly Report

Qtr 1 Report

Position as at 30 June 2024

Report Prepared by PHA Complaints Office

CONTEXT

This report has been created as a mechanism to ensure that senior leaders within the PHA, at both Executive and Non-Executive level, receive regular and adequate information in respect of complaints and claims made against the organisation.

SECTION 1 - COMPLAINTS

1. Definition

In line with the guidance set out in the HSC Complaints Procedure, a complaint is '*an expression of dissatisfaction that requires a response*' in relation to the work undertaken by the PHA.

This is in contrast to the many general queries, public health concerns or complaints made against other organisations that make their way to the PHA - these being dealt with through alternate channels.

2. Key Performance Indicators

The management of complaints are monitored in line with the following key performance indicators (KPIs):

a. A complaint should be acknowledged in writing within 2 working days of receipt;

b. A complaint should be responded to within 20 working days of receipt;

c. Where a full response within 20 days is not possible, a complainant should be updated every 20 working days on the progress of their complaint.

3. 2024/25 Overview

During the period, 1st April 2024 - 30 June 2024, the PHA received no formal complaints.

Table 1 Number of complaints by month/quarter 2023/24 VS 2024/25

	Q1			Q2			Q3			Q4			
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**TOTAL**
2024/25	0	0	0										**0**
2023/24	1	1	1	2	0	0	1	0	0	0	1	1	**8**

The following table sets out a breakdown of the number of complaints by Directorate between fiscal years 2023/24 and 2024/25. The 2024/25 position is as at 30 June 2024.

Table 2 Complaints by Directorate 2023/24 VS 2024/5

	Number of Complaints Received	
Responsible Directorate	**2023/24**	**2024/25**
Chief Executive's Office	N/A	0
Nursing Midwifery & AHP	3	0
Operations	1	0
Public Health	4	0
Quality Improvement	0	0
TOTAL	**8**	**0**

4. 2024/25 Closed Complaints

The PHA has closed one complaint during 2024/25 - this complaint was received during 2023/24. Tables 3, 4 and 5 provide information in respect of closed complaints.

Table 3 Performance Against Key Performance Indicators for Closed Complaints 2023/24 VS 2024/5

		KPI 1		KPI 2		KPI 3	
	Number of Complaints Closed	Number of complaints acknowledged within 2 working days of receipt	Percentage of complaints acknowledged within 2 working days of receipt	Number of complaints responded to within 20 working days of receipt	Percentage of complaints responded to within 20 working days of receipt	Number of complainants updated every 20 days (where KPI 2 was not met)	Percentage of complainants updated every 20 days (where KPI 2 was not met)
2024/25	1	1	100%	1	100%	N/A	N/A
2023/24	7	6	85%	4	57%	3	100%

Table 4 Tenure of Closed Complaints 2023/24 VS 2024/25

	Average Time taken to conclude Complaint (working days)	Longest Time taken to conclude Complaint (working days)	Shortest Time taken to conclude Complaint (working days)
2024/25*	16 Days	16 Days	16 Days
2023/24	27 Days	106 Days	3 Days

** only one complaint closed as at 30 June 24 which was received in late 2023/24 and took 16 days to conclude*

Table 5 Synopsis of Closed Complaints 2024/25

PHA Ref	Responsible Directorate	Synopsis of Complaint and Response
C08/2324	Public Health	Complaint - Dissatisfaction with the approach taken by the PHA in relation to the management of an E Coli outbreak within a childcare setting. Response - A full rationale for the PHA response was provided to the complainant. The response acknowledged the level of disruption and stress that the management of the outbreak had caused which had to be considered against the need to prevent the transmission of a life-threatening illness.

5. 2024/25 Open Complaints

As at 30 June 2024, the PHA has no open complaints.

6. Northern Ireland Public Services Ombudsman

Upon the completion of the PHA complaints process, each complainant is signposted to the Ombudsman should they be dissatisfied with the outcome they have received.

In April 2024, the Ombudsman advised that they would not be accepting a complaint referred to them in relation to the PHA. This complaint was from November 2022 and was in relation to the perceived conduct of a PHA staff member with a service user during a training programme.

As at 30 June 2024, the PHA is aware of no open PHA investigations with the Ombudsman.

SECTION 2 - CLAIMS MANAGEMENT

1. Potential Liabilities

Claims within the PHA are aligned to four types of potential liability:

- Clinical/Medical Negligence,
- Employer's and Occupier's Liability,
- Injury Benefit and
- Employment Law.

The level of provision made in respect of potential liabilities for claims is based on professional legal advice from the Directorate of Legal Services (BSO). Information in respect of provisions are set out in the PHA Annual Report.

2. 2024/25 Closed Claims (Settled and Withdrawn)

No claims were closed by the PHA during the 1 April 2024 to 30 June 2024 period.

3. 2024/25 Open Claims

As at 30 June 2024, the PHA has two live claims open. Table 6 provides further detail in respect of each claim.

Table 6 PHA Open Claims

Date Opened	Type of Potential Liability	Claim Synopsis
November 2021	Clinical/Medical Negligence	This is a potential litigation claim threatened by an individual against numerous persons and entities under the guise of a 'freeman' claim which essentially challenge the lawfulness and legality of requiring citizens to abide by laws/be regulated by the state. These claims tend not to be pursued and previous claims have been dismissed with the personal litigant 'freemen' being subject to restrictions on the issuing of future litigation without the leave of the court.
March 2023	Employment Law	This is a claim that has been lodged with the Office of the Industrial Tribunal and Fair Employment Tribunal in which both SBNI and PHA are named Respondents. The Claimant is challenging the Respondents in relation to their personal employment status which precludes them from contributing to the HSC Pension Scheme. A Case Management Review Hearing is scheduled for August 2024. At the hearing, the claim will be further defined and a determination made as to whether SBNI should be removed from the claim to leave the PHA as the sole Respondent.

PHA Complaints Office
complaints.pha@hscni.net

END

HSC Public Health Agency

item 13

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	28 August 2024
Title of paper	ALB Self-Assessment
Reference	PHA/08/08/24
Prepared by	Robert Graham
Lead Director	Colin Coffey

Recommendation For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to bring the ALB Self-Assessment to the PHA Board for approval.

2 Background Information

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

3 Key Issues

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

4 Next Steps

For 2024/25 onwards it is planned that a new self-assessment template will be used.

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

BOARD GOVERNANCE SELF ASSESSMENT TOOL

For use by Department of Health Sponsored Arms Length Bodies

Updated 16th June 2016

Contents

1.Board Composition and Commitment

2. Board evaluation, development and learning

3. Board Insight and foresight

4. Board Engagement and Involvement

5. Self Assessment Template....

6. Board Impact Case Studies

Introduction

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

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

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

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

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

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

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

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

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

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

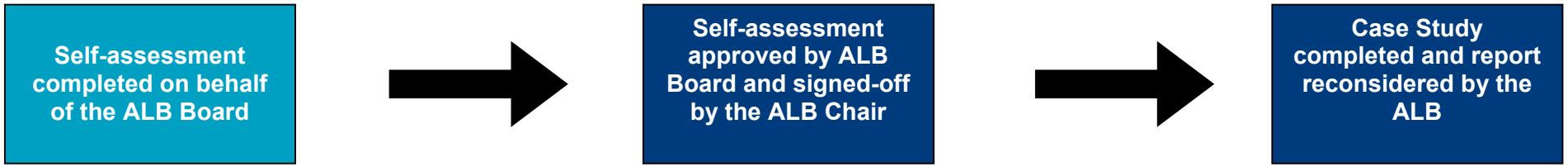
Complete the self-assessment: It is recommended that responsibility for completing the self-assessment sits with the Board and is completed section by section with identification of any key risks and good practice that the Board can evidence. The Board must collectively consider the evidence and reach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

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

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

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

Overview



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

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

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

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

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

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

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

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

Step 1

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

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

Step 2

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

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

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

Step 3

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

Scoring Criteria

The scoring criteria for each section is as follows:

Green if the following applies:

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

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

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

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

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

Red if the following applies:

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

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

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

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

1. Board composition and commitment

1. Board composition and commitment overview

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

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

1. Board composition and commitment

1.1 Board positions and size

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

1. Board composition and commitment

1.2 Balance and calibre of Board members

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

1. Board composition and commitment

1.3 Role of the Board

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

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

1. Board composition and commitment

1.4 Committees of the Board

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

1. Board composition and commitment

1.5 Board member commitment

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

2. Board evaluation, development and learning

2. Board evaluation, development and learning overview

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

1. Effective Board-level evaluation;
2. Whole Board Development Programme;
3. Board induction, succession and contingency planning;
4. Board member appraisal and personal development.

2. Board evaluation, development and learning

2.1 Effective Board level evaluation

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

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

2. Board evaluation, development and learning

2.2 Whole Board development programme

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

2. Board evaluation, development and learning

2.3 Board induction, succession and contingency planning

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

2. Board evaluation, development and learning

2.4 Board member appraisal and personal development

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

3. Board insight and foresight

3. Board insight and foresight overview

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

1.Board Performance Reporting

2.Efficiency and productivity

3.Environmental and strategic focus

4.Quality of Board papers and timeliness of information

3. Board insight and foresight

3.1 Board performance reporting

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

3. Board insight and foresight

3.2 Efficiency and Productivity

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

3. Board insight and foresight

3.3 Environmental and strategic focus

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

3. Board insight and foresight

3.4 Quality of Board papers and timeliness of information

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

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

3. Board insight and foresight

3.5 Assurance and risk management

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

4. Board engagement and involvement

4. Board engagement and involvement overview

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

1.External Stakeholders

2.Internal Stakeholders

3.Board profile and visibility

4. Board engagement and involvement

4.1 External stakeholders

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

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

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

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

4. Board engagement and involvement

4.2 Internal stakeholders

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

4. Board engagement and involvement

4.3 Board profile and visibility

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

5. Board Governance Self- Assessment Submission

Name of ALB – Public Health Agency

Date of Board Meeting at which Submission was discussed – 20 June 2024

Approved by Colin Coffey (ALB Chair)

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2024

1.1 Board positions and size

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Amber	As at 31 March 2024, the Board has one vacant Non-Executive position. Of the Executive Directors, there is only now one post which is filled on an interim basis.	The Chair will raise with the Department the need for the vacant NED position to be resolved as quickly as possible.		
GP2 Green	The Board receives full information from senior officers in order to inform it in its deliberations, decisions and evaluatons.			
GP3 Green	The process for voting, and who the voting members are is as outlined in Standing Order 5.2.17. Members are aware of their responsibilities in this area from induction and through guidance from the Chair.			

GP4 Green	There are now three Committees of the Board and their terms of reference are outlined in Standing Orders. They are: • The Governance and Audit Committee • The Remuneration and Terms and Conditions of Service Committee • The Planning, Performance and Resources Committee			
GP5 Green	The appointment time of NEDs is appropriately managed to ensure continuity of corporate memory is retained across the Board.			

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

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2024

1.2 Balance and calibre of Board members

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The appointment of NED's is the responsibility of the Department of Health and the Public Appointments Unit over which the PHA has no control.			
GP2 Green	The Board has an appropriate representation of experienced members across all 3 sectors.			
GP3 Green	The Board is extremely conscientious in its concern to ensure equality of opportunity in accordance with Section 75 of the Northern Ireland Act 1998 and oversees the submission of the annual Equality report to the Equality Commission.			
GP4 Green	There are three Non-Executive Directors with a background specific to the business of the PHA.			
GP5 Green	As per legislation, the Board is constituted from local government and lay members. The Board includes people with			

	relevant technical and professional expertise.			
GP6 Green	As at 31 March 2024 the composition of the Board reflects the need for a balance between those that are new and those that have served for longer than 3 years.			
GP7 Green	All Board members are experienced board members.			
GP8 Green	The Chair of the Board has been Chair of the Agrifood and Biosciences Institute (AFBI for 5 years.			
GP9 Green	The Chair of the Board is currently Chair of AFBI as well as a Non-Executive Director in Invest NI and the Science Park.			
GP10 Green	The Chair of the Governance and Audit Committee has highly competent financial skills.			

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

RF5		
RF6		

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2024

1.3 Role of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The role and responsibility of the Board is outlined within Standing Orders. Standing Orders are normally reviewed annually with the last update approved at the Board meeting of February 2023.			
GP2 Green	There a clear understanding of the distinct roles of the executive officers and the non-executive board members as outlined in job descriptions and the scheme of delegation within Standing Orders. During 2021/22 a "Buddy" system was introduced to help improve understanding of roles and it is aimed to run this again during 2024/25.			
GP3 Green	The Board takes collective responsibility for the performance of the ALB. It is important that if there are any shortcomings that these are acknowledged and addressed			

	with vigour. In year a new performance monitoring system was introduced by the Board to address previous shortcomings in process. The Board is satisfied that it takes responsibility for the performance of the ALB.			
GP4 Green	Non-Executive Directors regularly make a point of emphasising the role of challenge and support for the Board.			
GP5 Green	Since taking up post the Chair has sought to establish a positive relationship with PHA's Sponsor Branch by setting up regular meetings. The Chair is also a member of the Health ALB's Chairs' Forum which provides a good opportunity to discuss issues directly with the Minister and Senior DoH colleagues.			
GP6 Green	All NEDs hold the CEO and Executive Directors to account at regular Board meetings and Committee meetings.			
GP7 Green	The Board effectiveness is considered to be of a high standard. This has improved following			

	the implementation of recommendations made by Internal Audit following an audit of Board effectiveness carried out during 2021/22.			
GP8 Green	The Board makes decisions based on data and evidence presented. The Board as a whole shares corporate responsibility for all decisions.			
GP9 Green	Board members do respect confidentiality and sensitive information. During 2022/23 all Board members ensured that their HSC issued laptops were operational and these are used for communicating confidential information.			
GP10 Green	The Board is clear on the relative responsiblilities to be discharged by Board and at Executive level. The Board governs and Executives manage.			
GP11 Green	Board members contribute fully to Board decisions and deliberations and exercise a challenge function which is both healthy and supportive.			

GP12 Green	The Chair is always available for guidance and advice for Board members.			
GP13 Green	The Chair maintains a clear focus on the important issues facing the Board and facilitates the Board discussions so that all members are heard, engaged and actively involved in debate and constructive challenge prior to making a Board decision.			
GP14 Green	The Board is provided with the appropriate information and considers the concerns and needs of identified stakeholders. As the Regional lead for PPI across the HSC the Board takes seriously its responsibility to drive forward its role in regard to Patient and Public Involvement across its programmes of work.			
GP15 Green	Currently the Board does not approve annually the scheme of delegation to its committees. While Committees do not have delegated powers of decision making, their terms of reference are included within Standing Orders which are approved by the Board.			

GP16 Green	The Board receives evaluation reviews on some programmes and projects. However, the Board has agreed that more work is required to ensure consistent and in depth evaluation is provided in a timely fashion on an outcomes-based plaform.			

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

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2024

1.4 Committees of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	Clear terms of reference have been given for the three Board Committees. The Chair has established a specific Committee to have oversight of the outworking of the Reshape and Refresh Programme. The Chair is currently reviewing the membership of the Planning, Performance and Resources Committee as well as its terms of reference.			
GP2 Green	The Board is aware that it has full responsibility for all decisions taken by Committees of the board.			
GP3 Green	The scheme of delegation is outlined in Standing Orders.			
GP4 Green	There are clear lines of responsibility in terms of reporting and accountability regarding each committee back			

	to the Board.			
GP5 Green	There is an Assurance Framework in place that covers the Board, and its Committees, and this is reviewed and approved by the Governance and Audit Committee and also the Board. It outlines the frequency of when certain reports and papers should come to the Board and the assurance provided.			
GP6 Green	The Board receives regular reports from its committees. These summarise the key issues as well as any decisions or recommendations made.			
GP7 Amber	The GAC undertakes a formal evaluation each year of the performance of its committee. (Self assessment). However, a formal evaluation of the Remuneration Committee has not been undertaken. The Chair is keen to carry out a review of the Board Committees during 2024/25 as well as a review of the Board, a NED review and a review of the appraisal process.	A review of Board Committees is to be carried out in 2024/25.		
GP8 Green	The Chair of the Committee is responsible for reporting back to the Board on all issues dealt			

	with by that Committee. This is understood by all Board members.			

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

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2024

1.5 Board member commitment

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

GP4 Green	An annual schedule of meetings is prepared and agreed with members in relation to Board meetings, workshops and strategic days. Schedules are also in place for Committee meetings.			

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

2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2024

2.1 Effective Board level evaluation

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The PHA Board completed its annual self-assessment for 2022/23. The completion of this was delayed due to changes at Chair level.			
GP2 Green	The PHA Board continues to review itself to ensure improvement and development.			
GP3 Red	A review of Board effectiveness was carried out by Internal Audit in 2021/22 and many of the recommendations have been fully implemented. The Chair intends that the Board complies with having an external assessment every 3 years with the aim of commencing this in 2025.	An independent evaluation of the Board and its Committees will be carried out by the end of 2024/25.		
GP4 Red	The Board has not obtained the perspective of staff or external stakeholders in the completion of this questionnaire.	The Board will consider a self-assessment process during 2024/25 that will include gaining the perspective of staff and		

		stakeholders.		
GP5 Green	The current self-assessment has covered those questions/areas included in the DoH checklist, both 'hard' and 'soft' dimensions of effectiveness.			

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

2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2024

2.2 Whole Board development programme

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Amber	Following the Internal Audit of Board effectiveness, a programme of work was put in place, e.g. the Board "Buddy" initiative, which it is intended to run again in 2024/25. During 2022/23 there were also Board workshops on strategy and governance. With a new Chair having been appointed during 2023/24, a new Board Development Programme will be put in place for 2024/25. The Chair intends to discuss personal development during the NED appraisal process with a plan to be agreed with each individual NED as to how they can develop.	Board Development Programme to be put in place during 2024/25.		
GP2 Green	The relationship between the Minister, Department and ALB board members is included in the Management Statement.			

	It should be noted that Management Statements are due to be replaced by Partnership Agreements and work on this is progressing. This matter has been raised at Accountability Review meetings.			
GP3 Green	The Governance and Audit Committee has oversight on all matters of the control and challenge function of the PHA Board. Its meetings are reported directly to the Board both for noting and action. The GAC Chair also provides an update alongside the minutes whilst compiling an Annual Report.			
GP4 Green	This will be covered as part of the Board Development Programme referenced at GP1 above.			
GP5 Green	This will be covered as part of the Board Development Programme referenced at GP1 above.			
GP6 Green	This will be covered as part of the Board Development Programme referenced at GP1 above.			

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

2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2024

2.3 Board induction, succession and contingency planning

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	All Board members have had induction which includes attendance at the On Board training course. Specific induction is also provided for new members of the Governance and Audit Committee. New Board members will meet with in the first instance the Chair followed by a meeting with the Chief Executive, the Director of Finance, Director of Public Health, the Director of Nursing and AHP and the Director of HSCQI.			
GP2 Green	Induction is undertaken as soon as possible after appointment. Members must attend On Board training within 6 months of appointment and this has always been complied with.			

GP3 Green	At the induction, new members will receive a pack of relevant corporate and strategic documentation. Meetings are organised with Executive Directors and other senior staff.			
GP4 Green	Deputising arrangements are specified within Standing Orders. The Chair will ensure that, in the event that he cannot carry out his duties, a deputy will be named.			
GP5 Green	Appropriate action has been taken by the PHA. The Chair will liaise with PAU to ensure that any future vacancies do not impact on the governance of the PHA.			

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

2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2024

2.4 Board member appraisal and personal development

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	Annual appraisals are carried out by the Chair in line with the requirements of the PAU.			
GP2 Green	The Chief Executive carries out appraisals with Executive Directors. The performance of the Chief Executive and Executive Directors is discussed at the Remuneration Committee.			
GP3 Green	The Chair receives an appraisal from the head of PHA's Sponsor Branch.			
GP4 Green	As part of the appraisal system, this is clearly discussed and specified to ensure continuous development. Not all will have been given specific responsibilities, this will be reviewed by the Chair.			
GP5 Green	Board members appraisals allow members to highlight development needs.			

	At each appraisal the chair explicitly asks each Non-Executive Director what additional training they feel would be useful.			
GP6 Green	This is covered through the appraisal system and PDPs, as well as through Director/Chief Executive away days. Relevant training/awareness is also built in where particular needs arise during the year.			
GP7 Green	It is assumed that where appropriate, this is the case.			

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

3. Board insight and foresight

ALB Name - Public Health Agency Date – 31 March 2024

3.1 Board performance reporting

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	PHA prepared an Annual Business Plan for 2023/24. The Board approved this Plan and also approved a Financial Plan. The PHA Corporate Strategy and Annual Business Plan (including commissioning direction targets) set the parameters for performance reporting. During 2024/25 work will commence on the development of a new PHA Corporate Strategy.			
GP2 Green	During the course of the year, quarterly progress reports were brought by AMT to the Board to update on progress against the actions in the Business Plan. The Board also received a monthly Finance Report.			

GP3 Green	The Committee Chairs provide updates to the Board following each Committee meetings as specified in Standing Orders. The approved minutes of each Committee are brought to the Board for noting.			
GP4 Green	The Corporate Risk Register is openly discussed and challenges on same are made at the Governance and Audit Committee. The Corporate Risk Register is brought to the Board annually, or more frequently at the request of the Governance and Audit Committee. The Board is briefed in both public and confidential sessions of new and emerging risks where necessary.			
GP5 Green	Following the Internal Audit review of Board Effectiveness a more detailed action log is kept following each Board meeting with updates against actions given in advance, or at, the next meeting. This approach also applies to Committees of the Board.			

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

3. Board insight and foresight

ALB Name - Public Health Agency Date – 31 March 2024

3.2 Efficiency and Productivity

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The Board is assured that there are robust processes for assessing risks and the potential knock on or impact these could have on the health and social care system. During 2022/23 and 2023/24 PHA has been asked to prepare a paper on savings proposals for the Department of Health.			
GP2	Not applicable.			
GP3 Green	While the Board has not received information on efficiency and productivity plans, any risks to non-achievement in performance are highlighted in the Performance Management Report.			
GP4 Green	Ongoing risks to service delivery across various PHA programmes are monitored.			

	Key performance is reported via the PHA Performance Management Report.			

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

3. Board insight and foresight

ALB Name - Public Health Agency Date – 31 March 2024

3.3 Environmental and strategic focus

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The Chief Executive presents a written "Chief Executive and Directors' Report" at every Board meeting which, if required, will cover areas such as the external environment, policy changes and any other areas as required. The Chair also gives a verbal update at each Board outlining meetings he has attended or stakeholders he has met with.			
GP2 Green	BSO Internal Audit carried out an audit of Serious Adverse Incidents (SAIs) within PHA and HSCB during 21/22, the report of which was discussed at the Governance and Audit Committee in April '22. Updates on the progress made against recommendations in that audit are presented to the Governance and Audit			

	Committee.			
GP3 Green	PHA prepared an Annual Business Plan for 2023/24 which was brought to the Board for approval. The Plan reflected the key actions from all functions and directorates across the five strategic outcomes and three delivery areas.			
GP4 Green	As GP3 above, and reports are brought to the board on a quarterly basis as outlined in section 3.1 (GP2). There is also an Assurance Framework which outlines what reports are required to be brought to the board and a corporate calendar outlining when these will be brought to the board. Work will commence during 2024/25 to develop a new PHA Corporate Strategy. In light of pressures on HSC organisations in 2021/22, DoH agreed that existing Corporate Strategies for all ALBs could be extended to cover 2023/24.			
GP5 Green	The Board's annual programme of work allows for time for the board to consider environmental and strategic			

	risks (including confidential board meetings, board workshops and board away day). Where relevant the Assurance Framework will be amended to include additional reporting, and/or amendments brought back through Executive Directors for the Risk Register. As per section 3.1 (GP4) the Corporate Risk Register is openly discussed and challenges on same are made at the Governance and Audit Committee. The Corporate Risk Register is brought to the Board annually, or more frequently at the request of the Governance and Audit Committee.			

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

3. Board insight and foresight ALB Name - Public Health Agency Date – 31 March 2024

3.4 Quality of Board papers and timeliness of information

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The timing of Committee meetings, is scheduled so that verbal updates can be given to the Board in a timely manner with Committee minutes shared with members for noting at the Board following their approval by the Committee.			
GP2 Green	A timetable is drawn up each year for Board meetings and Committee meetings. Papers are dispatched one week before the meeting giving members 5/6 days to absorb what is sometimes a very large volume of documents.			
GP3 Green	The Committee Manager has instituted a system whereby those submitting reports to the board must indicate clearly on the front page the role of the board i.e. noting, approving, decision, discussion. The Chair			

	of GAC has raised the issue of the need for clarity in terms of the rationale behind whether it should be noting, approving, decision-making or discussion.			
GP4 Green	During 2023/24 the Planning, Performance and Resources Committee looked at Trust programme expenditure as part of its remit and will continue to do so. Peformance management of Trust contracts will part of the Internal Audit work programme for 2024/25.			
GP5 Green	Board papers include the relevant information in respect of proposals or decisions that have been proposed or made. They also state if they have been considered by the Executive Team, or other board committee before they are brought to the board.			
GP6 Green	The Board is presented with quality updates. The PHA has a robust mechanism for ensuring the collection and analysing of data. Board members regularly question and challenge data to ensure quality and understanding of same when both verbal and formal papers			

	are brought to Board meetings. Also, the Governance and Audit Committee have the opportunity to challenge and question data provided. Internal and External Audit consider data quality in relevant audits.			
GP7 Green	The Board cannot recollect a discussion about the underlying data quality of performance measures. A review of PHA by Dr Ruth Hussey made recommendations with regard to the PHA developing its science and intelligence capability. PHA is hoping to secure funding to implement fully the recommendations of that Review.			
GP8 Green	The Assurance Framework outlines clearly the information being brought to the Board for approval/noting etc. Board members discuss the information status at various workshops.			
GP9 Green	Board members may not always be able to demonstrate			

	that they understand fully the information presented to them particularly how that information was collected and quality assured. Board members will be encouraged by the Chief Executive to contact him in an instance where they do not understand information or complex data. The Chair himself will attempt to answer this. if not this is not possible he will refer the matter to a senior member of staff with the appropriate expertise. That member of staff will report back either to the Chair or to the Board member concerned.			
GP10 Green	The PHA takes all steps to ensure that documentation presented to the Board complies with DoH guidance where appropriate. However, the design of reports needs to be reviewed.			

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

RF3		
RF4		
RF5		

3. Board insight and foresight ALB Name - Public Health Agency Date – 31 March 2024

3.5 Assurance and risk management

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The PHA has a clear strategy and policy and procedures in relation to risk management and emerging risks which have been approved by the GAC. These are regularly reviewed and are also supported by operational procedures. This clearly includes the level of risk, risk appetite and how risks escalate from directorate risk register to Corporate Risk Register, as well as reporting arrangements to GAC and PHA Board. During 2023/24, the Governance and Audit Committee continued to review directorate risk registers from across the organisation.			
GP2 Green	There is an Assurance Framework in place which outlines the key sources of assurances and how these will be reported to the board.			

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

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

4. Board engagement and involvement ALB Name - Public Health Agency Date – 31 March 2024

4.1 External stakeholders

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

GP3 Green	When the PHA developed its Corporate Plan for the period 2017/21, this involved a public consultation exercise, part of which saw two stakeholder events which offered an opportunity for stakeholders to attend and give their views on PHA's future strategic direction. When PHA is developing its Corporate Plan for 2025/30 during 2024/25, it will be undertaking a programme of stakeholder engagement.			
GP4 Green	The PHA Business Plan is available in a number of formats to ensure access to a wide range of stakeholders. The Business Plan is in a format that has been tried and tested to ensure a wide range of stakeholders understand the work of the PHA.			
GP5 Green	The PHA ensures that the learning from SAIs is disseminated and where appropriate influences the commissioning of services. The role of PHA within the SAI process is currently being reviewed.			
GP6 Green	PHA Board / Agency has very constructive and effective			

	relationships with a range of key stakeholders.			

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

4. Board engagement and involvement ALB Name - Public Health Agency Date – 31 March 2024

4.2 Internal stakeholders

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The Chair and Chief Executive have undertaken staff engagement sessions with staff in order to discuss issues of concern throughout the organisation. As part of the Reshape and Refresh review programme, the Chief Executive has carried out a series of engagements with staff in all PHA offices to keep informed as to the progress of the programme and to answer queries from staff.			
GP2 Green	Staff are involved in the development of corporate and directorate business plans at directorate/function level. This information is then fed through to the PHA Business Plan. Staff will also be involved in the development of the new PHA Corporate Plan.			
GP3 Green	This is communicated through Directors to their teams, and is			

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

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

4. Board engagement and involvement ALB Name - Public Health Agency Date – 31 March 2024

4.3 Board profile and visibility

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Amber	Board members have been invited to the events which have been organised for all staff in relation to the Reshape and Refresh programme. While there is not a structured programme of events that Board members are invited to, invitations are sent when the opportunity arises.	Board members should continue to be kept informed of opportunities to attend PHA staff events.		
GP2 Green	Since taking up post in November 2023 the Chair has commenced a series of meetings with other HSC Chief Executives and Local Council Chief Executives The Chief Executive also meets with HSC Chief Executives on a regular basis.			
GP3 Amber	Board members are given the opportunity to attend high profile events when such opportunities arise, e.g. the Balmoral Show.	Board members should continue to be kept informed of opportunities to attend high profile events.		

GP4 Red	The Board does not routinely meet with stakeholders and service users. The Chair is keen to invite stakeholders to Board meetings and to hear from PHA staff (and service users) about projects PHA is involved in.	Further opportunities need to be created for the Board to meet with stakeholders and service users.		
GP5 Green	The Board holds its meetings in public, and only has a small number of confidential sessions, with very specific, sensitive and/or urgent agendas. Board agendas and minutes are published on the PHA website. The annual schedule of meetings usually includes meetings in other PHA offices, e.g. Tower Hill and Gransha Park.			
GP6 Green	As part of the Board member appraisal process, the Chair gives feedback to NEDs on their contributions at meetings and values informed and challenging contributions at Board meetings.			

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

Summary Results **ALB Name - Public Health Agency** **Date – 31 March 2024**

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

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

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

3.5 Assurance and risk management	Green	

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

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

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

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

6. Board impact case studies

6. Board impact case studies

Overview

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

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

2. Organisational culture change; and

3. Organisational strategy.

6. Board impact case studies

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

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

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

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

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

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

6. Board impact case studies ALB Name – Public Health Agency Date – 31 March 2024

6.1 Case Study 1

Performance issues in the area of quality, resources (finance, HR, Estates) or Service Delivery	
Brief description of issue	Following a request by the Chief Executive and the Chair of the Governance and Audit Committee, Internal Audit was asked to carry out an audit of recruitment services, with a specific focus on those elements of the recruitment process that fall under the responsibility of PHA.
Outline Board's understanding of the issue and how it arrived at this	The PHA Board has regularly expressed its concern at the number of vacancies in PHA and the length of time it can take for posts to be filled, which in turn places pressure on other staff. This issue has featured on the PHA's Corporate Risk Register since June 2020. PHA avails of a Shared Service arrangement for Recruitment through BSO which covers a number of other HSC organisations and while there is a high demand on that Service which can cause delays, there are elements of the process which are the responsibility of PHA. Therefore the Chief Executive and the Chair of the Governance and Audit Committee wished to obtain a better understanding of where the delays are in the recruitment process.
Outline the challenge/scrutiny process involved	BSO Internal Audit was commissioned to carry out a review, the outcome of which was brought to the Governance and Audit Committee in June 2023.
Outline how the issue was resolved	The Internal Audit report highlighted findings in four areas and made a total of four recommendations, three of which were Priority 2 and one of which was Priority 3. At the year-end, two of the three Priority 2 recommendations had been fully implemented with the other being partially implemented. Progress on these is monitored by the Governance and Audit Committee.
Summarise the key learning points	The audit highlighted issues for the Shared Services Centre, but there was learning for PHA in areas including: the need for interview panel members to have completed both parts of their Recruitment and Selection training, the need for more robust performance management arrangements around recruitment processes; and the need to clarify reporting arrangements in PHA's SLA with BSO.
Summarise the key improvements made to the governance arrangements directly as a result of above	While some improvements have been made, the area of performance management and KPIs has still not yet been fully resolved. The appointment by BSO of a Senior HR Business Partner for PHA has been of assistance to PHA. The Governance and Audit Committee will continue to keep a keen interest on this area.

6. Board impact case studies ALB Name – Date –

6.2 Case Study 2

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

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

6.3 Case Study 3

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

HSC Public Health Agency

ALB Self-Assessment Action Plan 2024/25 (based on 2023/24 Self-Assessment)

Section	Good Practice / Red Flag Reference	Action	Target Date	Progress (Red / Amber / Green rating)
1.1 Board positions and size	GP1	The Chair will raise with the Department the need for the vacant NED position to be resolved as quickly as possible.	30 June 2024	
1.4 Committees of the Board	GP7	A review of Board Committees is to be carried out in 2024/25.	31 December 2024	
2.1 Effective Board Level Evaluation	GP3	An independent evaluation of the Board and its Committees will be carried out by the end of 2024/25.	31 March 2025	
2.1 Effective Board Level Evaluation	GP4	The Board will consider a self-assessment process during 2024/25 that will include gaining the perspective of staff and stakeholders.	31 March 2025	

2.2 Whole Board Development Programme	GP1	Board Development Programme to be put in place during 2024/25.	31 March 2025	
4.3 Board Profile and Visibility	GP1	Board members should continue to be kept informed of opportunities to attend PHA staff events.	Ongoing throughout 2024/25	
4.3 Board Profile and Visibility	GP3	Board members should continue to be kept informed of opportunities to attend high profile events.	Ongoing throughout 2024/25	
4.3 Board Profile and Visibility	GP4	Further opportunities need to be created for the Board to meet with stakeholders and service users.	Ongoing throughout 2024/25	

HSC Public Health Agency

item 14

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	28 August 2024
Title of paper	Partnership Agreement between Department of Health and Public Health Agency
Reference	PHA/09/08/24
Prepared by	DoH / PHA leads
Lead Director	Leah Scott

Recommendation For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to bring the draft Partnership Agreement between the Department of Health and PHA to the Board for approval.

2 Background Information

This Partnership Agreement replaces the Management Statement and Financial Memorandum. It explains the overall governance framework within which Public Health Agency operates, including the framework through which the necessary assurances are provided to stakeholders.

This Agreement has been finalised in consultation between PHA and its Sponsor Branch within the Department of Health and approved by the Agency Management Team.

3 Next Steps

The approved Partnership Agreement will be placed in the Assembly Library and will be available on the Department of Health and PHA websites.

A light touch review of the Partnership Agreement is scheduled to take place following the end of this financial year. A formal review will be carried out every 3 years.

As part of the review process an Annual Engagement Plan will be develop to reflect the interworking between both parties.

Partnership Agreement between

Department of Health and Public Health Agency

August 2024

CONTENTS

Introduction

The Partnership Agreement

1.1. This document sets out the partnership arrangements between Public Health Agency and the Department of Health. In particular, it explains the overall governance framework within which Public Health Agency operates, including the framework through which the necessary assurances are provided to stakeholders. Roles/responsibilities of partners within the overall governance framework are also outlined.

1.2. The partnership is based on a mutual understanding of strategic aims and objectives; clear accountability; and a recognition of the distinct roles each party contributes. Underpinning the arrangements are the principles set out in the NI Code of Good Practice ***'Partnerships between Departments and Arm's-Length Bodies'*** which should be read in conjunction with this document. The principles which are laid out in the Code are:

LEADERSHIP
Partnerships work well when Departments and Arm's Length Bodies demonstrate good leadership to achieve a shared vision and effective delivery of public services. Strong leadership will provide inspiration, instil confidence and trust and empower their respective teams to deliver good outcomes for citizens.
PURPOSE
Partnerships work well when the purpose, objectives and roles of Arm's Length Bodies and the sponsor department are clear, mutually understood and reviewed on a regular basis. There needs to be absolute clarity about lines of accountability and responsibility between departments and Arm's Length Bodies. In exercising statutory functions Arm's Length Bodies need to have clarity about how their purpose and objectives align with those of departments.
ASSURANCE
Partnerships work well when departments adopt a proportionate approach to assurance, based on Arm's Length Bodies' purpose and a mutual understanding of risk. Arm's Length Bodies should have robust governance arrangements in place and in turn departments should give Arm's Length Bodies the autonomy to deliver effectively. Management information should be what is needed to enable departments and Arm's Length Bodies to provide assurance and assess performance.

VALUE
Partnerships work well when departments and Arm's Length Bodies share knowledge, skills and experience in order to enhance their impact and delivery. Arm's Length Bodies are able to contribute to policy making and departmental priorities. There is a focus on innovation, and on how departments and Arm's Length Bodies work together to deliver the most effective policies and services for its customers.
ENGAGEMENT
Partnerships work well when relationships between departments and Arm's Length Bodies are open, honest, constructive and based on trust. There is mutual understanding about each other's objectives and clear expectations about the terms of engagement.

A full copy of the NI Code can be found at Annex 8.

1.3. This document should also be read in conjunction with guidance on proportionate autonomy which provides an outline of the principles and characteristics for proportionate autonomy. Guidance on proportionate autonomy has been considered in determining the extent of engagement and assurance to be established between Public Health Agency and the Department of Health and this is reflected in this agreement.

1.4. Department of Health and Public Health Agency are committed to:

- Working together within distinct roles and responsibilities;
- Maintaining focus on successful delivery of Programme for Government outcomes and Ministerial priorities (see also paras 2.5 and 2.6);
- Maintaining open and honest communication and dialogue;
- Keeping each other informed of any issues and concerns, and of emerging areas of risk;
- Supporting and challenging each other on developing policy and delivery – when developing policy this may cut across more than one department;
- Seeking to resolve issues quickly and constructively; and
- Acting at all times in the public interest and in line with the values of integrity, honesty, objectivity and impartiality.

1.5. The effectiveness of the partnership and the associated Engagement Plan will be reviewed each year by the Department and the Public Health Agency in order to assess whether the partnership is operating as intended and to identify any emerging issues/opportunities for enhancement. This can be carried out as part of existing governance arrangements. The Partnership Agreement document itself will be reviewed formally at least once every three years to ensure it remains fit for purpose and up-to-date in terms of current governance frameworks. The formal review will be proportionate to the Agency's size and overall responsibilities and will be published on departmental and PHA websites as soon as practicable following completion.

1.6. A copy of this agreement has been placed in the Assembly Library and is available on the Department of Health and Public Health Agency websites.

Public Health Agency Establishment and Purpose

Statutory Purpose and Strategic Objectives

2.1. The Public Health Agency is a body corporate established under section 12 (1) of the Health and Social Care (Reform) Act (Northern Ireland) 2009 (hereafter referred to as the Act). It is named in the legislation as the Regional Agency for Public Health and Social Wellbeing, but it operates under the shorter title of the Public Health Agency (PHA). The PHA does not carry out its functions on behalf of the Crown. For national accounts purposes the PHA is classified to the central government sector.

2.2. The PHA is established for the purposes specified in section 13 of the Act. The approved overall aim for the PHA is to improve the health and social well-being of the population and the quality of care provided, and to protect the population from communicable disease or emergencies or other threats to public health. As well as the provision or securing of services related to those functions, the PHA will commission or undertake programmes of research, health awareness and promotion etc. This aim will be delivered through three core functions of the PHA:

- securing the provision of, developing, and providing programmes and initiatives designed to secure the improvement of the health and social well-being of and reduce health inequalities between people in Northern Ireland,
- protecting the community (or any part of the community) against communicable disease and other dangers to health and social well-being including dangers arising on environmental or public health grounds or arising out of emergencies; and
- providing professional input to the commissioning of health and social care services which meet established quality standards and which support innovation.

2.3. The Agency's general powers etc. are listed in Schedule 2 to the Act.

2.4. The Minister for Department of Health is answerable to the Assembly for the overall performance and delivery of both the Department of Health and Public Health Agency.

2.5. The Executive's outcome-based approach to delivery recognises the importance of arm's length bodies and departments working collaboratively and together in a joined-up approach to improve overall outcomes and results. To that end there is strategic alignment between the aims, objectives and expected outcomes and results of PHA and Department of Health.

2.6. As per PHA's corporate plan, the Agency's purpose is to 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. Its vision is that all people and communities are enabled and supported in achieving their full health and wellbeing potential, and inequalities in health are reduced.

Organisational Status

3.1. The PHA is a legal entity in its own right, employing its own staff and operating at arm's-length from the Department. As a legal entity it must comply with all associated legislation including legislation relating to its employer status.

3.2. In accordance with the Health and Social Care (Reform) Act (NI) 2009, the following services are required to be carried out by the Regional Business Services Organisation for, and in partnership with, the PHA as directed by the Department of Health:

i) Administrative support, advice and assistance

ii) Financial services

iii) Human resource, Personnel & Corporate Services

iv) Training

v) The management & maintenance of buildings equipment & land

vi) Information technology & information management

vii) The procurement of goods & services

viii) Legal, medical, scientific or other professional services

ix) Contractual compliance internal audit and counter fraud & probity services

Governance Framework

4.1. The PHA has an established Corporate Governance Framework which reflects all relevant good practice guidance. The framework includes the governance structures established within the PHA and the internal control and risk management arrangements in place, including the PHA's Standing Orders, Standing Financial Instructions and the Scheme of Delegation. This includes its Board and Committee Structure. The Department should be satisfied with the framework.

4.2. An account of this is included in PHA annual Governance Statement together with the PHA Board's assessment of its compliance with the extant Corporate Governance Code of Good Practice (NI). Any departure from the Corporate Governance Code must be explained in the Governance Statement. The extant Corporate Governance Code of Good Practice (NI) is available on the DoF website at https://www.finance-ni.gov.uk/publications/governance-and-risk-guidance.

4.3. PHA is required to follow the principles, rules, guidance and advice in Managing Public Money Northern Ireland. A list of other applicable guidance and instructions which PHA is required to follow is set out in Annex 6. Good governance should also include positive stakeholder engagement, the building of positive relationships and a listening and learning culture.

4.4. The Health and Social Care (Reform) Act (Northern Ireland) 2009 provides the legislative framework within which the health and social care structures operate. It sets out the high-level functions of the various HSC bodies. It also provides the parameters within which each body must operate, and describes the necessary governance and accountability arrangements to support the effective delivery of health and social care in Northern Ireland.

4.5. The Public Health Agency is accountable to the Department of Health, through its Sponsor Branch and the relevant Executive board member, for governance and financial management within the organisation and is operationally independent from other HSC bodies.

PHA Board

5.1. The PHA is led by a Board, non-executive members of which are appointed by the Minister of Health, following an open competition. The appointment process for non-executive Board members complies with the Code of Practice on Public Appointments for Northern Ireland. Board membership is defined by The Regional Agency for Public Health and Social Well-being (Membership) Regulations (Northern Ireland) 2009, which prescribes that five non-executive members shall be appointed by the Department and that one officer shall be appointed by the Chair and other specified members of the Agency. The regulations also prescribe that the Director of Public Health and the Director of Nursing and Allied Health Professions shall be (executive) members and that 2 (non-executive) members appointed by the Department shall be district councillors.

5.2. As Public Appointees non-executive Board members are office holders rather than employees, they are not subject to employee terms and conditions. Board appraisal arrangements are set out in paras 16.1 and 16.2, and matters for consideration in dealing with concerns/complaints in respect of Non-executive Board members are provided in Annex 5.

5.3. The Board's operating framework/terms of reference provides further detail on roles and responsibilities and should align closely with this Partnership Agreement. Four members of the Agency's executive sit on the PHA Board – the Chief Executive and the Directors of Nursing and Allied Professions, Finance and Corporate Services, and Public Health respectively. The Director of Health and Social Care Quality Improvement (HSCQI) also sits on the PHA Board.

5.4. The purpose of the Public Health Agency Board is to provide effective leadership and strategic direction to the organisation and to ensure that the policies and priorities set by the Minister of Health are implemented. It is responsible for ensuring that the organisation has effective and proportionate governance arrangements in place and an internal control framework which allow risks to be effectively identified and managed. The Board will set the culture and values of the organisation, and set the tone for the organisation's engagement with stakeholders and clients.

5.5. The Board is responsible for holding the Chief Executive to account for the management of the organisation and the delivery of agreed plans and outcomes. The Board should also however support the Chief Executive as appropriate in the exercise of their duties.

5.6. Board members act solely in the interests of the Public Health Agency and must not use the Board as a platform to champion their own interests or pursue personal agendas. They occupy a position of trust and their standards of action and behaviour must be exemplary and in line with the seven principles of public life (Nolan principles). The Public Health Agency has a Board Code of Conduct and there are mechanisms in place to deal with any Board disputes/conflicts to ensure they do not become wider issues that impact on the effectiveness of the Board. A Board Register of Interests is maintained, kept up to date and is publicly available to help provide transparency and promote public confidence in the Public Health Agency Board by providing a mechanism to publicly declare any private interests which may conflict, or may be perceived to conflict, with their public duties.

5.7. Communication and relationships within the Board are underpinned by a spirit of trust and professional respect. The Board recognises that using consensus to avoid conflict or encouraging members to consistently express similar views or consider only a few alternative views does not encourage constructive debate and does not give rise to an effective Board dynamic.

5.8. It is for the Board to decide what information it needs, and in what format, for its meetings/effective operation. If the Board is not confident that it is being

fully informed about the organisation this will be addressed by the Chair of the Board as the Board cannot be effective with out-of-date or only partial knowledge.

5.9. In order to fulfil their duties, Board members must undertake initial training (in relation to the duties and responsibilities of a non-executive Director), and regular ongoing training and development. Review of Board skills and development will be a key part of the annual review of Board effectiveness.

Governance and Audit Committee

6.1. A further important aspect of the Public Health Agency's governance framework is its Governance and Audit Committee, established in line with the extant Audit and Risk Assurance Committee Handbook (NI).

6.2. The Governance and Audit Committee's purpose/role is to support the Accounting Officer and Board on governance issues. In line with the handbook the Governance and Audit Committee focuses on:

- assurance arrangements over governance; financial reporting; annual reports and accounts, including the Governance Statement; and
- ensuring there is an adequate and effective risk management and assurance framework in place.

6.3. The Public Health Agency and the Department of Health have agreed arrangements in respect of Governance and Audit Committee which may include:

- attendance by departmental representatives in an observer capacity at Public Health Agency's Governance and Audit Committee meetings;
- Access to Public Health Agency Governance and Audit Committee papers and minutes; and
- Any input required from Public Health Agency's Governance and Audit Committee to the departmental Audit and Risk Assurance Committee.

6.4. Full compliance with the Audit and Risk Assurance Committee Handbook (NI) is an essential requirement. In the event of significant non-compliance with the handbook's five good practice principles (or other non-compliance) discussion will be required with the Department and a full explanation provided in the annual Governance Statement.

6.5. The extant Audit and Risk Assurance Committee Handbook (NI) is available on the DoF website at https://www.finance-ni.gov.uk/publications/audit-committees.

Public Health Agency Chair

7.1. The Chair, who is appointed by the Health Minister, is responsible for setting the agenda and managing the Board to enable collaborative and robust discussion of issues. The Chair's role is to develop and motivate the Board and ensure effective relationships in order that the Board can work collaboratively to reach a consensus on decisions. To achieve this, they should ensure:

- The Board has an appropriate balance of skills appropriate to its business;
- Board members are fully briefed on terms of appointment, duties, rights and responsibilities;
- Board members receive and maintain appropriate training;
- The Minister is advised of the Public Health Agency's needs when board vacancies arise;
- There is a Board Operating Framework in place setting out the roles and responsibilities of the Board in line with relevant guidance;
- There is a code of practice for Board members in place, consistent with relevant guidance.

7.2. The role also requires the establishment of an effective working relationship with the Chief Executive that is simultaneously collaborative and challenging. It is important that the Chair and Chief Executive act in accordance with their

distinct roles and responsibilities as laid out in Managing Public Money NI and their Accounting Officer appointment letter.

7.3. The Chair has a presence in the organisation and cultivates external relationships which provide useful links for the organisation while being mindful of overstepping boundaries and becoming too involved in day to day operations or executive activities. Responsibility for the performance assessment of the Chair rest with the Department of Health, via Sponsorship and Executive Board Member arrangements.

PHA Chief Executive

8.1. The role of the Public Health Agency Chief Executive is to run the Public Health Agency's business. The Chief Executive is responsible for all executive management matters affecting the organisation and for leadership of the executive management team.

8.2. The Chief Executive is designated as Public Health Agency Accounting Officer by the departmental Accounting Officer (see section 12). As Accounting Officer they are responsible for safeguarding the public funds in their charge and ensuring they are applied only to the purposes for which they were voted and more generally for efficient and economical administration. It should be noted that the PHA provides hosting arrangements for the Safeguarding Board Northern Ireland (SBNI). The responsibilities for expenses relating to SBNI are set out in section 15 of the 2012 HSC (SBNI) regulations. The Memorandum of Understanding between the DoH, PHA and SBNI is attached at Annex 9.

8.3. The Chief Executive is accountable to the Board for the Public Health Agency's performance and delivery of outcomes and targets and is responsible for implementing the decisions of the Board and its Committees. They maintain a dialogue with the Chair on the important strategic issues facing the organisation and for proposing Board agendas to the Chair to reflect these. They ensure effective communication with stakeholders and communication on this to the Board. They also ensure that the Chair is alerted

to forthcoming complex, contentious or sensitive issues, including risks affecting the organisation.

8.4. The Chief Executive acts as a role model to other executives by exhibiting open support for the Chair and Board members and the contribution they make. The Chair and Chief Executive have agreed how they will work together in practice, understanding and respecting each other's role, including the Chief Executive's responsibility as Accounting Officer.

8.5. Further detail on the role and responsibilities of the Chief Executive are as laid out in Managing Public Money NI and their Accounting Officer appointment letter.

The Chief Executive's role as Principal Officer for Ombudsman Cases

8.6. The Chief Executive is the Principal Officer for handling cases involving the NI Public Sector Ombudsman. They shall advise the departmental Accounting Officer of any complaints about Public Health Agency accepted by the Ombudsman for investigation, and about the proposed response to any subsequent recommendations from the Ombudsman.

Role of the Department of Health

Partnership Working with the Public Health Agency

9.1. The Department of Health and Public Health Agency are part of a total delivery system, within the same Ministerial portfolio. The partnership between Department of Health and Public Health Agency is open, honest, constructive and based on trust. There is mutual understanding of each other's objectives and clear expectations on the terms of engagement.

9.2. Through the Strategic Outcomes Framework, set by the Department, in exercising its functions Public Health Agency has absolute clarity on how its purpose and objectives align with those of Department of Health. and this is reflected in PHA Corporate and Annual business plans. There is also a shared understanding of the risks that may impact on each other and these are reflected in respective Risk Registers.

9.3. There is a regular exchange of skills and experience between Department of Health and Public Health Agency and where possible joint programme/project delivery boards/ arrangements. Public Health Agency may also be involved as a stakeholder in policy/strategy development and provides advice on policy implementation/ the impact of policies in practice.

9.4. The Department of Finance (DoF) has established, on behalf of the Assembly, a delegated authority framework which sets out the circumstances where prior DoF approval is required before expenditure can be occurred or commitments entered into. The Accounting Officer of the Department of Health has established an internal framework of delegated authority for the Department and its ALBs which apply to Public Health Agency. This can be found online within DoH External Guidance at https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-hscf-09-2024.pdf. Other specific approval requirements established in respect of Public Health Agency as set out at Annex 3.

9.5. Once the Public Health Agency's budget has been approved by the Minister of Health, the Public Health Agency shall have authority to incur expenditure

approved in the budget without further reference to the Department. Inclusion of any planned and approved expenditure in the budget shall not however remove the need to seek formal departmental approval where proposed expenditure is outside the delegated limits (as laid out in Annex 3) or is for new schemes not previously agreed. Nor does it negate the need to follow due processes laid out in guidance contained in Managing Public Money NI and Better Business Cases NI (previously NI Guide to Expenditure Appraisal and Evaluation).

Lead Official

10.1. The Department of Health has appointed Deputy Secretary for Social Care and Public Health Policy Group as the Executive Board member and lead senior official to manage the relationship with Public Health Agency and ensure effective partnership working. Engagement between the Department and Public Health Agency will be co-ordinated, collaborative and consistent. A clear sense of collaboration and partnership will be communicated to staff in both the Department and the Public Health Agency in order to promote mutual understanding and support. The lead senior official is supported by the Director of Population Health and Health Development Policy branch is responsible for managing PHA sponsorship (known as the Sponsor Branch). The Finance liaison in DoH is the 'Grade 7 Accountant' within DoH Financial Planning Unit.

10.2. The lead senior official is the policy lead for the policy area relating to the Public Health Agency's business and has a clear understanding of the Public Health Agency's responsibilities for policy implementation/operational delivery and the relevant audiences/stakeholders involved.

10.3. The lead senior official will ensure that where there are departmental staff changes, time is taken to ensure they have a full understanding of the Public Health Agency's business and challenges.

Annual Engagement Plan

11.1. The Department and the Public Health Agency will agree an engagement plan before the start of each business year. The Annual Engagement Plan (Annex 2) will set out the timing and nature of engagement between the Public Health Agency and the Department. The engagement plan will be specific to the Public Health Agency and should not stray into operational oversight.

11.2. Engagement between the Department's lead official/their teams and the Public Health Agency will be centred on partnership working, understanding of shared risks and working together on business developments that align with policy objectives.

11.3. In line with relevant guidance[1], the Public Health Agency will work in collaboration and partnership with the Department to prepare corporate and business plans. There should be high level strategic alignment between departmental and Public Health Agency plans. Once approved it will be the Board of the Public Health Agency that primarily holds the Chief Executive to account for delivery and performance. The Department will engage with the Public Health Agency on areas of strategic interest, linking departmental policy and Public Health Agency delivery of policy intent.

11.4. The Annual Engagement Plan will also reference the agreed management and financial information to be shared over the course of a year. The aim will be to ensure clear understanding of why information is necessary and how it will be used. Where the same, or similar information is required for internal governance information requirements will be aligned so that a single report can be used for both purposes. In addition, the engagement plan should consider opportunities for learning and development, growth and actions which could help achieve better outcomes.

[1] Guidance issued by TEO on NICS Work Programme which includes guidance on business planning for an outcomes-based PfG/ODP

Departmental Accounting Officer

12.1. The departmental Accounting Officer is accountable to the NI Assembly for the issue of grant in aid to the Public Health Agency. They have designated the Chief Executive of the Public Health Agency as the Public Health Agency Accounting Officer and respective responsibilities of the departmental Accounting Officer and the Public Health Agency Accounting Officer are set out in Chapter 3 of Managing Public Money Northern Ireland. The departmental Accounting Officer may withdraw the Public Health Agency Accounting Officer designation if they conclude that the Public Health Agency Accounting Officer is no longer a fit person to carry out the responsibilities of an Accounting Officer or that it is otherwise in the public interest that the designation be withdrawn. In such circumstances the Public Health Agency Board will be given a full account of the reasons for withdrawal and the opportunity to make representations by way of response to the Permanent Secretary as Principal Accounting Officer. Withdrawal of Public Health Agency Accounting Officer status would bring into question employment as Chief Executive and the Chair should engage with the Department should such circumstances arise.

12.2. As outlined in section 8, the Public Health Agency Chief Executive is accountable to the Public Health Agency Board for their stewardship of Public Health Agency. This includes advising the Board on matters of financial propriety, regularity, prudent and economical administration, efficiency and effectiveness.

12.3. The departmental Accounting Officer must be informed in the event that the judgement of the Public Health Agency Accounting Officer (on matters for which they are responsible) is over-ridden by the Public Health Agency Board. The Public Health Agency Accounting Officer must also take action if the Public Health Agency Board is contemplating a course that would infringe the requirement for financial propriety, regularity, prudent and economical administration, efficiency or effectiveness. In all other regards, the departmental Accounting Officer has no day-to-day direct operational involvement with the Public Health Agency or its' Chief Executive.

12.4. In line with DoF requirements, the Public Health Agency Accounting Officer will provide a yearly declaration of fitness to act as Accounting Officer to the departmental Accounting Officer within the mid-year assurance statement, in line with DAO (DoF) 05/17, found at https://www.finance-ni.gov.uk/sites/default/files/publications/dfp/daodof0517_0.pdf.

Attendance at Public Accounts Committee

13.1. The Public Health Agency Chief Executive/Accounting Officer may be summoned to appear before the Public Accounts Committee to give evidence on the discharge of their responsibilities as Accounting Officer (as laid out in their Accounting Officer appointment letter) on issues arising from the C&AG's studies or reports following the annual audit of accounts.

13.2. The Chair may also, on occasion, be called to give evidence to the Public Accounts Committee on such relevant issues arising within the C&AG's studies or reports, in relation to the role and actions taken by the Board, where appropriate.

13.3. In addition, the Department of Health Accounting Officer may be summoned to appear before the Public Accounts Committee to give evidence on the discharge of their responsibilities as departmental Accounting Officer with overarching responsibility for the Public Health Agency. In such circumstances, the departmental accounting Officer may therefore expect to be questioned on their responsibilities to ensure that:

- there is a clear strategic control framework for the Public Health Agency;
- sufficient and appropriate management and financial controls are in place to safeguard public funds;
- the nominated Accounting Officer is fit to discharge their responsibilities;
- there are suitable internal audit arrangements;
- accounts are prepared in accordance with the relevant legislation and any accounting direction; and

- intervention is made, where necessary, in situations where the Public Health Agency Accounting Officer's advice on transactions in relation to regularity, propriety or value for money is overruled by the Public Health Agency's Board or its Chair.

Assurance Framework

Autonomy and Proportionality

14.1. The Department of Health will ensure that the Public Health Agency has the autonomy to deliver effectively, recognising its status as a separate legal entity which has its own Board and governance arrangements. Guidance on proportionate autonomy has been considered in determining the extent of engagement and assurance established between the Public Health Agency and the Department of Health and is reflected in this agreement.

14.2. A proportionate approach to assurance will be taken based on the Public Health Agency's overall purpose, business and budget and a mutual understanding of risk. The approach will include an agreed process through which the Public Health Agency Accounting Officer provides written assurance to the Department that the public funds and organisational assets for which they are personally responsible are safeguarded, have been managed with propriety and regularity, and use of public funds represents value for money.

14.3. Recognising the governance arrangements in place within the organisation, the Public Health Agency Accounting Officer will arrange for their written assurance to be discussed at the Public Health Agency Governance and Audit Committee and presented to the Public Health Agency Board prior to submission to the Department where possible. If not possible, or practicable, the Chair of the Public Health Agency Board should have sight of the assurance statement, prior to being submitted to the Department.

14.4. The Public Health Agency Chair will provide written confirmation that the Public Health Agency Accounting Officer's formal assurance has been considered by the Board and is reflective of the Public Health Agency's current position.

14.5. In addition to the Public Health Agency Accounting Officer's written assurance, the Department will take assurance from the following key aspects of Public Health Agency's own governance framework:

- Annual Review of Board Effectiveness;
- Completion of Board Appraisals which confirm Board member effectiveness;
- Internal Audit assurance and External Quality Assessment of the Internal Audit function;
- Externally audited Annual Report and Accounts, reviewed/considered by the Public Health Agency Governance and Audit Committee.

Board Effectiveness

15.1. The Public Health Agency Chair will ensure that the PHA Board undertakes an annual review of Board Effectiveness[2] which encompasses committees established by the Board.

15.2. The Chair will discuss the outcome of the annual review of Board Effectiveness with the lead official to ensure a partnership approach to any improvements identified. This will inform the annual programme of Board training/development and discussions in respect of Board composition and succession.

15.3. In line with any parameters set out in founding (or other) legislation, the Chair in conjunction with the Department, and Ministers where appropriate, will consider the size and composition of the Public Health Agency Board, proportionate to the size and complexity of the Public Health Agency and keep this under review.

15.4. In addition to the annual review of Board Effectiveness, the Public Health Agency will undertake an externally facilitated review of Board effectiveness at least once every three years covering the performance of the Board, its Committees and individual Board members. The Chair will liaise with the Department to identify a suitably skilled facilitator for the external review (this

[2] NIAO Good Practice Guide on Board Effectiveness

can be a peer review, and should be proportionate) and will share the findings/outcome report with the Department on completion of the review.

Board Appraisals

16.1. The Chair of the Public Health Agency will conduct an annual appraisal in respect of each Board member which will also inform the annual programme of Board training/ development. The Chair will engage with the Chief Executive/lead official as appropriate on improvements identified through the appraisal process and the annual training/development programme.

16.2. The Chair's annual appraisal will be completed by the lead official within the Department. The appraisal will take account of the Key Characteristics of a good chairperson (particularly for the Chair to have well developed interpersonal skills) set out in the NIAO Good Practice Guide on Board Effectiveness available on the NIAO website. There will be close engagement between the Chair and the lead official on improvements identified through the appraisal process.

Internal Audit Assurance

17.1. The Public Health Agency is required to establish and maintain arrangements for an internal audit function that operates in accordance with the Public Sector Internal Audit Standards (PSIAS). The Department of Health must be satisfied with the competence and qualifications of the Head of Internal Audit and that the requirements for approving appointments are in accordance with PSIAS.

17.2. The Public Health Agency utilise BSO's Internal Audit services. BSO Internal Audit is PSIAS compliant and based on an overarching Service Level Agreement and Memorandum of Understanding with the Department, BSO discharges functions, such as Internal Audit to the PHA, on behalf of DoH.

17.3. The Public Health Agency will provide its internal audit strategy, periodic audit plans and annual audit report, including the Head of Internal Audit's opinion on risk management, control and governance to the Department. The Public Health Agency will ensure the Department of Health's internal audit team have

complete right of access to all relevant records. This applies whether the internal audit function is provided in-house or is contracted out.

17.4. The Public Health Agency will ensure regular, periodic self-assessments of the internal audit function in line with PSIAS and will share these with the Department. The Public Health Agency will also liaise with the Department on the External Quality Assessment (EQA) of the internal audit function which (in line with PSIAS) is required to be conducted at least once every five years by a qualified independent assessor.

17.5. The Public Health Agency will alert the Department to any less than satisfactory audit reports at the earliest opportunity on an ongoing basis. The Public Health Agency will also alert the Department to a less than satisfactory annual opinion from the Head of Internal Audit at the earliest opportunity. The Public Health Agency and the Department will then engage closely on actions required to address the less than satisfactory opinion in order to move the Public Health Agency to a satisfactory position as soon as possible.

17.6. The Department will take assurance from the fact that the Public Health Agency has met the requirements of PSIAS and has a satisfactory annual opinion from the Head of Internal Audit as part of its overall assurance assessment.

Externally Audited Annual Report and Accounts

18.1. The Public Health Agency is required to prepare an Annual Report and Accounts in line with the Government Financial Reporting Manual (FReM) issued by the Department of Finance (DoF) and the specific Accounts Direction issued by Department of Health, and in accordance with the deadlines specified.

18.2. The Comptroller & Auditor General (C&AG) will arrange to audit the Public Health Agency's annual accounts and will issue an independent opinion on the accounts. The C&AG passes the accounts to Department of Health who shall lay/present/deposit them before the NI Assembly together with The Public Health Agency's annual report.

18.3. The C&AG will also provide a Report to Those Charged with Governance (RTTCWG) to the Public Health Agency which will be shared with the Department.

18.4. The Public Health Agency will alert the Department to any likely qualification of the accounts at the earliest opportunity. In the event of a qualified audit opinion or significant issues reported in the RTTCWG the Department will engage with the Public Health Agency on actions required to address the qualification/significant issues.

18.5. The Department will take assurance from the external audit process and an unqualified position as part of its overall assurance assessment.

18.6. The C&AG may carry out examinations into the economy, efficiency and effectiveness with which the Public Health Agency has used its resources in discharging its functions. The C&AG may also carry out thematic examinations that encompass the functions of the Public Health Agency.

18.7. For the purpose of audit and any other examinations, the C&AG has statutory access to documents as provided for under Articles 3 and 4 of the Audit and Accountability (Northern Ireland) Order 2003.

18.8. Where making payment of a grant, or drawing up a contract, the Public Health Agency should ensure that it includes a clause which makes the grant or contract conditional upon the recipient or contractor providing access to the C&AG in relation to documents relevant to the transaction. Where subcontractors are likely to be involved, it should also be made clear that the requirements extend to them.

Signatories

Public Health Agency and the Department of Health agree to work in partnership with each other in line with the NI Code of Good Practice ***'Partnerships between Departments and Arm's-Length Bodies'*** and the arrangements set out in this Agreement.

Signed (Public Health Agency Chair)
Date

Signed (Public Health Agency Chief Executive)
Date

Signed (Department – *[at least Senior Lead Official]*)
Date

Annex 1 - Applicable Legislation

List the founding legislation and other key statutes which provide the Public Health Agency with its statutory functions, duties and powers.

Health and Social Care (Reform) Act (Northern Ireland) 2009, paragraphs 12 and 13, and Schedule 2 - https://www.legislation.gov.uk/nia/2009/1/contents

The Regional Agency for Public Health and Social Well-being (Membership) Regulations (Northern Ireland) 2009 - https://www.legislation.gov.uk/nisr/2009/93/contents

Annex 2 – Illustrative Annual Engagement Plan

Good engagement is one of the key principles in the Partnership Code, underpinning the other principles of: Leadership; Purpose; Assurance; and Value.

As laid out in the Code, partnerships work well when relationships between departments and ALBs are open, transparent, honest, constructive and based on trust and when there is mutual understanding of each other's objectives and clear expectations about the terms of engagement.

The template provided outlines the key areas of engagement between Departments and ALBs. The template is not intended to be prescriptive and should be completed collaboratively and agreed between the Department and the ALB.

Engagement Plan 2024/25		
Policy Development and Delivery *Add details of the planned engagement between the ALB and the Department in relation to development and monitoring of existing and new areas of policy.*		
Policy Area	**Frequency/Timing**	**Lead Departmental/ALB Officials**
Health Emergency planning	2x p.a.	**Chris Matthews (G5) DoH / PHA DPH**
Strategic Planning		
Activity	**Date**	**Lead Departmental/ALB Official**
PHA Strategic Planning Workshops – encompassing strategic planning and risk identification. Informed by input on departmental priorities/plans and risk areas	Sufficiently well in advance of the Business Year to inform development of the Business Plan for the year ahead	As deemed appropriate

Engagement on the draft Business Plan and identification of areas of strategic interest to the Department to inform further scheduled engagement during the year		*Sponsor Branch Team / PHA CE, Director of Finance & Corporate Service, Assistant Director Planning and Performance*
Submission/presentation of the ALB Business Plan		*Sponsor Branch Team / PHA CE, Director of Finance & Corporate Service, Assistant Director Planning and Performance*
Approval of the PHA Business Plan		*Sponsor Branch Team*
Engagement on areas of strategic interest iro the ALB Business Plan during the year		*Sponsor Branch Team / PHA CE, Director of Finance & Corporate Service, Assistant Director Planning and Performance*
Joint Working *Add details of any interchange opportunities, and/or joint programme/project delivery boards*		
Activity	**Frequency/Timing**	**Lead Departmental/ALB Official**
All Dept Officials Group – MLB	2x p.a.	Siobhan Broderick DoH / Aidan Dawson PHA
Health Inequalities 'Live Better' area based programme	tbc	Peter Jacobson DoH / Heather Reid PHA
Joint Emergency Planning Board	2x p.a.	BSO/SPPG/PHA with DoH in membership

Board Appointments *Add details of any engagement related to Public Appointment exercises*		
Activity	**Date**	**Lead Departmental/ALB Official**
Skills Audit of PHA Board	*Annual*	*Sponsor Branch Team / PHA Chair*
Recruitment of non-executive members to the PHA Board	*As vacancies occur*	*Public Appointment Unit*
Code of conduct for PHA Board members	*Once and when revised*	*Public Appointment Unit / PHA Chair*
All newly appointed PHA Board Members have attended an appropriate training course preferably within 6 months of appointment. This training course (which is provided by either CIPFA or ON BOARD TRAINING) is in addition to any Induction training provided by the Chair and the PHA and increases their effectiveness in discharging their roles and responsibilities	*As required, following appointment*	
Chief Executive Recruitment *Add details of any engagement related to the recruitment of a new Chief Executive (if anticipated during the year ahead). ALBs should engage with the Department at an early stage in the event of the recruitment of a new Chief Executive. While recognising the role of the Board as employer, the Department will work closely with the ALB in the recruitment and selection process in line with extant guidance.*		
Activity	**Date**	**Lead Departmental/ALB Official**
PHA Chief Executive has acknowledged in writing receipt of a formal letter of designation as Accounting Officer defining the role	*On appointment*	*Sponsor Branch Team / PHA CE*

and responsibilities of this position		
The PHA Chief Executive has, within six months and preferably within three months of appointment, attended an accounting officer training course run by Chief Executives Forum	*Within 6 months of appointment*	*Sponsor Branch Team / PHA CE*
Refresher Accounting Officer Training is undertaken at least every six years	*As appropriate*	*Sponsor Branch Team / PHA CE*
Assurances *Add details of the timetable for submission of key assurance sources and any other assurance related activity*		
Action	**Date**	**Lead Departmental/ALB Official**
Pre-Ground Clearing Sponsorship Review Meetings	*Biannually – mid-year and end-year, in advance of Ground Clearing SRM*	*Sponsor Branch Team / PHA Director of Finance & Corporate Service, Assistant Director Planning and Performance*
Ground Clearing Sponsorship Review Meetings	*Biannually – mid-year and end-year, in advance of Accountability meeting*	*Lead official, Sponsor Branch Team / PHA CE, PHA Executive Board Members*
Accountability Meetings	*Biannually – mid-year and end-year*	*Permanent Secretary, Lead official / PHA Chair, PHA CE*
Outcome of the Review of Board Effectiveness	*Annual review with an externally facilitated review at least once every three years*	*Lead official / Sponsor Branch Team*
Planning for the externally facilitated review of Board Effectiveness	*Externally facilitated review at least once every three years*	*Lead official / Sponsor Branch Team*

Board Appraisals and planned training/development for Board members	*Following the end of the Business year.*	*PHA Chair*
Chair Appraisal	*Following the end of the Business year. After Board Appraisals have been completed by the Chair and the annual Review of Board Effectiveness has concluded*	*Lead official*
Departmental Attendance at GAC	*Attendance as observer 1xpa*	*Sponsor Branch Team*
Assurance Statement	*Specify frequency. In most cases this is bi-annual.*	*PHA CE*
Draft Governance Statement	*Annually*	*PHA CE / Director of Finance & Corporate Service*
Annual Report and Accounts	*Annually*	*PHA CE / Director of Finance & Corporate Service*
Report to those Charged with Governance	*As required*	*PHA CE / Director of Finance & Corporate Service*
Engagement on other planned NIAO reports	*As required*	*PHA CE / Director of Finance & Corporate Service*
Head of Internal Audit Annual report/Opinion	*Annually*	*PHA CE / Director of Finance & Corporate Service*
Internal Audit Strategy and Plans	*Annually*	*PHA CE / Director of Finance & Corporate Service*
Internal Audit External Quality Assessment	*To be conducted at least once every five years*	*PHA CE / Director of Finance & Corporate Service*
Budget Management *Add details of the information and returns to be provided.*		
Item and Purpose	**Date**	**Lead Departmental/ALB Official**
Engagement on budget requirements and		

Forecast Expenditure for the Financial Year		
Departmental approval of the annual budget		
Monthly Financial Management Returns		
Monthly Cash Forecast		
Monitoring Round Returns		
Provisional Outturn		
Final Outturn		
Other *Tailor as required to reflect the specific requirements*		
Item and Purpose	**Submission Date**	**Lead Departmental/ALB Official**
Accounting Officer - Fitness to Act as Accounting Officer	Periodic (annual) request from the departmental Accounting Officer within mid-year assurance statement	*Sponsor Branch Team / PHA CE*
Fraud Reporting	Immediate reporting of all frauds (proven or suspected including attempted fraud	Department will report frauds immediately to DoF and C&AG.
Fraud Reporting	Annual fraud return commissioned by DoF on fraud and theft suffered by Public Health Agency.	*PHA CE / Director of Operations*
Media management protocols – independence of PHA to engage with media/announcements of corporate and policy		*PHA CE /Head of CE Office / DoH Director of Communications*

communications significant to PHA - arrangements to share press releases where relevant – ensure no surprises.		
Preparation of business cases – departments and ALBs to consider working together to share expertise where appropriate.		*PHA CE / Director of Finance & Corporate Service*
Whistleblowing cases/ Speaking Up/Raising Concerns.		*PHA CE / Director of Finance & Corporate Service*
Review of the Partnership Arrangement *Tailor as required to reflect the specific requirements*		
Item and Purpose	**Date**	**Lead Departmental/ALB Official**
Light touch review of the Partnership Agreement	Schedule following the end of the Business Year	*Sponsor Branch Team / PHA CE, Director of Finance & Corporate Service, Assistant Director Planning and Performance*
Formal review of the Partnership Agreement	To be conducted once every three years	*Sponsor Branch Team, Lead official / PHA Chair, PHA CE*

Annex 3 - Delegations

Delegated authorities

The Public Health Agency shall obtain the Department's prior written approval before:

- entering into any undertaking to incur any expenditure that falls outside the delegations or which is not provided for in the Public Health Agency's annual budget as approved by the Department;
- incurring expenditure for any purpose that is or might be considered novel or contentious, or which has or could have significant future cost implications;
- making any significant change in the scale of operation or funding of any initiative or particular scheme previously approved by the Department;
- making any change of policy or practice which has wider financial implications that might prove repercussive or which might significantly affect the future level of resources required; or
- carrying out policies that go against the principles, rules, guidance and advice in Managing Public Money Northern Ireland.

Public Health Agency Specific Delegated Authorities

As set out at 4.4 of this Agreement, The Public Health Agency is accountable to the Department of Health, through its Sponsor Branch, for governance and financial management within the organisation. It is operationally independent from other HSC bodies. This means that:

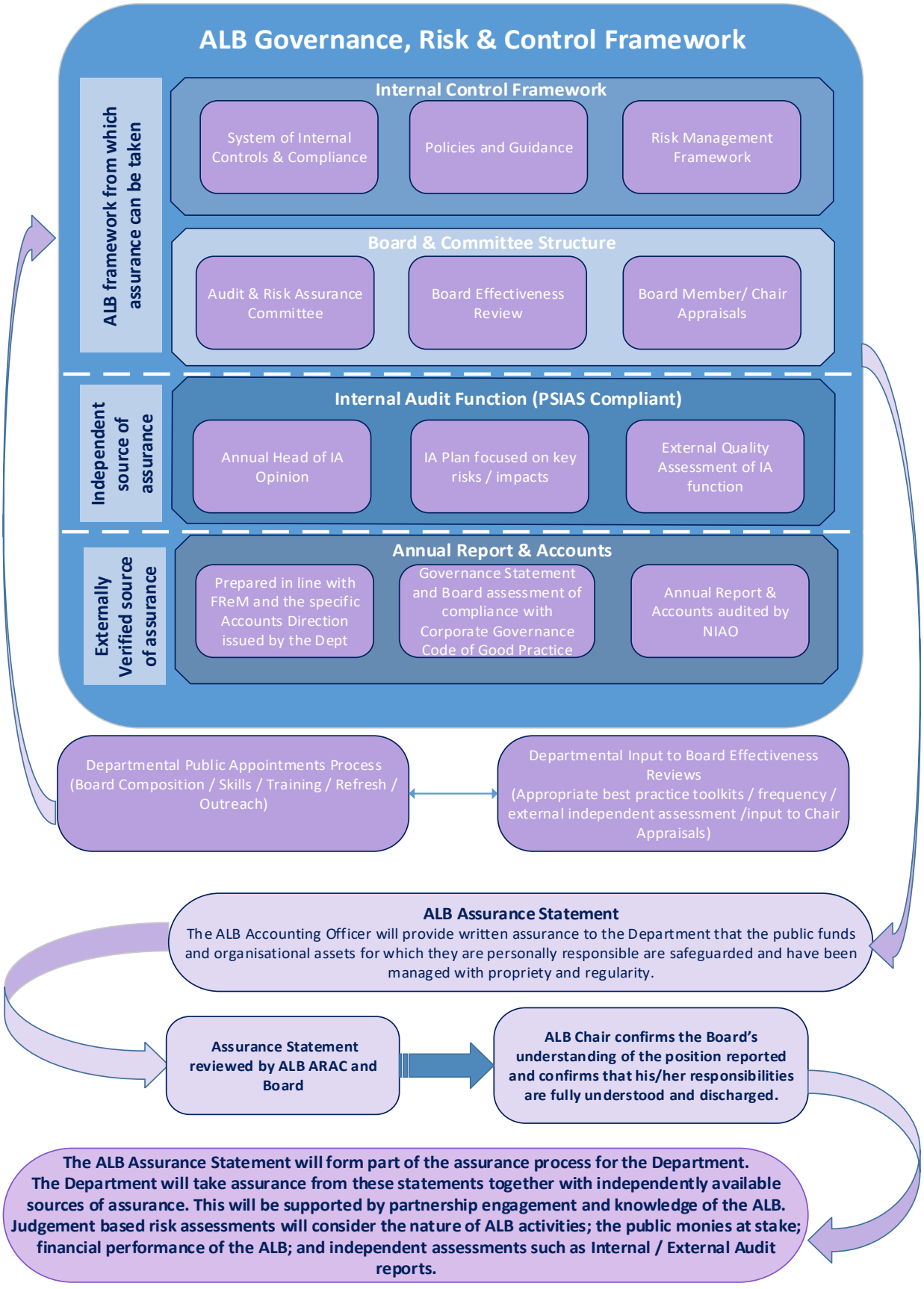
- The Public Health Agency has a high degree of autonomy in relation to its operational activities and how it operationally fulfils its statutory functions. In the context of the status of the Public Health Agency as an arms-length body of the Department of Health, this is demonstrated by a maximum

degree of distance, or ‘long arm’, related to the operations of the organisation.

- The Accounting Officer of the DOH has established an internal framework of delegated authority for the Department and the Public Health Agency, found online at https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-hscf-09-2024.pdf

These delegations shall not be altered without the prior agreement of the department and, where applicable, DoF.

Annex 4 – Illustrative System of Assurance



Annex 5 – Concerns/Complaints in respect of Board members

18.9. In line with the NI Code of Good Practice and the arrangements in this Partnership Agreement the approach to concerns/complaints raised in respect of the Public Health Agency Board members should be transparent and collaborative. The principle of early and open engagement is important, with the Department made aware of any concerns/complaints as soon as practicable.

While Board Members are Public Appointees/office holders rather than Public Health Agency employees a Public Health Agency employee may utilise the Public Health Agency's grievance procedure/other HR procedure to raise a complaint against a Board member. The Public Health Agency employee raising the grievance should expect this to be handled in line with the Public Health Agency's HR procedures.

Concerns/complaints might also be raised through:

- Raising Concerns/Whistleblowing arrangements;
- Complaints processes;
- Directly with the Public Health Agency or the Department.

Where a concern/complaint is received within the Public Health Agency in respect of an individual Board Member this should be provided to the Public Health Agency Chair who should notify the Department at the outset in order that lead responsibility for handling the complaint/concern is clear in advance.

Where a concern/complaint relates to the Public Health Agency Chair, the Public Health Agency should notify the Department at the outset for the Department to determine the approach to handling the complaint/concern.

Differences of view in relation to matters which fall within the Board's responsibilities are a matter for the Board to resolve through consensus-based decision making in the best interests of the Public Health Agency.

Exceptionally a concern/complaint may be raised by a Board Member about a fellow Board Member or a senior member of Public Health Agency staff. The Public Health Agency Chair should notify the Department at the outset to ensure that arrangements for handling the concern/complaint are clear. The Department may determine that it should make arrangements to deal with the concern/complaint. This will be agreed at the outset.

Arrangements for concerns/complaints in respect of Board members should be reflected in all relevant procedures, including Standing Orders and Board Operating Frameworks.

Annex 6 - Applicable Guidance

The following guidance is applicable to the Public Health Agency

Guidance issued by the Department of Finance

- Managing Public Money NI
- Public Bodies – A Guide for NI Departments
- Corporate Governance in central government departments – code of good practice
- DoF Risk Management Framework
- HMT Orange Book (Management of Risks)
- The Audit and Risk Assurance Committee Handbook
- Public Sector Internal Audit Standards
- Accounting Officer Handbook – HMT Regularity, Propriety and Value for Money
- Better Business Cases and the Approval Process: https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-hscf-10-2024.pdf
- Dear Accounting Officer Letters
- Dear Finance Director Letters
- Dear Consolidation Officer and Dear Consolidation Manager Letters
- The Consolidation Officer Letter of Appointment
- Government Financial Reporting Manual (FReM)
- Guidance for preparation and publication of annual report and accounts
- Procurement Guidance

Other Guidance and Best Practice

- Specific guidance issued by the Department
- EU Delegations
- Recommendations made by the NI Audit Office/NI Assembly Public Accounts Committee
- NIAO Good Practice Guides
- Guidance issued by the Executive's Asset Management Unit
- NI Public Services Ombudsman guidance

Annex 7 – Role of the Minister

Role of the Minister

The Chair of the Public Health Agency is responsible to the Minister. Communication between the Board and the Minister should normally be through the Chair.

The departmental Accounting Officer is responsible for advising the relevant Minister on a number of issues including the Public Health Agency objectives and targets, budgets and performance.

In addition to being answerable to the Assembly as laid out in paragraph 2.4, the Minister is also responsible for:

- Setting the strategic direction and overall policies and priorities for the ALB as reflected in the PfG;
- Approving the ALB's Business Plan;
- Setting the ALB's budget; and
- Appointment of non-executive board members. The Minister may also be involved in considering the size and composition of the Public Health Agency Board – see para 15.3.

Annex 8 – Partnerships between Departments and Arm's Length Bodies: NI Code of Good Practice

NI Code of Good Practice

Partnerships between Departments and Arm's Length Bodies: NI Code of Good Practice – online at:

https://www.finance-ni.gov.uk/sites/default/files/publications/dfp/NI%20Code%20of%20Good%20Practice%20v3%20%28300323%29.pdf

Annex 9 – Memorandum of Understanding between DOH, PHA and SBNI

MEMORANDUM OF UNDERSTANDING

BETWEEN

THE DEPARTMENT OF HEALTH,

THE PUBLIC HEALTH AGENCY

AND

THE SAFEGUARDING BOARD FOR NORTHERN IRELAND

November 2019

CONTENTS

INTRODUCTION

1. The Safeguarding Board for Northern Ireland is a partnership of 27 members whose common purpose is to help safeguard and promote the welfare of children and young people in Northern Ireland and protect them as far as possible from all forms of neglect and abuse. The partnership is chaired by a person independent of the member agencies, and receives corporate support from the Regional Agency for Public Health and Social Well-being (PHA) to facilitate the operation of the partnership.

2. This Memorandum of Understanding (MoU) is a tri-lateral agreement between the Department of Health (the Department), the Regional Agency for Public Health and Social Well-being (hereafter referred to as the Public Health Agency (PHA)) and the Safeguarding Board for Northern Ireland (SBNI). This MoU replaces the MoU dated September 2012 between the Department, the PHA and the SBNI. It takes account of the findings and recommendations of the SBNI Review Report (the 'Jay Report'), accepted by the Minister of Health and published in August 2016. It also takes account of a subsequent review of the SBNI staffing and hosting arrangements completed in December 2016.

PURPOSE OF THIS MOU

3. This MoU specifies the roles, responsibilities and obligations of the Department and the PHA in relation to the SBNI. It also sets out how the SBNI will relate to the PHA and the Department in accountability terms. A full description of the statutory objective, functions and duties of the SBNI is set out in separate guidance[3] to the SBNI. They are summarised below.

4. As the corporate host, the PHA will either provide or secure the necessary corporate governance structures, accommodation, financial management, IT, HR and legal services, necessary to meet the staffing, accommodation and running of

[3] SBNI Guidance is currently under review.

the SBNI. The PHA will also employ the staff supporting the SBNI (The SBNI Central Support Team). This will enable the SBNI to effectively function within the resources made available to it by the Department and SBNI members.

5. The majority of the 'corporate host' services will be provided to the SBNI on the same basis as they are available to all PHA staff. However, where the SBNI requires services above and beyond those provided by the PHA's Service Level Agreement with the Business Services Organisation, the additional costs will be covered by the SBNI. In particular the SBNI will cover the costs for its Equality Unit support (because the SBNI is required to register with the Equality Commission), and its accommodation (including equipment, telephone rental and calls and other office running costs). The Chair of the SBNI and the SBNI Central Support Team will comply with PHA policies and procedures relating to corporate hosting services and functions.

6. This MoU does not affect existing statutory functions nor amend any other policies or agreements relating to the activities of the PHA or the SBNI. It is not a legally binding document; it is not a contract between partners, nor is it intended to cover every aspect of the relationship between the three parties. Each signatory agrees to work together within the framework outlined in this MoU.

The SBNI

7. The SBNI was established under the Safeguarding Board Act (NI) 2011 (SBNI Act) [4] as an unincorporated statutory partnership. It is sponsored by the Department. The SBNI is a multi-disciplinary interagency partnership, chaired independently from its members, and its statutory objective is to coordinate and ensure the effectiveness of what is done by each person or body represented on the SBNI (its members) for the purposes of safeguarding and promoting the welfare of children and young people in Northern Ireland. The statutory functions of the SBNI are:

[4] The SBNI Act is available at: http://www.legislation.gov.uk/nia/2011/7/contents

i. to develop policies and procedures for safeguarding and promoting the welfare of children in Northern Ireland;
ii. to promote an awareness of the need to safeguard and promote the welfare of children;
iii. to keep under review the effectiveness of what is done by members to safeguard and promote the welfare of children;
iv. to undertake case management reviews without discretion in such circumstances as may be prescribed;
v. to review such information as may be prescribed in relation to deaths of children in NI;
vi. to advise the Regional Health and Social Care Board and Local Commissioning Groups in relation to safeguarding and promoting the welfare of children:
    i. as soon as reasonably practicable after receipt of a request for advice; and
    ii. on such other occasions as the SBNI thinks appropriate.
vii. to promote communication between the SBNI and children and young people; and
viii. to make arrangements for consultation and discussion in relation to safeguarding and promoting the welfare of children.

The PHA

8. The PHA was established under section 12(1) of the Health and Social Care (Reform) Act (Northern Ireland) 2009 and is an Arm's Length Body (ALB) of the Department of Health. It delivers a range of health functions including:

    i. health and social wellbeing improvement;
    ii. health protection;
    iii. public health support to commissioning and policy development; and
    iv. HSC research and development.

In addition, PHA is a member of the SBNI under section 1(3) of the SBNI Act.

9. In accordance with Regulations[5] made under the SBNI Act, the PHA is required to:

   i. Employ and appoint staff to support the operation of the SBNI;

   ii. Provide office and other accommodation to staff appointed to support the SBNI; and

   iii. Make arrangements for the upkeep of that accommodation.

PHA Corporate Host Functions

10. The PHA will act as corporate host to the SBNI. The staff it employs to support the SBNI (The SBNI Central Support Team) will have access to the full range of corporate services available to any employee of the PHA. Some of these services will be provided by the Health and Social Care Board or the Business Services Organisation under Service Level Agreement with the PHA. The SBNI Central Support Team is required to adhere to corporate policies and procedures of the PHA and their performance will be managed in accordance with the performance management arrangements of the PHA.

11. The PHA will provide the SBNI with the following:

- PHA staff who will act as the SBNI Central Support Team;
- accommodation and office facilities; and
- access to a range of corporate services: HR, training, finance, IT, legal, equality proofing and advice and support in connection with complaints handling and information management.

12. The PHA will assume line management responsibility for the most senior members of SBNI staff. It is a matter for the CEO of the PHA to decide where within the PHA line management responsibility will sit, and to nominate a PHA official with sufficient seniority to act as line manager to the most senior SBNI members of staff.

[5] The Safeguarding Board for Northern Ireland (Membership, Procedure, Functions and Committee) Regulations (Northern Ireland) 2012 are available at: http://www.legislation.gov.uk/nisr/2012/324/contents/made

13. The nominated PHA official and the SBNI Chair must establish formal arrangements to:
    - agree the performance objectives of the most senior staff;
    - be kept informed of achievements against agreed objectives; and
    - with the support of corporate HR, address any performance issues arising relating to any member of SBNI staff.

14. The nominated PHA official will also act as the link between the SBNI Central Support Team and PHA Corporate Services. This will require the individual to keep corporate hosting arrangements under review and to work with the SBNI Chair to address any issues arising relating to corporate hosting. Any issues that cannot be resolved between the Chair and the nominated PHA official should be brought to the attention of the Chief Executive of the PHA. If necessary, the Chief Executive of the PHA will bring any unresolved issues to the attention of the Director of Family and Children's Policy in the Department.

15. The PHA is a member agency of the SBNI and, in that role, must fulfil the duties ascribed to all member agencies, including the specific duty to cooperate under section 10 of the SBNI Act. The PHA must also play its role in the exercise of the SBNI's statutory functions and the delivery of its statutory objective. However, the PHA is not accountable for the overall performance of the SBNI in terms of its statutory objective, functions and duties.

16. While the financial allocation to support the operation of the SBNI is made to the PHA by the Department of Health, decisions relating to the use of the allocation in support of strategic and annual business plan objectives are a matter for the SBNI under the guidance and leadership of the Chair of the SBNI. However, the PHA will ensure that all expenditure mandated by the SBNI fully complies with financial legislation, policy and procedures. In addition, if the PHA is of the view that additional resources are required to effectively provide corporate support to the SBNI, this should be brought to the attention of the Department through the PHA sponsor branch.

The Department

17. On behalf of the Northern Ireland Executive, the Department sponsors and will provide funding to support the operation of the SBNI on an annual basis. Funding allocations will be made through the PHA. Expectations in connection with the funding allocation to the SBNI through the PHA are set out below (see Financial Management). On behalf of the Executive, the Department will continue to set the policy and legislative frameworks within which the SBNI operates and provide guidance as necessary. It will hold the SBNI to account for the exercise of its statutory objective, functions and duties through the Chair of the SBNI. It will hold the PHA to account for its corporate hosting role through the PHA Chief Executive. See Assurance and Accountability Arrangements below.

ASSURANCE AND ACCOUNTABILITY ARRANGEMENTS

PHA Corporate Host Responsibilities

18. The relationship between the PHA and the Department, and the framework within which the PHA operates as an ALB of the Department is specified in the Management Statement and Financial Memorandum (MSFM)[6] in place between these bodies. The MSFM makes reference to the PHA's corporate hosting responsibilities to the SBNI, acknowledging that the PHA is accountable to the Department for the discharge of its corporate host obligations to the SBNI. However, the PHA is not accountable for how the SBNI discharges its statutory objective, functions and duties.

19. As an unincorporated statutory partnership, the SBNI will not have a separate MSFM. A copy of this MoU will be appended to the MSFM of the PHA and these arrangements should be reflected in any future update to the Department's Framework Document[7].

[6] MSFM for PHA was reviewed and signed off in October 2018 (HE1/18/227679)
[7] https://www.health-ni.gov.uk/publications/dhssps-framework-document-september-2011

20. The Chair of the SBNI and the PHA nominated official may be asked by the Department to attend a relevant section of the PHA/Department Accounting Officer-led assurance and accountability meetings if there are particular SBNI corporate host issues which require discussion. The CEO of the PHA will be advised in advance of the attendance of the Chair of the SBNI.

21. If requested, the SBNI Chair and/or the PHA nominated official will attend meetings of the PHA Governance and Audit Committee in relation to matters of relevance to the Committee arising from corporate hosting responsibilities/functions.

SBNI Statutory Objective, Functions and Duties

22. The SBNI, through the Chair, will account directly to the Department for the exercise of its statutory objective, functions and duties. In accordance with guidance issued by the Department, the SBNI will develop a Strategic Plan and Annual Business Plans and in accordance with section 6 of the Safeguarding Board Act (Northern Ireland) 2011 will produce an annual report. See Performance against Objectives below.

23. Every 4 years, the SBNI, through the Chair, will submit to the Department a draft strategic plan covering the planned priorities, strategic aims and objectives for the next 4 years. It will set out how the SBNI will deliver on its statutory objective, functions and statutory duties. The plan will be subject to Departmental approval and will be supported by annual Business Plans.

24. In January each year, the SBNI, through the Chair, will provide the Department with a draft Business Plan for the year ahead (April to March). It will include key actions, supported by measures of success/expected outcomes, to be undertaken in the year ahead and will include financial information.

25. By August each year, the SBNI, through the Chair, will provide the Department with a draft annual report for the previous year.

26. The PHA, as corporate host for the SBNI, has no responsibility for the development of the SBNI Strategic and Business Plans, their review or approval. However as a core member of the SBNI, the PHA will contribute fully to the development of the SBNI's Strategic and Business Plans.

27. The Chair of the SBNI will formally meet with the Department's Director of Family and Children's Policy twice each year. The PHA nominated official may be asked to attend if there are particular SBNI corporate host issues which require discussion. In February, the agenda will include the discussion and agreement of the SBNI's Business Plan for the year ahead. In August, the agenda will include discussion and acceptance of the annual report. The attendance by others at the meeting will be agreed by the Chair of the SBNI and the Department's Director. These meetings will be minuted by the Department.

Performance Against Objectives

28. As indicated in paragraph 23, the SBNI is required to submit to the Department a draft 4-year Strategic Plan. The plan will reflect the SBNI priorities, strategic aims and objectives. It will set out how the SBNI will deliver on its statutory objective, functions and statutory duties. The plan will be subject to Departmental approval and will be supported by an annual Business Plan.

Declaration of Assurance to the PHA

29. The Chair of the SBNI must provide a declaration of assurance to the PHA, confirming (or otherwise) that:
    - The SBNI Central Support Team has adhered to all relevant PHA policies and procedures;
    - The resources allocated to the SBNI by the Department have been deployed in full to further the objectives/priorities of the SBNI identified in its Strategic Plan and supporting Business Plans;
    - Any unused resources have been flagged to the PHA within a reasonable timescale.

30. The declaration of assurance will inform the PHA mid-year and year-end Assurance Statement and Governance Statement to the Department. In circumstances where the Chair cannot provide an assurance to the PHA in connection with any of the above, an explanation must be provided in the declaration.

FINANCIAL MANAGEMENT

31. As an unincorporated statutory partnership, the SBNI is unable to hold its own funds. It receives funds from the Department via the PHA and may receive funding from other sources. Any financial allocation from sources other than the Department must be declared to the PHA and must be held by the PHA.

32. The PHA will receive an annual financial allocation from the Department to enable the SBNI to meet its statutory objective, functions and duties. This funding will provide for both running costs including the staff, accommodation and services provided by the PHA and the programme activity agreed by the SBNI and included in its annual Business Plan.

33. Prior to the approval of the SBNI Business Plans, the Department will consult with the Chief Executive of the PHA to confirm that in his/her role as Accounting Officer there are no financial issues that may impact on either the content or delivery of the SBNI plans. Where plans are subject to change after approval, the Department will further consult the Chief Executive of the PHA if this is deemed necessary.

34. The PHA will not use funds allocated for the SBNI for any other purpose. Any request for additional resources in respect of the SBNI must be referred to the Department. The PHA Accounting Officer will be advised of all requests and approvals of additional resources and expenditure, as he/she will be held accountable for this expenditure.

35. Details of the SBNI's financial allocations and expenditure will be included within the PHA Annual Accounts. The PHA must be satisfied that the level of detail fully accounts for all SBNI financial allocations.

36. The Chair of the SBNI and the SBNI Central Support Team will comply with PHA Standing Financial Instructions (SFI) and all other financial policies and procedures of the PHA.

37. Responsibility for the proper management of financial allocations to the SBNI, from all sources, falls to the Chief Executive of the PHA as Accounting Officer.

PROCUREMENT

38. The SBNI will comply with HSC procurement regulations and processes as set out in the PHA Standing Orders and SFI and other relevant policies and procedures. Goods and Services will be procured by the SBNI Central Support Team in line with the normal HSC policies and procedures, as specified in PHA Standing Orders and SFI, or through BSO PALS where this is required.

39. SBNI will work with PHA in respect of any social care procurements it is undertaking and these will be included on the PHA Social Care Procurement Plan. They will be taken forward by the SBNI Central Support Team with access to the full range of guidance and advice from BSO PALS Social Care Procurement Unit (over threshold) and PHA staff (under threshold).

GOVERNANCE

Risk Registers

40. The SBNI must maintain its own internal Risk Register. It must inform the Department of risks identified in relation to the exercise of its statutory objective, functions and duties or the delivery of its Strategic Plan and/or Business Plan. It must inform the PHA of risks identified that relate to corporate hosting arrangements. The PHA must determine if any such risks should be included in its Risk Register and/or identified to the Department.

Business Continuity Plan

41. The Chair of the SBNI will nominate a member of the SBNI Central Support Team to liaise with the PHA in connection with Business Continuity Planning arrangements to ensure the continued functioning of the SBNI in the event of disruption to normal business.

Internal Audit

42. The SBNI will be included within the PHA annual Internal Audit work plan in respect of those areas relating to the PHA corporate host functions. The SBNI will provide Management Responses to relevant draft audit findings or recommendations and will designate a senior member of the SBNI Central Support Team to undertake this function. Responses must be provided to Internal Audit within required timescales to enable it to finalise the report for submission to the PHA Governance and Audit Committee, in compliance with the standard Internal Audit reporting procedures of the HSC. Where it considers it necessary, the Department will establish separate audit arrangements for those areas for which the SBNI provides assurance directly to the Department.

Information Management

43. The remit of the PHA Personal Data Guardian (PDG) and Senior Information Risk Owner (SIRO) encompasses the SBNI in respect of records generated by or held by the SBNI Central Support Team in pursuance of SBNI business. The SBNI will designate a senior member of the SBNI Central Support Team as Information Asset Owner (IAO) who will be responsible for ensuring that information is managed appropriately and for providing assurances to the SBNI via the Chair and the PHA. The IAO will participate in the PHA's Information Governance Steering Group.

44. The SBNI Central Support Team will comply with all the PHA Information Governance policies and procedures. PHA will provide advice and guidance.

45. Freedom of Information (FOI) requests relating to the work of the SBNI will be dealt with in accordance with PHA FOI policies and procedures. On receipt of a relevant FOI request by the PHA Information Governance Team, it will be forwarded to the SBNI IAO, who will identify the relevant SBNI information handler. The response will be issued through the PHA, based on the SBNI information provided, PHA Information Governance advice and approval of the SBNI IAO.

Complaints Handling

46. Complaints relating to the work of the SBNI, will be dealt with through the normal PHA complaints procedure. SBNI staff will provide the necessary information and input to respond to the complaint. The PHA, and where appropriate, the Department, will provide advice and guidance.

47. The Chair of the SBNI will inform the Permanent Secretary of the Department of any complaints about the SBNI accepted by the NI Public Services Ombudsman for investigation and about the SBNI's proposed response to any subsequent recommendations from the Ombudsman.

48. The Chair of the SBNI will inform the PHA nominated official of any matters arising from complaints relating to any member of the SBNI Central Support Team.

Alerts

49. The Chair of the SBNI must alert:
    - the Department in a timely manner of any matter which he/she considers would adversely impact the delivery of the SBNI's statutory objective, functions, duties or reputation or the reputation of the Department;
    - the PHA in a timely manner of any matter which would adversely impact the functions or reputation of the PHA.

50. The PHA must alert:
    - the Chair of the SBNI and the Department in a timely manner of any matter which it considers would adversely impact the reputation of the SBNI.
    - the Department in a timely manner of any matter arising from its SBNI corporate host responsibilities/functions, which would adversely impact the delivery of PHA functions or reputation or the reputation of the Department.

LEGAL SERVICES

51. The Departmental Solicitor's Office will provide legal services for matters relating to the SBNI's statutory objective, functions and duties. The PHA will secure legal services from the BSO Directorate of Legal Services for those matters relevant to the PHA's corporate hosting responsibilities/functions.

ACCOMMODATION AND EQUIPMENT

52. The PHA will provide agreed office accommodation, and standard office equipment for specific use by the SBNI Central Support Team and Chair of the SBNI. The costs of accommodation, (including equipment, telephone rental and calls, and other office running costs) will be covered by the SBNI management and

administration budget. The SBNI may secure alternative accommodation, for example, as currently at the HSC Leadership premises, covering the total cost from the SBNI management and administration budget. In these instances the SBNI will comply with the normal approval mechanisms as set out by DoH Assets and Estate Management Branch.

HUMAN RESOURCES

53. With the exception of the Chair of the SBNI and Lay Members, who are publicly appointed by the Department, SBNI Central Support Team staff are employees of the PHA assigned specifically to support the SBNI. The creation of new posts within the SBNI Central Support Team will require the prior approval of the Department. The SBNI Central Support Team staff should not be utilised elsewhere in the PHA without formal agreement with the Department.

Management of SBNI Central Support Team Staff

54. The relationship between the PHA and the SBNI will be one of partnership and collaboration, ensuring appropriate working relationships and support for SBNI Central Support Team staff.

55. The SBNI Central Support Team staff, as employees of the PHA, will be subject to the same policies and procedures as other PHA staff, including leave and attendance, complaints, grievances, discipline and whistle blowing.

56. A line management structure must exist within the SBNI Central Support Team. The PHA nominated official must assure him/herself that the structure is sufficiently robust and bring any concerns about the structure to the attention of the Chair of the SBNI. Any unresolved concerns must be brought to the attention of the Department. The arrangements for approving staff leave requests as they relate to the most senior members of SBNI Central Support Team must be agreed by the Chair of the SBNI and the PHA nominated official. All other leave requests will be handled in accordance with ‘internal’ SBNI line management arrangements.

57. The Chair of the SBNI will advise the PHA nominated official of any issues emerging in relation to SBNI Central Support Team staff and their adherence to PHA policies and procedures. Individual incidents/breaches of these policies and procedures will be managed in keeping with normal HSC good practice, PHA guidance and escalation arrangements.

Performance Appraisal

58. Annual appraisal of SBNI Central Support Team staff will be conducted against SBNI business and individual staff objectives and in line with the HSC Performance Appraisal processes operated by the PHA. Appraisal of the most senior staff of the SBNI Central Support Team will be conducted jointly by the Chair of the SBNI and the PHA nominated official. Line Managers of other Central Support Team staff will be responsible for performance appraisal/management with input from the SBNI Chair where relevant/necessary.

59. Appraisal of the performance of the SBNI Chair and Lay Members will be conducted in line with established Public Appointment arrangements.

Staff Training and Development

60. The PHA is responsible for induction training and for securing the provision of training and development of members of the SBNI Central Support Team in line with performance management agreements.

Recruitment of Staff

61. Through the BSO HR service, the PHA will secure the timely recruitment of staff to SBNI Central Support Team posts approved by the Department.

PRESENTATIONAL ISSUES

Communication and Liaison Arrangements

62. The PHA and the SBNI (through the Chair) will keep each other promptly and regularly informed about any work being undertaken or issues arising which may impact on the other, or in which the other has an interest. Both parties must keep the Department informed about any matter which is likely to be of interest to the Department or the Minister.

Media Handling and Support

63. It is anticipated that day to day media handling and planned communications outputs will be managed and delivered directly by the SBNI. Where additional support over and above day-to-day communication activities is required the SBNI, through the Chair, will consult the PHA to determine whether the PHA Communications Team can provide support and to agree the cost of that support where appropriate.

64. If the SBNI plans to conduct a media/social marketing campaign, this should be discussed and agreed with the Department, and PHA where appropriate, including how the cost of conducting the campaign will be met.

Web site

65. The SBNI Central Support Team is responsible for the ongoing maintenance of the SBNI website. The cost of maintaining and developing the SBNI website will be met from the SBNI's financial allocation.

OTHER MATTERS

Indemnity

66. The SBNI Chair and publicly appointed Lay Members will be indemnified by the Department while engaged in SBNI business, provided they have acted honestly and in good faith, and have not acted recklessly. This means that the Department will indemnify the Chair of the SBNI and publicly appointed lay members in relation to any legal costs and damages which may be awarded against them in connection with the conduct of SBNI business.

Conflicts of Interest

67. If any conflicts of interest should arise for the Chief Executive of the PHA in connection with his/her SBNI corporate hosting responsibilities/functions, the matter should be referred to the Department for resolution. Any conflicts of interest or perceived conflicts of interest, which arise for the Chair of the SBNI, must be notified to the Department immediately.

AGREEMENT AND REVIEW OF THE MEMORANDUM OF UNDERSTANDING

68. This MOU will be reviewed after one year of operation and then every three years. It will also be amended, if necessary, following any relevant changes to the policies, procedures and structures of the parties concerned. Any issues arising at any stage from the operation of the MoU, must be brought to the Department's attention by the SBNI or the PHA, as soon as practicable.

69. Agreement to this Memorandum of Understanding is given by signature of the following:

On behalf of the PHA

Ms Valerie Watts
(Interim) Chief Executive

On behalf of the SBNI

Ms Bernie McNally
SBNI Chair

On behalf of the Department of Health

Mr Richard Pengelly
Permanent Secretary

Annex 1

TEMPLATE - SBNI Declaration of Assurance to the Department

This statement concerns the condition of the system of internal control in the Safeguarding Board NI as at DD/ MMM /YYYY

The purpose of this assurance statement is to attest to the effectiveness of the system of internal control. In accordance with Departmental guidance, I do this under the following headings.

1. Governance

A system of governance which encompasses effective corporate control arrangements is in operation e.g. corporate and business planning arrangements; risk management and internal controls; and monitoring and assurance thereon.

A Declaration of assurance (see attached) has been provided to the PHA to inform their mid-year assurance statement or SIC.

2. Significant Internal Control Problems –

[Insert details of significant internal control problems not otherwise covered e.g. description of the issue that has arisen and its (potential) impact on services, service-users, stakeholders etc, and a summary of the action taken or proposed to address the issue]

3. Assurance Framework

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

4. Risk Register

I confirm that the Corporate Risk Register has been regularly reviewed by organisation and that risk management systems/processes are in place throughout the organisation. As part of the system of risk management, the Register is presented to the Department, and for consideration, to the PHA *Governance Audit* Committee, every six months – most recently on *[dd.mm.yy]*.

5. Performance against Departmental Objectives

I confirm satisfactory progress towards the achievement of the objectives and targets set by the Department [*with the following exceptions:-*]

6. External and Internal Audit reports (if relevant)

I confirm implementation of the accepted recommendations made by internal or external audit**,** with the following exception:

Signed

SBNI Chair

HSC Public Health Agency

item 15

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	28 August 2024
Title of paper	Information Management Systems in the Population Screening Programmes
Reference	PHA/10/08/24
Prepared by	Gary Loughran / Dr Tracy Owen
Lead Director	Dr Joanne McClean

Recommendation For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is for the Board to note an update on the digital landscape, challenges and opportunities associated with Information Systems which support the population screening programmes. The paper proposes the establishment of a Screening Digital Modernisation Programme Board.

2 Background Information

There are nine population screening programmes provided in Northern Ireland, supported by a range of Information Management Systems which facilitate operational and administrative functions of each programme and the production of essential data reports.

There have been two significant reviews of these systems in recent years which have highlighted significant challenges, but recognise that any risks are currently being managed.

Both reports acknowledge the complex interactions of myriad, often disparate, IT systems and manual processes required to perform screening operations for our population. Overarchingly, and often necessarily, a disconnected, system-by-system, approach has been adopted to identify and commission supporting IT systems on a per screening programme basis. This has resulted in numerous systems to be managed, which exist on separate platforms, sourced from a range of providers, now at various stages of useful life and, in many cases, undergoing managed change.

3 Key Issues

There are a number of immediately known challenges with the current screening systems. These are primarily due to the following;

1) Pending end of NHSE contract for AAA screening in Spring 2025 – mitigated by ongoing conversations to ensure HSCNI remains a partner in any contract extension or new solution.

2) Changes to regional digital systems
   a) NHAIS acts as a demographic data source for AAA, Bowel, Cervical (as well as the call/recall functions) and Breast screening programmes. This system is due to be decommissioned in the next 12 months.
   b) Regional LIMS implementation impacts the Cervical screening programme and transition of the interim pHPV solution to the new LIMS.
   c) encompass implementation directly impacts Infectious Diseases in Pregnancy, Newborn Bloodspot and Newborn Hearing screening programmes
   d) encompass will replace the Regional Child Health System which is used for completing the screening services and reporting data on the screening services identified in c. above.
   e) Additionally, encompass will replace the Excelicare colposcopy management system which is used by the cervical screening programme.

All of these challenges of transition are being managed by the relevant digital Programme teams in collaboration with PHA Subject Matter Experts.

While the impact of a sustained disruption of service is high, the likelihood of this occurring is low. The overall risk assessment of the impact of digital landscape changes on screening programmes is **Low**.

The current digital transformation in HSCNI places NI in a systemically unique position within the UK and presents opportunities, for screening modernisation, not available to other UK health economies. HSCNI should take advantage of the commonalities across all the screening programmes, using the advanced digital solutions in place, to

- modernise the delivery of screening services
- automate services where possible:
  - cohort selection
  - call/recall
  - communications
  - appointments
  - diagnostic tests and results reporting
  - data and reporting
- review and optimise resources in line with modernisation

4 Next Steps

A Screening Digital Modernisation Programme Board to be established (draft TOR appended).

Information Management Systems in the Population Screening Programmes

Summary

There are nine population screening programmes provided in Northern Ireland, supported by a range of Information Management Systems which facilitate operational and administrative functions of each programme and the production of essential data reports.

There have been two significant reviews of these systems in recent years:

- A 2021 technical review by David Harrison of CSV Compliance Limited focussed on IT systems and attendant risks (attached in appendix A);
- A 2023 encompass review of screening programmes and the impact of encompass (attached in appendix B).

Harrison's report concluded:

> '*At this time all existing screening applications are fit for purpose and are professionally run and maintained by dedicated internal and external teams. At this time there are no immediate high criticality risks with any of the systems.'*

However, many of the short term more critical risks related to planned replacement of key components tightly integrated with screening pathways, such as NHAIS, Child Health System (CHS), Northern Ireland Maternity System (NIMATS), Laboratory Information System (LIMS) and the encompass introduction.

Whilst there has been excellent progress on all these transitions there remain a number of challenges particularly with CHS replacement impacting newborn screening programmes and with LIMS in respect of cervical screening. All of these are being managed – variously, through encompass Design Groups in collaboration with PHA and Trusts and dedicated Project Boards such as LIMS.

CHS transition and encompass impacts on screening programmes will require continued and dedicated engagement and management, through involvement of PHA in the appropriate governance structures, to ensure safe transition.

Both reports acknowledged the complex interactions of myriad, often disparate, IT systems and manual processes required to perform screening operations for our population.

Historically each information system has been established in the context of the individual screening programme, with limited consideration for reuse from other programmes. Many solutions have been inherited from elsewhere in the UK and adapted to operate within the specific technical landscape of HSCNI.

Overarchingly, and often necessarily, a disconnected, system-by-system, approach has been adopted to identify and commission supporting IT systems on a per screening programme basis. This has resulted in numerous systems to be managed, which exist on separate platforms, sourced from a range of providers, now at various stages of useful life and, in many cases, undergoing managed change.

There is evidence the historic development of standalone screening systems has led to scenarios where normal and adverse screening findings are known only to the screening pathway and their GP and are not captured in the person's acute secondary care clinical record, which may create potential care and treatment knowledge gaps.

As noted, the digital landscape in HSCNI has significantly changed in recent years, with varying degrees of impact on screening programmes, these include;

- Encompass
- Laboratory Information Management Systems (LIMS)
    - Northern Ireland Pathology Information Management System (NIPIMS) is replacing the current Laboratory Information System which will impact screening programmes such as Cervical screening
- Northern Ireland Picture Archive and Communications System (NIPACS+)
    - Extends the regional radiology imaging capability to integrate with other disciplines, including - Cardiology, Oncology, Obstetrics, Endoscopy, Medical Photography, Nuclear Medicine, Dental and Ophthalmology.
- Northern Ireland Digital Identity Service (NIDIS)
    - The Northern Ireland Digital Identity Service (NIDIS) replacing NHAIS which acts as a data source for many of the population demographic data sets used by screening programmes to identify the eligible population for invite.

This 'once for Northern Ireland' approach, which reduces the number of solutions to be managed and maintained by HSCNI, increases consistency, integrates interconnectivity between key systems by design and removes unwarranted variation in administrative and care workflows.

encompass will have an impact on screening such as, the processes for diagnostic testing requests, appointment booking, diagnostic testing and results reporting amongst other things. Further, encompass will, through delivery of a regional capability, replace a number of systems currently integrated into screening programmes – these include the Child Health System (CHS), excelicare (colposcopy) and Northern Ireland Maternity System (NIMATS).

The PHA are represented within the highest level of encompass governance and decision-making structures with the Chief Executive representing PHA on the encompass Programme Board and the Director of Public Health representing PHA on the encompass Care Executive. The Agency can use these positions to:

- proactively influence future screening programme requirements and resources where encompass has been identified as a key enabler;

- escalate for mitigation current challenges relating to screening programmes where and when appropriate.

The ongoing changes in HSCNIs digital landscape, as well as changes with current screening solution suppliers and contracts, has created a significant additional workload for PHA screening staff. They are involved in system meetings, advising on interfaces, ensuring that testing of new systems is robust, identifying issues and risks and ensuring that appropriate failsafe processes or workarounds are in place. This is particularly challenging in the absence of supporting PHA digital specialist teams.

As with any pathway, screening is a product of many interactions between the public, pathway administrators, screeners, clinicians, laboratory technicians, call/recall teams, public health consultants, programme managers and digital solutions. There is opportunity for screening systems to be viewed in more holistic terms across programmes – building on commonality of processes, data and resources.

Overall, the current digital transformation in HSCNI places NI in a systemically unique position within the UK and presents opportunities, for screening modernisation, not available to other UK health economies. HSCNI should take advantage of the commonalities across all the screening programmes, using the advanced digital solutions in place, to

- modernise the delivery of screening services
- automate services where possible:
    - cohort selection
    - call/recall
    - communications
    - appointments
    - diagnostic tests and results reporting
    - data and reporting
- review and optimise resources in line with modernisation

Screening Context and Challenges

Population screening programmes have a key role to play in early detection of disease and a range of programmes are currently available in Northern Ireland. The PHA has responsibility for commissioning, coordinating and quality assuring these programmes.

In Northern Ireland the PHA commissions the following screening programmes:

1. Abdominal aortic aneurysm (AAA) screening
2. Infectious Diseases in Pregnancy screening
3. Breast screening (and very high-risk breast screening)
4. Bowel cancer screening
5. Cervical cancer screening
6. Diabetic eye screening
7. Newborn blood spot screening
8. Newborn hearing screening

Immediate challenges

There are a number of immediately known challenges with the current screening systems. These are primarily due to the following;

1) Pending end of NHSE contract for AAA screening in Spring 2025 – mitigated by ongoing conversations to ensure HSCNI remains a partner in any contract extension or new solution.

2) Changes to regional digital systems;

a) NHAIS acts as a demographic data source for AAA, Bowel, Cervical (as well as the call/recall functions) and Breast screening programmes. This system is due to be decommissioned in the next 12 months.
b) Regional LIMS implementation impacts the Cervical screening programme and transition of the interim pHPV solution to the new LIMS.
c) encompass implementation directly impacts Infectious Diseases in Pregnancy, Newborn Bloodspot and Newborn Hearing screening programmes
d) encompass will replace the Regional Child Health System which is used for completing the screening services and reporting data on the screening services identified in c. above.
e) Additionally, encompass will replace the Excelicare colposcopy management system which is used by the cervical screening programme.

All of these challenges of transition are being managed by the relevant digital Programme teams in collaboration with PHA Subject Matter Experts.

While the impact of a sustained disruption of service is high, the likelihood of this occurring is low. The overall risk assessment of the impact of digital landscape changes on screening programmes is **Low**.

Wider challenges

The Programme Management of screening programmes is challenged by an array of complications requiring a significant number of manual interventions and work arounds throughout the screening pathway to ensure service.

These include cases where;

- There is uncertainty about responsibilities throughout the pathway
- There is uncertainty about contract ownership
- Service Level Agreements for some services are not in place
    - Some systems experience high downtimes
    - Some systems have no formal hosting arrangements

- Due to some systems being managed for various UK regions there are challenges getting system changes required to support NI screening pathways

- Quality Assurance of some programmes is limited due to:
    - the number of systems used and the limitations of reporting across multiple systems
    - training deficits meaning an external supplier is used for QA

- Reporting and data
    - some reports are in formats e.g. PDF which necessitate transcription to excel to allow reporting
    - change requests need to be raised with support companies to create essential reports
    - governance and access challenges for essential data

- Governance
    - Crucial screening demographic threshold change only alerted and picked up through reading a quarterly newsletter provided by a supplier
    - System upgrades unmanaged - some systems many versions behind other UK equivalents
    - Difficult to make required system changes for NI due to central UK provision of system
    - Essential IT changes sometimes only made available in a quarterly newsletter and appear not to be actioned locally

- Anecdotally (evidence not provided) – screening accessibility is not being maximised as out-dated communications are used. (Scotland/Wales screening programmes are seeking move to more accessible communications such as patient apps)

While these challenges and associated risks are being managed within individual programmes, going forward, the over focus and resourcing of continuous reactionary maintenance of the current disparate screening solutions may present a greater overall risk. So, a more joined up, strategic approach is proposed.

The key mitigation for the currently identified risks is to establish a Screening Digital Modernisation Programme Board (outlined in detail in Recommendations section) which should be led by PHA with senior stakeholder input from relevant dependent Programmes. Engendering a proactive, PHA led approach to managing screening requirements will best position the PHA to get the optimal outcome for screening.

Strategic Context

The PHA Digital Strategy developed in February 2024 localises the key themes of the HSC strategy:

- Providing common solutions to common problems – this is a ubiquitous strategy for digital globally, and underpins the HSC Digital Strategy's once for Northern Ireland principle.

- Digital technologies and data will have a significant influence on how the PHA develops and executes its corporate strategy and action plans.

- To become a modern, intelligent, outcomes focused digital organisation, the PHA should proactively plan, the implementation of its digital solutions, to principally serve functional requirements, as well as, acquire the data necessary to leverage and support achievement of its strategic priorities, service commissioning and future plans using best evidence.

The PHA is undertaking a programme of change under the Reshape and Refresh Programme. This has identified the need to establish a Digital Directorate within PHA to provide:

- An intelligent internal and external customer function

- Digital support to translate professional and organisational requirements in to digital potential and assist decision making

- Proactive engagement internally and externally to ensure the best solutions for corporate operations, as well as, to ensure essential and best of breed public health services are in place.

- Proactive management of digital change: putting in place the right processes and workflows, human and digital, to ensure both functional and data requirements are met by digital solution implementation

- Embedded digital approaches into all strategic service planning and commissioning to ensure services fully realise and are informed by the potential benefits of data and digital technology.

Embracing and accelerating these strategies should be a priority objective for PHA to ensure its screening platforms are on a safe, stable foundation and to generally better manage digital contracts, information governance and to resource digital leadership internally to better integrate and interpret PHA requirements with regional digital initiatives.

Recommendations

To mitigate current risks and challenges and establish a better integrated future for screening the creation of a Screening Digital Modernisation Programme should be established and led by PHA (terms of reference for the Programme Board attached as Appendix C).

The Programme will have responsibility for 3 key themes;

i) Managing the current challenges through formalised reporting mechanisms with extant Projects
ii) Managing the transition of screening programmes to best utilise the new digital landscape, especially the opportunities presented by encompass
iii) Managing the planning and transition of the Child Health System into encompass

This should include stakeholder leadership from all the digital and human actors required to deliver screening for our population.

The challenges with screening exist across all screening programmes and to varying extents. There exists a need to manage the current digital transitions as well as to plan for a screening future which adopts the new HSC digital landscape and its enhanced capabilities. Additionally, the human factor for screening management should be considered and every effort should be made to improve ownership and confidence in the end-to-end screening programmes.

These activities should not be isolated from one another and should be managed with a holistic approach to screening which addresses;

- Current digital transitions
- Future digital states
- Contracts and SLAs
- Governance
- Resources
- Funding
- Quality Assurance and reporting

The Screening Digital Modernisation Programme required to deliver safe and stable screening modernisation affords PHA with an opportunity to introduce the regional and local strategic principles, mentioned previously, to deliver population screening as envisaged by the Digital Strategy and through the attendant Directorate.

This is a significant undertaking and to be successful will require skilled resources in digital and Programme governance to support the inherent screening teams. In the absence of an internal capability, these resources may not currently exist within PHA. This resource and skills gap could be met by accelerating the creation of the proposed digital directorate; outsourcing to BSO ITS and/or recruiting external skills to support the delivery of screening.

Objectives of the Screening Digital Modernisation Programme

The overall objectives of the screening digital modernisation programme will be to:

1. Review screening programme in the following areas:
    a. Overall functionality and commonalities
    b. Key stakeholders' roles and responsibilities
    c. Business processes
    d. Information flows and outputs required
    e. Cohort identification
    f. Dependent systems
    g. Solution status
    h. Contract status
    i. Business case funding status
2. Identify and manage current constraints, risks and mitigations through formal reporting and decision making
3. Identify and deliver the future for screening delivery model(s) for NI and manage changes required to support this;
4. Establish stakeholder commitment to transformation
5. Use best practice digital and Programme Management tools and resources
6. Review resource requirements for future screening state
7. Create resilience and increase flexibility in business continuity through harmonisation of screening commonalities
8. Reduce reliance on external providers creating responsive, proactive local change processes
9. Ensure all key stakeholders are able to contribute to and help to shape the future state, such that it addresses their interests and issues.
10. Provide expertise, direction and assurance to agreed workstreams
11. Act as an escalation body to provide assurance on workstream outputs providing recommendations for approval to proceed.

Appendix A

RA_1504_Overall_Summary_1.0.docx

Appendix B

PHA Screenings
encompass Impact c

Appendix C

Screening Digital Modernisation Programme Board

Terms of Reference

Draft v0.1

Document control

Purpose of this document

The purpose of this document is to set out the Terms of Reference for Screening Digital Modernisation Programme Board (SDMPB) for screening solutions primarily commissioned by the Public Health Agency. and to plan for the future state of these systems.

The SDMPB will be responsible for the management and delivery of a number of outputs, including a detailed plan, future state roadmap taking account of the improved HSC digital landscape and the opportunities it provides, management of current screening solutions with attendant mitigations to ensure systems are maintained until the preferred future state is achieved and the financial and human resource requirements required to deliver the screening digital modernisation screening Programme objectives.

The SDMPB will be accountable, and report, to the PHA Chief Executive and, as required, to the DHCNI Management Board.

Author

Version	Author	Description	Date
0.1	Gary Loughran	Initial draft of ToR	22 August 24

Contents

Introduction

Strategic Context

The HSC Digital Strategy outlines and prioritises what is to be delivered between 2022 – 2030. Digital is a fundamental enabler for everything we do within health and care and the DHCNI Digital strategy considers how digital will enable better processes, support improved care pathways, change our ways of working and, ultimately, deliver better outcomes for people.

Key strategic outcomes for the HSC Digital strategy are; (see Figure 1 below)-

- ***Effective and joined up care through systems integration and streamlined information flows.***
- ***Digital will provide our population with greater visibility and control over treatment and care journeys***
- ***Intelligent use of data will optimise performance and harness population health insights, whilst ensuring robust data protection standards***

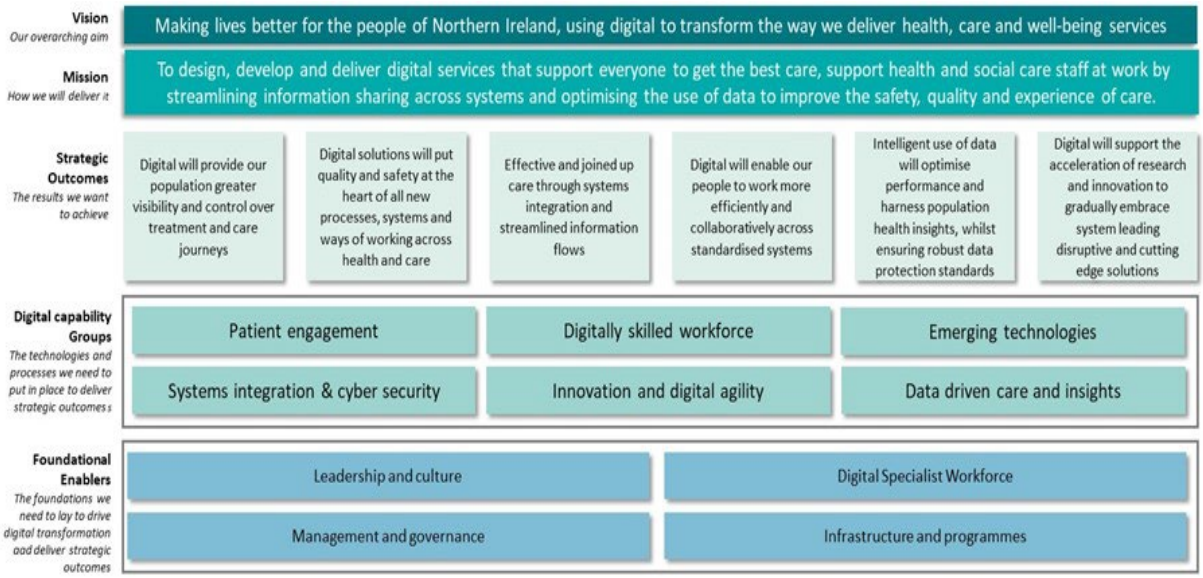


Figure 1

[Digital Strategy - HSC Northern Ireland 2022 - 2030 | Department of Health (health-ni.gov.uk)]

The strategy recognises that to realise its ambition and deliver the strategic outcomes, HSC must invest in developing and **enhancing care delivery through improved digital solutions.** Through a focus on solutions which improve decision-making and release staff time.

The PHA Digital Strategy developed in February 2024 localises the key themes of the HSC strategy:

- Providing common solutions to common problems has become a ubiquitous strategy for digital globally, and underpins the HSC Digital Strategy's once for Northern Ireland principle.
- Digital technologies and data will have a significant influence on how the PHA develops and executes its corporate strategy and action plans.
- To become a modern, intelligent, outcomes focused digital organisation, the PHA will proactively plan, through the implementation of its digital solutions, to serve functional needs and acquire the data necessary to leverage and support achievement of its strategic priorities and service commissioning and future plans using best evidence.

The PHA is undertaking a programme of change under the banner of Reshape and Refresh. This has identified the need to establish a Digital Directorate with the Agency to provide:

- An intelligent internal and external customer function.
- **Digital support** to translate professional and organisational requirements in to digital potential and assist decision making.
- **Proactive engagement internally and externally** to ensure the best solutions for corporate operations, as well as, to ensure essential and best of breed public health services are in place.
- **Proactive management of digital change**: putting in place the right processes and workflows, human and digital, to ensure both functional and data requirements are met by digital solution implementation.
- Embedded **digital approaches into all strategic service planning and commissioning** to ensure services fully realise and are informed by the potential benefits of data and digital technology.

The Screening Digital Modernisation Programme Board affords PHA with an opportunity to proactively manage the introduction of these strategic principles to create a modern, safe and robust screening service which best utilises the current HSCNI digital landscape and optimises resources.

Screening Context

Population screening programmes have a key role to play in early detection of disease and a range of programmes are currently available in Northern Ireland. The PHA has responsibility for commissioning, coordinating and quality assuring these programmes.

In Northern Ireland the PHA operates the following screening programmes:

9. Abdominal aortic aneurysm (AAA) screening
10. Antenatal screening
11. Breast screening
12. Bowel cancer screening
13. Cervical cancer screening
14. Diabetic retinopathy screening
15. New-born blood spot screening
16. New-born hearing screening

All screening systems are likely to be impacted by the implementation of encompass. In instances where the screening application itself is not affected directly by encompass it is likely the processes for diagnostic testing requests, appointments and results will be impacted. Further, encompass will, through delivery of a regional capability, replace systems currently integrated into screening programmes – these include the Child Health System (CHS) and Northern Ireland Maternity System (NIMATS).

In addition to encompass HSC is implementing a number of other regional solutions which may impact on screening Programmes. Including;

The Northern Ireland Digital Identity Service (NIDIS) replacing NHAIS which acts as a data source for many of the population demographic data sets used by screening programmes.

Northern Ireland Pathology Information Management System (NIPIMS) is replacing the current Laboratory Information System which will impact screening programmes such as Cervical screening.

These changes in HSCNIs digital landscape as well as changes with current screening solution suppliers and contracts has created a significant additional workload for PHA screening staff. They are involved in system meetings, advising on interfaces, ensuring that testing of new systems is

robust, identifying issues and risks and ensuring that appropriate failsafe processes or workarounds are in place. This is particularly challenging in the absence of in-house digital specialist teams.

Encompass, in particular, provides a potential platform for the harmonisation of screening programmes underpinning digital solutions and, in doing so, provide a more consistent approach to processes.

Objectives of the Screening Digital Modernisation Programme Board

The overall objectives of the SDMPB will be to:

12. Review screening programme in the following areas:
    a. Overall functionality and commonalities
    b. Key stakeholders' roles and responsibilities
    c. Business processes
    d. Information flows and outputs required
    e. Cohort identification
    f. Dependent systems
    g. Solution status
    h. Contract status
    i. Business case funding status
13. Identify and manage current constraints, risks and mitigations through formal reporting and decision making
14. Identify and deliver the future for screening delivery model(s) for NI and manage changes required to support this;
15. Establish stakeholder commitment to transformation
16. Use best practice digital and Programme Management tools and resources
17. Review resource requirements for future screening state
18. Create resilience and increase flexibility in business continuity through harmonisation of screening commonalities
19. Reduce reliance on external providers creating responsive, proactive local change processes
20. Ensure all key stakeholders are able to contribute to and help to shape the future state, such that it addresses their interests and issues.
21. Provide expertise, direction and assurance to agreed workstreams
22. Act as an escalation body to provide assurance on workstream outputs providing recommendations for approval to proceed.

Reporting and Operation

The Screening Digital Modernisation Programme Board will be accountable, and report, to the Chief Executive of the PHA. Progress updates and reports will be provided to the DHCNI Management Board and the Screening Programme Board as required.

The quorum for meetings shall be:

- the Chair (or an appointed deputy chair);
- half the membership plus 1 to form a quorum.

The Board's collective role is to achieve the strategic aims and objectives of the programme and will have responsibility for 3 key themes;

iv) Managing the current challenges through formalised reporting mechanisms with extant Projects
v) Managing the transition of screening programmes to best utilise the new digital landscape, especially the opportunities presented by encompass
vi) Managing the planning and transition of the Child Health System into encompass

Frequency and business of the Board

The Screening Digital Modernisation Programme Board must meet at least 6 times per year.

Within 6 months of first meeting the Screening Digital Modernisation Programme Board it must develop and agree a plan outlining:

- Meeting timetable
- How the objectives of the Screening Digital Modernisation Programme Board will be fully/partially met
- Resources (human and financial) required to achieve the Programme objectives
- Strategic and operational challenges which may require intervention or DHCNI Management Board intervention/approval
- The risk appetite, in particular on risks emerging outside of any identified risk tolerance, which may need intervention to mitigate risks and facilitate success

The Screening Digital Modernisation Programme Board will monitor performance against the approved plan and report, at least every 6 months, to the PHA Board and as appropriate to DHCNI Management Board and the Screening Programme Board.

If funding is identified as required to achieve specific objectives, the Screening Digital Modernisation Programme Board must manage and report on finances against the objectives for which funding was allocated.

Report on ongoing transitional activities with extant screening programmes.

Recommend to appropriate authority any significant strategic changes which materially affect the operation of current and future screening functions.

The Screening Digital Modernisation Programme Board should also receive regular reports from each of the current screening programmes especially where this indicates risk or has the ability to impact the achievement of objectives.

Chair

In the chair's absence, the deputy chair will chair the meeting.

If the deputy chair is not available, the attending members may elect a chair for that meeting.

Quorum and Board decisions

The quorum for a meeting of the Screening Digital Modernisation Programmes Board is half the membership plus 1, including the chair per 5.2

For the avoidance of doubt, presence remotely at a meeting, for example, by telephone or virtually, is permitted and counts towards attendance and the quorum.

The Screening Digital Modernisation Programme Board will act collectively in making decisions and seek to achieve consensus on decisions where everyone's view is respected, differing views are welcome.

If required, on matters requiring member voting, the chair has a casting vote.

Unless otherwise agreed, the agenda and papers for Screening Digital Modernisation Programme Board meetings will usually be issued a week before meetings.

A meeting record of proceedings and decisions of each meeting must be made, including the names of those present and in attendance and any declarations of conflict of interest.

Membership

Members will be invited to join the Screening Digital Modernisation Programme Board as follows:

- Chief Executive PHA(Chair)
- Director of Public Health
- Director of Nursing, Midwifery and AHPs
- Deputy Director Public Health (Service Development & Screening)
- Programme Director/SRO encompass
- NIDIS (NI Digital Identity Service) SRO
- TBC
- TBC
- etc.

HSC Public Health Agency

item 16

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	28 August 2024
Title of paper	UK Covid-19 Inquiry - Module 1 Update Paper
Reference	PHA/11/08/24
Prepared by	Alastair Ross / Catherine Collins
Lead Director	Aidan Dawson

Recommendation For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is for the Board to note the update on developments to date relating to Module 1 of the UK COVID Inquiry.

2 Background Information

Module 1 of the Inquiry examined the state of the UK's central structures and procedures for pandemic emergency preparedness, resilience and response. It opened in July 2022 with hearings running between June 2023 and July 2023. A Report was published in July 2024.

3 Key Issues

The Report found that the UK system of building preparedness for the pandemic suffered from a number of significant flaws, namely that:

- The UK prepared for the wrong pandemic.
- The institutions and structures responsible for emergency planning were overly complex.
- Risk assessments were flawed.
- The sole pandemic strategy (from 2011) was outdated and lacked adaptability.
- Emergency planning failed to account sufficiently for the pre-existing health and societal inequalities and deprivation in society.
- There had been a failure to learn sufficiently from past civil emergency exercises and outbreaks of disease.

- Planning guidance was insufficiently robust and flexible, and policy documentation was outdated, unnecessarily bureaucratic and infected by jargon.
- Prior to the pandemic there had been a lack of adequate leadership, coordination and oversight.
- Advisers and advisory groups did not have sufficient freedom and autonomy to express dissenting views and suffered from a lack of significant external oversight and challenge

A total of 10 recommendations were made and further detail on these is contained with the paper.

4 Next Steps

The immediate implications of the Module 1 Report will be discussed at a future meeting of the Agency Management Team. An update will be brought to the PHA Board in respect of progress relating to the recommendations.

UK Covid-19 Inquiry - Module 1 Update Paper

August 2024

1. Context

This paper has been drafted to provide PHA Board members with an update on the developments to date in respect of Module 1 of the UK Covid-19 Inquiry.

Module 1 of the Inquiry examined the state of the UK's central structures and procedures for pandemic emergency preparedness, resilience and response.

A brief timeline of the Module is set out below:

→	21 July 2022	Opening of Module 1	↑
→	25 April 2023	Submission of PHA Corporate Witness Statement signatory Aidan Dawson	Two Year Duration
→	13 June 2023	Commencement of Public Hearings	
→	12 July 2023	Evidence Session - Aidan Dawson	
→	21 July 2023	Closure of Public Hearings	
→	20 February 2024	Receipt of Warning Letter from the Inquiry	
→	18 July 2024	Publication of Module 1 Report	↓

2. Recent Developments

Findings

On Thursday 18 July, the Module 1 Report was published.

The Report runs to over 200 pages and is set out across six distinct chapters. Beyond its inclusion in a diagram setting out the central structures in Northern Ireland, the PHA is not mentioned within the Report. A number of pertinent extracts in relation to NI are included at Appendix 1 of this paper.

The Report found that the UK system of building preparedness for the pandemic suffered from a number of significant flaws, namely that:

- The UK prepared for the wrong pandemic.
- The institutions and structures responsible for emergency planning were overly complex.
- Risk assessments were flawed.
- The sole pandemic strategy (from 2011) was outdated and lacked adaptability.

- Emergency planning failed to account sufficiently for the pre-existing health and societal inequalities and deprivation in society.
- There had been a failure to learn sufficiently from past civil emergency exercises and outbreaks of disease.
- Planning guidance was insufficiently robust and flexible, and policy documentation was outdated, unnecessarily bureaucratic and infected by jargon.
- Prior to the pandemic there had been a lack of adequate leadership, coordination and oversight.
- Advisers and advisory groups did not have sufficient freedom and autonomy to express dissenting views and suffered from a lack of significant external oversight and challenge

Recommendations

The Inquiry has set out ten recommendations designed to collectively overhaul how the UK government and devolved administrations prepare for whole-system civil emergencies.

The recommendations are high level and directed at UK government level. It is anticipated that they will be accepted in their entirety by the UK Government with the expectation from the Inquiry Chair that they will be '*acted upon and implemented in a timely manner*'.

While the PHA has not been named as a 'responsible institution' for any of the recommendations, there will be implications for the Agency as the process of implementation takes place.

- Short Term Requirement (Immediate)

  - Consider the findings of the Module 1 Report against any ongoing/proposed preparedness work that the Agency is leading on or involved in.

- Longer Term Requirement (Over Six Months)

  - Await the formal response from UK Government/NI Executive in relation to each recommendation.
  - Consider the existing capacity of the Agency to respond to the demands of the recommendations. By way of example, the PHA will no doubt, have an active role in shaping the new structure for emergency preparedness/resilience and contributing to the regular pandemic response exercises recommended by the Inquiry.

A summation of each recommendation and its *likely* outworking for Northern Ireland is set out at table 1.

3. Module 1 Recommendations and Likely Outworking for NI

No.	Recommendation	Likely Outworking for NI	Proposed Implementation Date
1.	A simplified structure for whole-system civil emergency preparedness and resilience	• New NI Assembly Executive committee established with responsibility for whole-system civil emergency preparedness and resilience, chaired by FM / DFM and including Minister for Health • New single cross-departmental group of senior officials reporting to new Ministerial committee above, to oversee and implement policy on civil emergency preparedness and resilience. - Group to complete a review to simplify and reduce the number of structures responsible for whole system civil emergency preparedness and resilience - Executive to rationalise and streamline extant supporting structures ensuring that remaining structures have a clear purpose and streamlined reporting programme	July 25 July 25 Jan 26 July 26
2.	Cabinet Office leadership for whole-system emergencies in the UK	• (TBC) NI whole system civil emergency preparedness and resilience planning will interface with Cabinet office directives	July 25
3.	Better approach to risk assessment that provides for a more comprehensive evaluation of a wider range of scenarios	• DA's to work together with UK Govt and replace reasonable worst-case scenario risk assessment planning with a fuller assessment of short term/ long term risks, impact of risks on vulnerable people and takes account UK capacity and capabilities • NI to have its own specific risk assessment	None set (Ongoing)
4.	UK -wide whole system civil emergency strategy	• DAs and UK Govt to introduce a new whole system wide strategy for civil emergency (including pandemic) to prevent each emergency and also to reduce, control and mitigate its effects. • Clear demarcation around responsibilities of each partner • Reassessment at least every 3 years	July 25

No.	Recommendation	Likely Outworking for NI	Proposed Implementation Date
5.	Data and research for future pandemics	• DAs / UK Govt to establish mechanisms for timey collection, analysis, secure sharing and use of data for informing emergency response • Wider range of research projects (in hibernation) but ready to be activated at short notice e.g. prevalence of a new virus, measuring effectiveness of range of different public health measures; and identifying most vulnerable groups etc. • Better working with international partners to be encouraged.	July 25
6.	Regular UK wide pandemic response exercise	• DAs /UK Govt to hold a UK wide pandemic response exercise together <3yrs	Every 3 yrs.
7.	Publication of findings and lessons from civil emergency exercises	• NI to publish an exercise report within 3 months of each exercise – together with an action plan (within 6 months) setting out specific steps to be taken in response to the report findings and by what partner	Upon completion of each exercise
8.	Published reports on whole-system civil emergency preparedness and resilience	• NI to produce and publish report to the Assembly on preparedness and resilience	Every 3 yrs.
9.	Regular use of Red Teams	• Practice of bringing in Red teams from outside of govt and Civil Service to be introduced to scrutinise and challenge the assumptions / planning / evidence etc underpinning preparedness and resilience	July 25
10.	UK wide independent statutory body for WS civil emergency preparedness and resilience	• New body est. on a non -statutory basis within 12 months, and upgraded to statutory asap. • Role in providing independent strategic advice to UK Govt and DAs on their planning for preparedness for and building resilience to WS civil emergencies	July 25

4. PHA Actions

Actions Taken

To date the following actions have been taken following publication of the Module 1 Report:

- 22 July Updating of PHA Connect Statutory Public Inquiries page
- 24 July Consideration of the Report at PHA Public Inquiries Programme Board
- 6 August Staff Update at PHA 'First Tuesday' engagement session
- 21 August Consideration of the Module 1 Update Paper at AMT

Action Proposed

The following actions are proposed:

- To use a future AMT Strategy Meeting to consider the immediate implications of the Module 1 Report.
- To bring a future update to PHA Board in respect of Module 1 progress and the impending Module 2C Report from the Covid-19 Inquiry. Module 2C has examined decision-making and political governance within NI and will be published in 2025.

END

Appendix 1

Module 1 Report Extracts in Relation to Northern Ireland

Chapter 2: The system - institutions, structures and leadership

2.76. Dr Denis McMahon, Permanent Secretary to The Executive Office of Northern Ireland from July 2021, maintained to the Inquiry that, notwithstanding its outward appearance of complexity, the situation was more straightforward in practice:

2.77. When asked if the system, complex though it may be, was effective, Dr McMahon's evidence to the Inquiry was that "*overall it has worked well*", but he attributed that in some measure to "*personal leadership*".[183] He cautioned against radical reform in Northern Ireland, as he was concerned not to undo the "*years of conditioning*" of people working in emergency planning.[184] The Inquiry has greater understanding for this in Northern Ireland than elsewhere in the UK, but that does not mean the system ought not to be subject to simplification and rationalisation.

2.78. Professor Sir Michael McBride, Chief Medical Officer for Northern Ireland from September 2006, did not believe that it was the complexity of the structures that caused those working in emergency preparedness and planning to be ineffective.

2.84. It is clear that the structural problems in Northern Ireland, in its preparedness for the Covid-19 pandemic, were exacerbated by the suspension of the power-sharing arrangements. The Inquiry is considering the longer-term impact that the suspension

Chapter 3: The assessment of risk

3.16. The Northern Ireland Executive did, however, maintain corporate risk registers. The 2018/2019 Department of Health (Northern Ireland) Departmental Risk Register warned:

> "*The health and social care sector may be unable to respond to the health and social care consequences of any emergency (including those for which the* [Department of Health (Northern Ireland)] *is the Lead Government Department) due to inadequate planning and preparedness which could impact on the health and well-being of the population.*"[36]

Insufficient action was taken on this crucial warning in advance of the pandemic. The Inquiry was informed that this was because the Department of Health (Northern Ireland) did not have sufficient resources.[37]

Chapter 5: Learning from experience

5.83. The health and social care services in Wales and Scotland confronted similar challenges to England.[129] In Northern Ireland, the health and social care system suffered, in particular, from the lack of an Executive between 2017 and 2020. Professor Sir Michael McBride, Chief Medical Officer for Northern Ireland from September 2006, told the Inquiry that the health service in 2020 was not even as resilient as it had been in 2009.[130]

5.98. In 2018, Professor McBride established the Northern Ireland Pandemic Flu Oversight Group.[136] A 'task and finish group' was also formed in 2019 in the Department of Health (Northern Ireland), and its functions included reviewing and updating health and social care influenza pandemic surge guidance.[137] This work was paused to redirect to Operation Yellowhammer throughout 2019. It was not resumed prior to the emergence of Covid-19 in January 2020.[138] The under-resourcing of the Civil Contingencies Policy Branch of the Executive Office of Northern Ireland had been a longstanding issue. In November 2019, an internal email stated:

> "*The overall position is dire. There has been systemic failure to invest funding and resources in* [the Civil Contingencies Policy Branch] *over a number of years and the current position is that at a time of focus, the lack of investment I regret to advise you has left it not fit for purpose.*"[139]

Therefore, in Northern Ireland, the crucial work required to prepare the health and social care sector for a pandemic was not completed.

HSC Public Health Agency

item 17

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	28 August 2024
Title of paper	PPI Update Report
Reference	PHA/12/08/24
Prepared by	Martin Quinn
Lead Director	Heather Reid

Recommendation For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to provide an update on PHA's Personal and Public Involvement work.

2 Background Information

The PHA has lead responsibility for the oversight of the implementation of PPI Policy across the HSC. In the main, the PHA manages these responsibilities by working in partnership with other HSC bodies and service users and carers through the Regional HSC PPI Forum.

3 Key Issues

The PHA continues to drive forward our collective endeavours in PPI, Co-Production and Partnership Working at a time of major flux.

4 Next Steps

The next report will be brought to the Board within the next year.

PERSONAL AND PUBLIC INVOLVEMENT

BOARD REPORT APRIL 2023 - MARCH 2024

INVOLVEMENT, CO-PRODUCTION AND PARTNERSHIP WORKING

'AN ENGAGED POPULATION IS A HEALTHIER POPULATION'

Personal and Public Involvement (PPI)

Involving you, improving care

HSC Public Health Agency

CONTENTS PAGE

PERSONAL AND PUBLIC INVOLVEMENT

Personal and Public Involvement (PPI) is the active and effective involvement of service users, carers (SUC) and the public, in health and social care services. People have a right to be involved in and consulted on decisions that affect their health and social care. Involvement has a key role in the commissioning, development and delivery of services. Under the Health and Social Care (HSC) Reform Act (NI) 2009, involvement is a legislative requirement and is further underpinned by the Co-Production Guide of 2018 and other related policies and circulars.

The primary responsibility for overseeing the implementation of PPI across the HSC system is assigned to the PHA by the DoH as per the 2012 PPI Policy Circular. This circular also sets out the requirements on the PHA to provide DoH with assurances that HSC bodies, and in particular Trusts, meet their PPI statutory and policy responsibilities. This update report is presented to the PHA Board annually as part of our governance and reporting arrangements.

The report covers the period from April 2023 to March 2024 and will give an overview of the developments and progress made, including how the PHA has discharged their leadership responsibilities in involvement, co-production and partnership working in the PHA and across the HSC system, at a time of unprecedented change, pressure and demand.

Who are we:

Martin Quinn - Regional HSC PPI Lead
Bronagh Donnelly - Senior PPI Officer
Emmett Lynch - Senior PPI Officer
Martin Mc Crory - Regional Peer Mentor Lead for Service Users and Carers
James Mc Laughin - Involvement Officer (Interim)

‘An Engaged Population Is a Healthier Population’

STRATEGIC LEADERSHIP, ADVICE AND GUIDANCE.

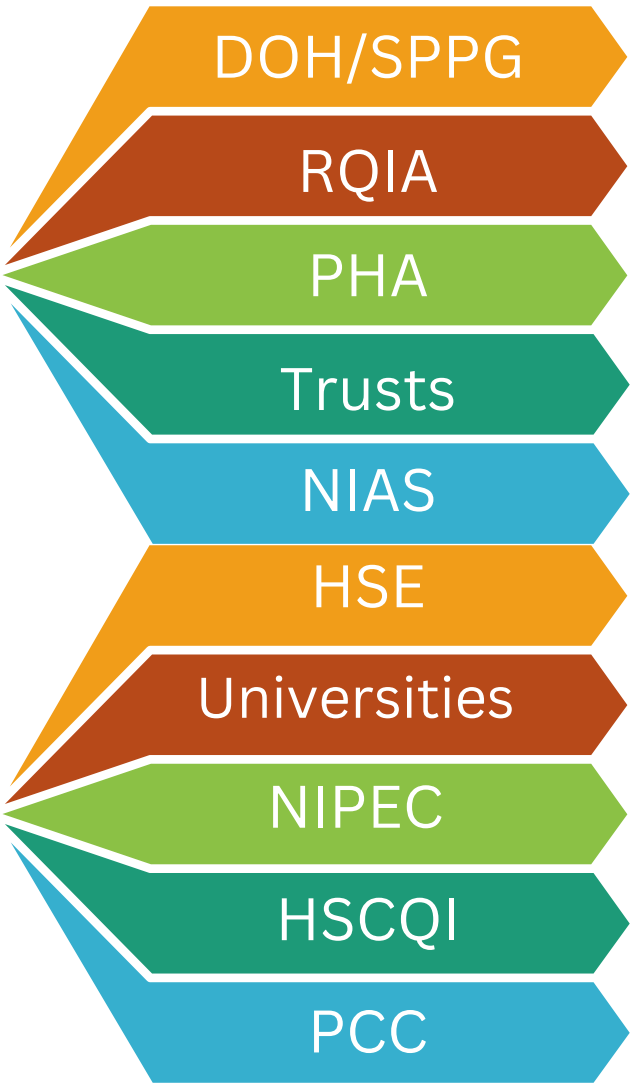
Professional advice and guidance

In line with the PHA's strategic involvement responsibilities, including the recently issued 2023 Change and Withdrawal of Services Circular, the PHA PPI team provides advice and guidance on best involvement and consultation practices. This advice, guidance, and support on involvement are available in areas of strategic importance, high profile, sensitive, cross-organisational issues/projects.

The work helps to ensure that the voice of the service users and carers is valued, respected, and integrated into the work of the HSC in a consistent and effective manner. This includes:

- The provision of professional involvement advice and guidance, stakeholder analysis, and development of involvement plans.
- Practical support in helping the project promoter to identify, secure, and facilitate service user/carer participation.
- Development of monitoring arrangements.

The PHA PPI team has provided involvement leadership, advice, and guidance last year across a wide range of organsations including those detailed below:



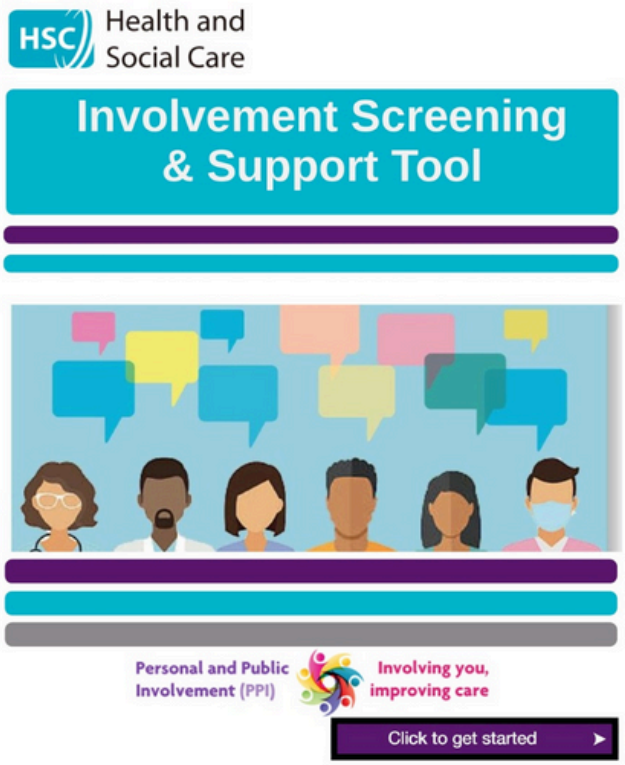
The PHA PPI team has received 117 individual requests from stakeholders for leadership, advice, and guidance over the past 12 months. This has equated to 179 specific requests, which is a 50% increase from the previous year. In the main, these requests for advice and guidance are of a strategic, high-profile/sensitive, or cross-organisational nature. The Change or Withdrawal of Services Circular issued in September 2023 seems to have been partially responsible for this increase. Requests ranged from advice and guidance on the establishment of service user and carer reference groups, to advice on appropriate involvement training for staff, to how to develop an Involvement Plan, etc. The graphics below give a sense of the range of types of request and where they originate from.

The remaining 26% of requests relate to advice and guidance on remuneration, reimbursement, consultation events, monitoring, verifications, etc. Requests for support came from many HSC organisations, as well as community and voluntary organisations and service users and carers, including The Leadership Centre, Clinical Education Centre, and NI Practice and Education Centre.

*Word cloud derived from requests for Involvement advice and guidance.

Involvement Screening and Support Tool

The PHA PPI team developed an 'Involvement Screening & Support Tool' to act as a 'ready reckoner' to address the high demand for advice and support across the HSC system. This tool supports staff to incorporate the right level and input of involvement for the various initiatives they are working on. It also provided advice on what they may need to support and facilitate this and provides links out to more detailed resources, guides and additional help.



The use of the Involvement Screening & Support Tool will Influence the drive for a systemic approach for Involvement, Co-Production and Partnership Working. It will support staff who are working in pressured environments, to quickly gain an understanding of the value of Involvement. It provides some key insights into what will enable them to integrate Involvement into their culture and practice, whilst also pointing them in the direction of further resources and support. It will also promote consistency of practice in this area, helping to embed Involvement and evidence the impact it can make it the HSC system. The adoption of this tool into the commissioning, planning, development, delivering and reviewing of services will in turn support the wider public health agenda through support for partnership working, collaboration and associated improvements in safety, quality and efficiency.

Regional HSC PPI Forum

The Regional HSC PPI Forum is the vehicle through which the PHA exercises much of its leadership in the field of Involvement, Co-Production, and Partnership Working. It is comprised of HSC staff, service users and carers, and third sector partners. The members of this Forum bring their collaborative expertise together to advance the concepts and practices of involvement in the work of the HSC and to understand the benefits associated with this way of working.

Key achievements over the past year:

Involvement and Consultation Scheme

There is a statutory duty for Involvement and Consultation, as placed upon the HSC by sections 19 & 20 of The Health and Social Care (Reform) Act (NI) 2009. Under the leadership of the PHA PPI team and working alongside Trust PPI Leads colleagues, a standardized Involvement and Consultation Scheme template has been produced. This will help to ensure consistency of approach to Involvement and Consultation and clarity about what and how organizations will discharge their responsibility. The PHA and HSC Trusts have now used the common template to develop their Involvement and Consultation Schemes and have taken them through their respective approval processes. The PHA PPI team will now lead a public consultation on the schemes in a collaborative fashion. The consultation process will take place during Summer/Autumn 2024 and should see the schemes being operational from Winter 2024.

Monitoring and learning

The quantitative monitoring of involvement activity is now well established within the Trusts and PHA. The PHA PPI team has led on the development of a qualitative monitoring process to accompany this. Its components enable the identification and sharing of good practice, with a view to advancing learning. It also serves to enhance the reassurance that the PHA can provide to the DoH in regards to involvement in the HSC. This was co-produced with service users and carers and will be operational from Summer 2024.

Peer mentoring

The Forum members had identified the importance of establishing a 'Peer Mentoring' model that would support service user and carer voices to be heard at all levels of HSC developments. The model has been developed in pilot form with the service user and carer representatives on the newly established ICS Area Integrated Partnership Boards. It will be evaluated later in 2024 to determine the outcomes and impact of this initiative and any learning and adjustments that need to be adopted in the model going forward.

Regional HSC PPI Forum

Training

The PHA PPI team along with Trust colleagues, service users and carers partners have identified, collated and reviewed the current suite of Involvement related training that is available across the HSC. The aim of this initiative was to have clarity on training available and also to ensure consistency of approach and standards in Involvement training. The next stage of work on this project has been agreed which includes the development of a training matrix and a plan for delivery across the HSC system.

Strategy Development

The Forum has been very active in developing a new 5 year PPI Strategy, that includes a vision and associated key priority areas for action. With the progress of the PHA's Reshape and Refresh programme and the move towards integration between PPI and PCE, a period of review and reflection has been entered, enabling us to build on our thinking and to work towards an integrated strategy for PPI and PCE that respects the value of each area, but which also utilises synergies and opportunities for added value. Going forward the PPI and PCE teams will work towards an integrated strategy to enhance the PPI and PCE function across the PHA

Priority Areas for the last Year

The Forum remains an important place for HSC organisations to share good practice. At each meeting of the Forum, a particular Involvement project is highlighted, reviewed, impacts assessed and learning identified and shared. Many of these are then written up, with the aim of being placed on the Engage website, including:

NIAS - Consultation on the introduction of body worn cameras for staff for the purpose of violence prevention and reduction.
WHSCT - Multi Disciplinary Team (MDT's) Positive Mental Health initiative.
SHSCT - Fit 4 U/Fit 4 U 2 service, which is a community-based physical activity programme for adults with physical disabilities and adults with learning disabilities
NHSCT - Co-production and Co-delivery of a Disability Awareness video, used during staff training.

HSC Transformation/Rebuild Work

To provide professional Involvement, Co-Production, Consultation and Engagement support to the DoH across a number of Directorates, one of our Senior PPI Officers has supported this work.

A range of modernisation and reform projects have been supported in this way, including:

The Review of Urgent and Emergency Care:

With the approval from the Minster for Health to implement the recommendation of the review, a new programme management structure was established to take forward the wide-ranging recommendations and build on the work piloted during the No More Silos programme. As such, a new involvement plan was developed to ensure that service user and carer voices are central to the strategic implementation of the three main review themes

1. Creating an integrated urgent and emergency care service
2. Capacity, Co-ordination and performance
3. Intermediate Care, a Regionalised Approach. This included the inclusion of service users and carers within the programme structure.

Elective Care / General Surgery:

An update workshop was held for service users and carers to provide information on the progress of the Elective Care Centres and General Surgery. This was attended by service users and carers who had been involved in both policy areas, as well as some participants from the PCC membership scheme. The Elective Care Centre Implementation Board has been established and includes wide representation across the HSC including service user and carer representatives.

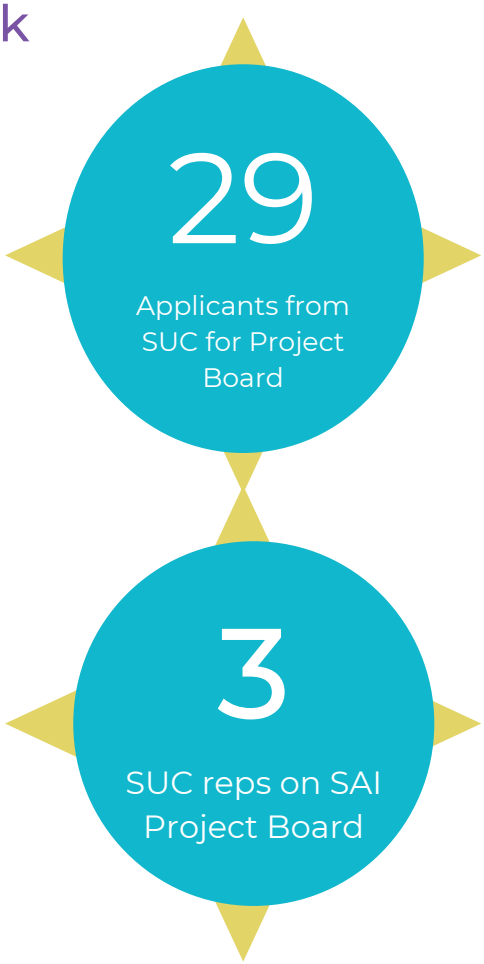
Hospital Reconfiguration Blueprint:

An involvement and stakeholder engagement plan has been developed and approved by the Hospital Reconfiguration Blueprint programme board. Our officer continues to provide advice on this regarding all aspects of Involvement, Co-Production and possible pre-and public consultation. This work is progressing with significant engagement with Trust Chief Executives and political representatives. Service user/carer representation has also been included on the programme board to embed involvement at that level.

HSC Transformation/Rebuild Work

Serious Adverse Incidents:

Working with the Deputy Chief Medical Officer and DoH Director an approach for involvement has been designed, that will incorporate feedback from service users and carers at multiple levels of the project. This approach was fed into by the Patient Client Council, The Regulation and Quality Improvement and the Mental Health Commissioner. It builds on involvement work which took place during the IHRD programme. The approach includes co-production at strategic level, research/literature review of service user/carer perspective, wider engagement via PCC SAI group and specific workshops



Continued support is given to additional programmes of work including:

- The Review of General Surgery
- The Cancer Strategy for Northern Ireland 2021-31
- No More Silos

Other Strategic work supported by PPI Team

The PHA PPI team continues to support strategic areas of work, a few examples include:

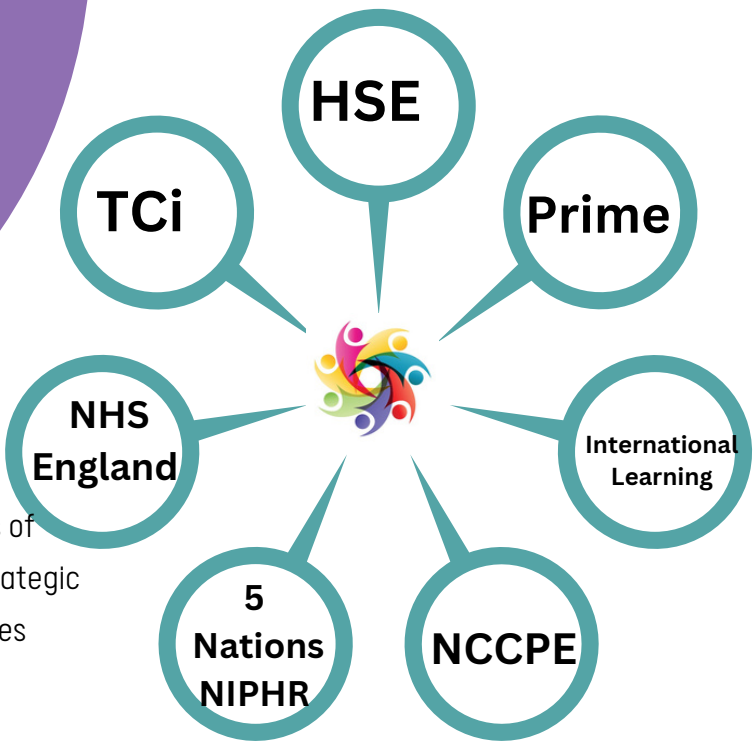
Integrated Care System:

We have supported the development of involvement structures within the Integrated Care Systems programme for the past two years. Working closely with ICS leadership with responsibility for involvement to advise how the Involvement agenda within ICS can be progressed effectively. This has involved supporting the development of their Involvement Plan and the Terms of Reference for the Involvement Workstream, recruitment of Service User and Carers, regional Involvement training, evaluation and the development of the Involvement Level Screening & Support Tool.

Transforming Medicine Safety NI (TSMNI):

The over-all aim of the TMSNI initiative, is to promote and embed a long term cultural and practical change to improve medication safety in Northern Ireland. The PHA PPI team have worked with the TSMI Programme leads since the programme launched, to provide professional advice, support and to help facilitate and encourage the active and meaningful involvement of service users, carers and the wider public, in matters related to the Transforming Medication Safety NI programme via the co-designed Communication, Participation and Engagement Group.

LOCAL,NATIONAL AND INTERNATIONAL CONNECTIONS



The PHA PPI team have developed networks and a series of working relationships amongst colleagues who have strategic level Involvement and Partnership Working responsibilities across Ireland, the UK and beyond.

In the last year, we have further enhanced relationships that we had already established and made new connections. This has supported an increased level of discussion, exchanges of ideas, sharing of information, good practice, expertise, resources and learning. More recently, we have also started to explore possible areas of collaboration which could identify joint projects with associated funding opportunities.

The PHA PPI team are actively involved in partnerships with:

- The Consultation Institute (TCi) - Global leaders in Involvement & Consultation best practice
- National Co-ordinating Centre for Public Engagement (NCCPE)
- 5 Nations National Institute Public Health Research (NIPHR) led Involvement collaborations,
- PRIME - International Centre for Primary & Emergency Care Research
- NHS England

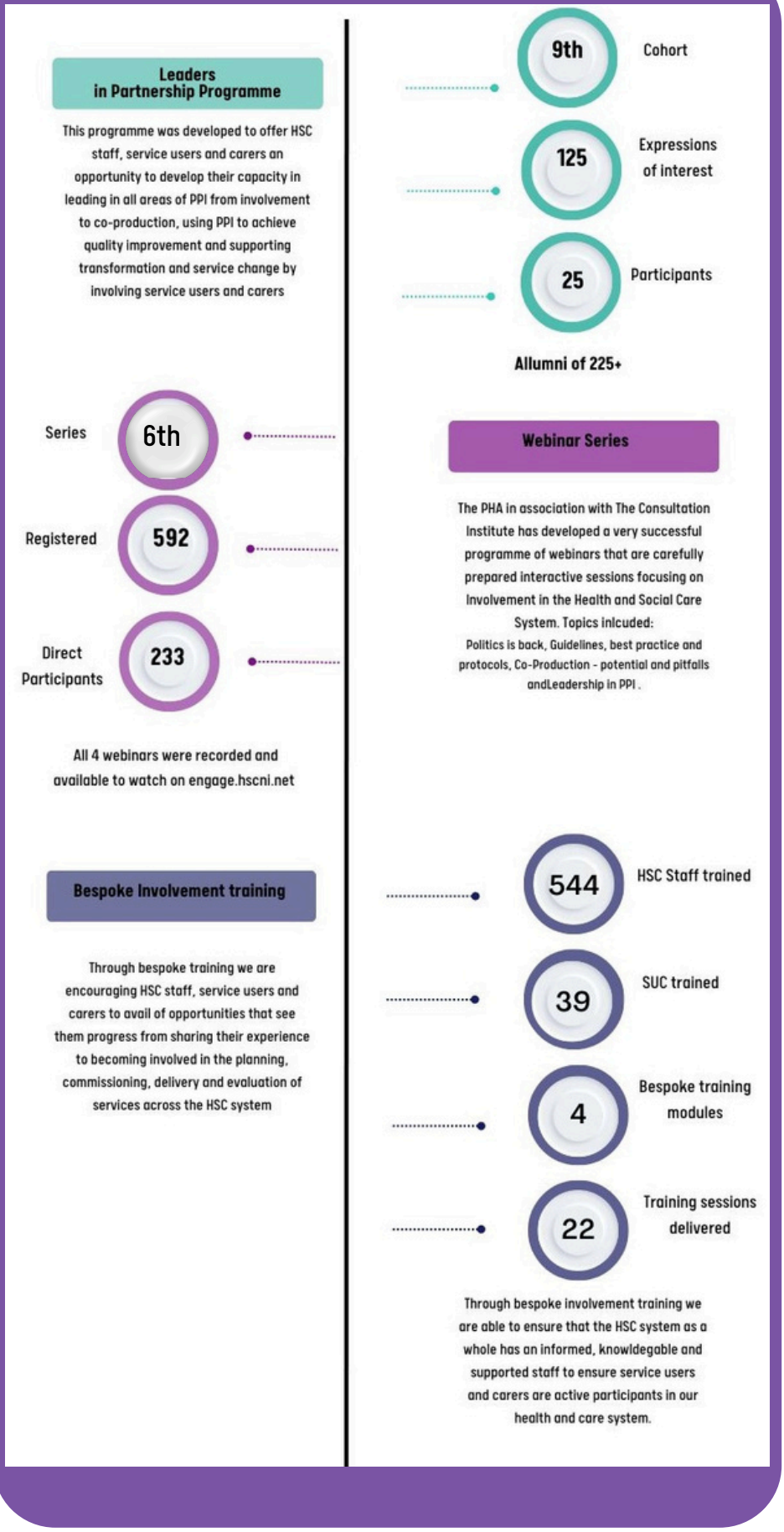
We continue to build relationships with the wider Community & Voluntary Sector locally including organisations such as the Community Development & Health Network (CDHN) and the Northern Ireland Council for Voluntary Action (NICVA).

These relationships and partnerships are beneficial in many different ways and is adding value to our work and to the concepts and practices of involvement, co-production and partnership working, with potentially wider benefits for our respective communities. This includes learning about latest developments in Involvement approaches, examples of best practice, evidence of impact etc.

SPECIALISED INVOLVEMENT TRAINING

A key aim in this area, is to build a critical mass of HSC staff who have knowledge skills and experience in Involvement, Co-Production and Partnership Working. The PHA PPI team commissions, develops, promotes and co-delivers Involvement training opportunities targeted at HSC Staff, but also available to service users, carers, Community and Voluntary Sector colleagues.

This training focuses on more strategic or bespoke areas that are best addressed through the regional and collegiate approaches under the leadership and guidance of the PHA. There are three main areas where our attention has been focused: Leaders in Partnership Programme, Spring Webinar series and Bespoke Involvement training.



What's the impact?

We have seen a significant rise in the number of staff, Divisions and Directorates requesting for bespoke training in Involvement. Over the past 12 months the team has delivered training to **544** HSC staff members. This helps to ensure staff have the information, knowledge and understanding of what is required to fulfil their statutory duty to involve service users and carers in the planning and delivery of services. There is a continuous rolling programme of evaluation of the training provided by the PHA PPI team. This helps to ensure that what is delivered, in terms of the training, is relevant and appropriate, enabling staff to engage effectively with service users and carers. Equipping staff with the knowledge and skills helps us to generate the most effective ways of partnering with service users and carers, contributing to the advancement of the public health agenda, fostering genuine collaboration, use of expertise by experience, added value and increased ownership and self-responsibility for health and well- being.

PCC

I have developed a keen interest in service user engagement and will hopefully be able to use the knowledge and skills learned on this course in the future

Macmillan

Following my participation in the Leaders in Partnership Programme in 2022 my project has established a service user forum, which is integral to our work team.

Service user

I look forward to your webinars every year, they always consist of very interesting and relevant topics, I particularly enjoyed your session on how the HSC can help with the climate emergency.

HSQI Officer

Thank you PPI Team for a very informative session, it has given the HSCQI team some food for thought and we look forward to working together in the future.

SPPG

As I move into a leadership role, I will certainly use some of the tools I have learned on this course in my day-to-day approach to leadership and management

NHSCT

The course has helped me to develop a PPI panel in my organisation

ENGAGE

engage.hscni.net

Engage is the HSC's online platform for all things Involvement, Co-Production and Partnership Working. The website provides users with access to information, resources, training, advice and guidance and details of Involvement opportunities. The new dashboard analytics has enabled an enhanced assessment of usage, user feedback, changed behaviours and links to improve service user and carer participation.

Further enhancements have seen the inclusion of Involvement good practice examples from across the region, new tools and guides being made available alongside our new Involvement Screening and Support tool. Related areas such as Patient Client Experience and Shared Decision Making also now feature on the site.

New additions:

A **feedback** page was introduced to ascertain how we can improve the site and also to determine what difference it is making for people. In addition, a **News page** has been included that will highlight areas of significant news stories that users might find interesting.

There has also been the inclusion of the **Involvement Stories** section. This will facilitate the sharing of knowledge and insight into the benefits and outcomes of Involvement.

Activity and Impact:

The graphic above provides some insight into the levels of activity on the Engage website. This represents an increase of almost 50% in terms of use of the site from the previous year. Feedback indicates how much people value this resource and that people are now also looking to the site to both, inform/shape work that they are planning to undertake and are using it to promote/encourage participation.

MONITORING

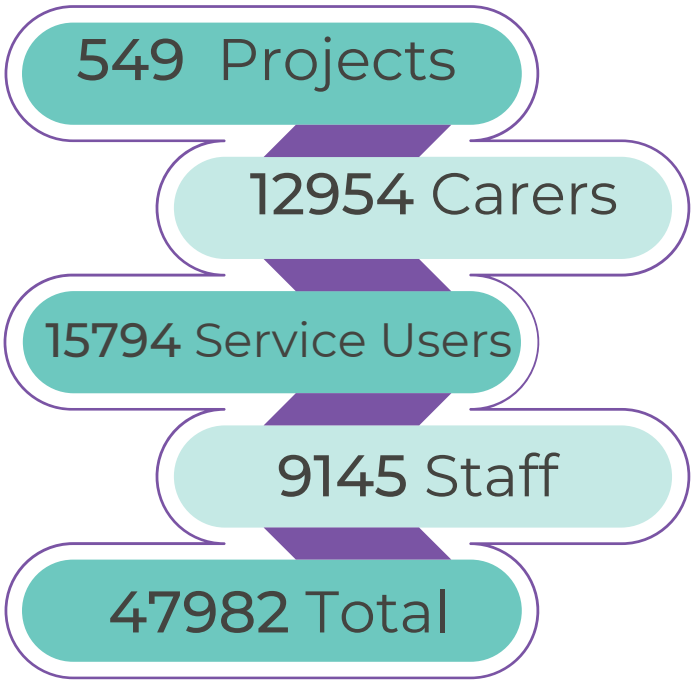
The PHA have HSC wide responsibility for the oversight of the implementation of PPI Policy and have a leadership role in regards to encouraging, promoting and progressing Involvement, Co-Production and Partnership Working with service users, carers and the Public. The DoH have tasked the PHA with assessing the progress being made in the HSC against this policy imperative and with developing and deploying monitoring arrangements in order to assess how HSC Trusts are meeting their statutory and policy obligations in respect of Involvement.

The PHA uses the;

- Personal and Public Involvement (5 Standards) Assessment Monitoring compliance return,
- The Involvement activity monitoring data return,
- PPI training data return,

Alongside the above, HSC Trusts also submit a signed Assurance Statement in relation to their advised progress in these matters. The PHA undertakes an evaluation of the returns, including comments and makes recommendations (with input from service users and carers from the PHA PPI Regional Forum). The PHA PPI Team then take these reports through its internal governance/reporting arrangements before submitting to the DoH for their consideration as part of the wider system of accountability with HSC Trusts.

External Involvement Activity



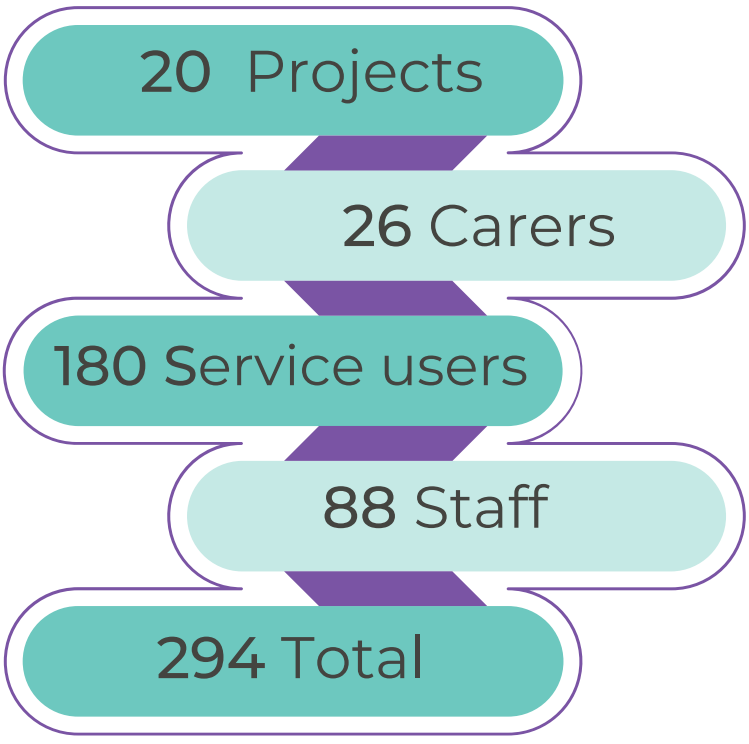
What has been the impact?

Below we have highlighted 4 key reported outcomes of the involvement activity that has been completed in the past 12 months. Other reported outcomes have seen improved relationships, more efficient services, improved access to services, improved safety, increased ownership and services needs/concerns identified.

INTERNAL PHA MONITORING

This year has seen an increase in Involvement activity across the Directorates. The PHA PPI Internal Leads Group has further strengthened during 23/24. The group is committed to advancing Involvement, Co-Production and Partnership Working at all levels and across all programmes of work within the organisation. Involving our service users, carers, public and also staff in the development of our plans and services, supports us to ensure they are more effective, targeted and safer. Research has shown where there are high levels of involvement and ownership, that there are higher levels of compliance with advice and guidance and increased levels of self-responsibility.

Involvement Activity



PHA PPI Internal Leads Group

The PHA PPI Internal Leads Group is set up to bring together staff from various Directorates within the organisation to advance and embed Involvement into our culture and practice.

Name:	PHA Directorate / Division:
Martin Mc Crory	Nursing & AHP
Bronagh Donnelly	Nursing & AHP
Emmett Lynch	Nursing & AHP
Janet Diffen	Research & Development
Alison Ferris	Nursing, Midwifery & AHP
Jessica Murray	Health Improvement
Wendy Thornton	Service Development & Screening
Soo Hun	Centre for Connected Health
Danny Wilson	Operations
Bronagh Mc Brien	Health Protection
Domenica Gilroy	HSCQI

What has been the impact?

Improving levels of involvement activity have been reported in the last year. As part of the monitoring arrangements, reported outcomes have included: improved access to services, increased ownership, increased understanding of the value of involvement and increased focus.

8 Projects reported an improvement in relationships

7 Projects reported better communication

5 Projects reported Quality Improvement

SUPPORTING SERVICE USERS AND CARERS

Strengthening Partnership Working with people with lived and living experiences in the HSC.

The focus of this work area is to advance the concept and practice of engagement, support and infrastructure for people with lived and living experience to become partners in the HSC:

PHA Service User and Carer Reference Group

The PHA PPI team has established a Service User and Carer Reference Group to support the strategic work of the PHA. It is comprised of a diverse range of service users and carers, people with an interest in working with the PHA to contribute to our thinking, plans and projects. This group have an interest in Public Health matters and are keen to work with the PHA on relevant plans, programmes and projects which could benefit from public input.

The group will also work with the PHA in advancing the concept and practice of Peer Mentoring for Involvement. The PHA has noted the need to utilise the skills and knowledge of experienced service users and carers and create a structure and mechanism through which they can share these acquired skills to other, less experienced service users and carers. This will allow for development of capacity and skills for those less experienced service users and carers, and support succession planning for those service users and carers who can engage at high, strategic levels of involvement. This role of Peer Mentoring will develop in partnership with the service user and carer representatives on the newly established ICS Area Integrated Partnership Boards, and progress through the wider HSC system to support service user and carer voices to be heard at all levels of HSC developments.

Impact:

Having service users and carers supported and trained to engage with and support the work of the PHA and its strategic drivers for Public Health is essential to effective commissioning, planning and delivery of services. This group will support strategic programmes of work within the PHA and be a reference point to help make involvement part of the culture of PHA business.

Shared Decision Making

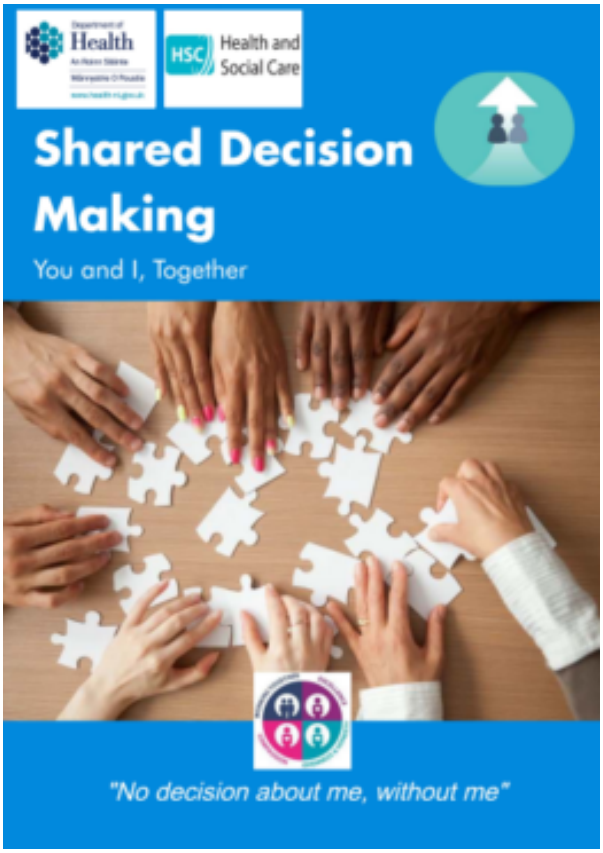
The PHA have been assigned a leadership role in respect of advancing the concept of Shared Decision Making (SDM) in the HSC. The NICE Guidance note 197 and the DoH Circular set out expectations for SDM. A Regional External Stakeholder Group was established by the PHA with multi-disciplinary representation from across the HSC, including service user and carer membership and is co-chaired by the PHA PPI and PCE leads. Whilst Trusts have specific recommendations from NG197 that they must progress internally and report on through established monitoring structures; several areas were highlighted that will be progressed through partnership working, which the regional group will lead on, these are:

1. Creating consistency around the writing of Clinical Letters to patients in terms of appropriate use of language, letter structure and dissemination.
2. Training and Resource developments for SDM to include the use of Patient Decision Aids.
3. The promotion of SDM to service users, carers and the general public.

Impact

Developing the skills and knowledge of our staff and population to contribute to and share in decision making processes about their own health and also at more strategic levels, will have a positive impact in several ways:

1. It enables people to share information and discuss options with healthcare professionals.
2. It facilitates better understanding of the benefits, harms and possible outcomes of different options.
3. It empowers people to make decisions about the treatment and care that is right for them at that time.
4. It provides opportunities for strategic partnership working between providers and recipients of care.



Remuneration

The PHA and PCC jointly led on a programme of work to develop draft regional guidelines for the remuneration of service users and carers who contribute at a strategic level within the HSC system. This has been a long-standing area of development for involvement, with the origins in the Co-Production Circular 2018. An options paper was developed by PHA and PCC for DoH for consideration. It is hoped pilot models of remuneration will be in operation in 2024/25.

Impact

1. Remove barriers to Involvement from otherwise potentially marginalised groups.
2. A potential increase in the range of service users and carers, the HSC attracts to be involved, who might otherwise be less able to give up the time needed to contribute at strategic levels.
3. Service users and carers feel their strategic contributions are recognised, valued, respected and reciprocated.
4. Service users and carers will have a greater sense of equality with HSC staff when it come to working together on projects.
5. Establish and advance possible pathways for service users and carers to work more collaboratively and strategically with the HSC.

Health Literacy

DoH have re-established a Health Literacy Forum in the HSC. The PHA PPI Team play a key role in supporting this work, as both health literacy and Involvement have strong synergies. The PPI team have reviewed over 50 HSC Public Consultations (which were carried out in the past 15 years), utilising a readability tool to ascertain their accessibility and compatibility with the concepts and practices of Health Literacy.

It is anticipated the Forum will provide a central point for discussing / sharing information to progress the health literacy agenda. The PPI team have also led on the development, implementation and analysis of a Health Literacy Baseline Survey amongst Forum members to help inform thinking and influence the direction of travel for this area of work.

Impact

The wider health literacy agenda is key to reducing health inequalities within our population. Health literacy is related to health and social care outcomes for service users and carers. Limited health literacy is linked with, poor medication safety, unhealthy lifestyle behaviours such as poor diet, smoking and a lack of physical activity and an increased risk of morbidity and premature death. People with limited health literacy are more likely to use emergency services, less likely to successfully manage long-term health conditions and as a result, incur higher healthcare costs. Efforts to improve health literacy can have a range of benefits. They can increase health knowledge and build resilience, encourage positive lifestyle change, empower people to effectively manage long-term health conditions and reduce the burden on health and social care services. There is also a close alignment with work we are involved in with Transforming Medication Safety and in SDM.

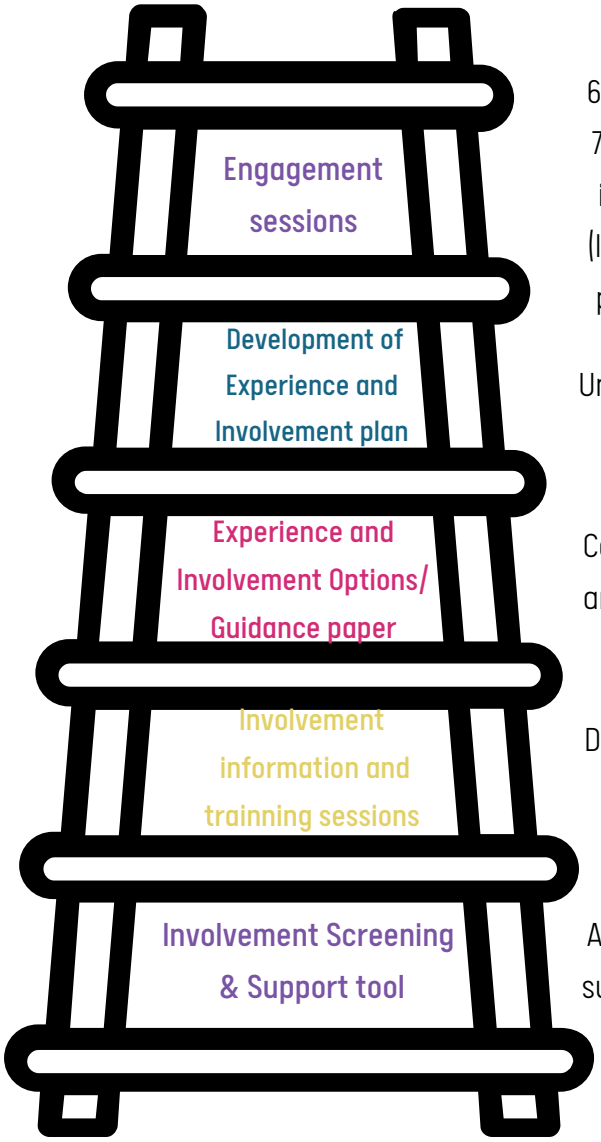
PHA Strategic Planning Teams (SPTs)

The Strategic Planning Teams (SPTs) are a new PHA structure/arrangement aiming to increase multi-disciplinary collaboration across commissioning, planning, decision making, investment and resource allocation. The PHA PPI team have always worked in a cross departmental way. SPTs represent a tangible opportunity to further embed experience and involvement into the culture and practice of the PHA and help us to meet our policy and statutory obligations in respect of PPI.

Evidence indicates that an 'engaged and involved population' is a healthier one, supporting our endeavours to improve public health and to reduce health inequalities.

Progress to date:

Working in collaboration with our PCE colleagues, PPI staff are active members of all current SPTs and have worked to promote the value of service user and carer voice, helping to build involvement into the foundations of each programme of work. To date we have developed/provided:



Drugs & Alcohol SPT

The Drugs and Alcohol SPT has recruited a dedicated resource for Involvement to directly support the work of this SPT.

Since publication of the vision outlined in the Department of Health's recent Substance Use Strategy Making Life Better, Preventing Harm, Empowering Recovery, a major focus has been placed on growing and improving involvement of people with lived and living experience by the PHA Regional Drug and Alcohol team.

Progress to date:

What's next?

- Co-production with our community and voluntary sector partner and our peer leadership of a community network of people with lived and living experience of substance use.
- Coproduction of a development plan for peer support and education in substance use services.
- Coproduction of a peer support pilot in harm reduction services.
- Growth of involvement in development of Needle and Syringe Exchange Service (NSES) and Naloxone distribution.
- Growing and improving pre-procurement engagement.
- Undertaking recruitment of lived and living experienced members for PHA substance use strategic monitoring or working groups.
- Expanding involvement reach through forming connections with work of the Anti-Stigma Network and research priorities being set by Addiction Mission and James Lind Alliance.

Impact:

The impact of making changes to how we work and involve people with real life experience have included;

- Improved planning and practice of engaging and involving
- Increase in genuine connections and positive relationships with the people who use or need the services we commission.
- Increased understanding of what matters to people who use or have used substances to reduce risk of harm, for addressing problems related to substance use and for maintaining recovery from problematic substance use.
- Increased awareness into what decisions and actions could alleviate issues and improve services.

Hearing the Voice of Children with Complex and Profound Special Educational Needs

The Special schools community Partnership Pilot is a jointly DoH and DE funded initiative led by the PHA. This initiative led by the PHA Partnership Lead and is jointly managed within the AHP and PPI team.

The aim of this initiative is to work in collaboration across the health and education sectors, increasing visibility and connecting professions. It provides a dedicated space to hear the voice of children, young people and their parents or support networks.

The aim is to work in collaboration to increase visibility, connections and influence of Special Schools across sectors, organisations, professions and provide space to hear the voice of our children, young people and their parents or support networks. It also aims to improve outcomes for children with Special Educational Needs and Disability through creating and testing a model of Partnership and Engagement across Special Schools in N.I.

This pilot currently engages with seven Special Schools in local community partnerships with key stakeholders across sectors and professions, in a Hub and Spoke network model, overseen by a Regional Strategic Steering Group. This work has facilitated 4 visits of the NI Children's Commissioner to Special Schools that has enabled engagement with staff, parents and children. This work has also proactively sought to test an innovative approach to hear the voices of over 70 children and young people who have the most profound and complex disabilities, behaviour and communication needs. This work which was facilitated through the medium of Art, Drama, Music and Play Therapy on what was important to the children in school, home and in the community.

The voice of these children and young people will be heard front and centre at a conference which will be held in October 2024, jointly opened by The Minister for Health and Minister for Education and attended by a wide range of senior government officials, Health, Education, Special Schools and parents.

Impact

- Children and their carers are being facilitated to have their voice heard, valued and respected.
- Children who have been unable to engage in any activity for more than a few minutes have been engaging in therapy for 45-50 mins
- Through the therapies, children have been making daily choices rather than being passive recipients of care
- Teachers have reported a positive impact in the classroom
- Parents have reported the positive impact at home
- Information gathered has enhanced our understanding of the children's needs including their feeling of isolation from their communities

Music Therapy

CHALLENGES & OPPORTUNITIES

In 24/25 with the return of the NI Assembly and the pressures on the HSC, the need for change and improvement is a huge challenge for us all.

The PHA itself is also in the midst of a major change through our Reshape and Refresh Programme. Added to this, are the growing expectations of service users and carers and their advocates for a greater insight, say and role in how health and social care services are commissioned, designed, delivered and evaluated at strategic, operational and individual level.

Patient and Client Experience and Personal and Public Involvement have never been a more important area to embrace and embed into the culture and practices of health and social care.

It is through these related areas of PCE and PPI, that the HSC and PHA will be able to truly embrace the concepts of partnership, between those charged with commissioning, planning and delivering services and those who are the recipients of these services.

The synergies, the added value, the improvements in insight, tailoring of services, improved safety, efficiency, ownership and improved public health from such a genuine partnership, are there for the taking if we truly embrace it.

As part of our Reshape and Refresh Programme, there will be a focus in 24/25 to further integrate the work of PCE and PPI teams in a much more formal way. We will look to determine how this integration can add value, bring about synergies and most effectively deploy our resources to advance and embed Experience and Involvement into:

- How the PHA does its business,
- How we advance the public health agenda and
- How we provide leadership to the HSC in these connected areas.

We will co-produce a new strategy for Experience and Involvement during 2024/25, enabling the PHA to share our intended direction of travel for these critically important areas and which also provides leadership across the HSC in line with our regional responsibilities.

ABBREVIATIONS

Throughout this report we have made reference to organisations, services and programmes. Below is a list of abbreviations for the readers convenience.

CDHN..... Community Development and Health Network
DE..... Department of Education
DoH..... Department of Health
EA..... Education Authority
HSC..... Health and Social Care
HSE..... Health Service Executive
HSCQI..... Health and Social Care Quality Improvement
ICS..... Integrated Care System
LinP..... Leading in Partnership
NCCPE..... National Co-ordinating Centre for Public Engagement
NIAS ..... Northern Ireland Ambulance Service
NICVA..... Northern Ireland Council for Voluntary Action
NIPEC..... Northern Ireland Practice Education Council
NIPHR..... National Institute for Public Health Research
PCC..... Patient Client Council
PCE..... Patient Client Experience
PHA..... Public Health Agency
PPI..... Personal and Public Involvement
PRIME..... Centre for Primary and Emergency Care Research
RQIA.....Regulation and Quality Improvement Authority
SDM ..... Shared Decision Making
SPPG..... Strategic Planning and Performance Group
SPT..... Strategic Planning Teams
USCRG..... Unscheduled Care Reference Group

Leaders in Partnership Training

HSCQI Staff training for PCE & PPI Teams

SUC Involvement event

Emmett Lynch Senior PPI Officer meets The Health Minister

Bespoke PPI Training with The Leadership Centr

Celebrating involvement

The PHA PPI Board Report

Martin Quinn - Regional HSC PPI Lead
Geraldine Teague - Interim Deputy Director for Nursing, AHP, PPI & PCE

Contact PPI team - ppi.secretary@hscni.net
Engage.hscni.net