HSC Public Health Agency

agenda

PHA Board Meeting

Date and Time 30 January 2025 at 1.30pm

Venue Fifth Floor Meeting Room, 12/22 Linenhall Street

1 1.30	Welcome and Apologies	Chair
2 1.30	Declaration of Interests	Chair
3 1.30	Minutes of Previous Meeting held on 21 November 2024	Chair
4 1.35	Actions from Previous Meeting / Matters Arising	Chair
5 1.40	Reshape and Refresh Programme	Chair
6 1.45	Reports of New or Emerging Risks	Chief Executive
7 1.50	Raising Concerns	Chief Executive
8 1.55	Updates from Committees: • Governance and Audit Committee • Remuneration Committee • Planning, Performance and Resources Committee • Screening Programme Board • Procurement Board • Information Governance Steering Group • Public Inquiries Programme Board	Committee Chairs
9 2.15	Presentation on Protect Life 2	Dr McClean
10 2.45	Presentation on the Development of Regional Multi-agency Guidelines for Sudden Unexpected Death in Infancy and Childhood (SUDIC)	Ms Reid
11 3.10	Operational Updates: • Chief Executive's and Executive Directors' Report	Chief Executive/ Executive Directors
	• Finance Report **[PHA/01/01/25]**	Ms Scott
12 3.35	Establishment of PHA Working Group **[PHA/02/01/25]** **(For noting)**	Mr Wilson

13 3.45	Final Partnership Agreement between Department of Health and Public Health Agency **[PHA/03/01/25] (For noting)**	Ms Scott
14 3.55	Chair's Remarks	Chair
15 4.05	Any Other Business	Chair

16 Details of next meeting:

Thursday 27 February 2025 at 1.30pm

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

HSC Public Health Agency

minutes

PHA Board Meeting

Date and Time 21 November 2024 at 1.30pm

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

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
Mr John Patrick Clayton	-	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 Stephen Wilson	-	Head of Chief Executive's Office
Professor Sir Michael McBride	-	Chief Medical Officer, Department of Health
Ms Meadhbha Monaghan	-	Chief Executive, Patient Client Council
Mr Robert Graham	-	Secretariat

Apologies

None

126/24	**Item 1 – Welcome and Apologies**
126/24.1	The Chair welcomed everyone to the meeting. There were no apologies.
127/24	**Item 2 – Declaration of Interests**
127/24.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda.
127/24.2	Mr Clayton declared an interest in relation to Public Inquiries as Unison is engaging with the Inquiries.

128/24	**Item 3 – Minutes of previous meeting held on 18 October 2024**
128/24.1	The minutes of the Board meeting held on 18 October 2024 were **APPROVED** as an accurate record of that meeting, subject to minor amendments.
129/24	**Item 4 – Actions from Previous Meeting / Matters Arising**
129/24.1	Mr Clayton asked about a briefing for members on the Live Better initiative. Mr Wilson advised that a full update will be brought to the Board once the two practices that have been selected have agreed the outcomes that they will be focusing on.
129/24.2	Mr Stewart asked whether correspondence has been sent to the Minister regarding campaigns. The Chair replied that he has spoken to Professor McBride about this. Professor McBride agreed that it is counter strategic not to have campaigns as they are needed to affect behavioural change. He felt that it would be timely to write to the Minister concerning this. Professor Rooney advised that she has had discussions with universities about behavioural change. She stated that if PHA has a budget for vaccination programmes, it should be allowed to carry out a campaign. Mr Clayton restated his offer that Trade Unions can assist with getting messaging out to staff about getting their flu vaccine.
129/24.3	The Chair asked if members were content to record that the Annual Quality Report, which was circulated by e-mail, was approved by members. Members **APPROVED** this.
129/24.4	In relation to the action log that was circulated, the Chair advised that for action 1, a meeting will be set up to discuss joint commissioning. For action 2, he said that he would also raise this with Mr Peter Toogood as well as at PHA's Accountability Review meeting on 11 December. For action 7, the Chief Executive explained that an update on Protect Life 2 will come to the Board in January as it would not have been possible to accommodate this on today's agenda.
129/24.5	Ms Henderson asked about action 5 and the terms of reference for the NHS England Quality Assurance Review. Dr McClean advised that these are still under development.
130/24	**Item 7 – Reports of New or Emerging Risks**
130/24.1	The Chief Executive advised that he had no new or emerging risks to report on.
131/24	**Item 8 – Raising Concerns**
131/24.1	The Chief Executive advised that he had no new concerns to report to the Board.

132/24 **Item 6 – Reshape and Refresh Programme**

132/24.1 The Chair noted that members had received an update on the Reshape and Refresh Programme. He noted that the recruitment of the senior leadership team remains ongoing.

132/24.2 The Chief Executive advised that there is a number of interviews taking place and he hoped that the exercise to recruit the Assistant Director posts would be completed by the end of the first week in December. He added that following the establishment of this senior leadership group, he would like it to meet at least once a month to discuss how areas can be taken forward, for example the Corporate Plan. He said that this group should be fully informed of what PHA's priorities are and be aware of their responsibilities and the expectations of the Board.

132/24.3 The Chief Executive said that he was excited to see this group working together as it will be involved in setting up the layers underneath that tier. He added that they will look at the life course approach and the running of the planning teams. The Chair said that the new strategic planning teams are crucial and how they interact with the Board will be key. He added that there needs to be a clear set of priorities with PHA setting its own goals, linking with stakeholders and making sure people are aware of PHA.

132/24.4 Mr Irvine asked if it would be possible to have an organisational chart now that the Programme is progressing, as well as a timeline for filling all of the other posts. The Chair said that Ms Gráinne Cushley could provide that **(Action 1 – Chief Executive)**.

132/24.5 Professor Rooney said that there had been discussion about learning and reflection at the Public Inquiries Programme Board and asked what difference the new structure will make to the organisation. The Chair agreed that this is an important point and that the Board should get a presentation from the Agency Management Team (AMT) showing how PHA is implementing the recommendations from Public Inquiries as well as the EY and Hussey Reviews, and what the risks are. The Chief Executive said that he was content to have a workshop with the new senior leadership team and task them to do this **(Action 2 - Chief Executive)**. He advised that there was a meeting with the Chief Executives of the 4 UK nations public health bodies and that Scotland and Wales will share their approaches.

132/24.6 The Chair noted that the Programme commenced 18 months ago and asked if PHA is evolving and developing. He agreed that the workshop is a good idea and suggested that Non-Executive Directors should attend if they are available. He added that the Board needs to have oversight of this and suggested that there could be a session once a year going forward so that the Board can be assured that learning continues to be embedded.

132/24.7 Professor McBride said that at the outset, the purpose of the Hussey Review was around preparing PHA for the next wave of the pandemic.

He added that PHA was responding to a huge challenge and it was not surprising that PHA was challenged. In future, he said that a question will be asked as to whether PHA is now in a better place to respond.

132/24.8 Mr Clayton agreed that the workshop with the new team would be useful as it could look at areas such as campaigns, pressures on public health consultants, staffing and data, but he noted that one of the main features of the Hussey Review was about PHA strengthening its resources and capacity and he did not feel that this has happened yet. He said that while the structure may be better, he queried if PHA is properly resourced. The Chair said that if there are any gaps, PHA has to advise the Department.

132/24.9 Dr McClean said that a lot of the Hussey Review has been implemented, and the Chair agreed that there needs to be a recognition of what has been achieved.

132/24.10 The Chair said that he wished to acknowledge how well the Chief Executive and senior team were communicating with PHA staff during this Programme and how well staff are being kept informed. He added that he could not fault the amount of effort that staff are putting in.

133/24 Item 5 - Presentation from Department of Health Serious Adverse Incident Redesign Programme Team

Dr Lourda Geoghegan, Dr Seamus O'Reilly and Ms Julie Houston joined the meeting for this item

133/24.1 Dr Geoghegan said that she wished to update members on work ongoing in this area, including a planned public consultation, data on current Serious Adverse Incidents (SAIs), outstanding learning reports and feedback from the Patient Client Council (PCC) Engagement Platform. She advised that the team has been meeting with all Trust Boards to get their help to refocus the SAI system and that there have been discussions with senior officers in the Department as well as the previous and current Health Ministers.

133/24.2 Dr Geoghegan explained that the proposal is to go out to public consultation by the end of November on four documents. She said that there has been a focus on changing the language to reframe the public narrative. She added that there needs to be standards and principles for dealing with what will now be called Patient Safety Incidents.

133/24.3 Dr Geoghegan advised that the next piece of work is to discuss the backlog in SAIs with Trust Boards as these represent a huge risk. She noted that some Trusts are in a better position than others.

133/24.4 Dr Geoghegan said that there is a need to rebalance governance oversight, but the detail of that has not yet been worked through as help is needed from Trusts, SPPG and PHA. She explained that going forward it will be responsibility of provider organisations' Boards and

	senior teams to ensure that learning is implemented. She added that surveillance data is also needed.
133/24.5	Dr Geoghegan explained that this will be an iterative change and it is hoped to have the new process in place by early autumn 2025. She said that this later date is due to there being a new complaints process and two Trusts introducing Encompass. She added that the transition needs to be effective. She said that this is a unique opportunity to get this process right in Northern Ireland. She advised that there will be a robust surveillance function for PHA and that PHA's assistance will be required in reshaping the regional oversight arrangements.
133/24.6	Dr McClean said that PHA staff need to step back from being involved in the detail of individual SAIs and agreed that PHA needs to have a surveillance system. She queried how regional change will come about at local level.
133/24.7	Mr Stewart said that the Board has had a major concern in its ability to be clear about what PHA's responsibilities are within the SAI process and it has been seeking this clarity for 3/4 years. He added that when agreement is reached, that clarity needs to be there in terms of where PHA's responsibilities start and stop.
133/24.8	Ms Henderson welcomed the presentation and said that this will bring a huge cultural change. If the plan is to push this back towards the Trusts, she asked how it will be enforced. Dr Geoghegan explained that the current process is not delivering and the extant governance arrangements are that responsibility lies with the Trusts, and there is also the whole system of accountability and ground clearing. Ms Henderson hoped that within the next number of years there will be a change of culture and increased awareness and Trusts will take accountability. Dr Geoghegan agreed that this is the aim. Ms Henderson asked if the Trusts are in agreement with this, and Dr Geoghegan reiterated that this is their responsibility and there should never be a situation where SAI reports are outstanding for 3/4 years.
133/24.9	Mr Clayton said that as a Trade Union representative, it would be useful to ensure that this work is flagged up with the regional group and if there is to be a new process, that Trade Union advice is sought. He advised that PHA had an Internal Audit of SAIs and it highlighted that there were issues for PHA in terms of disseminating learning, and that PHA seemed to be giving advice. Dr McClean explained that part of PHA's role is to ensure terms of reference are appropriate. She said that nurses and doctors can be left feeling vulnerable following an SAI review. She welcomed that the responsibility will be placed back with the Trusts and that PHA will have an oversight role and provide surveillance. Mr Clayton said that the lack of clarity has been a difficulty for the Board and he reiterated that staff side engagement would be important.
133/24.10	Professor Rooney also said that clarity of roles is important, but added that the process needs to be sped up.

133/24.11 Mr Irvine welcomed that there will be clear definitions around roles, but said that he would emphasise the need for accountability. In the past, he said that if historic reports had not been finished they would fall away, so there is a need for a timeline to get these up to date. He added that there will be negative consequences if work is not completed on time and unless people are held to account, the process will rumble on.

133/24.12 Ms Monaghan said that from a PCC perspective, it is important to bring the public along if there is to be a culture change. She said that this has to be got right and that patient safety really matters. She noted that there remain some concerns about public trust, openness, candour and Board oversight as well as questions about checks and balances and the quality of investigations. She said that trust needs to be rebuilt and having an independent view can be useful with that and she offered PCC's assistance.

133/24.13 Professor McBride stated that the current process is not working and it will be hard to bring individuals along with any new process who have been hurt. He said that there is no dodging the fact that the statutory duty of quality is an extant requirement. He added that there will be no new funding to do this work. He said that as part of the new escalation process, independence is crucial and Trusts needs to think about how they can access that expert advice and give assurance to families about how standards are being adhered to.

133/24.14 Dr Geoghegan said that the importance of disentangling this whole process cannot be underestimated, and that blame and retribution are putting people off from coming forward. She acknowledged that there is a responsibility to the public, but this has to be balanced with supporting staff. She said that there needs to be a learning system that supports people and supports learning.

133/24.15 Professor Rooney agreed that this is a complicated area and she asked how this is going to be put across to the public. Dr Geoghegan said that the frameworks and standards are in a format that the public will be able to understand.

133/24.16 The Chair asked whether all outstanding cases will move across to the new process, but Dr Geoghegan explained that there will be an iterative change to the new arrangements. The Chair asked what this new process will mean for PHA. Dr McClean replied that PHA will have a different role as it will be developing surveillance and identifying trends so PHA will need a different type of resource. She added that she did not consider learning letters to be the best way of disseminating learning. She noted that this is a complex area and given the same issues are recurring, it is clear that the system is not learning so all organisations have to come on board.

133/24.17 The Chair said that he could sense that there is support but if this is to happen during 2025/26, he would like to have an understanding of the cost so as to determine if PHA can support it. Dr McClean advised that this needs to be scoped because PHA's focus will be different.

Professor Rooney added that PHA will be developing its health intelligence.

133/24.18 Ms Henderson asked if the new terminology should be used. Dr Geoghegan advised that there is an aim to move away from SAI technology and refer to Patient Safety Incidents or Patient Safety Events, therefore moving from a culture of retribution and blame to one of learning and improvement. Dr McClean advised that once the new framework comes out and there is clarity on PHA's role, PHA will have another look at it.

133/24.19 The Chair thanked Dr Geoghegan and the team for their presentation.

134/24 Item 9 – Draft PHA Corporate Plan 2025/30 [PHA/01/11/24]

At this point Ms Reid joined the meeting

Ms Julie Mawhinney joined the meeting for this item.

134/24.1 Ms Scott said that work commenced in early summer to develop PHA's Corporate Plan with the intention being to develop a 5-year Plan rather than a 3-year one. She outlined the approach to developing this Plan which included sessions with staff where there was robust and extensive engagement, and also the project structure around the Plan. She said that she hoped that the Plan reflected PHA's current priorities.

134/24.2 Ms Scott showed the timeline for developing the Plan and advised that the aim today is to seek approval to go out to public consultation with a view to a final approved Plan being published for the new financial year.

134/24.3 Ms Mawhinney explained that PHA's Plan has been developed around four outcomes, each with their own ambition, priorities and measures. She advised that the purpose and vision have been revised following consultation with staff and there is also a new strapline.

134/24.4 Ms Mawhinney demonstrated how the design of the Plan represents the overlapping nature of the work that PHA does. She added that there will be slightly different reporting arrangements. She advised that a longer-term implementation and delivery plan will be provided with the new public health teams having their own plans.

134/24.5 Ms Mawhinney gave an overview of the main changes between this Plan and PHA's previous Corporate Plan. She then outlined the consultation process and what communications there will be.

134/24.6 Mr Clayton said that he had a difficulty with the draft Plan in that there is no accompanying implementation plan so he is not sure as to what PHA's priority actions are over the next 5 years. He added that the Plan seems very general and while it talks about the right areas, it lacks in specificity and he is not clear what PHA is going to prioritise. With regard to the Equality Screening, he said that it does not identify any differing needs or priorities and while it makes a commitment to carrying

	out Equality Screenings of different elements, he noted that historically PHA does not have a good record of conducting many Equality Screenings. He said that it is known that different Section 75 groups have different needs, this is not reflected in this Plan. He acknowledged that while PHA's annual Business Plan is clear, this document is not clear in terms of trends over time.
134/24.7	Ms Mawhinney said that she took the point about the specificity of the Plan, but population health and an Outcomes-Based Approach (OBA) do not generally sit together. She explained that PHA is looking at long term issues, and while PHA can set measures, there are some that it cannot achieve without the help of others. She said that the delivery plan will set out the annual aims as it is difficult to be specific in this Plan while trying to cover everything that PHA does. For the Equality Screening, she advised that there is a document that sets out where PHA can see issues, but this is still in draft, and she acknowledged that Equality Screenings are not carried out as often as they should. Mr Clayton said that he was confident that this would improve. He asked if there will be an implementation plan and Ms Mawhinney replied that developing that is the next step.
134/24.8	Mr Stewart said that he wished to recognise the amount of work that has been carried out by the team on this Plan which he said is understandable and not too long. He asked where PHA wants to make an impact. He said that PHA has a budget of £130m, and once staffing costs are taken out, it has the funds to invest in people's health and he would like to get a sense of where that money is going and how it will help and how PHA will influence and improve societal measures. He added that even if PHA cannot make the target, it should still set a target. Ms Scott agreed that PHA needs to be seen to be making a difference and she would like to spend time getting performance frameworks in place to underpin this Plan.
134/24.9	Dr McClean said this Plan has been developed against a challenging timeframe. From the engagement she had with staff, she advised that one of the issues that arose was around the level of detail which members have referred to, but this is a high level document. She added that this is a 5-year Plan where PHA has to identify the health needs for a range of groups.
134/24.10	Ms Reid said that the Plan is an opportunity to reset and put processes in place, starting at a high level and working down. She added that there will be more detail in the directorate plans and that the implementation plan for the first year will be helpful. She advised that the public health planning teams are up and running so there are a lot of things happening together which will take time to settle down.
134/24.11	Ms Henderson advised that she welcomed this Plan and noted that while her initial reaction was that she would not know how PHA had achieved success after 5 years, she is convinced that there will be a detailed plan against which PHA can measure success. With regard to inequalities, she said that everything PHA does is at the hard end of

that. She felt that this document is sufficient in terms of setting direction, and that she would support the draft Plan as is. Mr Clayton commented that while people will have a clear idea about how PHA can make change, PHA should state what changes it would like to see, and that should be in the Plan. He acknowledged that this Plan is being developed during a period of change. He said that while the Plan might set direction, he is not sure as to what the destination is.

134/24.12 Professor Rooney said that she would be content if PHA set a target, and if it did not meet the target, at least it was known that it had tried. She agreed that the implementation plan is needed so as to protect the organisation and for PHA to outline its priorities to the Department so that if it is required to carry out any other work, this will have to wait until PHA has the resources.

134/24.13 The Chief Executive advised that the Corporate Plan has to be seen in tandem with an implementation plan. He said that a lot can happen in 5 years, and that after 2 years priorities may change. He stated that this is PHA's strategy and that PHA is not in a position to determine the priorities for Black and Ethnic Minorities (BAME), but it can work with these groups to determine what is important for them and that engaging with these groups is part of the strategy.

134/24.14 The Chief Executive said that the organisation has come a long way in a short period of time because previously the Board has sat together and could not come up with a plan that all members bought into, but now there is one. He added that this Plan is about being focused and working with all groups.

134/24.15 Professor McBride said that he feels better informed now having had that presentation, and can see that it is clear that there are things that PHA cannot fix and the Plan needs to indicate that there are areas where PHA will have to work with others to achieve its aim. He added that the Plan should state upfront that it will be accompanied by a delivery plan. He commented on some of the pictures in the documents and if they were truly representative. In the Equality Screening template, he suggested that the order of the list of documents should be reviewed to reflect the order of the policies which form PHA's work, noting that Making Life Better was at number 13. He said that it was a good document.

134/24.16 Mr Wilson said that this document does not capture the journey that PHA has been on and there is a need to strike a balance between giving staff clarity about their priorities over the next 5 years and how PHA can deliver against population indicators. He noted that the previous Plan did not include an implementation plan. He accepted that the Plan is not perfect because if an individual is looking for specifics, it does not contain those, but if an individual is looking for an OBA-type Plan, it may be too detailed. He said that progress will commence on the delivery plan.

134/24.17 In summary, the Chair advised that there are changes that need to be made and he asked if those could be done. He suggested that the foreword needs to reference the implementation plan. He said that it would be useful to see how this Plan will affect the role and operation of the Board going forward and said that there should be a discussion at the January meeting around this.

134/24.18 Subject to amendments, the Board **APPROVED** the draft Corporate Plan.

135/24 Item 10 – Performance Management Report [PHA/02/11/24]

135/24.1 The Chair advised that this Report had been considered by the Planning, Performance and Resources (PPR) Committee, but the Committee was not content with it and it has been updated as result. He stated that the Report must be linked to PHA's strategic intent.

135/24.2 Ms Scott said that a revised version of the Report had been circulated to members and while the Report is for the period up to 30 September, it has been further updated based on current intelligence.

135/24.3 Ms Scott reported that there are concerns around vaccination uptake levels, particularly for pertussis and flu, and there are also concerns around the Child Health System (CHS) and having a new system in place by March 2025. She added that there are issues around reducing smoking cessation figures, and she reported that there are two targets which should not have been included in PHA's Business Plan as there are no additional resources.

135/24.4 Ms Scott advised that there are some issues in relation to procurement which PHA is reflecting on. She added that PHA will not deliver an updated Partnership Agreement on schedule as there are still some queries to be resolved. She said that the target relating to the Data/Digital Strategy is rated "red" as timescales need to be finalised for the establishment of the new directorate. She reported that the delivery of health inequality training has been delayed due to staff absence.

135/24.5 The Chair asked if there are plans to get those actions rated "red" to "green". Ms Scott explained that there are mitigations included in the Report outlining plans in place, but she noted that for some of the targets, there are external factors. The Chair noted that this is a quarterly report, but asked if there could be a further update at the January meeting **(Action 3 – Ms Scott)**. Mr Stewart suggested that if targets cannot be met due to factors outside PHA's control, then these targets should be set aside.

135/24.6 The Chief Executive advised that AMT wishes to meet with Mr Dermot Hughes to discuss IT systems. He said that there is a recognition that CHS sits within the Trusts, but it needs to be pushed forward through the Encompass programme and he would like to keep it in this Report so as to maintain PHA's focus on this area. The Chair said that he would like to know where PHA is being let down so that the Board can take

action. He added that a lot of the work that PHA is going to undertake during its 5-year Plan will rely on help from others. He said that if PHA sets a KPI, then it owns that KPI. The Chief Executive advised that there is now more reflection by AMT on KPIs now than there would have been previously. Professor Rooney thanked AMT for their work in updating this Report following the PPR Committee meeting on Monday.

135/24.7 Ms Reid reported that for KPI 18 on Advanced Care Planning, a paper has been prepared for the Department. Professor McBride advised that Advanced Care Planning is one of his key priorities and it will be a recommendation from the COVID Inquiry. In addition to PHA, he said that it will be an issue for SPPG, in its role as commissioner, as it will be delivered in care homes. Ms Reid said that she would share the options appraisal that went to the Department with Professor McBride.

135/24.8 Ms Henderson noted that when Advanced Care Planning was handed to PHA, there was no additional resources and PHA had made a case to the Department that it required funding, so she felt PHA had no ownership of it. Professor McBride advised that everyone should have an advanced care plan and that this is an important area of work. Ms Henderson asked whether it should sit with PHA as she was shocked it became one of PHA's KPIs. Professor McBride stated that all ALBs should look to prioritise within their existing budgets. Ms Henderson said that PHA will have to revisit this and review its resources. Ms Reid agreed and said that there is a huge risk if this work is not done properly. The Chair said that he would welcome a further update as part of the next Chief Executive's Report **(Action 4 – Ms Reid)**.

135/24.9 The Board noted the Performance Management Report.

136/24 Item 11 – Updates from Board Committees

Governance and Audit Committee

136/24.1 Mr Stewart advised that while this Committee has not met since the last Board meeting, he attended a meeting of the Audit Committee Chairs and he would report on this in the confidential section of the meeting.

Remuneration Committee

136/24.2 The Chair noted that this Committee has not met since the last Board meeting.

*Planning, Performance and Resources Committee **[PHA/03/11/24]***

136/24.3 The Chair advised that the PPR Committee had met on Monday and there had been a good presentation on tobacco control which he would like to see presented at a future Board meeting **(Action 5 – Dr McClean)**. He noted that under the new tobacco and vaping bill, there will be new powers. The Chief Executive advised that at yesterday's 4 Nations there had been an update from Ms Jeanelle de Gruchy and he

agreed to share her presentation with the Board **(Action 6 – Chief Executive)**.

136/24.4 The Chair said that the Committee had talked about the Corporate Plan and the Performance Management Report and had received an overview of the Finance Report and the Our People report. He asked that the Our People report is circulated to members **(Action 7 – Secretariat)**. Ms Henderson said that the Committee is a useful clearing meeting before the Board.

Screening Programme Board

136/24.5 The Chair noted that the Screening Programme Board has not met since the last Board meeting.

Procurement Board

136/24.6 The Chair advised that the Procurement Board is due to meet next week, but he has asked that procurement becomes a standing item on future PPR Committee agendas.

Information Governance Steering Group

136/24.7 The Chair noted that the Information Governance Steering Group has not met since the last Board meeting.

Public Inquiries Programme Board

136/24.8 Professor Rooney reported that the Programme Board continues to meet and that there is a lot of work for staff at present and a lot more work to come. She said that the key issue is learning. The Chair agreed and said that a date needs to be planned for a meeting to look at the learning **(Action 8 – Secretariat)**.

137/24 Item 12 – Operational Updates

Chief Executive's and Executive Directors' Report

137/24.1 The Chief Executive said that members have received this Report and he and the Directors would be content to respond to any queries.

137/24.2 Mr Clayton asked about the Renfrew Report and if there was a sense yet as to whether any of the recommendations would be relevant to PHA and its role. He also asked about the increase number of cases of HIV among people who inject drugs and for an update on PHA's involvement in this area and what options the Trust is looking at in terms of buildings it can free up for services for people who inject drugs.

137/24.3 Ms Reid advised that, with regard to the Renfrew Report, this was commissioned as part of a wider review looking at safety within maternity services. She said that the findings are at a high level and PHA is now working with the Department to review these and look at

what these mean and what actions there are. She advised that there has been a lot of engagement with mothers about their experiences.

137/24.4 Ms Reid said that the Maternity Services Strategy ran out last year so the aim is to bring various strands of work together and PHA will work with SPPG on developing recommendations, and she would bring further updates to the Board. Mr Clayton stated that this is a complex area and that PPI is important as well as assessing safety and quality of services. Ms Reid advised that a piece of work to identity stakeholders has commenced and it is hoped that there will be an action plan in due course.

137/24.5 Responding to the HIV issue, Dr McClean advised that PHA's first responsibility is to chair an Incident Management Team (IMT), and it will come up with a range of a measures. She added that PHA commissions a needle exchange scheme and makes testing available. She said that PHA would like to get an Inclusion Health Team out into the community, but she explained that some of the actions being taken forward are outside the reach of the health sector.

137/24.6 Dr McClean reported that Belfast City Council is scoping potential premises and is working hard to identify some. She advised that the Needle Exchange Scheme in Royal Avenue is very busy. She noted that one of the causes of this is homelessness which is a longer term issue.

137/24.7 Ms Henderson asked about the backlog in screening. Dr McClean advised that there is a plan to clear this backlog. She explained that there is now one laboratory, which has been operating since 1 November, and while a backlog was anticipated, it became bigger than expected due to a machine breaking down in the Western Trust area. However, she said that the Belfast Trust has engaged with an NHS Trust in England and all tests should be completed by next Friday and then there will be a manual process to get these inputted onto the system. She stated that the backlog should be cleared by the end of the year.

Finance Report ***[PHA/04/11/24]***

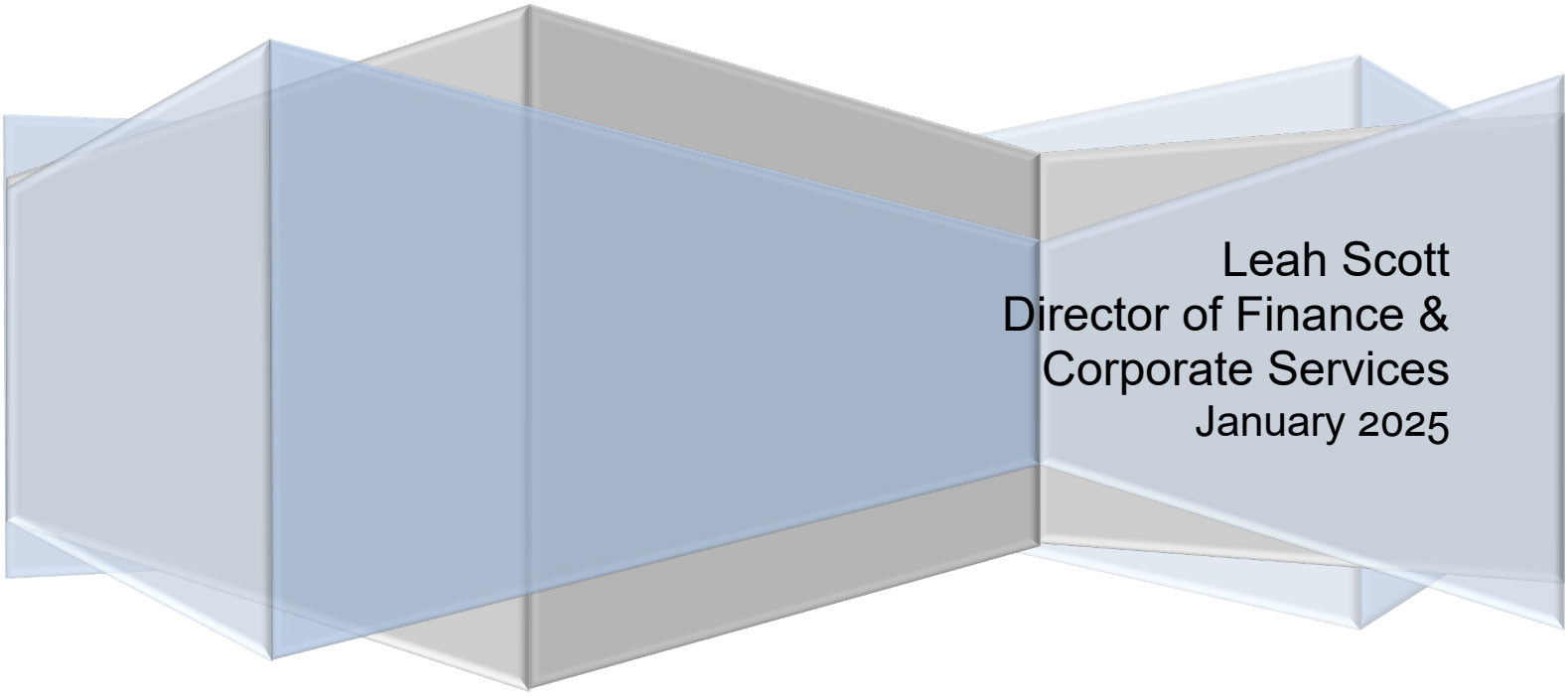
137/24.8 Ms Scott presented the latest Finance Report and advised that from a budget of £136m, PHA is currently managing a surplus of £237k which has arisen from various underspends offset by pressures in other areas. She advised that the PPR Committee had scrutinised this Report and there are some areas that she is going to follow up on. She reported that the capital budget is on target.

137/24.9 Ms Scott advised that PHA has been contacted by the Department and asked if it can surrender slippage to assist with pressures across the wider system. She said that, taking that into consideration, PHA is still forecasting a break-even outturn at the year end.

137/24.10	Ms Henderson agreed that there had been a good discussion on this at the PPR Committee where it was noted that there is a £0.2m underspend in the management and administration budget, but an overspend of £1.4m on the programme budget, and that there will be more information on this in the next Report.
137/24.10	The Board noted the Finance Report.
138/24	**Item 13 – Sealing of MOU between Western Trust and PHA [PHA/05/11/24]**
138/24.1	The Chair explained that PHA Board approval is required when the PHA Seal is to be applied to any document and he asked if members were content that the Seal is added to this Memorandum of Understanding with the Western Trust.
138/24.2	Mr Wilson advised that this relates to premises PHA leases from the Trust in Omagh.
138/24.3	Members **APPROVED** the use of the PHA Seal.
139/24	**Item 14 – Chair's Remarks**
139/24.1	The Chair advised that he had no business to report on.
140/24	**Item 15 – Any Other Business**
124/24.1	There was no other business.
141/24	**Item 16 – Details of Next Meeting**
	Thursday 30 January 2025 at 1.30pm
	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast
	Signed by Chair:
	Date:

HSC Public Health Agency

Finance Report
Month 8 - November 2024



Leah Scott
Director of Finance &
Corporate Services
January 2025

Section A: Introduction/Background

1. PHA Board agreed its financial plan in June 2024 based on draft allocations funding from the Department of Health and consultation with service users and the Agency Management Team. The 2023/24 opening allocation letter applied a £5.3m recurrent savings target to the PHA budget which was rolled forward to 2024/25 opening allocation.
2. The 2024/25 Financial Plan is based on funds available, risks and uncertainties for the financial year and summarises 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.
3. A final allocation was issued in July 2024, which included an additional savings target of £1.0m. The financial plan was amended to estimate funding based on the final allocation. The total revenue budget for the PHA, including assumed allocations to be issued later in the year, currently stands at £139.6m for 2024/25.
4. This summary report reflects the draft year-end position as at the end of November 2024 (month 8) and includes a range of risks associated with the delivery of the full year budget. A breakeven position is currently projected for the year, and supplementary detail is provided in **Annex A**.

Section B: Update – Revenue position

Update on the PHA budget allocation for 2024/25

5. During the year, the PHA baseline budget has been amended for the following changes:
    - £3.2m R&D Funding for the National Institute for Health and Care Research Payment;
    - £3.0m for Shingles vaccines;
    - £1.5m for RSV and mPox vaccinations;
    - £1.6m for Covid & Flu vaccinations (ringfenced Covid funding);
    - £0.6m for various Nursing programmes (Text-a-Nurse etc.);
    - £0.5m Fresh Start funding (ringfenced);
    - £0.3m for various Admin costs related to posts; and
    - £0.35m retraction resulting from the slippage exercise in month 7.

6. The total revenue budget for the PHA, including assumed allocations to be issued later in the year, currently stands at £139.6m for 2024-25.

7. The PHA has a year to date deficit at November 2024 of £12k (month 7 surplus, £0.7m) against the year to date budget for 2024/25 & is summarised in **Table 1** below:

Table 1: PHA Summary Revenue position – November 2024

	Annual Budget					Year to Date				
	Programme		Ringfenced	Mgt &	Total	Programme		Ringfenced	Mgt &	Total
	Trust £'000	PHA Direct £'000	Trust & £'000	Admin £'000	£'000	Trust £'000	PHA Direct £'000	Trust & £'000	Admin £'000	£'000
Available Resources										
Departmental Revenue Allocation	48,200	57,409	2,247	31,106	**138,961**	32,133	40,349	1,305	20,321	**94,110**
Assumed Retraction	-	-	-	-	**-**	-	-	-	-	**-**
Revenue Income from Other Sources	-	27	-	597	**624**	-	28	-	444	**472**
Total Available Resources	48,200	57,436	2,247	31,704	**139,585**	32,133	40,378	1,305	20,766	**94,581**
Expenditure										
Trusts	48,200	-	1,276	-	**49,476**	32,133	-	851	-	**32,984**
PHA Direct Programme *	-	58,703	970	-	**59,674**	-	40,866	462	-	**41,329**
PHA Administration	-	-	-	30,436	**30,436**	-	-	-	20,280	**20,280**
Total Proposed Budgets	48,200	58,703	2,247	30,436	**139,585**	32,133	40,866	1,314	20,280	**94,593**
Surplus/(Deficit) - Revenue	(0)	(1,268)	-	1,268	0	-	(489)	(9)	486	**(12)**
Cumulative variance (%)						***0.00%***	***-1.21%***	***-0.67%***	***2.34%***	***-0.01%***

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*

8. In respect of the year to date position:

- The annual budget for programme expenditure to Trusts of £48.2m has been profiled evenly over the year, with £32.1m expenditure reflected as at month 8 and a **nil variance** to year end budget shown.
- The remaining annual programme budget of £58.7m and expenditure of £40.9m has been recorded for the first eight months of the financial year with **an overspend of £0.5m reported** (month 7, £0.3m underspend). This budget is currently projected to achieve planned overspend of £1.3m by the end of the financial year which will be used to absorb some of the anticipated underspend in Administration budgets outlined below.
- In Management & Administration, a year-to-date **underspend of £0.5m** (month 7, £0.3m underspend) is reported which is primarily being generated by underspends in the areas of Finance & Corporate Service and Nursing & AHP due to high levels of vacancies, offset by the application of the balance of the 23-

24 savings target held in the PHA Board (£1.2m). The year-end underspend is expected to be approximately £1.3m (month 7, £1.3m).

- Ringfenced funding comprises NI Protocol funding (£0.156m), Tackling Paramilitarism / Fresh Start (£0.528m) and COVID (£1.563m). A small variance is reported on this budget to date, however a breakeven position is forecast for the full year.

9. The projected year-end position is breakeven (month 7, £350k surplus), following the £350k retraction identified last month, and work will continue to identify measures to maintain this position. The month 8 position is summarised across business areas in Table 2 below.

Table 2: PHA Summary financial position - November 2024

	Annual Budget	YTD Budget	YTD Expenditure	YTD Variance	Projected year end surplus / (deficit)
	£'000	£'000	£'000	£'000	£'000
Health Improvement	13,995	9,330	9,330	0	
Health Protection	10,895	7,264	7,264	0	
Service Development & Screening	15,370	10,247	10,247	0	
Nursing & AHP	7,913	5,276	5,276	0	
Centre for Connected Health	0	0	0	0	
Quality Improvement	25	17	17	0	
Other	0	0	0	0	
Programme expenditure - Trusts	**48,200**	**32,133**	**32,133**	**0**	**0**
Health Improvement	31,324	19,882	20,206	(324)	
Health Protection	18,856	15,990	16,131	(141)	
Service Development & Screening	4,352	1,656	1,523	133	
Research & Development	3,252	3,200	3,200	0	
Operations, incl. Campaigns	476	288	382	(95)	
Nursing & AHP	752	167	246	(79)	
Quality Improvement	18	12	42	(30)	
Other	(595)	(150)	(860)	710	
Savings target	(1,000)	(667)	0	(667)	
Programme expenditure - PHA	**57,436**	**40,378**	**40,867**	**(489)**	**(1,268)**
Subtotal Programme expenditure	**105,635**	**72,511**	**73,000**	**(489)**	**(1,268)**
Public Health	17,608	11,671	11,517	154	
Nursing & AHP	6,372	4,202	3,622	580	
Operations	5,471	3,579	2,891	688	
Quality Improvement	425	425	413	12	
PHA Board	470	55	1,071	(1,016)	
Centre for Connected Health	458	299	265	34	
SBNI	900	534	501	32	
Subtotal Management & Admin	**31,704**	**20,765**	**20,280**	**485**	**1,268**
Trusts	0	0	0	0	
PHA Direct	970	1,305	1,313	(8)	
Ringfenced	**970**	**1,305**	**1,313**	**(8)**	**0**
TOTAL	**138,309**	**94,581**	**94,593**	**(12)**	**0**

Note: Table may be subject to minor roundings.

Section C: Risks

10. The following significant assumptions, risks or uncertainties facing the organisation impact on the delivery of Financial Plan:

11. **Current Year projected Expenditure**

    Budget holders are required to keep programme budgets under close review and report any expected slippage or pressures at an early stage. A recent exercise to identify in-year pressures resulted in a number of projects being approved, however DoH Finance have issued clear guidance that any slippage should be returned to the centre to fund pay pressures, so a number of projects considered to be not inescapable were not approved, and an overall breakeven position is expected.

12. **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 structures 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.

13. **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 which has been reported through internal and external audits. 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. PHA has received £729k (€882k) from SEUPB in 2024/25 to date, and c.£0.9m remains outstanding (£0.9m at month 7).

14. **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 is being carefully tracked.

15. **Funding not yet allocated**: At the start of the financial year there were a number of areas where funding was anticipated but had not yet been released to the PHA. Some of this funding has now been received however the Pay awards for the 2024/25 financial year remain unfunded. No expenditure will be progressed in

these areas until allocations are approved and issued by DoH.

16. **2024/25 Financial Plan and Recurrent savings 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, the balance of £1.2m will be achieved non-recurrently from slippage on Administration budgets in 2024/25. An additional £1m recurrent savings has been applied in 2024/25, and it is expected this will be achieved non-recurrently from slippage on Administration budgets in 2024/25. Savings targets will continue to be monitored throughout the year with the identification of further recurrent savings plans finalised for 2024/25, however there are significant challenges in delivering the full requirement recurrently.

Section D: Update - Capital position

17. The PHA has a capital allocation (CRL) of £5m. This mainly relates to projects managed through the Research & Development (R&D) team. The overall summary position, as at November 2024, is reflected in **Table 3**, being a forecast breakeven position on capital funding.

18. 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.

19. CHITIN (Cross-border Healthcare Intervention Trials in Ireland Network) is a cross-border partnership between the PHA 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 – November 2024

Capital Summary	Total CRL	Year to date spend	Full year forecast	Forecast Surplus/ (Deficit)
	£'000	£'000	£'000	£'000
HSC R&D:				
R&D - Health ALBs	0	0	0	0
R&D - Trusts	0	0	0	0
R&D - Other Bodies	2,933	2,584	2,933	0
R&D - Capital Receipts	(385)	(42)	(385)	0
Subtotal HSC R&D	**2,548**	**2,541**	**2,548**	**0**
Other:				
Congenital Heart Disease Network	764	117	764	0
iReach Project	614	217	614	0
R&D - NICOLA	778	79	778	0
VMS Enhancement (Exc. Child flu)	196	171	196	0
VMS Pertussis Vaccination	45	42	45	0
VMS RSV Vaccination	45	32	45	0
MAC Books	2	2	2	0
Path Safe Wastewater Surveillance	752	208	752	0
Other - Capital receipts	(752)	(166)	(752)	0
Subtotal Other	**2,444**	**703**	**2,444**	**0**
Total PHA Capital position	**4,992**	**3,244**	**4,992**	**0**

20. PHA has also received other smaller capital allocations, including for the Congenital Heart Disease (CHD) Network (£0.8m), iReach Project (£0.6m) and NICOLA (£0.8m), all of which are managed through the PHA R&D team.

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

Recommendation

22. The PHA Board are asked to note the PHA financial update as at November 2024.

Public Health Agency

Annex A - Finance Report

2024/25

Month 8 - November 2024

PHA Financial Report - Executive Summary

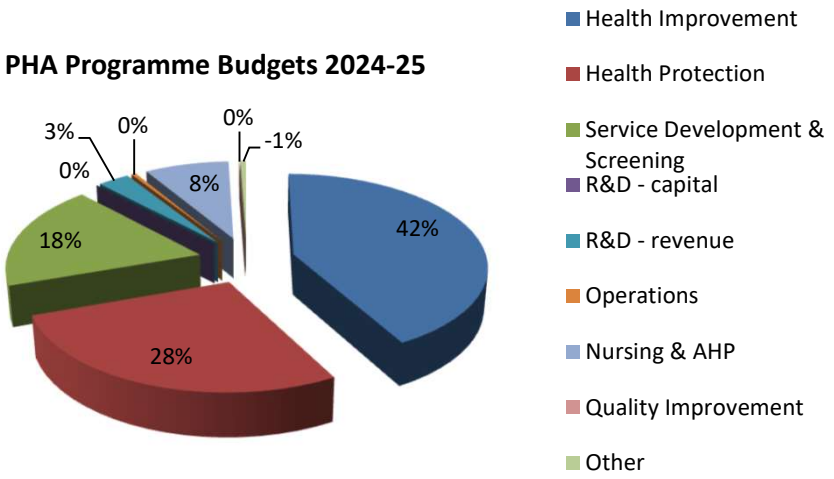
Year to Date Financial Position (page 2)

At the end of month 8, PHA is reporting a small deficit of £12k against its profiled budget. This position incorporates an underspend in Admin budgets (£0.5m) offset by overspends in Programme budgets (£0.5m).

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.

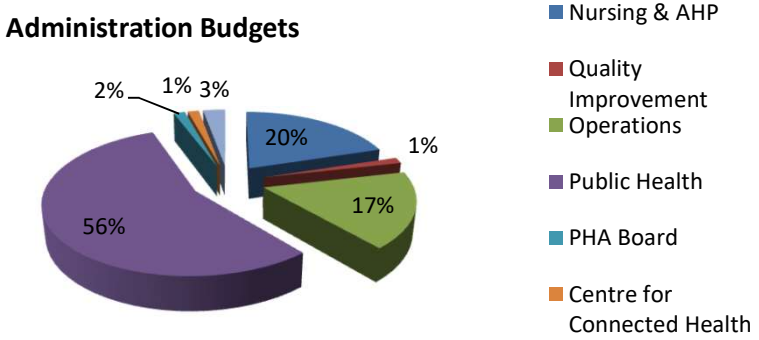


Administration Budgets (page 5)

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 following the £350k retration identified last month.

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 from Admin budgets in 2024/25 while a recurrent source is identified. A further £1m of recurrent savings has been applied to the PHA in 2024/25 and is being met non recurrently in-year from an unrequired prior year accrual while a recurrent solution is identified.

Public Health Agency
2024/25 Summary Position - November 2024

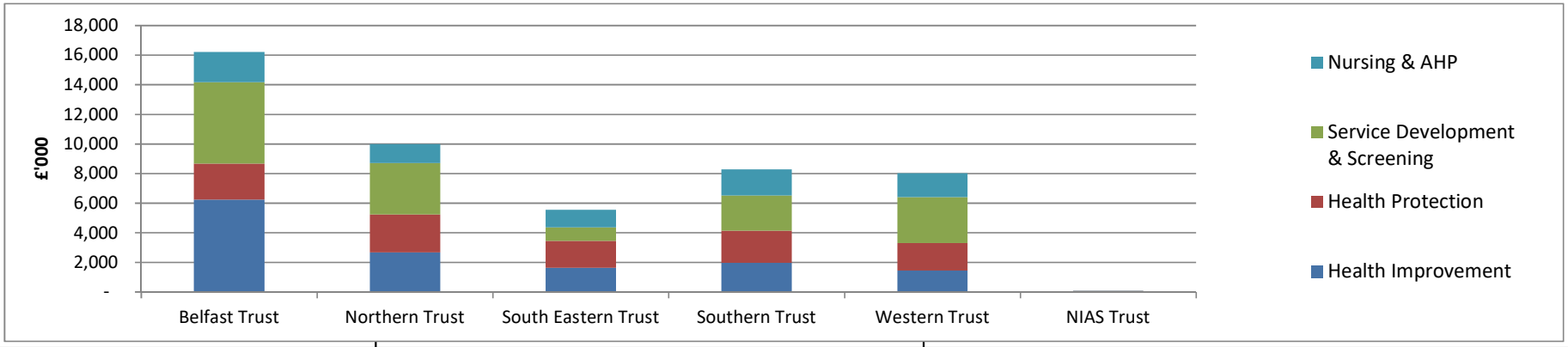
	Annual Budget					Year to Date				
	Programme		Ringfenced	Mgt &	Total	Programme		Ringfenced	Mgt &	Total
	Trust	PHA Direct	Trust & Direct	Admin		Trust	PHA Direct	Trust & Direct	Admin	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources										
Departmental Revenue Allocation	48,200	57,409	2,247	31,106	**138,961**	32,133	40,349	1,305	20,321	**94,110**
Assumed Retraction	-	-	-	-	**-**	-	-	-	-	**-**
Revenue Income from Other Sources	-	27	-	597	**624**	-	28	-	444	**472**
Total Available Resources	48,200	57,436	2,247	31,704	**139,585**	32,133	40,378	1,305	20,766	**94,581**
Expenditure										
Trusts	48,200	-	1,276	-	**49,476**	32,133	-	851	-	**32,984**
PHA Direct Programme *	-	58,703	970	-	**59,674**	-	40,866	462	-	**41,329**
PHA Administration	-	-	-	30,436	**30,436**	-	-	-	20,280	**20,280**
Total Proposed Budgets	48,200	58,703	2,247	30,436	**139,585**	32,133	40,866	1,314	20,280	**94,593**
Surplus/(Deficit) - Revenue	(0)	(1,268)	-	1,268	0	-	(489)	(9)	486	**(12)**
Cumulative variance (%)						***0.00%***	***-1.21%***	***-0.67%***	***2.34%***	***-0.01%***

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 a small deficit of £12k, with an underspend on Management and Admin budgets due to vacancies and an overspend in Programme budgets due to profiling.

The PHA is forecasting a breakeven position at year end, following the retraction of the £350k surplus which was declared to the Department last month.

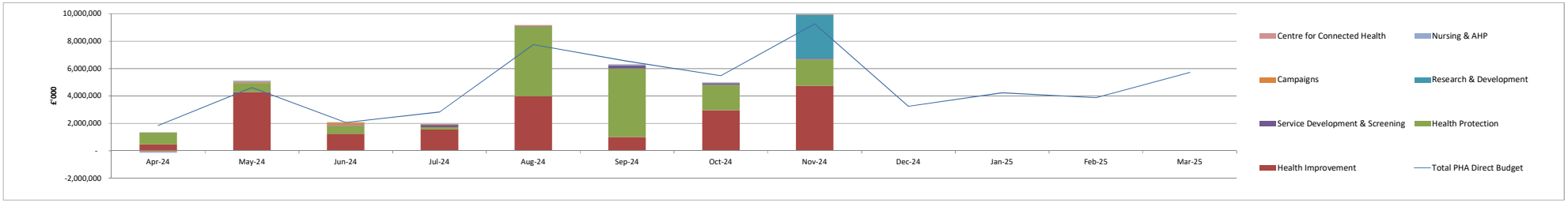
Programme Expenditure with Trusts



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	6,241	2,682	1,637	1,976	1,460	-	**13,995**	9,330	9,330	-
Health Protection	2,431	2,557	1,812	2,180	1,845	71	**10,895**	7,264	7,264	-
Service Development & Screening	5,491	3,487	924	2,367	3,102	-	**15,370**	10,247	10,247	-
Nursing & AHP	2,047	1,266	1,189	1,764	1,617	30	**7,913**	5,276	5,276	-
Quality Improvement	25	-	-	-	-	-	**25**	17	17	-
Total current RRLs	**16,235**	**9,992**	**5,561**	**8,287**	**8,024**	**100**	**48,200**	**32,133**	**32,133**	-
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	1,269	1,819	3,196	1,356	3,478	4,159	2,455	3,361	2,937	2,689	**31,324**	19,882	20,206	(324)	*-1.6%*
Health Protection	182	1,429	441	438	4,991	4,835	1,712	1,962	417	240	659	1,550	**18,856**	15,990	16,131	(141)	*-0.9%*
Service Development & Screening	0	150	143	452	77	327	335	172	464	773	363	1,096	**4,352**	1,656	1,523	133	*8.0%*
Research & Development	-	-	-	-	-	-	-	3,200	-	-	52	-	**3,252**	3,200	3,200	-	*0.0%*
Operations, incl. Campaigns	-	3	155	122	- 40	40	28	- 20	23	22	1	142	**476**	288	382	(95)	*-32.9%*
Nursing & AHP	59	11	55	0	- 59	64	7	28	116	62	138	269	**752**	167	246	(79)	*-47.2%*
Quality Improvement	2	2	2	2	2	2	2	2	2	2	2	2	**18**	12	42	(30)	*-243.6%*
Other	-	-	-	-	-	-	-	- 150	- 150	- 145	- 200	50	**(595)**	- 150	(860)	710	*100.0%*
Savings target	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	**(1,000)**	- 667	0	(667)	
Total PHA Direct Budget	**1,753**	**4,525**	**1,980**	**2,749**	**8,083**	**6,541**	**5,478**	**9,268**	**3,244**	**4,231**	**3,869**	**5,714**	**57,436**	**40,378**	**40,866**	**(488)**	
Cumulative variance (%)																***-1.21%***	
Actual Expenditure	**1,143**	**5,313**	**2,220**	**2,037**	**8,562**	**6,419**	**5,059**	**10,113**					**40,866**				
Variance	**609**	**(788)**	**(240)**	**712**	**(479)**	**123**	**419**	**(845)**					**(489)**				

The year-to-date position shows an overspend of £0.5m against profile. This is a result of minor variances in profiing and the timing of spend and has no year end implications. An overall year-end Programme overspend of c£1.3m 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. A further £1m of recurrent savings has been applied to the PHA in 2024/25 and has been met non-recurrently in-year from an unrequired prior year accrual 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	1,563	-	684	**2,247**	1,050	-	254	**1,305**
Assumed Allocation/(Retraction)	-	-	-	-	-	-	-	**-**
Total	1,563	-	684	**2,247**	1,050	-	254	**1,305**
Expenditure								
Trusts	1,276		-	**1,276**	851	0	-	**851**
PHA Direct	286	-	684	**970**	199	0	263	**462**
Total	1,563	-	684	**2,247**	1,050	0	263	**1,314**
Surplus/(Deficit)	**-**	**-**	**-**	**-**	**(0)**	**-**	**(8)**	**(9)**

The Covid funding relates primarily to vaccinations funding (both Flu and Covid), along with an allocation for sessional vaccinators in 2024-25.

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	Finance & Corporate Services £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Annual Budget								
Salaries	6,127	418	3,972	17,362	1,530	408	616	**30,432**
Goods & Services	245	7	1,499	246	(1,060)	50	284	**1,271**
Total Budget	**6,372**	**425**	**5,471**	**17,608**	**470**	**458**	**900**	**31,704**
Budget profiled to date								
Salaries	4,068	418	2,647	11,522	929	272	410	**20,265**
Goods & Services	135	7	933	149	(874)	27	123	**500**
Total	**4,202**	**425**	**3,579**	**11,671**	**55**	**299**	**534**	**20,765**
Actual expenditure to date								
Salaries	3,474	407	1,880	10,852	1,047	245	404	**18,309**
Goods & Services	149	6	1,011	664	24	20	98	**1,971**
Total	**3,622**	**413**	**2,891**	**11,517**	**1,071**	**265**	**501**	**20,280**
Surplus/(Deficit) to date								
Salaries	594	10	767	669	(118)	27	7	**1,956**
Goods & Services	(14)	1	(78)	(515)	(898)	7	26	**(1,471)**
Surplus/(Deficit)	**580**	**12**	**688**	**154**	**(1,016)**	**34**	**32**	**485**
Cumulative variance (%)	*13.80%*	*2.78%*	*19.23%*	*1.32%*	*-1843.70%*	*11.33%*	*6.08%*	***2.33%***

PHA's administration budget is showing a year-to-date surplus of £0.5m, which is being generated by a number of vacancies, particularly within the Nursing & AHP Directorates and Finance & Corporate Services, offset by the application of the balance of the 23-24 savings target held in the PHA Board (£1.2m). 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£1.3m, 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

	November 2024 Value	November 2024 Volume	Cumulative position as at November 2024 Value	Cumulative position as at November 2024 Volume
Total bills paid (relating to Prompt Payment target)	£10,477,361	479	£63,175,294	3,939
Total bills paid on time (within 30 days or under other agreed terms)	£10,405,565	474	£61,575,450	3,786
Percentage of bills paid on time	**99.3%**	**99.0%**	**97.5%**	**96.1%**

Prompt Payment performance for November 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 above the current DoH target for 2024/25 of 70%, at 83% on volume for the year to date. Recent correspondence from DoH refers to a 90% target, and PHA will take steps to ensure the 10 day target is adhered to.

item 12

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	30 January 2025
Title of paper	Establishment of PHA Working Group
Reference	PHA/02/01/25
Prepared by	Alastair Ross
Lead Director	Stephen Wilson

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

1 Purpose

The purpose of this paper is to update the Board on the establishment of a new PHA Working Group which will look at the learning from both historic and active statutory public inquiries on an organisational wide basis as well as the recommendations from other PHA reviews.

2 Context

In August 2023, the Agency created a Public Inquiry Programme Management Board as a means to oversee the PHA's response to historic and active statutory public inquiries.

Since that date, the work of the Public Inquiry Programme Management Board, and the wider Public Inquiry Team, has been largely reactive given the number of deadline-driven requests the Agency has received in respect of witness statements, disclosure and the need for formal evidence attendances.

Moving into 2025, this dynamic is expected to shift to the point at which the UK Covid-19 Inquiry will become the only active Inquiry requiring a response from the Agency. While the Agency will still need to devote significant time to the Covid-19 Inquiry, it is felt that during the year capacity will exist in which the Agency can start to fully explore the recommendations that have, and continue to, emerge from public inquiries.

This paper sets out a proposal as to how the recommendations from both historic and active statutory public inquiries can be thematically reviewed and embedded within the Agency as a wider aspect of its learning culture.

3 Extent of Public Inquiry Recommendations

Since the 2018 publication of the Hyponatraemia Report, a number of further public inquiries relevant to the work of the Agency have now concluded. This space will continue to build, into and beyond 2025, with the expected publication of the Urology Services Inquiry, the Muckamore Abbey Hospital Inquiry and further modules of the Covid-19 Inquiry.

Additionally, there may well be recommendations from other Inquiries like that of the Ireland Covid-19 Public Inquiry, the Grenfell Inquiry and the Thirlwall Inquiry which could have implications for the work of the Agency.

Figure 1 - Public Inquiry Synopsis

Inquiry into Hyponatraemia Related Deaths	Independent Neurology Inquiry	Infected Blood Inquiry	Urology Services Inquiry	Muckamore Abbey Hospital inquiry
• 96 Recommendations • Published Jan 2018	• 76 Recommendations • Published June 2022	• 58 Recommendations • Published May 2024	• Expected 2025	• Expected 2025

UK Covid-19 inquiry			
Module 1 • 10 Recommendations • Published July 2024	Modules 2,3,4 Expected 2025	Modules 5,6,7,8 Expected 2026	Modules 9, 10 Expected 2027

4 Relevance to PHA

While the PHA is not named as a dedicated owner of any of the recommendations made to date, and indeed a significant number of the recommendations have no relevance to the work of the Agency, there is learning that needs to be progressed.

Taken as a collective, several themes have, and continue to, emerge that the Agency needs to be cognisant of; be that in relation to candour, organisational culture, lines of accountability or weaknesses of internal governance structures.

In addition to the themes emerging from public inquiries, the Agency needs to assure itself that the recommendations from its own internal reports like that of the Bradley Report and the Hussey Review have been brought to a suitable conclusion.

5 Proposal

It is proposed that a Working Group is established to identify, review and progress the themes that have arisen from the suite of public inquiries and internal PHA reviews that have taken place across recent years

Once the initial review and theming has taken place, the working group would be tasked with setting tangible actions against each theme and agreeing a process through which actions could be allocated to named teams within the Agency for progression. The process would involve a significant amount of cross directorate discussion.

It is noted that many of the recommendations from previously published inquiries relate to organisational culture - given the same, it will likely be the case that the PHA Organisation Development and Engagement Forum is tasked with the implementation of several actions.

6. Constitution and Governance of Working Group

Leadership

To date, the Agency's public inquiry response has sat within the remit of the Chief Executive's office. Given that the thematic analysis and onward action planning is an extension of this work, it is proposed that the Working Group is led by the Head of Chief Executive's Office and Strategic Engagement with day to day support to be provided by the existing Public Inquiry team.

Oversight

Given the profile of this work, it is important that there is Non-Executive Director oversight. As a means to avoid the need to create another formal committee, it is proposed that progress reports would be brought to the Agency's Governance and Audit Committee for regular consideration. This in addition to regular reporting via the PHA Agency Management Team (AMT).

Membership

Given the organisational wide reach of the public inquiry response it is important that the Working Group has representation from each Directorate.

7. Implications

Current Structures

It is proposed that moving into 2025, the current Public Inquiry Programme Management Board would be stood down. Work in respect of the Agency's live public inquiry response will still continue through the PHA Public Inquiry team which will escalate issues as required through the Chief Executive's Office and where necessary AMT.

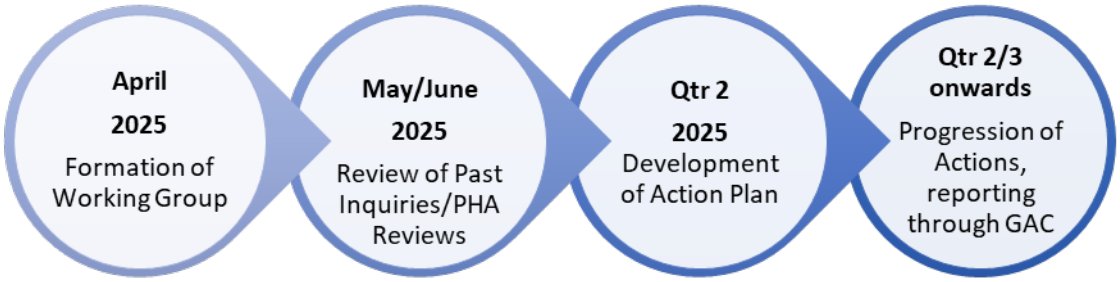
Future Work

While the scope of the proposed Working Group will initially be retrospective, this will be the space in which the implementation of future recommendations and collective thematic areas will be considered from the Urology Inquiry, the Muckamore Abbey Inquiry and the Covid-19 Inquiry.

The work of the group will also extend to capturing the tangible changes that have taken place already within the Agency as a result of the pandemic.

Depending on the success and longevity of the Working Group, there may also be scope to consider recommendations derived from other public inquiries and areas such as audit, SAI, RQIA reviews, complaints etc.

Possible 2025/26 Timeline



8. Summary

This paper proposes the creation of a small multi directorial Working Group whose role will be to identify, review and progress the themes that have arisen from the suite of public inquiries and internal PHA reviews that have taken place across recent years.

It is felt that this group will provide a means through which the Agency can shift from its live public inquiry response into a space where it is able to provide a level of assurance that inquiry learning is being formally considered and where necessary progressed within the organisation.

Following approval by the Agency Management Team, the Board is asked to note this proposal.

END

item 13

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	30 January 2025
Title of paper	Final Partnership Agreement between Department of Health and Public Health Agency
Reference	PHA/03/01/25
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 final Partnership Agreement between the Department of Health and PHA to the Board for noting.

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.

A draft Agreement was brought to the PHA Board in August 2024 and following comments from Board members, there was further engagement with the Department to develop this final version which has been reviewed by Governance Unit, Finance Policy, Accountability and Counter-Fraud Unit, and agreed to proceed for sign off. No further changes can be made at this point.

3 Next Steps

The next stage is for the PHA Chair and Chief Executive to sign and date a copy of the Agreement and return the signed copy to the Department. The Permanent Secretary will then sign off for the Department. At this point, the Partnership Agreement will replace the

Management Statement/Financial Memorandum with the effective date being the date of signature by Perm Secretary. A final version with all signatures will be published on both the PHA and DoH websites.

HSC Public Health Agency

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

Partnership Agreement between Department of Health and Public Health Agency

December 2024

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Introduction

1. 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

2. 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.

3. 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, 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

4. 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.

5. 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 [Chief Executive] 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. Three members of the Agency's executive sit on the PHA Board – the Chief Executive and the Directors of Nursing and Allied Health Professions, Finance and Corporate Services, and Public Health respectively.

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.

6. 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.

7. 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 appointment letters.

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.

8. ALB 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 expenditure 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

9. 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 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).

10. 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 the branch within the branch responsible for managing PHA sponsorship (known as the Sponsor Branch). The Finance business partner in DoH is the 'Grade 7 Accountant' within DoH Finance Directorate.

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.

11. 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

12. 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 a the opportunity to make representations by way of response to DoH officials or the Health Minister. 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 his/her 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, in line with DAO (DoF) 05/17, found at https://www.finance-ni.gov.uk/sites/default/files/publications/dfp/daodof0517_0.pdf.

13. 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

14. 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.

15. 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.

16. 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.

17. 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.

18. 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**
Annual meeting with Minister / Perm Sec to discuss policy and strategic issues affecting the PHA	Annual, as required	*Minister / Permanent Secretary*
Strategic Planning		
Activity	**Date**	**Lead Departmental/ALB Official**
PHA Strategic Planning Workshops – encompassing strategic planning and risk identification. Informed by input on departmental	Sufficiently well in advance of the Business Year to inform development of the Business Plan for the year ahead	*As deemed appropriate*

priorities/plans and risk areas		
Engagement on the draft Business Plan and identification of areas of strategic interest to the Department to inform further scheduled engagement during the year	December 2024	*Sponsor Branch Team / PHA CE, Director of Finance & Corporate Services, Assistant Director Planning and Performance*
Submission/presentation of the ALB Business Plan 2024/5	February 2025	*Sponsor Branch Team / PHA CE, Director of Finance & Corporate Services*
Approval of the PHA Business Plan 2024/5	March 2025	*Sponsor Branch Team*
Engagement on areas of strategic interest iro the ALB Business Plan during the year	As required	*Sponsor Branch Team / PHA CE, Director of Finance & Corporate Services*
Joint Working *Add details of any interchange opportunities, and/or joint programme/project delivery boards*		
Activity	**Frequency/Timing**	**Lead Departmental/ALB Official**
Development of Integrated Care System	As Required	*Sponsor Branch / SPPG / CEO PHA*
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 and responsibilities of this position	On appointment	*Sponsor Branch Team / PHA CE*
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 Services, 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	*Lead official*

	Board Effectiveness has concluded	
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 Services*
Annual Report and Accounts	Annually	*PHA CE / Director of Finance & Corporate Services*
Report to those Charged with Governance	As required	*PHA CE / Director of Finance & Corporate Services*
Engagement on other planned NIAO reports	As required	*PHA CE / Director of Finance & Corporate Services*
Head of Internal Audit Annual report/Opinion	Annually	*PHA CE / Director of Finance & Corporate Services*
Internal Audit Strategy and Plans	Annually	*PHA CE / Director of Finance & Corporate Services*
Internal Audit External Quality Assessment	To be conducted at least once every five years	*PHA CE / Director of Finance & Corporate Services*
Anti-Fraud Policy	Once, and then when revised - for information	*PHA CE / Director of Finance & Corporate Services*
Fraud Response Plan	Once, and then when revised - for information	*PHA CE / Director of Finance & Corporate Services*
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	November	*Director of Finance / Director of Finance and Corporate Services*

Departmental approval of the annual budget	March	*Director of Finance / Director of Finance and Corporate Services*
Monthly Financial Management Returns	Monthly	*Director of Finance / Director of Finance and Corporate Services*
Monthly Cash Forecast	Monthly	*Director of Finance / Director of Finance and Corporate Services*
Monitoring Round Returns	As required	*Director of Finance / Director of Finance and Corporate Services*
Provisional Outturn	Annual	*Director of Finance / Director of Finance and Corporate Services*
Final Outturn	Annual	*Director of Finance / Director of Finance and Corporate Services*
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 (specify) request from the departmental Accounting Officer	*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 Finance and Corporate Services*

Media management protocols – independence of PHA to engage with media/announcements of corporate and policy communications significant to PHA - arrangements to share press releases where relevant – ensure no surprises.	As required	*PHA CE / Head of Chief Executive Office / DoH Director of Communications*
Preparation of business cases – departments and ALBs to consider working together to share expertise where appropriate.	As Required	*PHA CE / Director of Finance & Corporate Services*
Whistleblowing cases/ Speaking Up/Raising Concerns.	As required	*PHA CE / Director of Finance & Corporate Services*
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 Services*
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

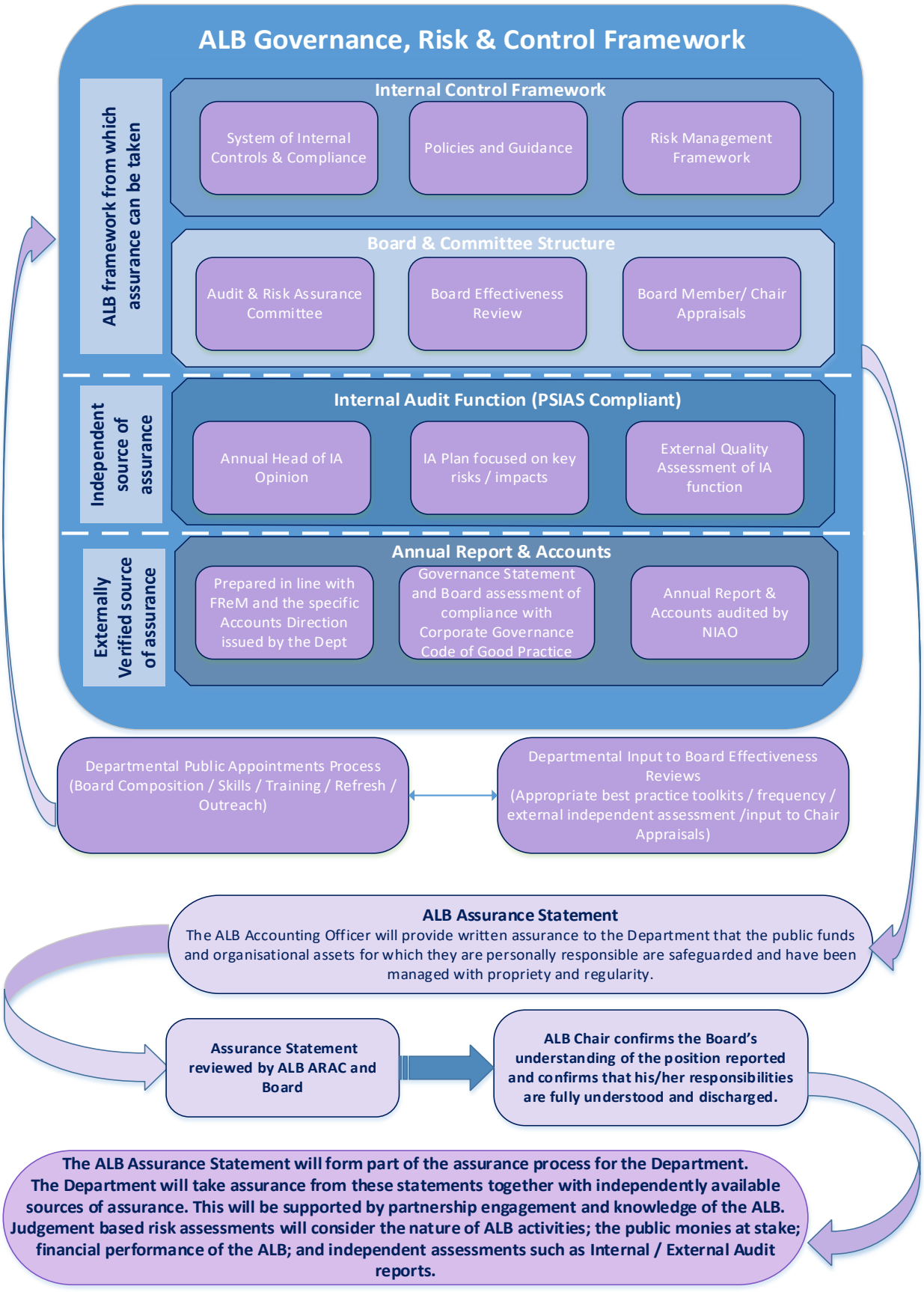
Department of Health, this is demonstrated by a maximum degree of distance, or ‘long arm’, related to the operations of the organisation.

- 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

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

January 2025: Memorandum of Understanding under review. Updated MOU to be appended to Partnership Agreement once agreed.