HSC Public Health Agency

Meeting agenda

PHA Board Meeting

Date and time	Venue
19 June 2025 at 1.45pm	Conference Rooms 1&2, 2nd Floor, 12/22 Linenhall Street

Item	Topic and details	Presenter
1	Welcome and Apologies	Chair
2	Declaration of Interests	Chair
3	Minutes of Previous Meeting held on 29 May 2025	Chair
4	Actions from Previous Meeting / Matters Arising	Chair
5	Reports of New or Emerging Risks	Chief Executive
6	Raising Concerns	Chief Executive
7	Statutory Public Inquiries and Reviews PHA Response - Implementation and Organisational Learning **[PHA/01/06/25]**	Chief Executive
8	Updates from Committees: • Governance and Audit Committee **[PHA/02/06/25]** • Remuneration Committee • Planning, Performance and Resources Committee • Screening Programme Board • Procurement Board • Information Governance Steering Group • Public Inquiries Programme Board	Committee Chairs

9	PHA Annual Compliments and Complaints Report 2024/25 **[PHA/03/06/25] (For noting)**	Mr Wilson
10	PHA Annual Report and Accounts 2024/25 **[PHA/04/06/25] (For approval)**	Ms Scott
11	Financial Plan 2025/26 **[PHA/05/06/25] (For approval)**	Ms Scott
12	Draft PHA Implementation Plan **[PHA/06/06/25] (For approval)**	Ms Scott
13	Chief Executive and Directors' Report	Chief Executive
14	Chair's Remarks	Chair
15	Any Other Business	Chair
16	Details of next meeting: *Thursday 28 August 2025 at 1.30pm* *Board Room, Tower Hill, Armagh*	Chair

PHA Board Meeting Minutes

Date and Time	Venue
29 May 2025 at 1.30pm	Room E206/207, Ulster University, Coleraine

Member	Title	Attendance status
Mr Colin Coffey	Chair	Present
Mr Aidan Dawson	Chief Executive	Present
Ms Heather Reid	Interim Director of Nursing, Midwifery and Allied Health Professionals	Present
Ms Leah Scott	Director of Finance and Corporate Services	Present
Mr Craig Blaney	Non-Executive Director	Present
Mr John Patrick Clayton	Non-Executive Director	Present (via Teams)
Ms Anne Henderson	Non-Executive Director	Present
Dr Declan Bradley	Deputy Director of Public Health	In attendance
Mr Robert Graham	Secretariat	In attendance
Mr Robert Irvine	Non-Executive Director	Apologies
Mr Joseph Stewart	Non-Executive Director	Apologies
Dr Joanne McClean	Director of Public Health	Apologies
Mr Stephen Wilson	Head of Chief Executive's Office	Apologies
Ms Meadhbha Monaghan	Chief Executive, Patient Client Council	Apologies

65/25 - Item 1 – Welcome and Apologies

65/25.1 The Chair welcomed everyone to the meeting. Apologies were noted from Mr Robert Irvine, Mr Joseph Stewart, Dr Joanne McClean, Mr Stephen Wilson and Ms Meadhbha Monaghan.

65/25.2 The Chair said that the mental health conference that members had attended in advance of the meeting had been excellent and a worthwhile event. He noted that it would have been useful to have heard about what progress has been made year on year.

66/25 - Item 2 – Declaration of Interests

66/25.1 The Chair asked if anyone had interests to declare relevant to any items on the agenda.

66/25.2 Mr Clayton declared an interest in relation to Public Inquiries as Unison is engaging with the Inquiries.

67/25 - Item 3 – Minutes of previous meeting held on 24 April 2025

67/25.5 The minutes of the Board meeting held on 24 April 2025 were **APPROVED** as an accurate record of that meeting.

68/25 - Item 4 – Actions from Previous Meeting / Matters Arising

68/25.1 Mr Graham went through the actions from the previous meeting. For action 1, he advised that PHA had not received any correspondence from the Department regarding pandemic preparedness, but this matter would be raised with Mr Chris Matthews as he is due to the attend the Agency Management Team (AMT) meeting on 3 June.

68/25.2 Mr Graham reported that for action 2, a Procurement Plan was brought to the meeting of the Planning, Performance and Resources (PPR) Committee last week and would be brought to a future Board meeting. He noted that action 3, regarding a meeting to discuss procurement, may no longer be required given this update.

68/25.3 Mr Graham advised that an update on stakeholder engagement will be brought to a future meeting which will close action 4, and that for action 5, Ms Scott will give an update on the financial outlook for 2025/26 later in the meeting.

69/25 - Item 5 – Reshape and Refresh Programme

69/25.1 The Chair reported that there has not been a meeting of the Programme Board since the last Board meeting, but Board members did have the opportunity to attend a session with the Senior Leaders Forum which he said was very positive and allowed members to see what the challenges are in developing the Implementation Plan. He said that there is a clear commitment to take this work forward. He noted that one of the groups which was looking at outcomes was focusing on outcomes where PHA was in control, but he felt that PHA should not narrow its focus and even if there are other organisations holding PHA back, PHA should own the outcome. He asked if the Board could be invited to a further session and said that there needs to be a discussion around "people" and "data and digital" **(Action 1 – Chief Executive)**. He advised that the Reshape and Refresh programme is progressing well.

69/25.2 Ms Henderson asked when all affected members of staff will be in their new posts as this process has been hanging over them for a couple of years. The Chair said that he has been asking the same question and that it will be covered in the presentation that is coming to the Board in June. He added that he is hoping to see a gap analysis in terms of what work PHA is required to do and then it would be up to the Board and himself to raise with the Permanent Secretary the need for more resources.

69/25.3 The Chief Executive advised that there is a draft structure and there are posts currently being evaluated. He hoped that the structure would be approved by the end of June and populated over the summer. He explained that there are enough posts for almost all staff, with possible displacement. He clarified that there will be no need for compulsory or voluntary redundancy, but there will still be some gaps in areas, for example health protection consultants, although there are interviews scheduled for next Monday. He advised that there are 32 staff impacted and he was confident of a satisfactory outcome. Ms Reid added that there is an Assistant Director post out for recruitment which is closing today and that there is ongoing modernisation work.

69/25.4 Ms Henderson asked if the affected staff know about the latest position. The Chief Executive replied that there has been a lot of communication with those staff and there has also been engagement with staff side to work through the process.

69/25.5 Mr Clayton agreed that the session looking at the Implementation Plan was very useful and said that a further session would be beneficial and that he would encourage all members to take part. With regard to the movement of affected staff in PHA, he advised that there are processes in place across the HSC and welcomed that there has been engagement with staff side and Trade Unions.

69/25.6 The Chair advised that he has been visiting the PHA offices and engagement with staff has been very positive. Ms Reid noted that the new approach in PHA is to focus on population grouping instead of being drawn down professional lines. The Chair agreed that the concept of the Strategic Planning Teams (SPTs) is a good one. The Chief Executive advised that not only has there been a major transformation in PHA in terms of its structure and operating model, but also in terms of its culture and that the difficulty in achieving this shift should not be mis-underestimated especially as PHA was going into a pandemic and was not able to deliver what it needed to. He noted that the change process is not coming to an end, but rather it will continue to evolve as PHA develops a workforce with public health skills and knowledge over the

next 5/6 years. He added that PHA can always improve and it will continue to invest in its staff to give them the skills that they need.

69/25.7 The Chair said that PHA is in a good place and that the foundations are there. He added that it is up to the Board to help PHA become the leader in its field.

70/25 - Item 6 – Reports of New or Emerging Risks

70/25.1 The Chief Executive advised that there were no new or emerging risks since the last Board meeting.

70/25.2 The Chair asked when the PHA Board should be made aware of new emerging public health risks. Dr Bradley replied that there is a new process within PHA where there is a weekly surveillance team meeting and where previously different teams would have worked in silos, these teams now come together to go through all the available data and prepare a report which is shared with the Department and the Chief Executive. He added that the Duty Room also shares information on outbreaks. The Chief Executive advised that there are always ongoing issues, but if there was going to be a major population event, for example avian flu, this would be brought to the attention of the Board.

70/25.3 Mr Blaney asked if the Board could be made aware of issues before they appear in the media. The Chair said that members are already well-informed, and he would make a judgement call on whether matters should be shared. Mr Clayton noted that previously members would have been made aware of issues, but he acknowledged that there is an element of judgement in this.

71/25 - Item 7 – Raising Concerns

71/25.1 The Chief Executive advised that there were no new concerns to report on.

71/25.2 The Chair asked if staff need to be reminded that there is a process by which they can report concerns. The Chief Executive advised this forms part of their induction and is picked up within mandatory training. The Chair welcomed this, but asked how effective the processes are. The Chief Executive acknowledged this and said that it is important that there is a culture where staff feel comfortable in speaking up.

72/25 - Item 8 – Updates from Board Committees

Governance and Audit Committee

72/25.1 The Chair noted that the Governance and Audit Committee had not met since the last Board meeting.

Remuneration Committee

72/25.2 The Chair noted that the Remuneration Committee had not met since the last Board meeting, but that a meeting will be arranged in June.

72/25.3 The Chair said that the minutes of the meeting of the PPR Committee from February were available for members for noting and that the Committee had met again last week where one of the issues discussed was the Implementation Plan. He advised that there was a good discussion and that AMT will look at the timings for finalising it. He added that there was also a discussion on procurement and how it links with the new SPTs and the need for joined up thinking.

72/25.4 Ms Henderson echoed that there was a good discussion on procurement and explained there is a volume of contracts which are currently being procured and a number currently being reviewed, as well as some that are proceeding through the use of grants. She added that this leaves a number which still require to be reviewed and for PHA to determine it if should be continuing with them. She advised that there are also contracts with Trusts that need to be reviewed. She asked what performance management role PHA has in terms of the overall health budget and what its commissioning role is.

72/25.5 The Chair said that if PHA is going to have an underspend this year, it needs to identify this as early as possible. He advised that he had spoken to Mr Peter Toogood who had confirmed that PHA's budget is for its own use. He asked that the Committee be kept informed. He noted that September is a key month because it is the halfway point of the year so that gives the organisation six months to make savings or reallocate the underspend.

72/25.6 Mr Clayton noted that when the PPR Committee was established, part of its role was that, if PHA had ability to reallocate funding, it would look at the proposed areas for funding. He said that it would be useful for the Committee to understand in more detail where funding is being allocated.

72/25.7 The Chief Executive advised that he is expecting to be asked by the Permanent Secretary to identify further savings and that any slippage that PHA has be returned to the Department. He added that he had made it clear to Directors that any slippage identified in their budgets is PHA slippage, and not for budget managers to reallocate. He noted that his preference is not to return funding, especially if it can be used to improve the health of the population.

72/25.8 Ms Scott commented that the Financial Plan is currently being developed and that a lot of where PHA spends it money is dictated by policy and PHA cannot go beyond that. She added that it can be difficult to identify areas to spend slippage where there is not a recurrent tail.

72/25.9 The Chair said that he accepted this, but said that PHA has always had slippage which is why September is a key month. He noted that last year PHA saved over £1m on vaccines. He stated that he wishes the Directors to be proactive and if there are opportunities to make savings, then to use that funding on other work as he does not wish PHA to be in a position where it is handing funding back.

Screening Programme Board

72/25.10 The Chair said that he attended the most recent meeting of the Screening Programme Board and the big issue in that area is Encompass. The Chief Executive

advised that a Digital Screening Board has been established which is being chaired by Dr Dermot Hughes. He added that there is a terms of reference and that membership includes PHA, SPPG, the Department and it is intended to have a service user on board. He said that this is why he wishes to establish a Digital and Information directorate in PHA. Mr Blaney noted that previously that there had been a suggestion of a PHA Board member being involved. The Chief Executive noted that Dr Hughes had commented that this work is not only about digitisation, but about improving the health outcomes for everyone in Northern Ireland. Ms Reid said that there has been a change in terms of the approach to dealing with the Child Health System.

72/25.11 Mr Blaney asked if Encompass is on the PHA's Corporate Risk Register. Mr Clayton noted that there are separate risks on the Register relating to screening programmes and the Child Health System. The Chief Executive explained that Encompass is the name of the overarching programme for the digitisation of the HSC, but the system that is being implemented is called Epic. He added that previously PHA would have had a number of different systems in screening, some of which were supported by NHS England and the idea is that going forward, all of the functionality should be migrated onto the Epic system or a determination should be made as to what system to use. He noted that PHA is dependent on a number of organisations who hold and manage other systems.

72/25.12 Dr Bradley highlighted that it is important that systems are operational because Trusts have a responsibility to report information to SPPG, for example on Anti-Microbial Resistance, but at present the reporting links are broken so he now attends a fortnightly meeting which looks at technical fixes for issues such as these.

72/25.13 Ms Scott advised that PHA added a risk to its Risk Register in December relating to the Child Health System. The Chair said that as well as identifying risks, PHA needs to be able to mitigate them and he asked that this risk be reviewed **(Action 2 – Chief Executive)**. The Chief Executive outlined that Dr Hughes is the Senior Responsible Officer for Encompass and that to date, the priority has been getting the five Trusts operational, and now that that process has been completed, the focus is now on other organisations, for example PHA. The Chair suggested that there could be oversight of this area either through the Governance and Audit Committee, or through a sub-group led by Mr Blaney which would look at how the PHA Board can help. Ms Reid noted that once the system is switched over, it can take up to five years for optimisation.

Procurement Board

72/25.14 There was no update on the Procurement Board.

Information Governance Steering Group

72/25.15 Mr Clayton advised that the Information Governance Steering Group had met last week and that a new updated Information Governance Action Plan is being developed to take stock of current issues, for example procurement. He noted that there remains an issue with regard to the uptake of training among new and existing staff. He said that there will be an update at the next meeting of the Governance and Audit Committee.

72/25.16 Mr Clayton noted that some of the Board members had attended the session on cyber security training and it was felt that cyber security does not sit within the remit

of the Information Governance Steering Group so there needs to be a discussion as to where its natural home is.

Public Inquiries Programme Board

72/25.17 There was no update on the Public Inquiries Programme Board.

73/25 - Item 9 – Performance Management Report [PHA/02/05/25]

73/25.1 The Chair said that there had been a good discussion on the Performance Management Report at the PPR Committee meeting last week. He sought assurance that those actions not achieved last year will be carried forward into this year. Mr Clayton echoed the need to ensure that PHA keeps track of those actions that were rated "red" as the new Business Plan is now in place.

73/25.2 Mr Clayton asked about KPI 6 saying that it was unclear from the narrative what the uptake for pertussis and MMR vaccines was for those in areas of greater health inequality. For KPI 28, he asked for further details on how PHA would resource an R&D office and what function it would have. Finally, he asked about KPI 32 regarding PHA's role in commissioning with SPPG and information on how this links with the new Integrated Care System (ICS), and how the PHA Board will get sighted on this going forward.

73/25.3 The Chief Executive said that targets for vaccines are determined on a yearly basis so this will be looked at. He agreed that it is important that PHA focuses on those living in the most deprived areas. He assured members that the new R&D office would be funded. He explained that at present PHA oversees R&D for the whole HSC and core funding is used for R&D offices within the Trusts, but this will see PHA have its own office for specific public health research. With regard to ICS, he outlined that PHA has a specific role to work with SPPG on commissioning and that monthly meetings between the senior teams of PHA and SPPG have been re-established. He added that PHA has asked that the HSC Framework Document is reviewed, particularly with regard to PHA's responsibilities.

73/25.4 Mr Clayton agreed that for vaccinations, PHA needs to be able to evidence that its approach is making a difference and it if needs to change. The Chief Executive said that PHA is considering setting KPIs for its vaccination programme. He added that from the Live Better initiative, it has become apparent that GPs working in more deprived areas are having difficulties getting people vaccinated. He advised that at a meeting of the Chief Executives of the 4 UK nations public health bodies, there was a discussion about KPIs and vaccinations, and each nation is having similar issues.

73/25.5 Dr Bradley advised that an evaluation is being finalised on the MMR campaign that took place and that this could look at inequalities as there is a dashboard which collects data on ethnicity. He noted that the capacity to look at this area is stretched. He advised that the Department has asked PHA to convene a group looking at behavioural change and it has held one meeting to date.

73/25.6 The Chief Executive said that PHA has been approached by a private sector company to assist with Shingrix and that going forward there may be more public/private sector partnerships.

73/25.7 The Board noted the Performance Management Report.

74/25 - Item 10 – Finance Report [PHA/03/05/25]

74/25.1 Ms Scott reported that PHA's final year position showed that it had achieved an underspend of 0.5%. She said that she wished to draw members' attention to the section in the Report outlining the changes to PHA's budget over the year. The Chair welcomed this outcome and offered his thanks to the staff.

74/25.2 Ms Henderson noted that the PPR Committee had considered this Report, and that the Report gives members an understanding of where some of the pressures are. She said that she did not know if there is an appreciation of the work to manage these pressures. She added that PHA is able to manage slippage in areas such as Nicotine Replacement Therapy (NRT) and vaccinations and that going forward the Board would like more oversight of slippage. The Chair said that this goes back to the earlier discussion around whether PHA has a plan for slippage. The Chief Executive explained that PHA goes through a process where it asks teams if they have projected slippage. He noted that this year PHA had to work out the cost of its new structure and that £1.25m of savings was taken from its bottom line.

74/25.3 The Chair asked if the Reshape and Refresh programme will be a cost to the organisation. The Chief Executive replied that there will be a reallocation of costs, but the new Digital and Data directorate will be a new cost. The Chair said that the Permanent Secretary had been informed that there may be additional costs associated with the Reshape and Refresh programme so the Department is aware. Ms Henderson noted PHA gave back £2m last year. The Chief Executive pointed out that some of this related to vaccinations and clarified that PHA would not be able to cover the cost of any increase in vaccines from its own flat cash budget. He added that PHA has saved on some of the management costs for vaccinations, but not the vaccines themselves.

74/25.4 Ms Henderson said that she would like to see potential areas for slippage highlighted earlier in the year. The Chair noted that each year PHA makes assumptions and each month it should know whether these assumptions are correct.

74/25.5 Ms Henderson noted that the appointment of the new Digital Director post will take place later in the year so there is already slippage. Ms Scott said that this will be taken into account as part of PHA's workforce plan.

74/25.6 The Board noted the Finance Report.

At this point Mr Clayton left the meeting.

75/25 - Item 11 – Items for Noting

75/25.1 The Chair said that the Our People report, which was considered at the PPR Committee last week, was a very positive report. The Chief Executive noted that although PHA is going through a change process, the Our People Report shows that the majority of the workplace is in a good place.

76/25 - Item 12 – Chair's Remarks

76/25.1 The Chair asked the Chief Executive if he had any matters he wished to update the Board on.

76/25.2 The Chief Executive advised that PHA has now received correspondence from the Department confirming that it has approved PHA's Corporate Plan.

76/25.3 The Chair reported that he had met with the Minister and that the Minister has requested that they meet every six months. He added that he has also met with Mr Peter Toogood.

76/25.4 The Chair advised that there was a discussion with the Permanent Secretary about how to drive forward change in the HSC and that a number of initiatives are being looked at, and while PHA is on the periphery of most of them, one that it may become involved in is the concept of a provider collaborative which looks at areas where organisations can work together. He explained that what is being considered is a Committee involving the Chairs and Chief Executives of each Trust. He said that PHA should play a role in this, especially if a prevention agenda is agreed as the way forward. The Chief Executive said that he has heard it described as a "Committee in Common" and that in England, these Committees have the power to make decisions so locally, this would mean the Chief Executives discussing issues and making recommendations which would go back to their own Boards. The Chair said that neither he nor the Chief Executive should attend these meetings without an understanding of the feeling of the PHA Board. He added that it will be inevitable that some Trusts will have to concede on issues. He said that he would raise this again at the next meeting **(Action 3 – Chair)**.

77/25 - Item 13 – Any Other Business

77/25.1 There was no other business.

78/25 - Item 14 – Details of Next Meeting

Thursday 19 June 2025 at 1.30pm

Board Room, County Hall, Ballymena

Signed by Chair:

Colin Coffey

Date: 19 June 2025

item 7

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	19 June 2025
Title of paper	Statutory Public Inquiries and Reviews PHA Response - Implementation and Organisational Learning
Reference	PHA/01/06/25
Prepared by	Alastair Ross / Grainne Cushley
Lead Director	Stephen Wilson

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

1. Purpose of the Paper

This paper has been drafted to provide the PHA Board with an overview of the work undertaken to date within the Agency as a result of the recommendations and wider learning from the following suite of statutory public inquiries and reviews conducted in recent years:

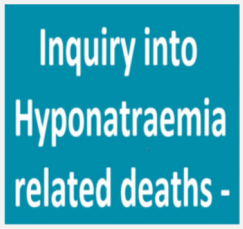
Inquiry into Hyponatraemia Related Deaths	- Report Published January 2018
Hussey Review	- Report Shared December 2020
Reshape and Refresh	- Report Shared March 2022
Independent Neurology Inquiry	- Report Published June 2022
Infected blood inquiry	- Report Published May 2024
UK Covid-19 Inquiry - Module 1	- Report Published July 2024

2. Outcomes - *Inquiries*

Although each Inquiry relates to its own specific issue, common to all is the requirement to agree a series of recommendations to prevent a reoccurrence. Across the four recent Inquiries relevant to the work of the Agency, there have been 240 recommendations made to date.

Whilst the Agency is not named as a recommendation 'owner' within any of the 240 recommendations, the collective themes of cultural change, openness, learning, transparency and accountability are all core tenets of a successful PHA and these are the pillars upon which the new Target Operational Model is being built.

A brief synopsis of the Inquiries that have concluded in recent years is set out below:



96 Recommendations

Recommendations focused on improving patient safety, transparency and governance within the health service.

Key recommendations included mandatory open disclosure to families following adverse incidents, strengthened clinical leadership/accountability, improved communication, record-keeping and a statutory duty of candour. The Inquiry also called for cultural change within the health system to prioritise honesty, learning and patient-centred care.

76 Recommendations

Recommendations aimed at improving patient safety, clinical governance and public confidence.

Key recommendations include the establishment of clear clinical governance frameworks, improved mechanisms for patient communication and informed consent, robust systems for the clinician monitoring and revalidation and enhanced transparency and responsiveness in complaints handling. The Inquiry also emphasised the importance of inter-organisational cooperation and leadership accountability across the health and social care system.

58 Recommendations

Recommendations to address systemic failures that led to patients being infected with HIV and hepatitis through contaminated blood products.

Key recommendations included the establishment of a permanent compensation scheme, a statutory duty of candour for individuals and organisations, stronger governance and accountability mechanisms, improved patient safety protocols and a commitment to transparency and learning. The Inquiry also stressed the need for cultural change to prioritise openness, patient voice and timely redress in the event of harm.

10 Recommendations

Recommendations to overhaul the nation's readiness for future whole-system emergencies such as a pandemic.

Recommendations were made to enable the creation of a more streamlined, transparent, data-informed and accountable emergency response system, with built-in evaluation and external challenge to guard against complacency and structural biases.

3. Outcomes - *Reviews*

In 2020, a rapid external review of the Agency was undertaken by Dr Ruth Hussey. Although focused on the Agency's resourcing requirements in the face of the Covid-19 pandemic, the report was undertaken more than ten years after the Agency's creation so was accepted as a timely point at which to assess the state of the organisation.

The 2020 Hussey Review set out four large recommendations which each encompassed a number of sub recommendations:

Recommendation 1 - *Strengthen the public health system in NI*
Recommendation 2 - *Strengthen health protection capability*
Recommendation 3 - *Develop science and intelligence capability*
Recommendation 4 - *A modern, effective and accountable organisation*

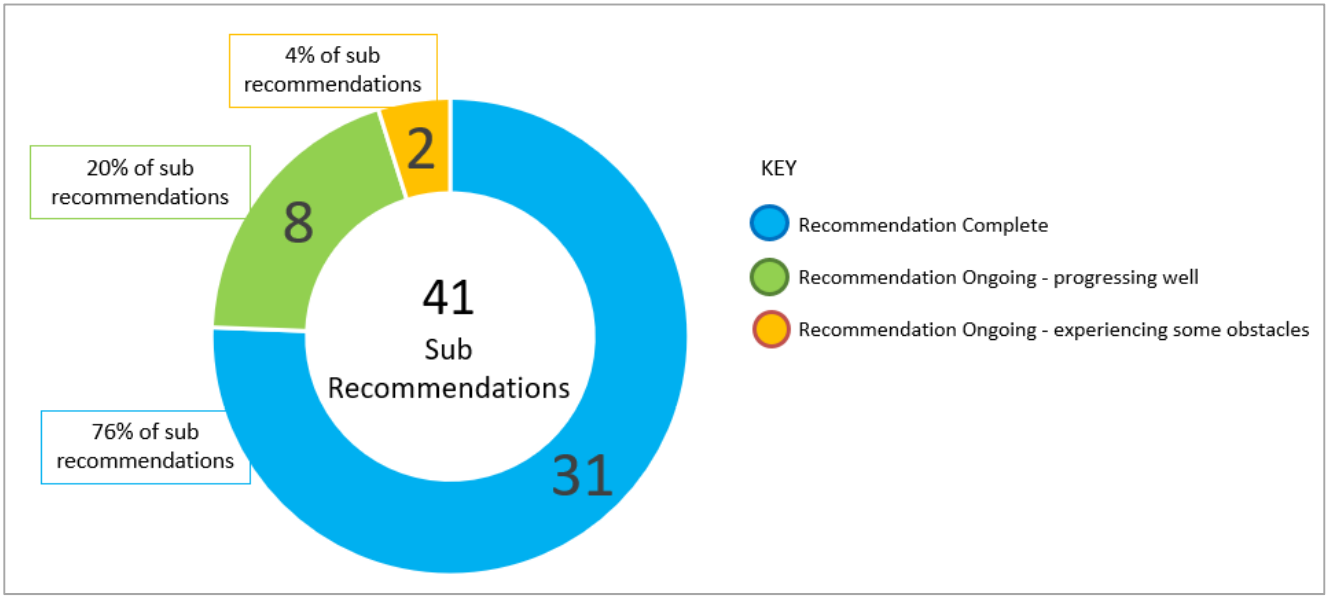
The Hussey recommendations formed the basis for the Agency's 2022 Programme of Reshape and Refresh which was facilitated in its initial development and design by EY (consultancy).

Reshape and Refresh was set in the context of three phases which moved the Agency through Hussey (Phase 1) and into the development (Phase 2) and implementation (Phase 3) of a Target Operating Model.

4. The 2020 Hussey Review - Closure Report

At the request of the PHA Board, a review exercise has now been undertaken to assess the progress that has been made on each of the 41 sub recommendations set out in the Hussey Review. The outcome of that review exercise is included in its entirety within a standalone Closure Report.

Sub Recommendations

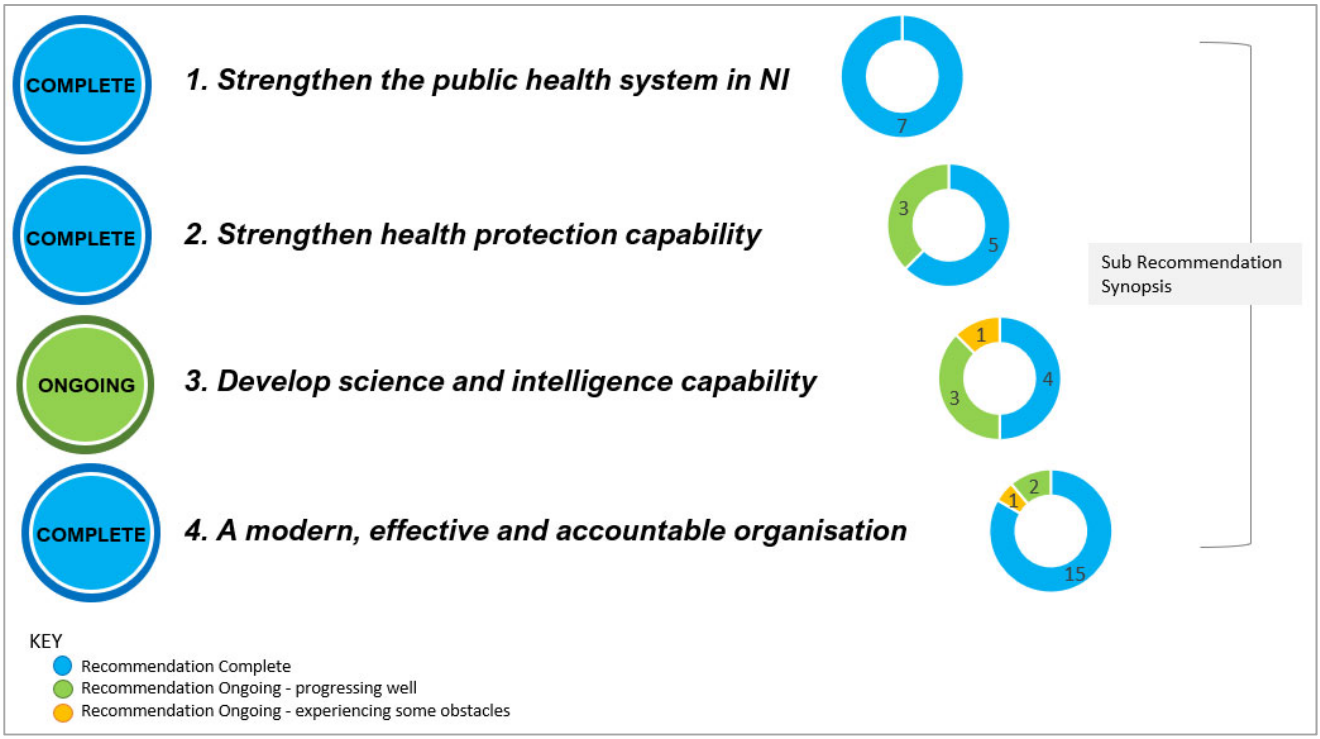


- 10 of the 41 sub recommendations remain ongoing - where possible these sub-recommendations will be mapped into the ongoing Reshape and Refresh Programme. If they cannot be adequately mapped they will be included as discrete actions within relevant Directorate Plans.

- The completion of this exercise will allow the Agency to formally close the outworking's of the Hussey Review.

Overarching Recommendations

Based on the outcome of the sub recommendation review, the following assessment has been made on each of the four overarching Hussey Recommendations



Key Achievements

Through the collective programme of work, the following larger scale actions have already been implemented:

- Creation and implementation of a new organisational structure - this includes the introduction of a Director role focusing on Data, Digital and Intelligence and the realignment of teams to focus on corporate themes. New Assistant Director roles have also been recruited with a process underway to support the implementation of Tier 4 (leads).

- Development of new five-Year Corporate Plan and associated Implementation Plan.

- Operationalisation of Public Health Planning Teams as a means to address silo working, encourage multi-disciplinary working and improvements relating to organisational performance management.

- Establishment of a Senior Leaders Forum, consisting of Directors and Assistant Directors - this is a key leadership group to drive the Agency's change process.

- Development of a Health Inequalities Framework to support organisational planning.

- Renewed Public Health focus through a number of key deliverables including the identification of public health skills profile, introduction of Public Health e-learning programme and transition arrangements to support a number of leadership roles to complete Public Health portfolios.

- Completion of a function alignment exercise through which finance has moved into the Agency and HSCQI has moved to RQIA.

- Creation of an Organisation Development Engagement Forum which provides a structure to support progress in areas relating to culture, staff experience and workforce development.

- Identification of Culture Champions and Health & Well Being Champions with associated workplans which continue to encourage engagement.

- Development and launch of a People Strategy which underpins the activities outlined above.

- Roll out of a revised internal communications process which includes the introduction of a weekly staff newsletter, monthly virtual sessions with senior staff, quarterly Chief Executive 'walk-arounds' and the introduction of a virtual Mural board to convey information.

- Creation of a bank team of contact tracing staff within the wider Health Protection Service who are now used to augment the wider work of the team when dealing with infectious disease outbreaks.

- Based on the learning from the NI Direct Covid Care telephony service, the PHA has utilised helplines as an efficient way to field queries from individuals on a given issue, most recently in relation to cervical screening concerns.

- The development of an Analytics Platform initially as a support to contact tracing has transformed how the PHA works in respect of data and analytics. The platform allows the secure ingestion, matching, analysis and display of healthcare data.

Impending Work - Inquiry Related

During 2025/26, the Agency will have work to do as the Department of Health (DoH) takes forward large pieces of work such as the Being Open Framework and the Regional Framework for Learning and Improvement from Patient Safety Incidents.

The Urology Services Inquiry, the Muckamore Abbey Hospital Inquiry and Module 2c (NI Decision Making & Governance) of the UK Covid-19 Inquiry are each expected to publish their recommendations in year. Given the localised focus of these inquiries, the recommendations will need to be considered and potentially moved into a new platform of work if they are not already being addressed through Reshape and Refresh.

5. Measuring Impact

At the outset of the Reshape and Refresh programme, the Agency agreed a number of markers through which the envisaged success of the change process could be measured.

A transformation survey relying on the opinions of staff was used to establish a baseline upon which the impact of the reform programme could be measured. It is anticipated that a similar exercise will be completed during 2025/26 as a means to assess the impact of the programme within the organisation.

- Clear vision and identity
- Shared culture
- No more silos
- Improved leadership
- Organisational resilience
- Agency wide resilience
- Agency wide consistency
- Data driven decision making and planning
- Improved efficiency
- Outcomes focused

6. Governance and Assurance

Existing Arrangements

The Agency's progress on Reshape and Refresh is coordinated through a Programme Board led by the PHA Chair and containing representation at both non-executive director and Chief Executive level. The Board reports progress through to the DoH via normal accountability arrangements.

The Agency's response to active Public Inquiries is managed through the PHA Statutory Public Inquiries Programme Management Board. The Chief Executive of the PHA sits as Chair with other Directors and the Directorate of Legal Services (BSO) in attendance. Prior

to her departure from the Agency, Professor Nichola Rooney attended in her role as a non-executive director.

Impending Changes

As the Agency's workload in relation to its active inquiry response diminishes, a new Public Inquiries Working Group will be created and Chaired by the Head of Chief Executive's Office. The establishment of the Working Group will coincide with the cessation of the Public Inquiry Programme Management Board

Through its operation, the Working Group will review the findings from each of the pending inquiries and put in place mechanisms through which any recommendations can be mapped to the Reshape and Refresh programme or translated into new actions for progression in standalone plans. The Working Group will report to PHA Governance and Audit Committee (GAC) on a quarterly basis via written update.

7. Next Steps (July 25 – December 25)

As the Agency moves into the second and third quarter of 2025/26, the main focus of work will be concerned with the continued implementation of the Reshape and Refresh Operating Model.

During this period the Agency will also establish a Public Inquiries Working Group and develop a work plan through which the impending recommendations from the Urology Services Inquiry, the Muckamore Abbey Hospital Inquiry and Module 2c of the UK Covid-19 Inquiry can be progressed. This work will take place alongside the Agency's response to the live modules of the Covid- 19 Inquiry (M6, M8, M9).

8. PHA Board Approvals

PHA Board are asked to note the content of this paper and the work undertaken in relation to the formal closure of the Hussey Review. PHA Board are asked to note the impending changes in relation to the management of the Agency's public inquiry response and the plans in place for GAC to monitor progress.

AUTHORS

Stephen Wilson	- Head of Chief Executive's Office
Grainne Cushley	- Reshape Refresh Programme Manager
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June 2025

Appendix 1

PHA Board Slide Deck

PHA Board Slides - 17.06.25.pptx

Closure Report

May 2025

The 2020 Hussey Review

Rapid, focused external review of the Public Health Agency for Northern Ireland's resource requirements to respond to the COVID-19 Pandemic over the next 18 – 24 months

HSC Public Health Agency

Position as at 31 May 2025

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The Hussey Review

In 2020, a rapid external review of the Agency was undertaken by Dr Ruth Hussey. Although focused on the Agency's resourcing requirements in the face of the Covid-19 pandemic, the report was undertaken more than ten years after the Agency's creation so was accepted as a timely point at which to assess the state of the organisation.

The 2020 Hussey Report set out four large recommendations which collectively encompassed 41 sub recommendations:

Recommendation 1 - *Strengthen the public health system in NI*
- *Seven Sub Recommendations*

Recommendation 2 - *Strengthen health protection capability*
- *Eight Sub Recommendations*

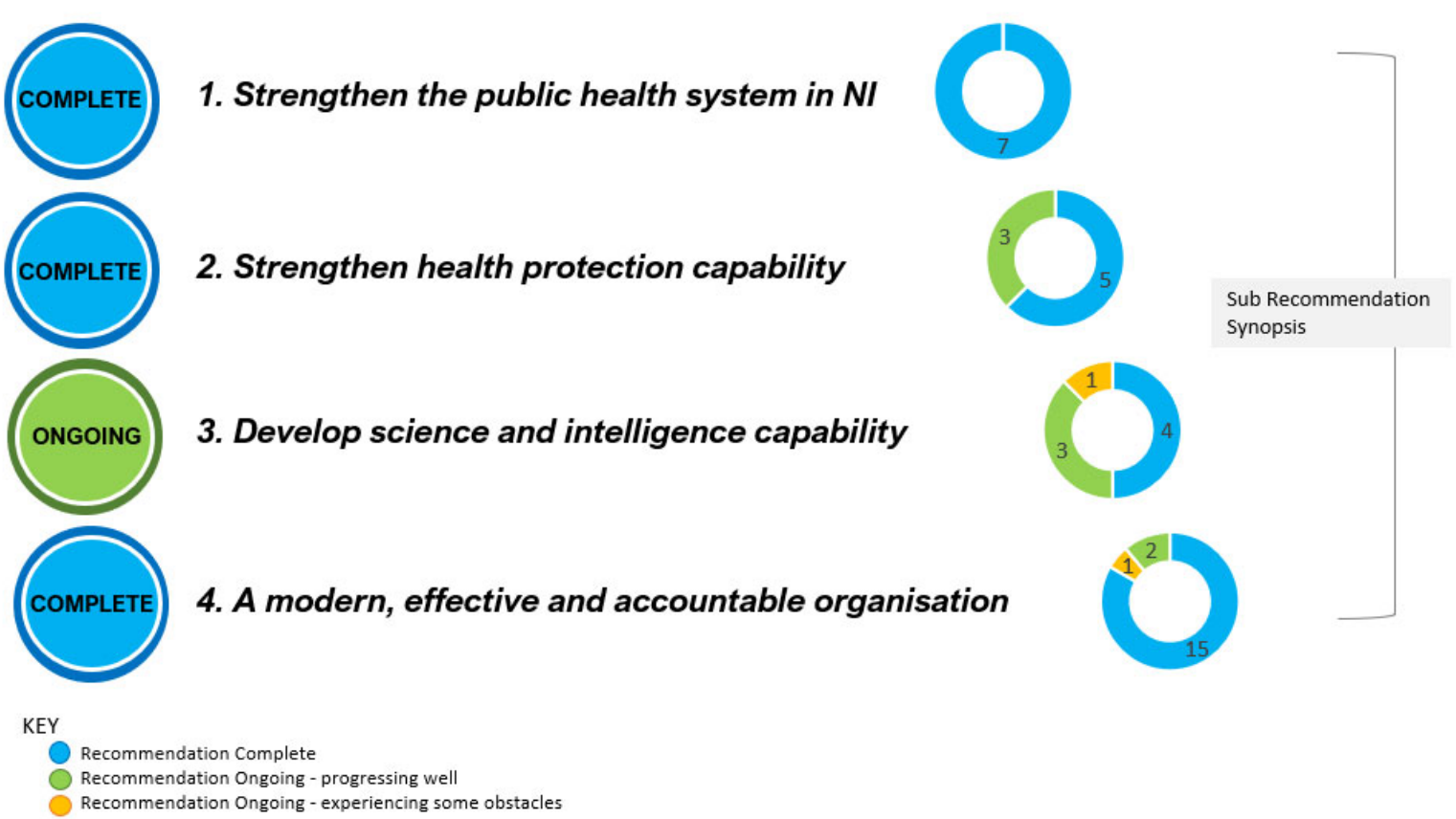
Recommendation 3 - *Develop science and intelligence capability*
- *Eight Sub Recommendations*

Recommendation 4 - *A modern, effective and accountable organisation*
- *Eighteen Sub Recommendations*

The Hussey recommendations formed the basis for the Agency's 2022 Programme of Reshape and Refresh which was facilitated in its initial development and design by EY (consultancy). Reshape and Refresh remains a live programme of work within the Agency, coordinated through a Programme Board led by the PHA Chair and containing representation at both non-executive director and Chief Executive level.

Hussey - Recommendation Progress Synopsis as at 31 May 2025

At the request of the PHA Board, a review exercise has now been undertaken to assess the progress that has been made on each of the 41 Hussey sub recommendations. The outcome of this exercise forms the body of this Report with each sub recommendation set out alongside a formal position and accompany rationale. Based on the outcome of the review, the following overall assessment is now made in relation to the four overarching Hussey Recommendations:



Recommendation 1 - Strengthen the public health system in NI

Sub Recommendation Review

	SUB RECOMMENDATION	STATUS 31 MAY 25	RATIONALE FOR STATUS	FUTURE STATE
1.1	Strengthening of the Agency's capability and clarity about its roles and responsibilities, especially in relation to partner agencies such as health and social care and Local Government.	**COMPLETE**	Functions placement as part of Operating Model has supported the Agency to realign its objectives. JAM re-established to strengthen joint working arrangements with SPPG. External engagement plan ongoing and will operate as part of CEX office business plan and the new public health planning teams. New structures demonstrate public leadership across senior levels with a strong emphasis on both generic and specialist public health functions.	Subsumed into B.A.U
1.2	A strategic plan is needed in order to set priorities and develop organisational capacity and capability. It is recommended that the strategic plan is supported by a three-year investment programme with senior transformational change management support.	**COMPLETE**	The Agency has now launched its five-year Corporate Plan launched 2025. The three-year investment programme referenced in Hussey has been delivered as a means to support the implementation of the Target Operating Model identified.	Closed
1.3	A modern public health system encompasses 10 essential public health services. The PHA should self-assess its capability to deliver these services.	**COMPLETE**	The self-assessment mapping exercise of the 10 essential public health services has been completed as part of Reshape and Refresh programme	Closed
1.4	The Agency should continue to develop academic networks and strengthen all Ireland collaboration.	**COMPLETE**	The Agency continue to encourage and promote academic networks and strengthen all Ireland collaboration. A number of UK wide and all Ireland wide networks in place. Regular meetings are held with the HSE Health Protection Surveillance Centre to share information and take forward projects of joint interest. The DPH is an external member of RoI oversight group for cervical cancer elimination. Collaboration in other areas of work for example traveller health is ongoing. The establishment of a new PHA R&D office has been approved and will further develop the links with academic networks.	Subsumed into B.A.U
1.5	Recruitment of a permanent CEO to lead the development of the Agency for the longer term should	**COMPLETE**	Permanent Chief Executive appointed to role in 2021	Closed

	be commenced now in order to ensure an effective handover.			
1.6	The Agency's strategy should address the following areas: 1. Strengthening health protection capability. 2. Assessing health impacts arising from the pandemic and seeking to address them, drawing on research, intelligence and international evidence. 3. Reactivation of core public health services affected by the pandemic, taking the opportunity to refresh models of delivery where needed. 4. Developing the Organisation.	**COMPLETE**	Corporate Plan 2025-2030 has been approved which sets out the Agency's plan for the coming years. Included in the plan are a range of actions to be taken forward which address the areas identified under 1.6. New Target Operating model is currently being implemented which address the areas outlined, progress against each will be managed through Directorate plans. Examples of progress in implementation detailed against recommendation 2 below. Further work to be undertaken to ensure that all aspects are progressed to an optimum level and this will be addressed over the course of the Corporate plan and reported through the new Performance management Framework.	Subsumed into B.A.U
1.7	Resumption of core public health services as soon as practicable.	**COMPLETE**	Core public health services have resumed, a formal update was provided to PHA Board on the matter in August 2020.	Closed

Recommendation 2 - Strengthen health protection capability

Sub Recommendation Review

	SUB RECOMMENDATION	STATUS 31 MAY 25	RATIONALE FOR STATUS	FUTURE STATE
2.1	Expand the capacity of the specialist health protection team, infection prevention and control capacity and emergency planning functions.	**ONGOING**	There has been an increase in staffing over the past number of years across a number of key functions including: Acute Response Nursing, Bank workforce to support resilience, Health Protection Programme Managers, Emergency Planning and IPC, Designated Responsibility role and Specialty Doctors. This is underpinned by strengthened arrangements for supervision and governance. However, a constraining factor remains the shortage of Public Health consultants being attracted into the functions. Routine review of this function will continue to be taken forward.	Action to be mapped to alternate Plan
2.2	Strengthening of Health Protection management arrangements in line with existing plans, to ensure optimal staff support, whilst enabling leadership development and succession planning.	**COMPLETE**	New Management structure in place (24/25) with further development planned. A new Assistant Director for HP and Surveillance was also appointed during 2025. Tier 4 structures agreed. Nurse Consultant and Senior Nurses also now in post. A new platform of meetings is also in place to strengthen governance and build more effective integration between Health protection and Surveillance teams	Subsumed into B.A.U
2.3	Evaluation of duty room staffing arrangements, from a staff and user perspective to inform ongoing and future needs. There should be clear accountability for quality assurance of processes.	**COMPLETE**	A Health Protection Acute Response Review was undertaken from September 2023-February 2024. The aim of the review was to streamline the existing processes within the Health Protection Acute Response service (Duty Room) to ensure the service is working effectively and efficiently to meet its core objectives and to ensure appropriate oversight and governance arrangements in place. Workstreams and deliverables were identified in a number of areas, with final	Subsumed into B.A.U

			work underway as part of the Duty Room's business as usual.	
2.4	Consideration of how best to sustain and resource a flexible Contract Tracing Service that can scale up capacity during future incidents.	**COMPLETE**	Through the HP Duty Room, the Agency has retained a group of rapid response bank staff that can be relied upon to contact trace if required. This list is supplemented by a wider bank that has been retained following the closure of the regional Contact Tracing Service (CTS). The Agency has also relied upon a model of internal redeployment to bolster capacity which could be relied upon again. Documentation from the CTS has also been retained for future reliance if required. As part of its business as usual work the Agency will need to revisit the legacy of the CTS to ensure that it remains fit for purpose. By way of example, although the CTS bank list is large as time passes individuals may be reluctant to reengage with the Agency. Documents and wider IT systems used for the CTS response may also become reductant through time. A UKHSA proposal for a UK wide CTS is currently under consideration through pandemic planning arrangements. This will require approval and buy in from DoH (NI) if it is to be mainstreamed	Subsumed into B.A.U
2.5	To refresh approaches to prevention of health and care acquired infection and review roles and responsibilities for actions in these settings is needed with sufficient capacity to provide a preventative approach and to service outbreak control teams.	**ONGOING**	Work remains ongoing in the Agency to strengthen regional IPC governance, structures and risk assessment approaches. This is supported by the PHA developed IPC Manual which is available on a regional basis. This recommendation is a large domain and although progressing, it will need to be continued through the Agency's Annual Business Plan and/or Directorate Plans. Further work in this area is required to ensure that the appropriate capability and capacity is available and working effectively across the system.	Action to be mapped to alternate Plan
2.6	Resumption of strategic health protection work and the development of environmental health protection	**COMPLETE**	Health Protection work resumed with a workplan outlined within Annual business plans / Directorate plans. Work relating to environmental health protection has	Subsumed into B.A.U

	work alongside that of infectious disease prevention and management.		commenced and will be taken forward formally through one of the Agency's Public Health Planning Teams as a business as usual task.	
2.7	Strengthening of public health links to microbiology.	**ONGOING**	Trust Microbiology lead working with the PHA 1 day per week. IPC is one of the groups established as part of the AMR action plan. PHA chair this group and there is microbiology representation on the group. This work will remain ongoing via an alternate plan.	Action to be mapped to alternate Plan
2.8	Learning from the pandemic incident response should be captured and used to inform and strengthen EPPR arrangements. This should be documented and codified into a business continuity plan with systematic training and development for the relevant roles. All relevant staff should have a minimum standard level of health protection training and knowledge of systems and processes	**COMPLETE**	The following actions have taken place in respect of this recommendation: • Enhancement of the PHA Emergency Planning Team. • Establishment of PHA SPPG BSO Pandemic Preparedness Task and Finish Group (June 2023) and supporting regional planning structures now in place. • Submission of draft pandemic preparedness plans and options appraisals to DoH (October 2024). Submission included options appraisal (including costs) for surge capacity for contact tracing. Development and implementation of PHA Incident Response Plan (May 2023) with supporting training and exercise programme for Health Protection staff. A mandatory e-learning training programme for all PHA staff and delivery of generic emergency preparedness training programme to all PHA staff is now being progressed as a business as usual task. A bespoke PHA Public Health training programme is also now a mandatory training requirement for staff.	Subsumed into B.A.U

Recommendation 3 - Develop science and intelligence capability

Sub Recommendation Review

	SUB RECOMMENDATION	STATUS 31 MAY 25	RATIONALE FOR STATUS	FUTURE STATE
3.1	The PHA should develop a strategic ambition, and plan to be, an evidence and data driven organisation to inform policy and practice	**COMPLETE**	The PHA Corporate plan 2025/30 has embraced a commitment to be evidence informed and data driven across its delivery programme. The PHA Digital and Data draft plan has been developed and will be taken forward under the direction of a new Director of Population Data and Intelligence once in post under business as usual.	Subsumed into B.A.U
3.2	The PHA should develop analytical capacity and invest in skills such as behaviour change, data science, modelling and health economics.	**ONGOING**	The Agency has invested significantly in skills relating to data science and modelling. Behaviour change has been considered as part of operating model design moving forward. Health Economics can draw on skills available from DoH, DoF and University partners until a dedicated function can be resourced.	Action to be mapped to alternate Plan
3.3	PHA analytical skills should be brought into one team to enhance the overarching capability of the function. A Chief Information Officer should be appointed to lead the function with alignment to the proposed Director - Research & Intelligence.	**ONGOING**	Subsequent to this recommendation a Directorate for Population Data & Intelligence has been agreed. Once this position is in place, a review of analytical functions across the organisation will be undertaken with a view of aligning resources.	Action to be mapped to alternate Plan
3.4	The PHA should invest in digitising its collection, storage and processing methods. An emphasis should be on real time data collection and analysis. Data flows should be reviewed.	**COMPLETE**	Work relating to real time data flows has made considerable progress and has moved into business as usual as a means to further refine. The PHA has invested in digitising collection, storage and processing methods this will continue to be developed as a business as usual function in conjunction with DoH.	Subsumed into B.A.U
3.5	Reporting of data should be reviewed against 'best in class' and with user feedback to ensure that products and publications are achieving maximum impact on public health outcomes	**COMPLETE**	This recommendation has moved on from Hussey. Reviews of data against best in class has been undertaken in a variety of areas across the Agency. Example of good practice includes publication of Health Protection weekly Situational surveillance report. This platform of work will be streamlined using a co-ordinated approach through the Public Health Planning teams.	Subsumed into B.A.U

3.6	The PHA should consider how best to develop an open data approach to its work and review its publication scheme to support openness and transparency.	**ONGOING**	Developing an open data approach is the subject of a wide range of activities across the Agency. This will be streamlined using a co-ordinated approach through planning teams and new Population data and intelligence Directorate.	Action to be mapped to alternate Plan
3.7	Some data sets are held by BSO the PHA should review access arrangements to these essential data sources as well as ensure all personal data in the PHA is held securely.	**COMPLETE**	This exercise is complete: Data Agreements and MOU's are in place between the Agency and the BSO - this space remains under live review with data managed in accordance with Agency IG processes.	Subsumed into B.A.U
3.8	Northern Ireland public health research network already exists and PHA staff should be enabled to participate fully in such work	**ONGOING**	HSC R&D are an integral part of the Agency. All information relating to work is shared through internal networks, A bid has been submitted which will financially support the development of a R&D office within the PHA. Further enhancements will be taken forward through BAU.	Action to be mapped to alternate Plan

Recommendation 4 - *A modern, effective and accountable organisation*
Sub Recommendation Review

	SUB RECOMMENDATION	STATUS 31 MAY 25	RATIONALE FOR STATUS	FUTURE STATE
4.1	The whole organisation undertakes a 'lessons learnt' pandemic debriefing exercise as soon as practicable to capture the experiences and learning in real time.	**COMPLETE**	A debrief exercise was conducted in conjunction with the HSC Leadership Centre in 2023/24. The outcome was however affected by low attendance and the events taking place sometime after the pandemic had subsided. A number of localised 'hot' and 'cold' debriefs also took place. Pandemic learning has been a focal point of each teams planning across recent years and the outworkings of the Covid Inquiry will provide a further means to identify and embed learning.	Closed
4.2	An organisational development plan should be activated as soon as possible. The second cultural assessment survey (Dec 2020) should be used as a platform to drive change.	**COMPLETE**	People Plan launched in 2024 supported by the establishment of an Organisational Development Engagement Forum which focuses on staff experience, culture and workforce development. This platform of work was built upon the outcomes of the baseline transformation survey.	Closed
4.3	The DPH role spans 2/3rds of the budget of the PHA and acts as Medical Director in the HSCB. This is a very wide role for one person and should be reconsidered.	**COMPLETE**	HSCB no longer exists. The budget and staffing complement for the DPH role has been taken into consideration during the design of the new structures with view to supporting a balance across Directorates as far as possible.	Closed
4.4	The directorates should be arranged around the key functions to be delivered. Accountability should align with strategic objectives, with more visibility of health protection at Board level	**COMPLETE**	This work was completed during the EY Review and has been taken into consideration when developing governance model for the operationalisation of Public Health Planning Teams. All Directorates have been aligned to core functions of the Agency.	Closed
4.5	There should be three deputies to the DPH - leading the respective functions of: Health protection director, Health improvement director, Health research & intelligence director	**COMPLETE**	Three deputy Directors of Public Health are in post covering health protection, screening and surveillance and epidemiology. These were identified as priority areas.	Closed
4.6	There are a number of hosted functions within the PHA which should be reviewed in due course to ensure they align with the Agency's core purposes.	**COMPLETE**	Hosted functions were reviewed during EY review. HSCQI was transferred to RQIA to better align with their improvement function. Discussions are ongoing re transfer of connected health to DCNI.	Closed

			MOU to support hosting arrangement with SBNI has been reviewed.	
4.7	The PHA should update its workforce plan so that it is aligned to its strategy. The plan should cover the development of current staff, include an ambition to be a learning organisation, address silo working and encourage the use of mentoring and coaching.	**COMPLETE**	A skills development plan has been introduced which supports the operationalisation of the People Plan.	Closed
4.8	The current public health training programme is recruiting and the PHA should seek funding for a one-off increase in multidisciplinary recruits as well as develop a longer-term plan for future numbers of specialist staff needed to be sustainable.	**COMPLETE**	The Agency have expanded number of trainees. Public Health skills profile has been developed as part of the skills development framework this will support the longer-term plan for increase number of trained public health specialists and a co-ordinated approach to increasing capacity.	Subsumed into B.A.U
4.9	The epidemiology Fellows scheme should continue to be supported.	**COMPLETE**	The agency continues to participate in the Field Epidemiology Training Programme (FETP) and is a training location. Four graduates from the programme are currently working in the PHA using the skills they gained as part of the programme.	Closed
4.10	The training programmes should seek to maximise placement opportunities within and outside NI to ensure public health registrars are exposed to a wide range of approaches and areas of practice that may not be available in house	**COMPLETE**	The Agency continues to promote placement opportunities within and outside NI. A number of staff have availed of placements in UKHSA. Trainees spend time in a range of locations in Northern Ireland including DoH, the Institute of Public Health and Queen's University.	Closed
4.11	More should be done to enhance links with Universities. Similarly, joint appointments with other public health agencies would foster collaboration and make best use of scarce resources.	**COMPLETE**	Agency has links with universities. Joint appointments with QUB are in place which foster collaboration in these areas.	Closed
4.12	The communications function should be supported and enhanced. The appointment of a Director of Communications and Engagement would provide the leadership needed to develop this capability	**ONGOING**	The communications function has been absorbed into Chief Executive Office and planning for modernisation /growth is ongoing. This work will be managed in an alternate plan.	Action to be mapped to alternate Plan
4.13	More use should be made of digital communication and behaviour change expertise. The website requires an upgrade to be more 'user accessible'.	**COMPLETE**	Proposed structure for communications team include digital & behaviour change expertise to complement a new central resource operating across the agency. Links established with PHW	Subsumed into B.A.U

			behaviour change unit to draw in learning to PHA programmes. Upgrades to PHA website were undertaken following the Hussey Review and plans are now being implemented for a full rebuild of the site.	
4.14	The Director of Operations role should be replaced to encompass strategic and operational functions and support the CEO in the daily running of the business. Project management and business support roles should be reviewed to ensure sufficient capacity and focus on programme delivery. The high level of temporary posts should be reviewed to ensure retention of necessary skills	**COMPLETE**	The design of the new operating model identified Director of Finance & Corporate Services, which subsumed a large proportion of Operations role. In addition, a Chief Executive office was established which subsumed the communications function. Temporary posts have been reduced.	Closed
4.15	The IT and HR functions should be enhanced to support efficient and timely recruitment as well as an upgrade of IT functionality.	**COMPLETE**	HR Business partner is in place to support Agency. Revised SLAs in place to support IT functionality.	Closed
4.16	A stakeholder survey should be undertaken to identify areas of strength and areas for improvement	**COMPLETE**	Stakeholder survey undertaken in the context of the Corporate plan development. New stakeholder engagement plan is in development in conjunction with PHA chair to accompany the finalised Corporate plan and actions being taken forward through business as usual.	Subsumed into B.A.U.
4.17	Whilst there is local engagement for health improvement activity in community planning, it should also be strengthened for health protection as well as for involvement in Integrated Care Partnerships, and including primary care	**ONGOING**	Further embedding of Health Improvement colleagues in membership of Health protection planning teams has been taken forward including for example, Immunisation and vaccination programme, Screening programme and Sexual Health planning team. New MDT strategic planning teams will further develop the co-location and integrated approach as and when they are fully established. The PHA Live Better initiative focuses on closer working across community sector and primary care partners in particular. Strategic planning teams will contribute to the agenda of the AIPBs going forward.	Action to be mapped to alternate Plan
4.18	The working environment needs improvement. An estates plan is underway and this should be underpinned with a strategic approach to future working methods. A survey of how people want to	**ONGOING**	Hybrid working evaluation complete with resources provided for staff. Resourcing required to enable the upgrading of the working environment and this is outwith the control of PHA. SPPG taking forward for the development of a facilities plan.	Action to be mapped to alternate Plan

	adapt their working arrangements after Covid-19 should inform decisions.			

Appendix 1 - Hussey Review 2020

NI Report FINAL - Ruth Hussey Jan 202

Rapid, focused external review of the Public Health Agency (PHA) for Northern Ireland's resource requirements to respond to the COVID-19 Pandemic over the next 18 - 24 months

Dr R Hussey CB, OBE, DL

Dec 2020

Acknowledgements

I am grateful for the support provided by the PHA to conduct the review in a short time frame. Staff and stakeholders gave freely of their time. I am particularly indebted to Libby Jones and Christine Thompson for administrative support and to Dr Paul Mc Gurnaghan for the comparison of Public Health Agencies.
Olive MacLeod, Hugo Van Woerden and Stephen Bergin provided valuable advice and support.

Context

The SARS-CoV-2 pandemic has impacted global society both in terms of the direct disease but also the social and economic consequences. There will be much for Governments and Public Health bodies to reflect on as the pandemic recedes. For now, the pandemic continues and sustaining an effective response whilst preparing for the post pandemic phase is crucial.

This rapid review arose from a desire to plan for the next phase, informed by the events of 2020, with the aim of securing a sustainable and strengthened Public Health function in Northern Ireland (NI).

The Terms of Reference of the review are at appendix A. Specifically, I was asked to provide a concise report to identify the short term (18-24 months) actions necessary to respond to the Covid-19 pandemic.

Background

The PHA in NI was established in 2009 under section 12 (1) of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

As stated in the Management Statement – *"The overall aim of 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:*

1 *securing the provision of and 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,*
2 ***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*
3 *providing professional input to the* ***commissioning of health and social care services which meet established quality standards and which support innovation.***

The PHA also has a general responsibility for promoting improved partnership working with local government and other public sector organisations to bring about real improvements in public health and social well-being on the ground and anticipating the new opportunities offered by community planning."

This rapid review is set in the context of the scope of responsibility of the PHA and consideration of the response to the Covid -19 pandemic so far.

During the rapid review, conducted between mid-November and mid-December 2020, I interviewed a wide range of staff and stakeholders. In total I conducted 25 staff, individual or group, interviews including Board members and Directors and I undertook 12 external, individual or group, stakeholder interviews. In addition, I contacted senior public health officials in other United Kingdom (UK) / Republic of Ireland (RoI) Public Health organisations. In total, I spoke with around 50 people. All interviews were conducted by Zoom or telephone.

In addition, I reviewed PHA reports and drew from comparisons with Public Health Agencies across the UK and RoI, completed as a desk top exercise by Dr Paul Mc Gurnaghan, Registrar in Public Health.

The aim was not to conduct a detailed review of pandemic management but to use the experience gained during 2020 to inform future plans.

Findings

As the Regional Public Health organisation, the PHA has mounted an unprecedented health protection response in support of the direction set by the Northern Ireland Executive to manage the pandemic. The agency provided a range of services, including specialist public health advice, data and epidemiology, public information and established a new Contact Tracing Service.

So far in the pandemic, Northern Ireland has the lowest death rate of the four UK countries, at 59.6 per 100,000 population for deaths within 28 days of a positive test (Table 1) and also where Covid-19 is mentioned on the death certificate as one of the causes of death.

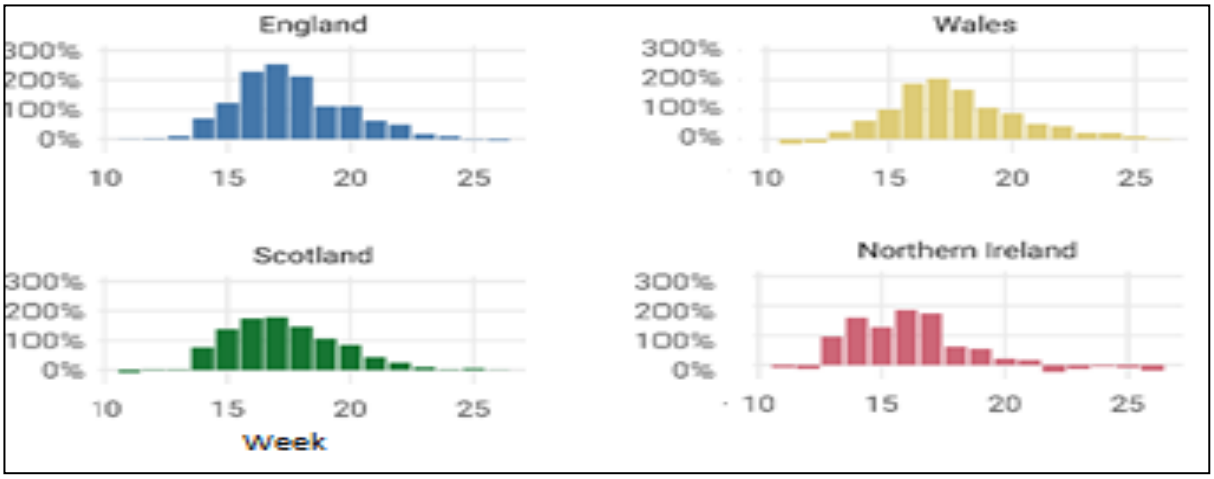
Table 1: Cumulative deaths within 28 days of a positive test, for the four UK countries per 100,000 population, to 14 December 2020

Country	Rate per 100,000 population
Wales	91.4
Scotland	75.2
Northern Ireland	59.6
England	100

Source: Deaths in the United Kingdom.
https://coronavirus.data.gov.uk/details/deaths

It was reported that Northern Ireland made a concerted effort to reduce Covid-19 care home deaths. When the rise in care home deaths was first identified, staff described how the PHA worked intensively with the care home sector on a wide range of measures to contain the spread of the virus and prepare care homes. Research shows that after week 17 there was a notable fall in death rates in Northern Ireland, which coincided with strong collective leadership efforts to protect the care home sector co-ordinated by the PHA (Figure 1).

Figure 1: Death Rates for England, Wales, Scotland and Northern Ireland during the first wave of the pandemic.



Source: Bell D, Comas-Herrera A, Henderson D, Jones S, Lemmon E, Moro M, Murphy S, O'Reilly D and Patrignani P (2020) COVID-19 mortality and long-term care: a UK comparison. Article in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, August 2020.

Additionally, Northern Ireland was the first of the UK nations to develop and put into operation a new Contact Tracing Service after wave one. An IT support system was designed from scratch, and Northern Ireland was also the first country in the UK to have a functioning proximity app.

The PHA has expanded the Contact Tracing Service at a rapid pace over the last four months, almost doubling the workforce, in terms of headcount.

Although vaccination against Covid -19 started in Dec 2020, the PHA will continue to be in incident response for many months to come and will have a role in the recovery phase as the wider impacts of the disease on health and wellbeing emerge.

The PHA has had temporary leadership arrangements for some years. A new interim CEO and a new Director of Public Health came into post as the first wave of the pandemic took hold. They faced a substantial challenge to pick up the reins of the organisation at such a crucial time and when the organisation had to embrace remote working at speed whilst mounting an effective response. There were vacancies in senior posts and a number of temporary appointments. For example, the Health Improvement function had 46% of its staff in temporary posts, as a result of delays to approval mechanisms at regional level.

The pandemic response has involved mobilising all staff in the health protection function as well as drawing on staff from across the agency to provide surge capacity. This has involved staff working well outside their comfort zone to help the response to the pandemic.

Staff were pleased with many aspects of their response, describing it as a supportive team in health protection. Others reported having been able to develop new data analyses and learning new methods 'on the job' had been pleasing.

Staff felt that they had done their best in the circumstances and were proud of many achievements. Examples cited included the education cell to support schools, data and professional support for care home outbreak management, testing co-ordination, contact tracing, communications and the work on case definition for children. Staff stepped up to help from across the organisation, though some said they didn't immediately feel welcomed. Training was necessary to work in the Duty Room and this added to the pressure, even if it ultimately helped provide support. Many described individual staff as 'very able'. The PHA employed a significant number of locum junior doctors to increase the capacity of the Duty Room, which helped to manage the rapidly expanding workload.

However, it is evident that the prolonged incident has put substantial strain on many of the staff involved. This effort has come at the expense of personal and family time with the added impact of new ways of remote working, adopted at pace. Some have found home working acceptable and effective, though IT support was critical to this.

Staff spoke of working 7 days a week for months during the first wave, with no let up. Public Health Registrars were at the front line of response in the Emergency Operations Centre for much of the early weeks in Feb – March 2020. They describe feeling under supported and overwhelmed with demand. Others also described the demands as being unmanageable and therefore giving rise to tensions and frustrations for both stakeholders and the service when the expectations were not met. Some staff are tired, frustrated, and anxious about blame. At times staff felt undermined when their professional advice was questioned by key stakeholders. Stakeholders understand the pressure but expected a more pro-active response to their needs – there was reported to be a strain, at times, in the relationship with some external stakeholders.

The most consistent, and widely mentioned, term used to describe working practices in the PHA was 'silo working', although some staff have felt that Covid-19 has had the converse effect and helped to reduce the silos. Staff from all parts of the organisation wanted more 'joined up effort' with better use of skills. In particular, staff felt there could be more use of project management support.

More generally, strategic planning was needed both in the pandemic response (which was described as reactive not proactive) but also in the PHA as a whole. Work was undertaken early in the pandemic, through a series of workshops, to develop multidisciplinary, multi-agency 'cells' to support more effective horizontal working. These cells operated across the PHA/HSCB under the SILVER tier of the national emergency response and were recognised as making a beneficial impact. A Business Continuity Plan was also rapidly developed and has been reviewed regularly by the senior management team. Work to produce a strategic plan is underway though not all staff were aware of this.

Feedback on service areas

The next section summarises some of the issues reported by participants in response to the specific areas of the terms of reference.

Health Protection Service and Emergency Preparedness

There was consistent reporting that the health protection service was under resourced to sustain the emergency response in the duty room; in providing specialist advice; and for emergency planning and response.

Specific points raised:

- Whole organisation surge capacity was not historically planned and trained for
- Overstretched staffing and insufficient training budget in Emergency Prevention, Preparedness, and Response (EPPR)
- Insufficient capacity to manage NHS / Care home outbreaks
- Duty room model changed – needs evaluating
- Strategic work paused
- Staff need a recovery period – 'no time for leave as no-one else to do the role'
- Lessons learnt so far not yet undertaken – no time to reflect
- Stretched business management / project management support– staff working below skill level
- Limited capacity to keep documentation and standard operating procedures up to date
- Limited supervision and support of Registrars
- Many temporary appointments – 'takes time to train them'
- IT inadequate – hardware and software, phones and internet crashing
- Working environment poor (Under discussion with landlord for some time)

➢ **Infection Prevention and Control**

- Capacity severely overstretched
- Pressure to service all Outbreak Control Teams
- Need access to sufficient genome sequencing and epidemiology to investigate nosocomial spread
- Roles and responsibility blurred between respective agencies (RQIA/HSCB/Trusts) especially for care homes
- Limited cross-divisional working/ support for professionals without relevant health protection qualifications
- Working environment poor – IT and accommodation

➢ **Contact Tracing Service (CTS)**

- Initial service extremely stretched by demand
- Insufficient project management in initial phases
- Pleased been able to get new CTS up and running quickly
- New IT system established at pace
- Links between Health Protection Service and CTS unclear initially but improving

- Strengthened leadership in place and business case for sustainable resource developed
- Need to further evaluate the model for CTS

The effective use of evidence, health information, epidemiology and research

The need for *timely* surveillance and epidemiology data to support decision making has far exceeded capacity. The response has also required rapid *new* surveillance analyses. Other essential surveillance schemes will have been impacted, having diverted all available resource to Covid -19. This risks missing other infectious disease outbreaks or changes to the incidence of other important infections. Staff recruitment was attempted with limited success, due to a lack of sultably qualified staff existing in Northern Ireland. A range of extenal staff were brought in to provide support including around six academic staff and two veterinary epidemiologists.

Specific points raised:

- Epidemiology and surveillance team overwhelmed with multiple demands and criticised / challenged
- Some of the skills and software needed for analysis were not available
- IT equipment inadequate e.g. 2 hour run times for analyses
- Analysts spread across the organisation with different priorities
- Short term funding for posts e.g. Antimicrobial Resistance
- Limited modelling skills available in PHA (despite some academic supplementation)
- Research was commissioned in support of the clinical and public health response (behaviour change advisory group established)
- Unclear publication policy and approach to open data
- Opportunity to further develop data science and modern data approaches
- General lack of awareness of plans to develop science and evidence capability – does not drive the work of the organisation
- PHA does not have direct access to the data in record linkage system and access to primary care data needs to be improved
- Reports could be more tailored to the audience and their desired impact

Communications including social media and online communication to enhance public messaging

There was general support for the way communications had been managed both with the public and professionals.

Specific points raised:

- Generally, thought to be a good response though severely over stretched

- Good collaboration with Department of Health
- Mainstream media expectations substantial
- Relied heavily on a few individuals as spokespeople
- Social media methods used but could do more segmentation and behaviour change work
- Website not easy to navigate – not 'click through' nor up to date
- Could have anticipated what information different sectors needed and made them accessible for direct access or download – some felt they were answering the same questions repeatedly
- Good engagement with voluntary sector – desire to build new relationships post pandemic and focus on community assets
- Public and professional awareness of PHA has increased significantly during the pandemic and this should be built upon.

Ensuring a strong and vibrant professional public health community in Northern Ireland.

The health protection service has been under strength for some time and is currently supported by a number of locum consultant posts. A minimum number of consultant posts is needed to deliver a 24/7 service and therefore more staffing pro rata is needed for a smaller population. The Faculty of Public Health has recently made a case for 30 consultants per million population. Northern Ireland currently stands at an estimated 15.3 consultants per million, whereas similar public health agencies such as Wales and Scotland stand at 24.8 and 22.7 respectively. This suggests that NI is under resourced at present and some way from the Faculty's future staffing goal.

Specific points raised:

- Many temporary posts
- Opportunity to strengthen multidisciplinary public health skills
- Limited succession planning
- Limited academic links
- Silo working between some professional groups
- Specialised functions with result that drawing in more skills for the surge response was difficult
- Working below skill level due to lack of support staff
- Training & career development needed
- Public Health training impacted by supporting the service response
- Masters programme for public health affected by availability of staff in PHA
- Good operational / individual links across UK agencies and some developing ones with RoI
- Some strategic development and training links outside NI

General comments

- **Context**

A comparison of the 5 agencies in UK and ROI showed that, up to 2020, all had responsibility for the 3 elements of public health (health protection, health improvement and service development). The creation of the National Institute of Health Protection (NIHP) in England will change the system but is still in development. Public Health England has an UK wide remit and it will be important for NI to clarify how the new arrangements in NIHP will continue to provide specialist support for NI.

The governance arrangements differ in each country but Public Health Scotland and Public Health Wales are similar to PHA NI.

Funding is not easily compared as each agency has a different mix of services and hosted functions. However, as stated earlier, it is clear that PHA NI has the lowest specialist public health staffing rate per million population in the UK. (A more detailed paper has been developed by Paul McGurnaghan and a summary page is included at Appendix B)

Organisational issues

Many of the points raised on the specific areas of the terms of reference have implications for the whole organisation.

- **Strategy** – Interviewees were keen to have a shared vision for the organisation and a clear strategic direction. Some raised concern that the PHA would become focused solely on health protection in future. There was a recognition that data and evidence are crucial to public health practice and that further strengthening of the strategic approach is needed to develop effective use of data science.

- **Governance** – issues raised with regard to governance included:

- It was suggested that the structure of the organisation might better follow key functions and thereby align to strategy
- Information governance - needed to review systems, especially in light of new data collection systems and need for data sharing.
- Multiple Freedom of Information requests – opportunity to further strengthen publication policy and management of FOIs
- The business continuity plan was insufficient for the pandemic response, given the substantial nature of the pandemic
- The agency has a range of ‘hosted services’ – respondents wanted clarity about the interface with such services, for example, related to child protection
- It was not evident that a stakeholder survey had been undertaken in recent times to inform partnership working

- The Board is undertaking development work in line with the new handbook on Arms-Length Bodies. The role of the Board during a prolonged Civil Contingencies emergency incident merits exploration.
- There was a desire to have more outcome / impact focus to Board reports and stronger performance monitoring against an agreed strategy

➢ **Workforce -** Many of the issues raised with regard to specific services were in relation to workforce.

Specific points raised:

- It was reported that the PHA has an out of date workforce plan
- Substantial concern was expressed about staff wellbeing in an overstretched system
- It was felt that the agency needed more HR support to recruit staff in a timely way
- A cultural assessment survey, reported in Feb 2020 showed the PHA to be mid-range on most scores but with lower scores on 'Vision, Quality and Innovation'
- A new survey will be completed in Dec 2020
- An organisational development plan was produced in early 2020 but not progressed because of the pandemic. Many of the areas identified for development work have been magnified negatively during the pandemic response.
- There is an appetite for leadership development at all levels and a recognition that there is a need for more succession planning
- Specific skills gaps were noted such as behavioural science (for which a business case has been developed), health economics, data science
- There is a need for more project management capacity to support delivery
- Public Health training has been disrupted because of the pandemic
- Staff across the agency wanted the opportunity to develop their skills
- It was reported that more in-house IT support was needed as well as up to date IT systems.
- Office accommodation was described as unsuitable and overcrowded
- Remote working had been established quickly and some would like it retained

➢ **External partnerships**

There was consistent evidence that there had been good collaboration with other Public Heath institutions, both before and during the pandemic, especially at individual and operational service levels. Strategic links had fallen back a little because of the pressure of the pandemic.

The interrelationship with the Health and Social Care Board (HSCB) ensures that public health is able to contribute to improving population health outcomes through health needs assessment and service planning. This is valued by the health and care system. The proposed changes to the HSCB, provide an opportunity to re-think

how public health inputs to community planning, integrated care partnerships and any future commissioning arrangements.

Despite the strain on the whole system, the NHS felt supported by the PHA. Information had been accessible and there was good communication with professionals. Also recognised that there was much to learn and incorporate into future plans e.g. roles and responsibility in regard to care homes, rapid communication of guidance, emergency plans etc. Specific, practical, issues also merited reflection such as staff needing Fit test assessments for different masks and ways this could be streamlined in future.

Local Authorities valued the work of the PHA. Outside the pandemic, there was joint working at local level on health improvement but less so on health protection. Relationships at a strategic level had been less actively managed by the PHA in recent years.

During the pandemic response, public health input at incident meetings was essential. More could be done to provide tailored public health support to LAs especially when guidance changes. LAs have a role in the recovery phase and early engagement to consider wider health impacts would be valuable.

The Department of Health is the strategic sponsor of the PHA. There is regular interaction between staff in both organisations and regular high-level monitoring. During the height of the pandemic there was a mismatch in expectation and available resource to deliver, which at times led to strain.

The Voluntary and Community sector supported the pandemic response in several ways such as when the contact tracing app was being developed and at community support level. The importance of using the experience of public involvement and connecting with community assets was emphasised. (The PHA provides regional leadership for PPI across Northern Ireland via the Nursing Directorate).

The academic sector was able to mobilise staff with specific skills to support the pandemic response. It was noted that more could be done to support staff development such as joint appointments and research development.

Conclusions and recommendations

The PHA has been subject to temporary leadership arrangements for some years and this, along with resource constraints, has slowed the development of the organisation. Covid-19 has challenged the health and care system and affected the whole PHA. There is an opportunity now to learn from the experience and design a public health system able to respond to future health threats. Although the Terms of Reference for this rapid review were focussed on the immediate challenge of Covid-19, it is apparent that action is needed at a number of levels to address the longer-term strategic challenges faced by the organisation.

Recommendation 1

Strengthen the public health system in NI

1.1 The PHA has a broad remit to promote and protect the health of the public – this should continue with a strengthening of the agency's capability and clarity about its roles and responsibilities, especially in relation to partner agencies such as health and social care and Local Government. The planned changes to the Health and Social Care Commissioning Board provide an opportunity to create a stand-alone, independent PHA, focussed on protecting and improving the public's health and wellbeing, and which continues to provide an effective population health input into service development and quality improvement.

1.2 The PHA should aim to be a modern, effective Public Health organisation. In order to do this, it must set out a clear vision and ambitious strategic direction in collaboration with the DoH. **A strategic plan is needed in order to set priorities and develop organisational capacity and capability.** It is recommended that the strategic plan is supported by a three-year investment programme with senior transformational change management support.

1.3 A modern public health system encompasses 10 essential public health services (appendix C). The PHA should self-assess its capability to deliver these services. The International Association of National Public Health Institutes has a range of tools and resources that could help to guide development as well as a peer support network. It is important that the Agency looks ahead to plan for global health challenges. For example, further pandemics, impact of climate change, antimicrobial resistance and delivering the UN Sustainable Development Goals. These issues should be set in the context of delivering the Northern Ireland Executive's ambitions for health and wellbeing.

1.4 It is unlikely that the Agency will be able to access all the necessary skills and should therefore seek to strengthen strategic and operational networks with the relevant UK agencies, in line with existing Memoranda of Understanding. It should continue to develop academic networks and strengthen all Ireland collaboration.

1.5 The interim CEO has been able to steer the Agency through the pandemic response but has made it clear that the interim role will come to an end in mid 2021. However, the transformation programme will require sustained leadership and

therefore the recruitment of a permanent CEO to lead the development of the agency for the longer term should be commenced now in order to ensure an effective handover.

The incoming CEO should have substantial strategic transformational skills, be an outstanding communicator and have a clear understanding and commitment to protecting and improving the public's health.

1.6 In the context of the pandemic and its aftermath, the Agency's strategy should address the following areas:

1 Strengthen health protection capability.
2 Assess health impacts arising from the pandemic and seek to address them, drawing on research, intelligence and international evidence.
3 Reactivate core public health services affected by the pandemic, taking the opportunity to refresh models of delivery where needed.
4 Develop the Organisation.

The wider health inequality impacts of the pandemic will require a range of policy and service responses over the short and medium term. There is also a requirement to restart core public health services as soon as practicable. These areas are not within the scope of this report but are, nevertheless, an important part of pandemic response and recovery.

There is a need to act now to improve specific functions. The rest of the report will focus on this and the 4th objective of organisational development.

Recommendation 2

Strengthen health protection capability

2.1 There is an urgent need to expand the current capacity of the specialist health protection team, infection prevention and control capacity and emergency planning functions. A business case has been prepared for consideration and this should be negotiated and implemented as soon as possible in order to ensure a sustainable service and allow staff time to reflect and refresh following a prolonged period in incident response.

2.2 The Associate Head of Health Protection has a large number of direct reports. Additional staffing will add managerial workload. Management arrangements could be strengthened, in line with existing plans, to ensure optimal staff support, whilst enabling leadership development and succession planning.

2.3 The duty room staffing arrangements have been adapted during the pandemic. These should be evaluated from a staff and user perspective to inform ongoing and future needs. There should be clear accountability for quality assurance of processes and advice. The education cell provided an effective model of support for the sector. The model could be replicated to provide tailored advice and support for other key sectors.

2.4 The Contract Tracing Service will need to be sustained for months to come. Leadership and accountability for the service is in place. Consideration of how best to sustain a flexible response is needed and confirmation of the appropriate resources. Further evaluation of the current system will enable strategic consideration of requirements for ongoing contact tracing systems and how to scale up capacity in future incidents.

2.5 Lessons learnt from the spread of Covid-19 in health and care settings should inform a refresh of approaches to prevention of health and care acquired infection. Review of roles and responsibility for action in these settings is needed with sufficient capacity to provide a preventative approach and to service outbreak control teams.

2.6 The sustained operational incident response has led to deferment of strategic work. Steps should be taken to re-start strategic health protection work as the pandemic response allows. Job roles may need to be reviewed to consider the balance of operational and strategic work in a future prolonged incident. Environmental health protection should continue to be developed along-side infectious disease prevention and management.

2.7 Modern public health practice relies, increasingly, on genome sequencing to enable tracking of spread in time and space. The HSCB should strengthen capacity and capability for genome sequencing and ensure it is strongly linked to health protection activity. Strengthened public health links to microbiology services are needed.

2.8 Learning from the pandemic incident response should be captured and used to inform and strengthen EPPR arrangements. Surge capacity was provided from across the organisation. This should be documented and codified into a business continuity plan with systematic training and development for the relevant roles. All relevant staff should have a minimum standard level of health protection training and knowledge of systems and processes.

2.9 IT systems and accommodation require attention and will be covered in the general section later.

Recommendation 3

Develop science and intelligence capability

Evidence and data are the ‘life blood’ of public health practice. The PHA should be a leader in developing and using science and intelligence to inform its work. Modern public health practice requires access to a broad base of sciences, such as epidemiology, microbiology, behavioural, economic and data sciences to name a few.

Data sources should include quantitative and qualitative methods. New methods of analysis should be developed as well as using record linkage opportunities. Digital

Health and Care Northern Ireland has an ambitious programme to enhance digital systems and PHA should ensure that it participates fully in exploiting the opportunities of this work. There should be a focus on 'horizon scanning' to anticipate future health trends and active participation in research & development.

3.1 The PHA should develop a strategic ambition, and plan to be, an evidence and data driven organisation to inform policy and practice. A science advisory board would help to bring a range of inputs to developing the strategy.

3. 2 In order to deliver such an ambition, there is an immediate need to develop analytical capacity and invest in skills such as behaviour change, data science, modelling and health economics.

3.3 The PHA already has a range of analytical skills and these should be brought into one team to enhance the overarching capability of the function. This will require strong leadership and a Chief Information Officer should be appointed to lead the function with alignment to the proposed Director - Research & Intelligence (see later 4.8).

3.4 The PHA should invest in digitising its collection, storage and processing methods. The emphasis should be on real time data collection and analysis. Data flows should be reviewed. For example, there was reported to be limited access to primary care data. The epidemiological surveillance function is an important asset which needs development.

3.5 Reporting of data should be reviewed against 'best in class' and with user feedback to ensure that products and publications are achieving maximum impact on public health outcomes.

3.6 The UK government has a new digital strategy with an ambitious goal to *encourage innovative uses of data by making it easier where possible to access and use data held by both government and businesses, within new legal frameworks and to ensure data is used to its maximum potential within government to provide more efficient and responsive public services*. The PHA should consider how best to develop an open data approach to its work and review its publication scheme to support openness and transparency.

3.7 Information governance is crucial to ensure high standards of data storage and usage. Some data sets are held by the Business Support Organisation and PHA should review access arrangements to these essential data sources as well as ensure all personal data in the PHA are held securely.

3.8 There is scope for the PHA to be a more research active organisation, both in identifying research questions and encouraging staff to engage in active research. A Northern Ireland public health research network already exists and staff should be enabled to participate fully in such work. Existing proposals for a Public Health R&D Director should be accelerated in line with para 4.8

3.9 At a basic level, analytical staff need higher computing power to do their work – this is covered in a later section.

Recommendation 4

A modern, effective and accountable organisation

4.1 The PHA has a substantial opportunity to learn from the pandemic as a whole organisation. No part of the organisation was untouched by the experience. It is important that the whole organisation undertakes a 'lessons learnt' debriefing exercise as soon as practicable to capture the experiences and learning in real time.

4.2 As part of its strategy to protect and improve the health and wellbeing of the population of Northern Ireland the PHA should optimise the use of scarce skills and resources and aim to create the best working environment.

There is much to be done to maintain the Covid-19 response and recover from the prolonged incident.

In terms of Organisational Development (OD), the areas that need early attention are:

- Culture
- Accountability
- Capacity and capability
- Working environment
- External relationships

- **Culture**

4.3 The health and wellbeing of staff has been impacted. There was evidence of severe pressure on individuals, some of whom also felt disempowered and undermined at times. These concerns should be addressed.

4.4 An organisational development (OD) plan was started and this should be activated as soon as possible. The second cultural assessment survey, due to be completed in Dec 2020, should be used as a platform to drive change.

- **Accountability**

4.5 Structural form should follow function. The organisation's core business is public health (covering health protection, health improvement and service quality development) and this should be centre stage in all its strategy, systems and structures.

4.6 There is an imbalance in the organisation's leadership team. The DPH role spans 2/3rds of the budget of the PHA and acts as Medical Director in the HSCB. This is a very wide role for one person and should be reconsidered.

4.7 The directorates should be arranged around the key functions to be delivered. Accountability should align with strategic objectives, with more visibility of health protection at Board level.

4.8 The DPH role will need to focus on strategic development of the public health function and external relationships. In order to strengthen leadership, support effective delivery and succession planning, I recommend three deputies to lead the respective functions of:

- Health protection director
- Health improvement director
- Health research & intelligence director

4.9 There are a number of hosted functions within the PHA which should be reviewed in due course to ensure they align with the Agency's core purposes. However, in the short term more collaboration with hosted functions would bring benefits. For example, with R&D to further support evidence-based practice and innovation and with the Quality Improvement function to drive innovation and improvement in public health services.

- **Capacity and capability**

4.10 The PHA should update its workforce plan so that it is aligned to its strategy.

The workforce plan should cover the development of current staff to upskill in their specific roles and ensure a basic level of public health skills for incident response and collaborative working. The plan should include an ambition to be a learning organisation.

4.11 The plan should ensure that ways of working within the agency address concerns about professional silo working, for example, by ensuring that all senior staff have adequate public health training. There should be more cross fertilisation of roles and ideas as well as joint project working focussed on shared outcomes. A leadership development programme is essential. Use of mentoring and coaching should be encouraged.

4.12 Specific public health, epidemiology and analytical training will need to be increased to replace staff as they retire / leave. The current public health training programme is recruiting and the PHA should seek funding for a one-off increase in multidisciplinary recruits as well as develop a longer-term plan for future numbers of specialist staff needed to be sustainable.

4.13 The epidemiology Fellows scheme should continue to be supported.

4.14 The training programmes should seek to maximise placement opportunities within and outside NI to ensure public health registrars are exposed to a wide range of approaches and areas of practice that may not be available in house. These could include placements in the Northern Ireland Executive and with local government to help develop public health practice in support of policy development and decision-making. Academic research opportunities should be readily available.

4.15 Joint service-academic appointments can help to attract candidates for roles, support research and innovation in practice and strengthen the training programme.

More should be done to enhance links with Universities. Similarly, joint appointments with other public health agencies would foster collaboration and make best use of scarce resources.

4.16 Public health centred communications and engagement is a vital part of delivering improved health outcomes. There was a call from stakeholders for more engagement. The communications function should be supported and enhanced. The appointment of a Director of Communications and Engagement would provide the leadership needed to develop this capability.

4.17 More use should be made of digital communication and behaviour change expertise. The website requires an upgrade to be more 'user accessible'.

4.18 There was a call for more overarching co-ordination within the organisation and a need to enhance strategic and operational planning. The recently retired Director of Operations role should be replaced to encompass these functions and support the CEO in the daily running of the business. Project management and business support roles should be reviewed to ensure sufficient capacity and focus on programme delivery. The high level of temporary posts should be reviewed to ensure retention of necessary skills.

4.19 The IT and HR functions should be enhanced to support efficient and timely recruitment as well as an upgrade of IT functionality.

- **External relationships**

4.20 Partnerships are a crucial part of public health practice. As recommended above, a Director of Communications and Engagement would bring strategic leadership to this work.

A stakeholder survey should be undertaken to identify areas of strength and areas for improvement.

Whilst there is local engagement for health improvement activity in community planning, it should also be strengthened for health protection as well as for involvement in Integrated Care Partnerships, and including primary care.

- **Working environment**

4.21 The working environment needs improvement. An estates plan is underway and this should be underpinned with a strategic approach to future working methods. A survey of how people want to adapt their working arrangements after Covid-19 should inform decisions. Even before the pandemic, other public bodies have achieved substantial transformations in creating flexible, 'location agnostic' ways of working which enhance staff engagement and wellbeing.

Implementation

The four high level recommendations in this report are supported by detailed actions that are necessary to re-invigorate the public health function in order to continue the response to Covid-19 and prepare for future health threats. Further work is underway to re-start other public health services which was not in the scope of this report.

The immediate priorities are to:

- Finalise and agree relevant business cases to ensure current service sustainability
- Commence appointment of the CEO
- Agree an investment and transformation plan

My recommendations constitute a major change programme which requires investment and leadership. The interim CEO should be supported to start the delivery of this programme forthwith, with assurance provided by PHA non - executive Board oversight.

Appendix A

Terms of Reference for a rapid, focused external review of the Public Health Agency for Northern Ireland's resource requirements to respond to the COVID-19 Pandemic over the next 18 - 24 months

Background

1. The Public Health Agency for Northern Ireland (PHA) is facing an unprecedented COVID-19 pandemic. Rapid, focused advice on the resource requirements to respond to the current situation over the next 18-24 months would be valuable.

2. Whilst the Agency has clearly responded well to most of the issues raised by the pandemic, it is also clear that the scope, scale, pace and complexity of the challenges will only increase and the Agency must be ready to respond with agility and with the capacity and capability required.

3. Furthermore, it is more than ten years since the Agency was established under the second phase of Review of Public Administration and such a review would be timely in any case.

4. An investment in public health – particularly in health protection – is likely to be required if we are to ensure a Public health Agency fit to deal with future challenges over the next decade. These include, but are not limited to:

- Pandemic threats such as COVID-19;
- The effective use of evidence, health information and epidemiology in a digital age;
- Analytical and epidemiological work including research
- Infection Prevention and Control
- The best use of public engagement, co-production, communications including social media and online communication to enhance public messaging; and
- Ensuring a strong and vibrant professional public health community in Northern Ireland.

Proposed Approach

1. The rapid review will be led by Dr Ruth Hussey, OBE, a previous CMO in Wales.

2. The recipient of the review will be: The Chef Medical Officer for Northern Ireland, the Chair of the Agency, and the Chief Executive of the Agency.

3. The Chief Executive of the PHA will ensure, with the support of the Director of Public Health, that Dr Hussey is provided with all the practical help required to undertake the review.

4. The review will aim to provide a concise report that can rapidly be undertaken to address the COVID-19 pandemic over the next 18-24 months.

5. The report will aim to have a draft available for comment by 31 December 2020.

6. Dr Hussey will be free to develop and structure the review as she sees fit, in discussion with the three recipients of the report and to engage other external advice, if she deems this advisable.

Appendix B

Information available online was used to describe the public health service arrangements across the five nations of Northern Ireland, Scotland, Wales, England, and Ireland. Each nation is set within its own context and subsequently direct comparisons between them are not easily achieved.

All of the services are explicit in stating their focus on protecting and improving the health and wellbeing of the population, and on reducing inequalities. The provision of each nation's service is also broadly framed around the three main domains of public health practice (health services, health improvement, and health protection). All services exhibit cross-sectoral and multi-disciplinary working. The systems in Ireland and England are undergoing periods of significant transition. Scotland's public health service - in its current form - was only created in Spring of this year.

There are differences in the organisational models adopted by each service - but, when each nation's service is taken as a whole (including any delegated public health functions), the types of output are similar. In turn, with regards to the scope of their Health Protection work, the composite functions appear comparable between nations. Close partnership between Microbiology services and Health Protection services is a feature for all nations. In Wales and England some Microbiology services are managed by the Public Health organisation.

The size of the population is likely to be a significant factor determining the scale of the service available. Funding is not easily compared as each agency has a different service mix. However, it is clear that Northern Ireland has the lowest specialist staffing rate in the UK, including having fewer Directors of Public Health per head of population.

All nations have responded to the pandemic by adapting pre-existing models of service delivery. During the pandemic, there has been close co-operation between all of the five nations. Collaboration between the agencies was also an important feature prior to COVID-19.

Selected elements of the five public health services

	Ireland	Wales	Scotland	England	Northern Ireland
Population	4.9 million	3.2 million	5.5 million	56.3 million	1.9 million
Number of specialists / consultants (per million)*	-	79.4 (24.8)	125 (22.7) *estimated*	1007 (17.9)	29 (15.3)
Directors of Public Health (per million head of population) &	8 (1.63)	7 (2.19)	14 (2.55)	134 (2.38)	1 (0.53)
Budget / expenditure 2018-19[ł]	Euro 241m (2019)	£135m *Includes all Wales' microbiology services*	£71m *This is an 'opening budget' for the new organisation, Public Health Scotland*	£4,013.0m *This represents net expenditure for Public Health England - about ¾ of funding is for local government public health*	£113m *Includes hosted services such as R&D for health and social care*

[ł] Note that each agency's budget may not be comparable due to differences in their functions.
*Figures taken from Representation to the Comprehensive Spending Review 2020 (Faculty of Public Health)
[&] Figures taken from Association of Directors of Public Health (UK) (www.adph.org.uk/). National Directors may not be included in figures.

Appendix C

Essential Public Health Services (Revised, 2020)

The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities.

1. Assess and monitor population health status, factors that influence health, and community needs and assets
2. Investigate, diagnose, and address health problems and hazards affecting the population
3. Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it
4. Strengthen, support, and mobilize communities and partnerships to improve health
5. Create, champion, and implement policies, plans, and laws that impact health
6. Utilize legal and regulatory actions designed to improve and protect the public's health
7. Assure an effective system that enables equitable access to the individual services and care needed to be healthy
8. Build and support a diverse and skilled public health workforce
9. Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement
10. Build and maintain a strong organizational infrastructure for public health

https://www.ianphi.org

item 8

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	19 June 2025
Title of paper	Governance and Audit Committee Update
Reference	PHA/02/06/25
Prepared by	Robert Graham
Lead Director	Joseph Stewart

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

1 Purpose

The purpose of this paper is to provide the PHA Board with an update following the last meeting of the Governance and Audit Committee.

2 Key Issues

The Governance and Audit Committee met on Thursday 12 June and the Committee Chair will give members a verbal update on that meeting. The approved minutes of the previous meeting, held on 17 April, are attached for noting.

At the request of the Committee Chair the following papers are attached for members' information and reference will be made to these at the Board meeting:

- Head of Internal Audit Annual Report for the Year Ended 31 March 2025
- Internal Audit General Annual Report for HSC for 2024/25*
- Draft External Audit Report to those Charged with Governance

* Within the General Report, PHA is organisation number 15.

3 Next Steps

The next Governance and Audit Committee update will be given at the PHA Board meeting on 28 August.

PHA Governance and Audit Committee Meeting Minutes

Date and Time	Venue
17 April 2025 at 10.00am	Fifth Floor Meeting Room, 12/22 Linenhall Street

Member	Title	Attendance status
Mr Joseph Stewart	Non-Executive Director (Chair)	Present
Mr John Patrick Clayton	Non-Executive Director	Present via Teams
Mr Robert Irvine	Non-Executive Director	Present
Ms Leah Scott	Director of Finance and Corporate Services	In attendance
Mr Stephen Wilson	Head of Chief Executive's Office	In attendance
Mr Stephen Murray	Assistant Director of Planning and Business Services	In attendance
Ms Helen O'Hare	Assistant Director of Finance and Corporate Services	In attendance
Mr David Charles	Internal Audit, BSO	In attendance
Mr Ryan Falls	Cavanagh Kelly	In attendance via Teams
Ms Siobhan Donald	Assistant Director	In attendance
Mr John Irwin	Northern Ireland Audit Office	In attendance
Mr Robert Graham	Chief Executive Office Manager	In attendance
Ms Aisling Smyth	Secretariat	In attendance

1/25 - Item 1 – Welcome and Apologies

1/25.1 Mr Stewart welcomed everyone to the meeting. There were no apologies. Mr Stewart welcomed the new attendees to the Committee and asked everyone to introduce themselves. He acknowledged the contribution of Mr Roger McCance from NIAO and welcomed Mr John Irwin to the meeting. Mr Stewart also thanked Mr Graham for his support in servicing the meeting.

2/25 - Item 2 – Declaration of Interests

2/25.1 Mr Stewart asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.

3/25 - Item 3 – Minutes of previous meeting held on 13 February 2025

3/25.1 The minutes of the previous meeting, held on 13 February 2025, were **APPROVED** as an accurate record of that meeting.

4/25 - Item 4 – Matters Arising

4/25.1 Mr Stewart noted that an Action Log had been circulated in advance of the meeting. He asked if there were any matters arising that were not covered in action plan. No matters arising.

5/25 - Item 5 – Chair's Business

5/25.1 Mr Stewart advised that he attended a meeting of the Audit Committee Chairs' Forum at the Department of Health on 20 February 2025 and that there were two matters he wished to update the Committee on.

5/25.2 Mr Stewart reported that there was an update on the budget and indicated that the Department of Finance is moving to a 3-year budget cycle which will allow organisations to make assumptions going forward and budget on basis of a 2-year look ahead cash budget/wage increase and taking account of Corporate Plan.

5/25.3 Mr Stewart advised that there was a discussion on effective business cases and whether expanded or shortened business cases are better. He added that there is a workshop in May on business cases.

5/25.4 Mr Stewart advised that he attended the Leadership and Governance Conference and there was an NIAO publication on Governance Risk Committees that the Committee may find useful. He asked that copies be distributed to Committee members **(Action 1 – Secretariat)**.

6/25 - Item 6 – Corporate Governance

Corporate Risk Register as at 31 March 2025 [GAC/01/04/25]

6/25.1 Ms Scott presented the Corporate Risk Register. She advised that a previous review was undertaken as at 31 December 2024 and it has gone through all processes and approvals. She advised that this current Corporate Risk Register reflects the review as at 31 March 2025 and the next review will be undertaken as at 30 June 2025. She noted that there have been no new risks added or removed from the register this quarter.

6/25.2 Mr Stewart thanked the team for preparing the Register and keeping it up to date. He noted that the number of risks has reduced and they are constantly being updated.

6/25.3 Mr Irvine advised that he had attending Cyber Security training and said that the key takeaway for him is that it only takes one incident to open the organisation to a threat. He said that while staff can all be astute and aware, it only takes one person and that is the weakest link. He noted that PHA is slightly vulnerable as an organisation as its ITS services are provided by BSO. He advised that PHA needs to be looking at global assurance when working with third party providers. He asked about how new staff are inducted when they join the organisation and how managers check that staff reporting to them have completed their training. He suggested that the threat increases when staff become complacent and said that he believes that there can be complacency.

6/25.4 Mr Stewart said that he needs to undertake this training. He asked if the Cyber Security risk has been properly assessed and if Mr Clayton had any comments.

6/25.5 Mr Clayton noted that Risks 39 and 64 both relate to Cyber Security risks with third parties. He noted the risk around Information Governance and Cyber Security. He asked how PHA can get assurance from external bodies and said that there may need to be a Memorandum of Understanding. He asked what oversight PHA has of third parties. He also noted the Business Continuity Testing was taking place in May and he hoped this would cover a Cyber Security incident.

6/25.6 Mr Stewart asked Ms Scott for her thoughts. Ms Scott noted that there is a gap of assurance with regards to cyber security and while there are assurances around training, third party organisations and Business Continuity Planning, it is not a comprehensive list. She said that the Board needs specific assurances. She added that PHA is as prepared as it can be and while it can plan extensively, an incident can happen that PHA is not prepared for.

6/25.7 Mr Stewart asked about planning around recruitment with regards to inducting staff and what training staff receive on systems. He noted that staff can access systems without having proper training. Mr Stewart noted that there is good training on Cyber Security. He asked if the organisation is tracking this training and if staff are logging in and actually doing the training. He also asked about what assurance PHA has with regard to third parties and their cyber security regulations.

6/25.8 Mr Murray advised that there is an annual assurance process. There is an Information Governance Assurance checklist. This is submitted with other processes. There is a question asking for the ICO registration number. There are questions in the process against cyber-attacks. Mr Stewart asked if PHA has the capability to check other organisations. Mr Murray replied that PHA does check to make sure that they have their checks in place.

6/25.9 Mr Stewart commented that these checks need to be in place. When working outside of the organisation he asked if 3 or 4 checks a year would be needed and if PHA were to do physical checks, would this tighten up the process.

6/25.10 Mr Irvine commented that this could be taken one step further. He noted that third party organisations give assurance by completing a tick box exercise, and that PHA has no way of testing this once the procurement process has been completed. He suggested that external checks of cyber security should be part of the tender process as this would allow PHA to check their cyber security regulations and give the level of security required.

6/25.11 My Murray noted that PHA has to take a balanced approach and also has to consider the legal perspective.

6/25.12 Ms Scott suggested that PHA could ask for certifications such as; ISO 27001 or Cyber Essentials. She noted that this may cause some disruption to the providers but they would need to support this. She advised that with the new Procurement Act there will be new KPI's & contract management arrangements, but this would need to be explored further.

6/25.13 Mr Stewart noted that this does give cause for thought. He asked Ms Scott if she could bring forward a paper with proposals from the course and for the organisation on cyber security. **(Action 2 – Ms Scott)**.

6/25.14 Mr Murray advised that as part of the procurement process there are cyber security assessments and providers must have a cyber security license. He noted that cyber security is an issue across all levels but there are robust risk processes embedded in this and there are assurances in place.

6/25.15 Mr Stewart asked Mr Clayton was there anything further he wanted to raise with regards to the Corporate Risk Register.

6/25.16 Mr Clayton raised questions about CR 75 on Pandemic Preparedness. He suggested that PHA needs to clearly articulate what the risks are. He highlighted the submission of draft plans and asked what this means. He suggested that there needs to be clearer articulation of the risk and to tie in with Dr Joanne McClean to see what submissions went to the Department.

6/25.17 Mr Stewart asked how we stand with pandemic preparedness. He noted that it has been put to the Department but there has been no clear answer. He asked how ready PHA is and what exposure the Agency could have.

6/25.18 Ms Scott said one of the biggest risks are the roles and responsibilities within a pandemic situation, as PHA must remain operational and strategic. She referred to Exercise Pegasus which could give clarity on roles and responsibilities.

6/25.19 Mr Wilson advised with this risk, PHA needs to see what capacity the organisation has to deliver and he referred to the Reshape and Refresh programme. He suggested that Exercise Pegasus will be the first scientific test post pandemic and PHA can take stock on how far it has come on the important recommendations. He suggested that Exercise Pegasus will give PHA clarity on the roles and responsibilities within a pandemic type situation. He advised that the exercise is planned for later this year.

6/25.20 Mr Graham clarified that Exercise Pegasus would be happening in 3 phases across September/October and November. There will then be further exercises in the summer of 2026.

6/25.21 Mr Stewart expressed his concern around this risk and said that more clarity is required from Dr McClean.

6/25.22 Members **APPROVED** the Corporate Risk Register.

Nursing and AHP Directorate Risk Register as at 31 March 2025 [GAC/02/04/25]

6/25.23 Ms Donald presented the Nursing and AHP Directorate Risk Register for noting. She advised that this current Risk Register reflects the review as at 31 March 2025. She added that if anyone has any questions or comments, she can take them back to Ms Heather Reid. She noted the PHA's PPI function was audited in December 2024/January 25 with a recommendation to ensure PHA's Partnership and Engagement strategy addresses underlying recommendations. She advised that there is a regional review ongoing. Ms Donald to check the dates and details around this review and report back to the committee **(Action 3 – Ms Donald)**.

6/25.24 Mr Clayton asked about the risk on the Family and Nurse Partnership (FNP). He noted that it is still outstanding. He asked if it would be completed by April 2025. Ms Donald advised that Ms Reid has said that discovery work continues with Encompass but there is currently no timeline.

6/25.25 Mr Irvine noted that there is a long tail and he would like to see this and some older recommendations closed off. Ms Donald asked if the committee would prefer to see this risk closed off. Mr Irvine asked what would be the mitigations if it is left open. He also asked would it be a greater risk than anticipated and what would be the rationale for mitigation.

6/25.26 Mr Clayton said that he had two queries. The first one was in relation to the risk on Large Scale Emergency. He questioned that a number of staff have not yet completed Emergency Planning Training. He asked if this was down to dates not being available, a lack of training budget, no resources or no dates for training. The second query was with regards to Safety and Quality. He said that there needs to be more clarity around the PHA roles and responsibilities related to Safety and Quality and that Internal Audit have flagged up that, since the migration to SPPG, governance arrangements around safety and quality are unclear.

6/25.27 Ms Donald noted that in relation to safety and quality, more clarity is still required and a regional review is ongoing. She also added that with regards to the emergency planning training that specialist training would only happen at a senior level and there will be an upcoming business continuity test which senior management would

be attending. She added that she had not heard about a resource issue with regards to internal training but for external specialist training, capacity would be limited and there would be a waiting list.

6/25.28 Mr Stewart added that with regards to the external training, it usually only happens once or twice a year and it depends who is running the courses and what capacity they have.

6/25.29 Mr Murray advised that PHA does have in house training. He said the baseline budget has not increased and that funds would need to be looked at for external training and added that the online training is mandatory for all staff.

6/25.30 Mr Stewart noted reference to secondment of staff in the Risk Register. He expressed concern as this can lead to a shortage of organisational resource. He added that an eye needs to be kept on the strategic approach and secondments need to be looked at, as secondment can mean promotion and opening opportunities but Directorates can feel the pinch and this is something that needs to be balanced between the Directorates.

6/25.31 Mr Wilson advised that gaps are being looked at as part of the recruitment process as gaps can be left with secondments.

6/25.32 Mr Stewart added that whilst personal development and promotion are positive, there needs to be a balance.

6/25.33 Members **NOTED** the Nursing and AHP Directorate Risk Register

At this point Ms Donald left the meeting.

Gifts and Hospitality Register [GAC/03/04/25]

6/25.34 Members **NOTED** the Gifts and Hospitality Register.

Update on Direct Award Contracts [GAC/04/04/25]

6/25.35 Ms Scott presented the report on the use of Direct Award Contracts 2024/25 for noting. She advised with the new Procurement Act which came into effect on 24th February 2025, it will bring more transparency within the process. She advised that the team has been trained. She highlighted that in 2024/25 there were 22 applications completed and signed off in comparison to 50 in the previous financial year. She advised that it is closely monitored and managed and whilst the trend is downward in numbers, it can be difficult to make direct comparisons from one year to the next.

6/25.36 Mr Stewart noted that it is important to understand the cumulative numbers because if you go over the threshold, then you are back to square one.

6/25.37 Mr Murray added that the Direct Award Contracts are constantly under scrutiny and the thresholds will be always changing in levels of scrutiny.

6/25.38 Mr Stewart asked that the paper on DAC's be circulated to the board as a whole and he thanked staff.

6/25.39 Mr Murray advised that there is a panel who helps with the procurement services, and that they help make the case where there are valid routes for DAC. He added that there is focus and scrutiny on contracts and alternative providers along with levels of opportunity.

6/25.40 Mr Stewart advised that it needs to be looked at with what is actually being procured and how it links back to the organisation. It needs a high level of scrutiny and how it fits in with the organisation's priorities and the Corporate Plan. He asked if the DAC paper should go to the Board and there was agreement it should **(Action 4 – Secretariat)**. Mr Stewart thanked staff for the preparation of the paper.

6/25.41 Members **NOTED** the update on Direct Award Contracts.

7/25 - Item 7 – Internal Audit

Internal Audit Progress Report [GAC/05/04/25]

7/25.1 Mr Charles presented the Internal Audit Progress Report as at April 2025. He formally confirmed that all assignments were completed for 2024/25. He summarised the detail on page 4 of the Internal Audit Progress Report. He summarised the recommendations and the findings.

7/25.2 Members noted the Internal Audit Progress Report.

Internal Audit Year End – Follow Up on Outstanding Internal Audit [GAC/07/02/25]

7/25.3 Mr Charles presented the year end follow up on the outstanding Internal Audit recommendations. He gave a summary of the year-end report and the numbers of implemented and partially implemented recommendations. He advised that page 2 of the report shows that 83 of the outstanding 97 (86%) recommendations were fully implemented and a further 14 (14%) were partially implemented. He also advised that from the 27 recommendations in the follow up,14 related to significant findings which caused limited assurances to be provided. Of these 14 recommendations, 8 (57%) were implemented during this follow up period (October 2024 to March 2025).

7/25.4 Mr Charles gave an overview of the longest outstanding audit recommendations. He advised that the oldest recommendation, which relates to the delivery of the procurement plan is 10 years old. He noted that PHA is progressing with the agreed procurement plan for 2024/25 and that it is a continual ongoing process.

7/25.5 Mr Charles advised that the next oldest recommendations are both 5 years old, the first of which relates to the need for a more efficient and cost-effective information system for the Family Nursing Partnership (FNP) programme. He advised that there is a revised date of the end of August 2025 for this. He said that the second relates to PHA needing to ensure that contracts are GDPR compliant and that terms of the contract have been signed by all providers. Mr Charles advised that this also had a revised date of the end of August 2025.

7/25.6 Mr Charles advised that there has been good progress in developing an action plan with the Population Screening recommendation from 2022-23. He then summarised some of the recommendations on page 6/7; Management of Vaccination Programmes 2024-25, Financial Review 24-25 and PPI Processes 24-25 (all limited assurance). He advised that there has been good traction. He noted that the number of outstanding recommendations is lower in PHA than peer organisations.

7/25.7 Mr Stewart noted that there had been some improvement in completing the recommendations but there is still a long tail. He noted that negotiations with third parties are not easy to complete. Mr Stewart asked if PHA should be concerned about the tail and also with regards to the recommendations of date not passed. He asked if there was any clarity of when these will be completed. Mr Stewart went through some of the upcoming recommendations and some which are due soon for completion and asked if the timescales and completion dates were realistic.

7/25.8 Ms Scott advised that the teams are working through the dates to follow and complete and she agreed that negotiating with third parties can be frustrating. She also advised that the recommendations are scrutinised to make sure the completion dates are realistic.

7/25.9 Mr Irvine noted that looking at other organisations, it takes a concerted effort to report into the Board. He asked what each Director is doing to embed the learning from the recommendations. He noted that the tails are long, but any recommendation is a matter of relevance to the organisation. He noted that we need to embed the assurances and best practices and also suggested that best practices can get lost as they filter through the organisation.

7/25.10 Mr Stewart asked Mr Clayton whether he had any comment on the Internal Audit Year End Follow up Report. Mr Clayton said that he had no further comment on the year-end report. He noted that the completions are encouraging. There is a timeline for some resolution which can be tracked through board level and it would be good to shorten the tail.

7/25.11 Mr Stewart advised that he would report back to the Board meeting. He would not want to add to people's frustrations and also suggested that if staff are not happy with the recommendations, they should talk to Internal Audit to discuss where there are issues.

7/25.12 Mr Charles advised that there is good engagement between Internal Audit and management, and that if a recommendation cannot be implemented, there are discussions on alternatives.

7/25.13 Members **NOTED** the Internal Audit Year End – Follow Up on Outstanding Internal Audit.

Shared Services Update [GAC/07/04/25]

7/25.14 Mr Stewart advised that the next report from Internal Audit was the Shared Services update. He noted that BSO are a business function team.

7/25.15 Mr Charles talked through the Shared Service Audits for information.

7/25.16 Members noted the Shared Services Update

Internal Audit Plan 2025/26 [GAC/08/04/25]

7/25.17 Mr Stewart advised the committee that he had discussed the audit plan with Mrs McKeown and had agreed to some timing changes. Mr Charles asked the Committee to note Appendix A on the plan with the proposed risk audits for 2025/26. Mr Charles advised that there had been close engagement with senior management to ensure best use of audit time. It is to be approved but flexible throughout the year. Mr Charles summarised the proposed Internal Audit Assignments for 2025/26.

7/25.18 Mr Stewart asked if any members of the Committee wanted to comment on the audit plan.

7/25.19 Mr Irvine asked if there was a default in which areas Internal Audit choose. He asked was the choice based on risks or was it a case if something has not been audited in 5/6 years or if a risk has had limited assurance in the past then it will be on the plan. He noted that it is good to look at systems that have never been looked at in the past.

7/25.20 Mr Clayton asked Mr Charles about the proposed audit on the Integrated Care System. He noted that there is a degree of ambiguity on the PHA structures and AIPB is in the pilot phase. He asked what assurance there would be that the second issue would not get lost. He also asked what role is in commissioning and where the audit process will go in the future.

7/25.21 Mr Charles advised that this audit is on the Internal Audit programme for 2025-26, but Internal Audit is content to leave this for another year to allow the structures to develop. He added that Internal Audit does not want to go into this area too soon, so they will come back early next year.

7/25.22 Members **APPROVED** the Internal Audit Plan 2025/26.

8/25 - Item 8 – Finance

8/25.1 Ms Scott presented the Fraud Liaison Officer Report for noting. She advised the Committee that the report had been compiled by Ms Karen Brown. She highlighted the action plan and summarised those actions which had been completed. She advised that there were no new fraud issues and that there were clear structures in place. She advised that there is awareness training planned in the future. Ms Scott also advised that with regards the Fraud Liaison Officer role, that now sits under Ms O'Hare.

8/25.2 Mr Stewart noted with satisfaction that no new issues were emergent.

8/25.4 Members **NOTED** the Fraud Liaison Report.

At this point Mr Irvine left the meeting.

9/25 - Item 9 – Draft PHA Annual Report [GAC/10/04/25]

9/25.1 Mr Wilson advised that there have been some issues with returns for the draft PHA Annual Report. He advised that there are still slots to be populated, around annual performance against business plan commitments. He added that there has been some debate with regards the format, and added that this format is moving in line with the new Corporate Plan.

9/25.2 Mr Stewart suggested that it was more of a draft than the previous Annual Report, he added that he thought some parts were repetitive and other parts hard to understand. Mr Stewart talked through some of the categories of the Annual Report. Mr Stewart noted that it represents a lot of work on behalf of the staff. He suggested that the report may be too long and was concerned that the information around the ALB was too long.

9/25.3 Mr Clayton said that he appreciated that work is ongoing with the report. He suggested that some work could be summarised. With regards to Population Screening, which is an issue for public concern, he suggested that it may be worthwhile to include some information on the cytology review. He added with regards to the Reshape and Refresh programme, there is something missing from the narrative, for example, how it will improve the Agency. He noted an additional point with regards to the Corporate Plan, the Agency needs to submit an Implementation Plan. Mr Clayton also added that his biography would need to be updated. He asked would the final version be available for the next GAC meeting.

9/25.4 Ms Scott asked if biographies are needed in the report when they are available on the website. Mr Clayton advised that this is something that would need to be discussed with the Board members.

9/25.5 Mr Stewart noted that the length of the report is an issue. Mr Wilson advised that the draft report will go to the Board next week and all comments will go with it.

9/25.6 Mr Stewart advised that there are issues on Governance Statement that need to be upfront in the report, but all the main points are there.

9/25.7 Members **APPROVED** the Draft PHA Annual Report.

10/25 - Item 10 – Governance and Audit Committee Annual Report [GAC/11/04/25]

10/25.1 Mr Stewart advised he had reviewed the report and suggested some amendments. He asked Mr Clayton for any comments.

10/25.2 Mr Clayton noted no major comments.

10/25.3 Members **NOTED** the Governance and Audit Committee Annual Report.

11/25 - Item 11 – SBNI Declaration of Assurance [GAC/12/04/25]

11/25.1 Ms Scott presented the SBNI Declaration of Assurance. She noted that PHA hosts SBNI and a limited number of corporate services. It provides annual assurance including finance. The SBNI Chair, Ms Bernie McNally, has provided a good overview in this report. Ms Scott summarised the report saying that it contains a breakdown of how SBNI spend its £1.3 million budget. Ms Scott explained that the report was here for noting.

11/25.2 Mr Stewart asked if there was an issue earlier in the year with regards to SBNI. Ms Scott advised that there was an unauthorised payment and an outstanding tribunal. Mr Murray confirmed that the unauthorised expenditure and tribunal were last year.

11/25.3 Ms Scott advised that Internal Audit had a recommendation around purchasing with regards to a DAC of £12,000 for Web Design Services. She advised that the DAC was not renewed. Ms Scott to check the date to see if it falls within this year. **(Action 5 – Ms Scott)**. Ms Scott advised that there is work ongoing with a MoU between PHA and SBNI.

11/25.5 Members **NOTED** the SBNI Declaration of Assurance.

12/25 - Item 12 – Any Other Business

12/25.1 Mr Stewart formally thanked Mr Graham for his long and diligent service as secretariat for the meeting. He extended a thank you from the Committee.

13/25 - Item 13 – Details of Next Meeting

Thursday 12 June 2025 at 10am

Fifth Floor Meeting Room, 12/22 Linenhall Street

Signed by Chair:

Joseph Stewart

Date: 12th June 2025

HSC Business Services Organisation

Internal Audit

PUBLIC HEALTH AGENCY

HIA ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2025

REPORT ISSUED ON 30 APRIL 2025

PUBLIC HEALTH AGENCY
HIA ANNUAL REPORT FOR YEAR ENDED 31 MARCH 2025

HSC Business Services Organisation
Internal Audit

CONTENTS

INTRODUCTION

The Business Services Organisation (BSO) Internal Audit's primary objective is to provide an independent and objective opinion to the Accounting Officer, Board and Governance & Audit Committee on the adequacy and effectiveness of risk, control and governance arrangements. The basis of this independent and objective opinion is the completion of the Annual Internal Audit Plan. The 2024/25 internal audit plan was developed in conjunction with Client Management and was approved by the Governance & Audit Committee in February 2024.

ACKNOWLEDGEMENT

The engagement and support we received from client Management and Staff during our Internal Audit work is very much appreciated.

INDEPENDENCE

During 2024/25, BSO Internal Audit has had no executive responsibilities within the audited body and has been sufficiently independent of the activities that it audits to enable us to perform our duties in a manner, which facilitates impartial and effective professional judgements and recommendations.

PERFORMANCE DURING 2024/25

Key Performance Indicator	% Achieved in 2023/24	% Achieved in 2024/25
100% Delivery of Annual Audit Plan	**100% (96%*)**	**100% (100%)**
85% of First Draft Reports Issued within 4 weeks of fieldwork completion	**100%**	**100%**
75% of reports finalised within 5 weeks of issue (and within 1 week of receiving management comments)	**71% (100%)**	**71% (100%)**
75% Management Comments should be received within 4 weeks	**29%**	**43%**
% of reports significantly amended between draft report and final report stage[1]	**0%**	**0%**

**Actual delivery against SLA annual audit days.*

The key objective of the Internal Audit service is to ensure the delivery of the Internal Audit Annual Plans to all client organisations, resulting in the provision of a Head of Internal Audit overall annual opinion on the adequacy and effectiveness of each client organisation's framework of governance, risk management and control. This key objective was achieved within the required timeline.

As shown in the table above, the KPI target to ensure timely response to draft reports by PHA Management is not currently being achieved. However, the delays are largely not significant, as demonstrated by the fact that the majority of reports are finalised within 5 weeks of issue.

[1] Significant change is defined as change in assurance level provided in report, a priority 1 recommendation being completely removed from report, or significant changes in a number of key findings

SUMMARY OF WORK UNDERTAKEN

All audit assignments included in the 2024/25 Internal Audit Plan, approved by the Governance & Audit Committee, have been carried out with the following approved amendment:

- At the request of Management, the Governance and Assurance audit was deferred pending the ongoing work in terms of restructuring Directorates within PHA. An audit of Personal and Public Involvement was brought forward from 2025/26 in its place.

The 2024/25 Internal Audit work is summarised as follows:

AUDIT ASSIGNMENT	LEVEL OF ASSURANCE
Corporate Risk Audits:	
Management of Vaccination Programme	Limited
Governance Audits:	
Board Effectiveness	Satisfactory
Personal and Public Involvement	Limited
Trust Commissioned Services	Limited
Finance Audits:	
Financial Review	Satisfactory: Financial Reporting to the PHA Board; Non-Pay Expenditure; Budgetary Control & Saving Plan Management and Management of Additional Payments to Staff Limited: Staff in Post Reports

The following significant findings were identified in the above audit assignments, impacting on the assurance provided:

Management of Vaccination Programme

1. There is no overarching formal memorandum of understanding, agreement or manual in place signed off by all of the various stakeholders (PHA, SPPG, Trusts, Primary Care Providers) defining each organisation's specific roles and responsibilities in respect of vaccines and what reporting, assurance and accountability arrangements are in place between each organisation. Without this, there is a lack of formal clarity over who is responsible and accountable for what in the process and a risk that application of control may fall between organisations. The MoU was between PHA, DoH and the Regional Pharmaceutical Procurement Service which outlines procurement arrangements for the supply of Childhood, Seasonal Flu and Shingles Vaccines for Northern Ireland expired in 2022 and has yet to be updated and agreed by all parties. A draft MoU is currently under review.
2. PHA have a contract in place with a pharmaceutical supplier to receive, store and deliver vaccines on their behalf to GP's, Community Pharmacies, Trusts etc. In 2023/24, £454.5k. of spend was approved via FPM, without appropriate checks or evidence available to ensure the accuracy of invoices.
3. There are no processes within PHA to validate the stock levels of vaccines actually held by vaccine administrators (e.g. GPs) to PHA records. In the absence of a stock validation exercise, there is a risk that the PHA data detailing the levels of stock held by vaccine administrators may not be accurate or it may become inaccurate over time, leading to incorrect quotas being calculated for each location.
4. There was significant influenza vaccine wastage (circa 25%) in 2023/24. Management recognise this and have developed an action plan to address going forward into 2024/25 onwards.

Personal and Public Involvement

5. PHA does not have an approved up to date PPI strategy in place. There is no business plan in place for PPI and no underpinning action plans. KPIs are not in place to performance measure and monitor PPI activity.
6. The regional PPI Forum meetings over recent years have not been well attended either by HSC or Service Users/Carers, indicating a lack of effectiveness. Actions arising from these meetings are not assigned to responsible officers and not formally followed up through a formal action plan.
7. PHA monitoring of Trust PPI activity needs improved.

Trust Commissioned Services

8. 1 commissioned service (£2.6m 2023/24 across 5 Trusts and £30m since 2010/11) provides funding for administrative support to free up Ward Managers in acute hospitals to allow them to spend more time interfacing with staff and patients on wards. A Business Case and Post Project Evaluation in respect of service was not available for audit review. There is lack of clarity as to how this funding should be utilised, what the targets were and what the reporting arrangements should be. It is unclear how this funding relates to public health agenda and the PHA has no visibility of how this funding has been spent by HSC Trusts over this 14-year period.
9. In relation to commissioning and performance management of Trust commissioned services:
    - Commissioned services are largely rolled forward from one year to the next. There is insufficient consideration of whether services as currently commissioned are sufficient aligned to current population health needs.
    - Where applicable, Project Evaluation Monitoring Returns were consistently not in place where required. PHA has not undertaken any recent formal reviews to confirm the continued need for all Trust commissioned services and whether any of these services should be amended or redefined to better reflect the current needs of the public and better utilisation of resource available.
    - SMART targets were often not in place to allow PHA to effectively measure whether the services being funded were being delivered by Trusts.
    - There is a lack of formalised structure up through the PHA assurance framework to corporately assess, report and hold individual Leads and Directors to account in terms of robust performance management of commissioned services and to ensure that smart targets set are being achieved. There is also no regular dedicated corporate report at Non-Executive level on whether targets set across all commissioned services are being achieved and if not, what is being taken forward to improve this.
    - Escalation of poor performance by Trusts is not sufficiently defined in PHA.
10. In respect of business cases:
    - PHA does not have a register of older legacy approved business cases. Some legacy business cases could not be located by PHA for Internal Audit review during audit fieldwork – these related to ongoing recurrent PHA funding of services to Trusts.
    - 2 Business Cases were approved by PHA after the start date of the service and 1 had not been signed as approved.

Financial Review

11. The controls in place to validate Staff in Post (SIP) Reports need strengthened. Internal Audit query the robustness of the SIP checking being conducted, given the 11 overpayments made to date in 2024/25 – some of which were over extended time periods and should have been detected earlier in SIP checks. 2 small business areas had not consistently and regularly confirmed the accuracy of their SIP as required between April and October 2024 (7 months) – only 1 from 14 SIP had been checked.

Consultancy/Non-Assurance Assignments

There were no non-assurance assignments conducted during 2024/25.

Follow Up Work

Internal Audit reviewed the implementation of accepted outstanding priority one and priority two Internal Audit recommendations, where the implementation date has passed, at mid-year and again at year-end.

At year-end, 83 (86%) out of the outstanding 97 recommendations examined were fully implemented and further 14 (14%) were partially implemented.

Of the recommendations reviewed in this follow up, 14 related to significant findings which caused Limited/Unacceptable assurance to be provided in individual previous audits. Of these 14 recommendations, 8 (57%) were implemented during this follow up period (October 2024 to March 2025).

Shared Service Audits
A number of audits (summarised below) have been conducted of BSO Financial/Recruitment Shared Services, as part of the BSO Internal Audit Plan. The recommendations in these Shared Service audit reports are the responsibility of BSO Management to take forward and the reports are presented to BSO Governance & Audit Committee. Given that PHA is a customer of BSO Shared Services, the final reports have been shared with PHA Management and a summary of the reports are presented to the PHA Governance and Audit Committee.

Shared Service Audit	Assurance
Payroll Shared Service	Satisfactory
Accounts Payable Shared Service	Satisfactory
Business Services Team	Satisfactory
Recruitment Shared Service	Satisfactory

QUALITY ASSURANCE

Documented Quality & Improvement Programme
The Unit's Quality Assurance and Improvement Programme is documented in the Internal Audit Manual. A variety of internal and external quality assurance measures are in place, as documented in the Internal Audit Strategy document.

Internal and External Quality Assessment
Internal Audit work for 2024/25 has been completed in accordance with Public Sector Internal Audit Standards (PSIAS) and conforms with the International Standards for the Professional Practice of Internal Auditing. This was confirmed via a self-assessment (an Internal Quality Assessment) of BSO Internal Audit Unit's compliance with the PSIAS in 2024/25.

Internal Audit Units are professionally required to undergo an independent External Quality Assessment (EQA) every 5 years. Mersey Internal Audit Agency (MIAA) performed an EQA of BSO Internal Audit during February/March 2024. The EQA concluded that the BSO Internal Audit Unit **generally conforms** to the requirements of the Public Sector Internal Audit Standards.

The new Global Internal Audit Standards are effective from April 2025. BSO Internal Audit have conducted a gap analysis against the new standards and work has been taken and continues to ensure the Unit complies with the required standards in 2025/26.

Other Quality and Development Work
BSO Internal Audit Unit is accredited with the ISO 9001:2015 quality standard and is an ACCA Gold accredited employer.

The Internal Audit Partnership Forum provides a forum for customers of the Internal Audit Unit to ensure the ongoing development of the service in line with customer needs. Internal Audit performance and developments are reported to the Forum.

In 2024/25, the Unit developed a formal staff training plan and has delivered training in line with this plan.

THE HEAD OF INTERNAL AUDIT'S OVERALL OPINION ON RISK MANAGEMENT, CONTROL AND GOVERNANCE FOR THE PUBLIC HEALTH AGENCY FOR THE YEAR ENDED 31 MARCH 2025

Introduction

The whole Board is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of the overall system. In discharging "accounting officer" responsibilities, the Accounting Officer is required to make an annual Governance Statement on behalf of the Board.

The Head of Internal Audit is required to provide an annual opinion on risk management, control and governance arrangements. This opinion is based upon and limited to, the internal audit work performed during the year, as approved by the Governance & Audit Committee.

Purpose of the Head of Internal Audit Opinion

The purpose of the annual opinion is to contribute to the assurances available to the Accounting Officer and the Board which underpin the PHA's own assessment of the effectiveness of the system of internal governance, which, in turn, will assist in the completion of the Governance Statement. The opinion expressed does not imply that Internal Audit has reviewed all risks and assurances relating to the organisation.

Overall Opinion

Overall, for the year ended 31 March 2025, I can provide **limited** assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.

I am providing Limited assurance because:

- Limited assurance has been provided in some core areas in 2024/25, namely Management of Vaccination Programmes, Personal and Public Involvement and Management of Trust Commissioned Services.
- In the last two consecutive years (2023/24 and 2024/25), Limited assurance has been provided in respect of the majority of audits performed.

I note the good performance of the Agency in implementing previous audit recommendations. Prompt Management action is required to address the significant issues raised in the 2024/25 Limited assurance reports.

Basis For Forming My Opinion

The basis for forming my overall opinion is an assessment of the range of individual opinions arising from the following risk-based audit assignments performed and reported on during 2024/25:

AUDIT ASSIGNMENT	LEVEL OF ASSURANCE
Corporate Risk Audits:	
Management of Vaccination Programmes	Limited
Governance Audits:	
Board Effectiveness	Satisfactory
Personal and Public Involvement	Limited
Trust Commissioned Services	Limited
Finance Audits:	
Financial Review	Satisfactory: Financial Reporting to the PHA Board; Non-Pay Expenditure; Budgetary Control & Saving Plan Management and Management of Additional Payments to Staff Limited: Staff in Post Reports

When forming my overall annual opinion, I have also taken into account the outcome of the year end follow up on the implementation of previous Internal Audit recommendations and the BSO Financial and Recruitment Shared Service audits.

Signed: Catherine McKeown **Date:** 30 April 2025
Head of Internal Audit

Appendix A: Definition of Levels of Assurance and Prioritisation of Audit Recommendations

Level of Assurance

Satisfactory	Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.
Limited	There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.
Unacceptable	The system of governance, risk management and control has failed or there is a real and substantial risk that the system will fail to meet its objectives.

Recommendation Priorities

Priority 1 Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.

Priority 2 Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.

Priority 3 Failure to implement the recommendation could lead to an increased risk exposure.

HSC Business Services Organisation

Internal Audit

BSO INTERNAL AUDIT GENERAL ANNUAL REPORT FOR HSC FOR 2024/25

ISSUED 10 JUNE 2025

BUSINESS SERVICES ORGANISATION
INTERNAL AUDIT GENERAL ANNUAL REPORT FOR HSC FOR 2024/25

CONTENTS

1 INTRODUCTION

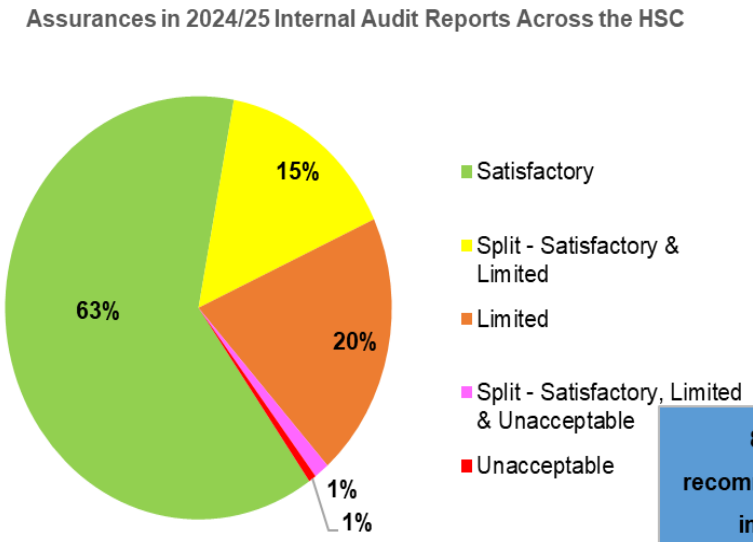
1.1 To assist in sharing learning across the HSC, BSO Internal Audit compiles a General Annual Report across the HSC each year. This report summarises the performance and outcome of Internal Audit activity in the HSC during 2024/25.

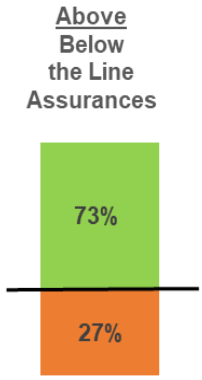
1.2 BSO Internal Audit continue to audit the Strategic Planning and Performance Group (SPPG) which is part of the Department of Health (DoH), reporting audit outcomes to the DoH Head of Internal Audit for presentation to the Departmental Audit and Risk Assurance Committee (DARAC). The SPPG has been included in this report even though it is a DoH Group rather than a separate HSC organisation.

2 ACKNOWLEDGEMENT

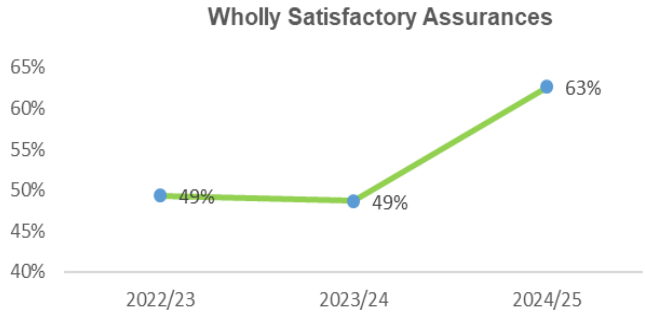
2.1 The engagement and support we received from client Management and Staff during our Internal Audit work in 2024/25 is recognised and very much appreciated.

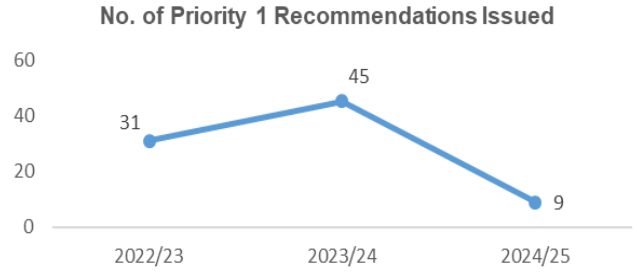
3 EXECUTIVE SUMMARY

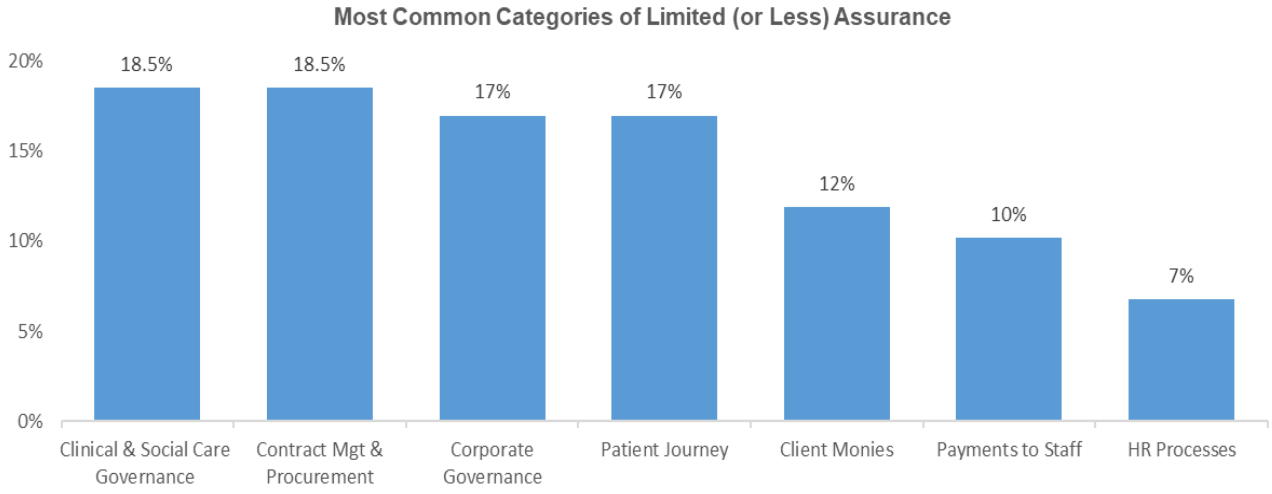




85% of outstanding P1 and P2 audit recommendations at year end 2024/25 were fully implemented.*(highest recorded level)*







63% of audit assignment assurances provided in 2024/25 were wholly Satisfactory and 73% were Satisfactory or mainly Satisfactory. This is significantly higher than recent years. The implementation rate of Priority 1 and 2 outstanding audit recommendations is at the highest recorded level of 85%.

Key learning themes from Limited/Unacceptable assurance audits in 2024/25 relate to Patient Journey/Flow audits, contract management and complaints management.

Looking ahead, HSC organisations should aim to maintain this improved position.

4 INTERNAL AUDIT ACTIVITY AND PERFORMANCE

4.1 BSO Internal Audit produced 191 audit reports in the 2024/25 year in the HSC and delivered 4,997 days.

4.2 The key objective of the Internal Audit service is to ensure the delivery of the Internal Audit Annual Plans to all client organisations, resulting in the provision of a Head of Internal Audit overall annual opinion on the adequacy and effectiveness of each client organisation's framework of governance, risk management and control. This key objective was achieved within the required timeline.

4.3 The Unit's overall performance against its Key Performance Indictors (KPIs) was:

Key Performance Indicator	% Achieved in 2023/24	% Achieved in 2024/25
100% Delivery of approved Annual Audit Plans	**100% (103%*)**	**100% (95%*)**
85% of First Draft Reports Issued within 4 weeks of fieldwork completion	**93%**	**94%**
75% of reports finalised within 5 weeks of issue (and within 1 week of receiving management comments)	**56% (91%)**	**75% (90%)**
75% Management Comments should be received within 4 weeks	**54%**	**69%**
% of reports significantly amended between draft report and final report stage[1]	**3% (5 reports)**	**1% (2 reports)**

**Actual delivery against SLA annual audit days*

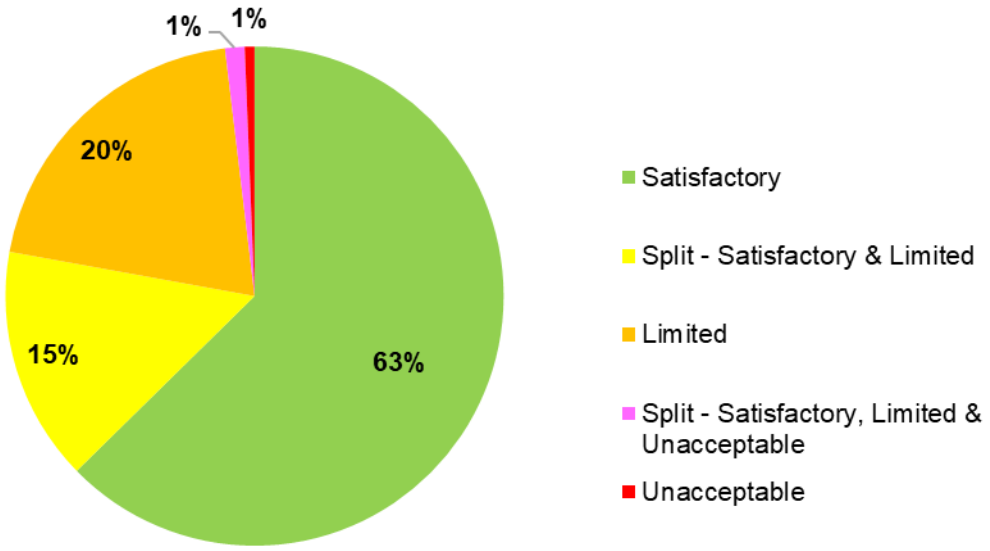
4.4 As shown in the table above, performance against KPIs is good. Although the target for client management to provide management comments within 4 weeks has not been met, performance has improved significantly from the previous year.

4.5 As well as ensuring our audit service was delivered in compliance with the Public Sector Internal Audit Standards in 2024/25, BSO Internal Audit conducted preparatory work for the introduction of the Global Internal Audit Standards (GIAS) in April 2025. Work to ensure we demonstrate compliance with GIAS will continue during 2025/26.

[1] Significant change is defined as change in assurance level provided in report, a priority 1 recommendation being completely removed from report, or significant changes in a number of key findings

5 2024/25 INTERNAL AUDIT ASSIGNMENT ASSURANCES IN HSC

Spread of Assurances Provided in HSC Audit Assignments in 2024/25



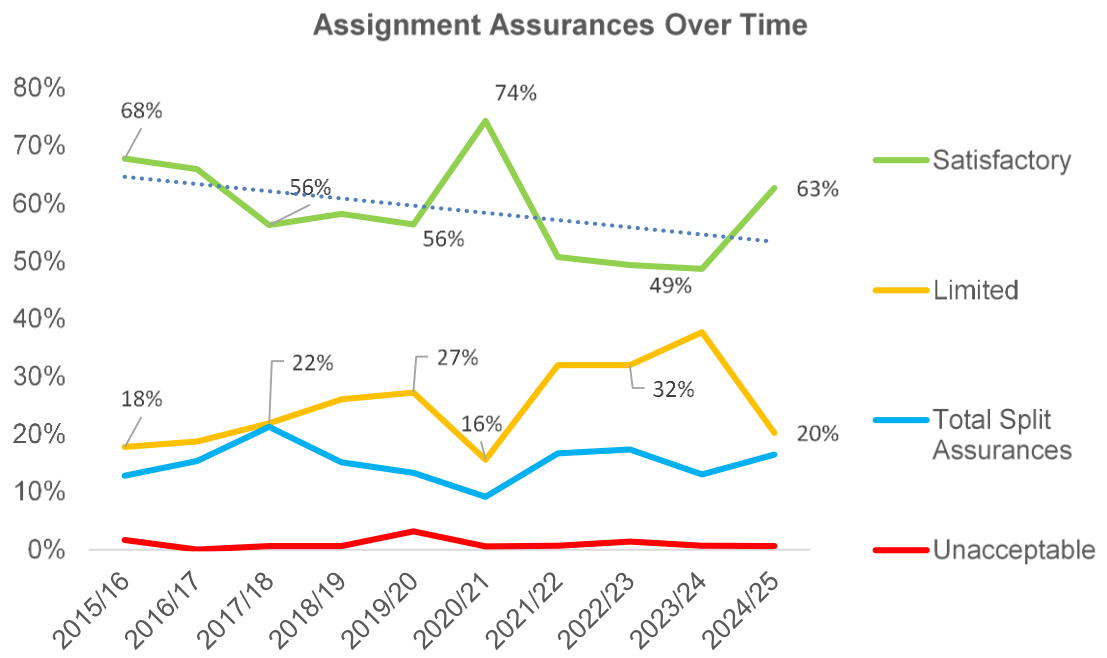
5.1 158 assurance audit reports were issued across the HSC in 2024/25. As illustrated in the chart above, 63% of assurance reports provided across the HSC in 2024/25 were wholly Satisfactory opinions.

5.2 A further 15% of opinions were split Satisfactory/Limited assurance; 20% were Limited assurance; 1% was split Satisfactory/Limited/Unacceptable; 1% (1 report) was Unacceptable assurance. *The Definitions of Assurance Levels are included in Appendix A.*

5.3 When further analysing the assurances in 2024/25 that were split (with an element of Satisfactory and an element of Limited and/or Unacceptable assurance), in total 73% of assurances provided in 2024/25 are considered 'Above the Line' ie Satisfactory or mainly Satisfactory and 27% are considered 'Below the Line'.

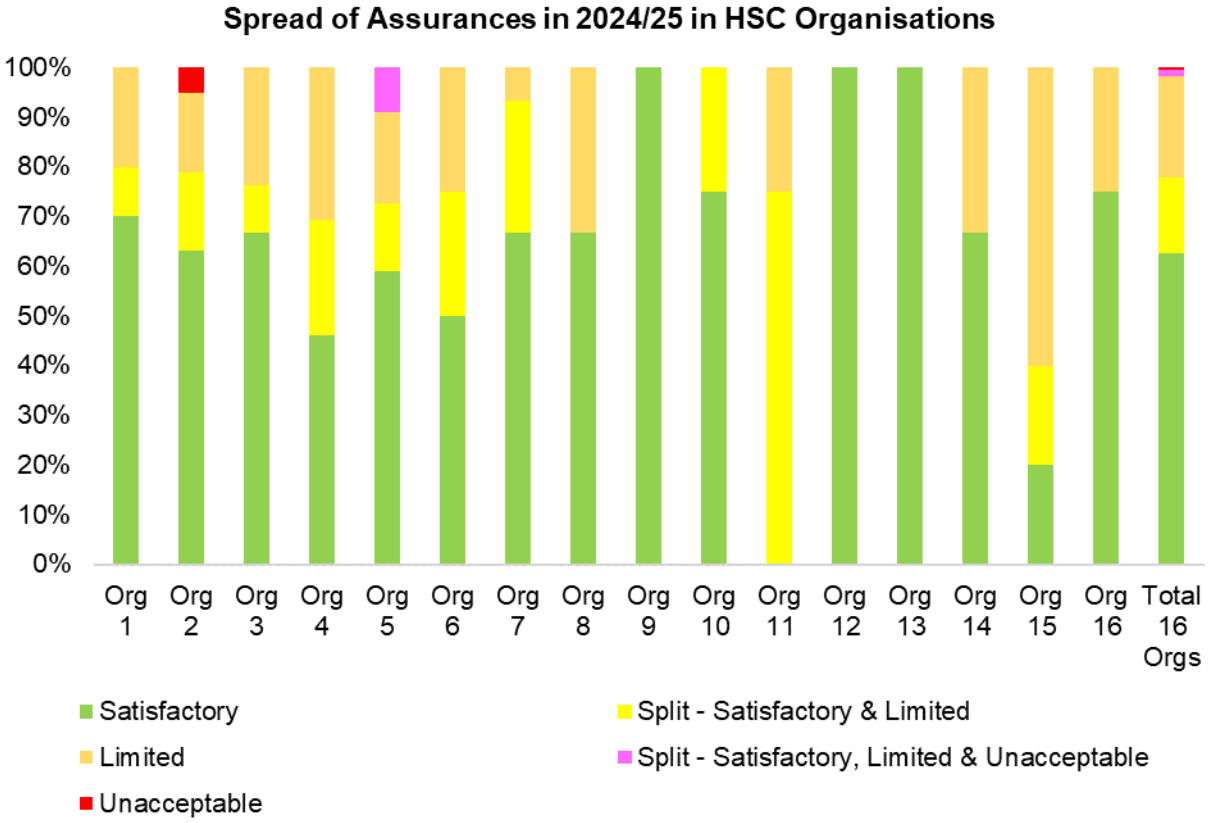
Comparison of Audit Assignment Assurance Spread Over Time

5.4 In 2024/25, there has been a significant increase in the percentage of wholly satisfactory assurance opinions. Up until this current year, there had been a downward trend over recent years in the percentage of wholly Satisfactory assurance assignment opinions across the HSC (with the exception of 2020/21 when the nature and extent of audit plans was impacted by COVID-19, particularly in the large HSC organisations).



Spread of Audit Assignment Assurances in each HSC Organisation

5.5 Anonymously, the following graph shows the breakdown of audit assignment assurances provided to each of the 15 HSC organisations and SPPG in 2024/25. 3 HSC organisations have 100% of assignment assurances that are Satisfactory. 3 organisations have less than 50% of assignment assurances that are wholly Satisfactory (an improvement from 6 organisations in 2023/24).



5.6 Overall for the year ended 31 March 2025, the Head of Internal Audit provided Satisfactory assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control to the majority of HSC organisations. However, overall Limited assurance was provided to two HSC organisations.

Trends in Limited/Unacceptable Assurances Provided in HSC Audit Assignments in 2024/25

5.7 The Limited/Unacceptable assurances across the HSC in 2024/25 are categorised as follows:

AUDIT AREA	% OF TOTAL LIMITED/ UNACCEPTABLE ASSURANCES
Clinical & Social Care Governance (Infection Prevention Control, Licenses and Accreditations, Clinical Governance of Cardiac Arrests; Direct Payments; Children Safeguarding & Unallocated Cases; Personal & Public Involvement; and Management of some other Specific C&SCG areas)	18.5%
Contract Management and Procurement Medical Locums, Agencies, Supply Chain Security Management, Voluntary and Community Organisation Contracts, Pharmacy Efficiencies, Management of Allocated Commissioned Funding, Management of Business Cases & PPEs/Contract Management)	18.5%
Patient Journey/Flow (Management of Waiting Lists; Management of Triage; Management of discharges; Management of GI Bleeds; Management of outpatients; Point of Care Testing; Safeguarding of Boarded Patients; Management of Change of Status Patients)	17%
Corporate Governance (Management of Complaints, Information Governance, Equality, Business Continuity Planning)	17%
Management of Patient/Service User Monies (elements of Management of Client Monies in Independent Sector Homes and Management of Cash and Valuables at Social Services facilities)	12%
Payments to Staff (Medical Job Planning; Staff in Post processes; Unsocial Payments; Nursing Enhanced Shift Payments; Control over payment files/validation)	10%
Human Resources related processes (Right to Work and Sponsorship; Absence Management; Rota Management; Management of Retention)	7%

5.8 Limited/unacceptable assurance opinions in 2024/25 audit reports were quite evenly categorised across 4 main themes: - Clinical & Social Care Governance; Contract Management & Procurement; Patient Journey/flow; and Corporate Governance.

5.9 Beneath the high level categories of Limited/Unacceptable assurance audits in 2024/25, key learning themes are:

i. Patient Journey/Flow audits often result in limited assurance opinions however these are often the most value adding audits.
ii. The need to strengthen and consistently apply robust contract management arrangements remains a persistent Limited assurance theme.
iii. The need for consistent application of process in respect of management of complaints, including identification of learning and ensuring this learning is implemented across the clients. In some smaller organisations with a limited number of complaints, corporate reporting processes require development.

5.10 The following graph analyses the nature of Limited and Unacceptable audit assurances in terms of whether they relate to a new audit area; whether the last audit conducted was also Limited/Unacceptable; or whether the last audit conducted was Satisfactory.

5.11 Key points in this analysis are:

i. 43% of Limited/Unacceptable audits in 2024/25 related to audit areas that had not been subject to internal audit in recent years (for example, management of discharges using epic, management of endoscope waiting lists, management of general surgical triage, safeguarding of boarded patients, right to work & sponsorship, and rota management).

ii. 37% of Limited audits are repeat assurance opinions in consecutive audits in the same HSC organisation. In many cases, enhancements in risk management, control and governance arrangements were observed, however despite this, further progress is needed to fully resolve the underlying reasons for Limited assurance. These repeat Limited audit areas were:

- Complaints Management;
- Management of Medical Locums and Agency Usage;
- Management of Safeguarding;
- Business Continuity Planning;
- Management of Medical Job Planning;
- Management of Direct Payments;
- Management of Change of Status Patients;
- Management of Unsocial Payments;
- Information Governance;
- Equality;
- Trust Monitoring Arrangements of Service Users Finances in Independent Sector Homes
- Staff in Post Processes;
- Management of a specific strategy/reform.

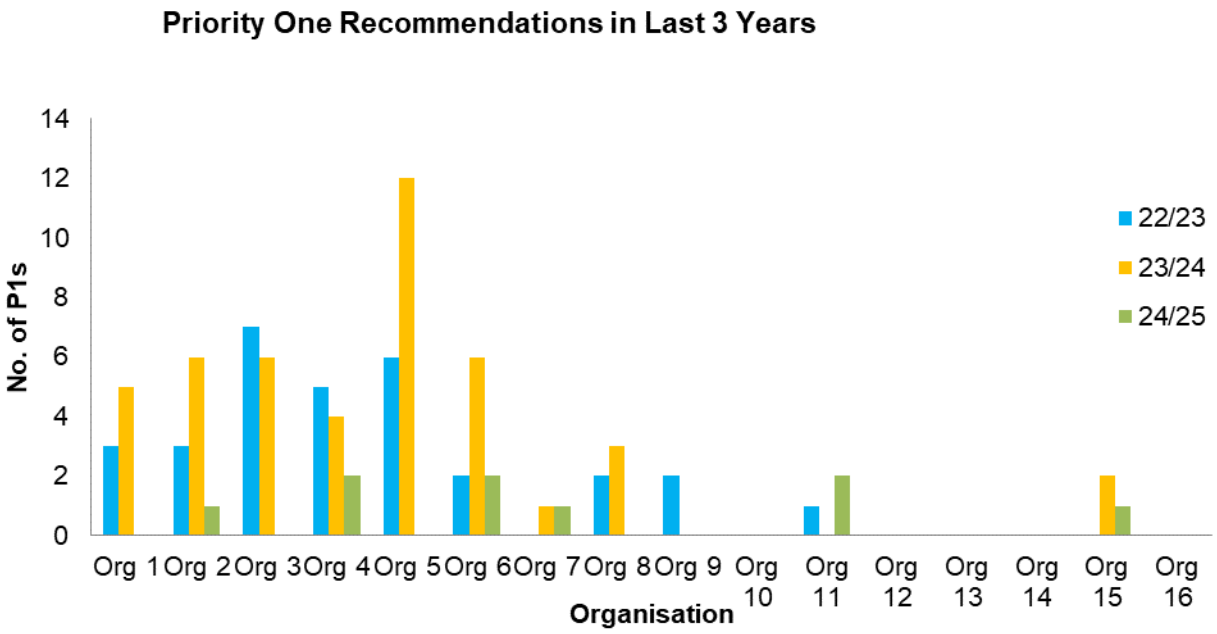
iii. 20% of Limited audits were in areas that previously were Satisfactory assurance audits in the same HSC organisation. These areas represent 12 audits across 9 HSC organisations (large and small). 3 of these 12 audits were Management of Complaints. Notably, despite the improved

spread of assurances across the HSC in 2024/25, the number and percentage of Limited audits that were previously Satisfactory is higher than the levels in the previous 2 years. The majority of these Limited audits are in non-trust organisations. This demonstrates the need for sustained focus on risk management, control and governance matters in all HSC organisations.

Priority One Recommendations in 2024/25

5.12 Internal Audit recommendations are prioritised as Priority 1, 2 or 3. Priority 1 recommendations are the most significant and are defined as 'Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.' *The Definitions of Recommendation Priorities are included in Appendix A.*

5.13 Across the HSC in 2024/25, 9 Priority 1 recommendations were made. This is a significant reduction compared to previous years (45 Priority 1 recommendations in 2023/24 and 31 in 2022/23). The graph below shows the number of Priority 1 recommendations by organisation in the last 3 years:



Good Practice and Improvement Observations During 2024/25

Good Practice Observations:

5.14 <u>Implementation of Audit Recommendations</u>
HSC organisations have embedded processes for co-ordinating and monitoring the implementation of internal audit recommendations. Organisations can demonstrate a strong performance in terms of implementation of previous audit recommendations. Audit Committees across the HSC hold Management to account for the implementation of audit recommendations.
2 organisations RAG rate outstanding audit recommendations in terms of whether implementation is on track by original/revised implementation dates. This enhances internal monitoring of progress as well as reporting to audit committee.

5.15 <u>Governance over encompass go/no-go live decisions in Relevant Trusts</u>
Similar to last year, we observed effective flows of information to Senior Management (and Trust Board), and mechanisms in place to make key decisions in the pre go-live phase. Processes to

identify risk and issues and escalate these to appropriate decision-making authorities were in place. Go-Live Readiness Assessments (GLRAs) are a key tool in the programme.

5.16 Supply Chain Security (Good Practice Observations within wider assurance audits)
The theme for our cyber security audit this year was IT Supply Chain Security. Following individual organisation audits, Internal Audit shared a regional learning brief with Trusts, highlighting areas of Good Practice as well as Areas needing Improvement. Good Practice observations included a risk assessment / due diligence function of the supplier and proposed service within Digital Services that includes providing approval conditions to the recognised service owners. These were subject to compliance spot check after Year1, 2 etc. Having standards in place for cloud based systems aligned with recognised good practice. Good technical controls were observed on supplier Active Directory accounts and where organisations retained control of potential areas of vulnerability such as server build, patching and anti-virus management. Having tested incident response plans specifically tailored to supplier scenarios was also positive.

General Improvements Observations:

5.17 Increase in Satisfactory Assurances and Reduction in Priority 1 Recommendations Raised
The improvement in the percentage of audit assurances that are wholly and also mainly Satisfactory assurance, in comparison with recent years is acknowledged. Similarly, the reduction in the number of Priority 1 recommendations across the sector is noteworthy – particularly the fact that 10 out of the 16 organisations had no Priority 1 recommendations in 2024/25 audit reports.

5.18 Payroll
For the first time since HRPTS was introduced over 10 years ago, Internal Audit provided a wholly Satisfactory assurance opinion in the BSO Payroll Service Centre audit in 2024/25. The majority of the HSC Trusts also received a wholly satisfactory assurance opinion within the scope of 2024/25 audits of Payments to Staff. In Trusts, sustained improvement in compliance with Staff in Post checking processes was observed, along with improved use of technology to facilitate this process.

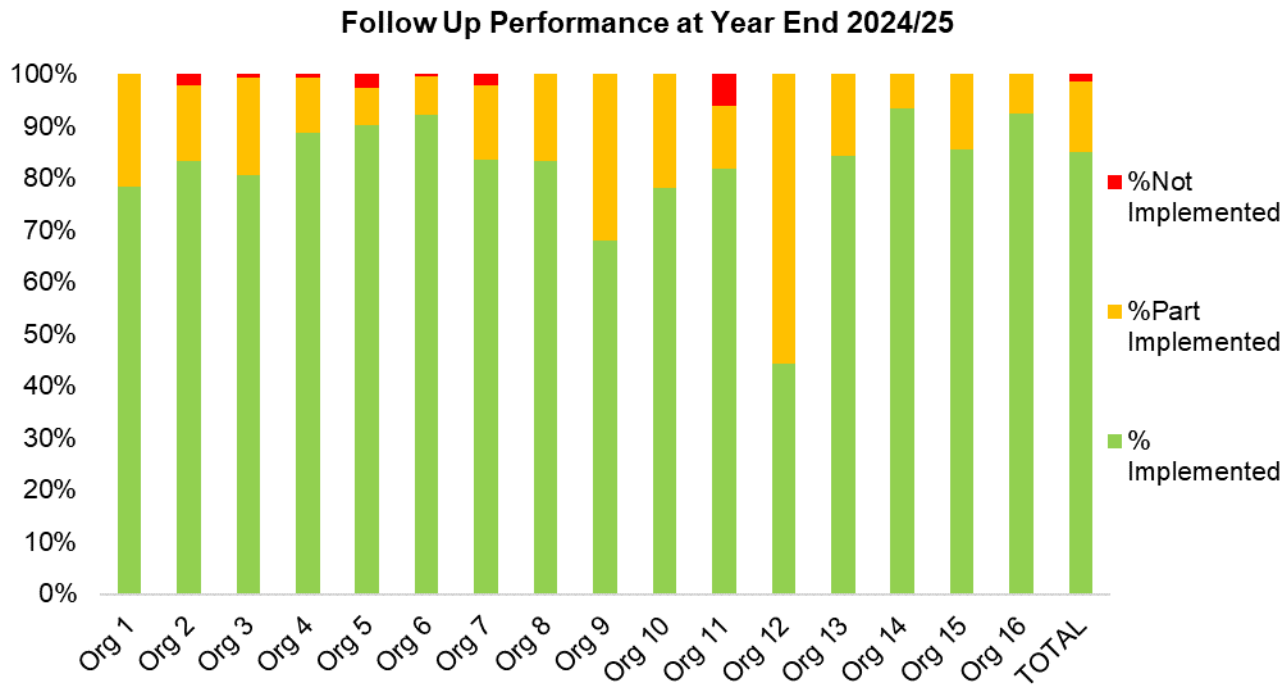
5.19 Estates
Despite Contract Management and Procurement historically being a Limited assurance theme in previous audits, the 4 Hospital Trusts where this audit was conducted achieved Satisfactory assurance in Estates procurement and contract management audits this year.

6 IMPLEMENTATION OF INTERNAL AUDIT RECOMMENDATIONS

6.1 BSO Internal Audit performs follow up on outstanding Priority 1 and 2 recommendations, at mid-year and year-end. It is the responsibility of an organisation's management team to implement accepted Internal Audit recommendations. During follow up, Internal Audit seek evidence from Management of the implementation of recommendations for which the original implementation date has past. Whilst evidence of implementation is sought during follow up, testing of the implementation is not generally conducted. It should be understood that follow up exercises are not substantive audits and assurance is not updated as a result of follow up. Follow up exercises are a snapshot at mid-year and year-end, of implementation of the total Priority 1 and 2 recommendations that are outstanding at that point in time.

6.2 Across the 15 HSC organisations and SPPG, the 2024/25 year-end follow up on Internal Audit recommendations found that 85% of recommendations reviewed were fully implemented, 14% were partially implemented and 1% were not implemented. The overall full implementation rate of 85% across the HSC in 2024/25 is the highest percentage implementation rate to date (since the first BSO Internal Audit General Annual Report in 2015/16). The implementation rate for outstanding audit recommendations has been increasing over the last few years.

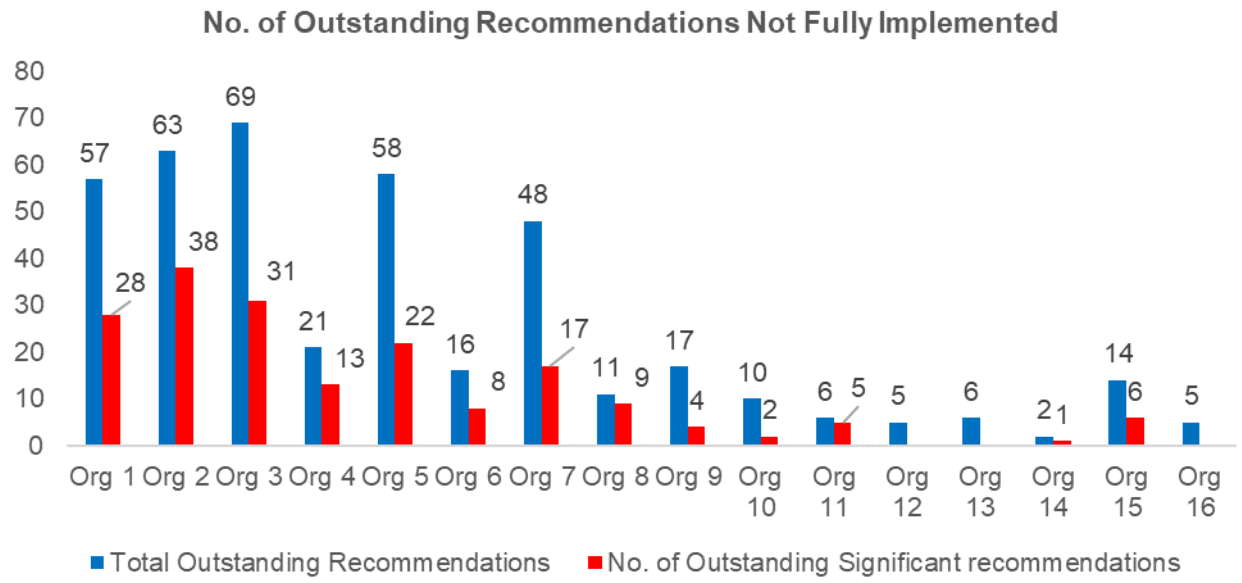
6.3 The graph below shows the follow up performance of each HSC organisation at year end 2024/25:



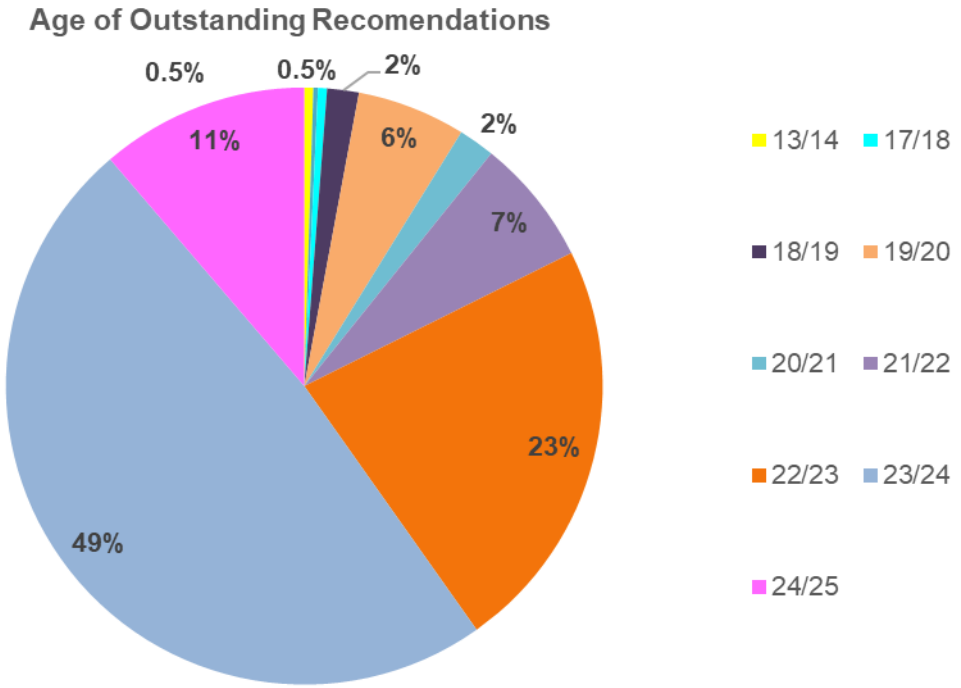
6.4 Across HSC, there were 529 outstanding recommendations not yet fully implemented at 31 March 2024. At 31 March 2025, this number reduced significantly to 408.

6.5 Out of the 408 outstanding recommendations not yet fully implemented, 184 are significant recommendations (ie those recommendations associated with audit findings that Internal Audit consider to be significant weaknesses within the governance, risk management and control framework in the audit area being reported on. Significant audit findings are the reasons why Limited or Unacceptable assurance is provided).

6.6 At year end 2024/25, the total number of outstanding Priority 1 and 2 audit recommendations (either partially implemented or not implemented) ranges from 2 recommendations in Organisation 14 to 69 recommendations in Organisation 3, as illustrated in the following chart. The chart also shows the number of outstanding significant recommendations included in the total outstanding Priority 1 and 2 audit recommendations – ranging from zero in Organisations 12, 13, & 16 to 38 in Organisation 2.



6.7 The age profile of the Outstanding Recommendations (ie either partially implemented or not implemented) as at year end 2024/25 is as follows:



6.8 83% of all outstanding Priority 1 and 2 recommendations relate to the last 3 years; 17% of recommendations are outstanding for more than 3 years.

7 LOOKING AHEAD

7.1 The proportion of Satisfactory assurances in 2024/25 is much improved from previous recent years. The ambition for organisations should be to sustain this improved position. Risk to the sustainability of some overall annual Satisfactory assurance opinions in future years remains. BSO Internal Audit advise the following:

Operation of 1st and 2nd line Assurances
There should be awareness and ongoing focus on 1st line assurance (comes from the department that performs the day to day activity) and 2nd line assurance (comes from organisation oversight functions), including identification and reporting of assurance around the effectiveness of controls in place to manage risk.

Definition and Application of Risk Appetite
The concept of risk appetite is still embedding and developing in the HSC. Boards should define their organisation's risk appetite and the appetite should then be disseminated and consistently applied and utilised in the risk management process. There should be understanding within organisations of what risks are within and out-with the risk appetite and what actions are required to ensure risks are managed within the risk appetite**.**

Implementation of Audit Recommendations
Management and Audit Committees should sustain regular attention on the implementation of outstanding audit recommendations, particularly the significant audit recommendations. Where Limited assurance is provided, organisations should, as much as possible, take prompt action to address the significant audit recommendations ahead of year end. Implementation of significant recommendations will be considered by the Head of Internal Audit when forming the overall assurance opinion.
Particular attention should be given to implementing longstanding audit recommendations.

Utilisation of Shared Learning Across Organisations
Internal Audit share high level learning associated with Limited/Unacceptable assurance audit reports at the Internal Audit Forum meetings. This learning should be shared appropriately within organisations and utilised to enhance internal control, risk management and governance arrangements.

Development of Epic Reporting
The need to develop reporting from the epic (encompass) system was a feature of several 2024/25 audits and it is expected to feature in a range of 2025/26 audits. Reporting is essential to enable monitoring of performance against targets and consistent compliance with process.

Procurement and Contract Management
Each HSC organisation should ensure that contract managers are consistently identified and suitably trained. Key to many of the procurement audit findings identified is regional progress in designing and procuring services (such as social care procurement and medical locums).

APPENDIX A - DEFINITIONS OF LEVELS OF ASSURANCE AND PRIORITIES

Level of Assurance (Public Sector Wide in Northern Ireland)

Satisfactory	Overall there is a satisfactory system of governance, risk management control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.
Limited	There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.
Unacceptable	The system of governance, risk management and control has failed or there is a real and substantial risk that the system will fail to meet its objectives.

Recommendation Priorities (Public Sector Wide in Northern Ireland)

Priority 1	Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.
Priority 2	Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.
Priority 3	Failure to implement the recommendation could lead to an increased risk exposure.

Northern Ireland Audit Office

Draft Report to those charged with Governance

Public Health Agency
2024-25

10 June 2025

Contents

1. Key Messages

This report summarises the key matters from our audit of the 2024-25 Public Health Agency financial statements which we must report to the Audit Committee, as those charged with governance. We would like to thank the Director of Finance and her staff for their assistance during the audit process.

Audit Opinion

It is proposed that the Comptroller and Auditor General (C&AG) will certify the 2024-25 financial statements with an unqualified audit opinion, without modification.

The Audit Certificate is included at Appendix Two.

Misstatements and Irregular Expenditure

Financial Statement Adjustments
The net effect of adjustments on the statement of comprehensive net expenditure and statement of financial position was £nil.

Uncorrected misstatements
Uncorrected misstatements would increase income and increase net assets by a further £nil.

Irregular expenditure
Irregular expenditure was not identified from our audit procedures

C&AG's Report

No report on the account was required

Audit Findings

During the audit we reviewed internal controls; accounting systems; and procedures to the extent considered necessary for the effective performance of the audit. We identified no priority one recommendations in relation to regularity[1] and the internal control environment.

Full details of findings are included at Findings from the Audit.

Status of the Audit

The Accounting Officer will sign the annual report and accounts together with a letter of representation, the wording of which is included at Appendix One.

The total audit fee charged is in line with that set out in our Audit Strategy.

Independence

We consider that we comply with the Financial Reporting Council (FRC) Ethical Standard and that, in our professional judgment, we are independent and our objectivity is not compromised.

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[1] Regularity - expenditure and income have been applied to the purposes intended by the Northern Ireland Assembly and that the transactions conform to the authorities which govern them.

Management of information and personal data

The Public Health Agency is required to comply with the General Data Protection Regulations (GDPR) in the handling and storage of personal data. Those Charged with Governance should ensure they have made sufficient enquiries of management to form a view on whether there were any significant specific data incidents which should be disclosed in the Governance Statement. We are unaware of any data handling incidents during the year and confirmation to this effect has been sought within the letter of representation included at Appendix One.

During the course of our audit we have access to personal data to support our audit testing. We have established processes to hold this data securely within encrypted files and to destroy it where relevant at the conclusion of our audit. We can confirm that we have discharged those responsibilities communicated to you in accordance with the requirements of General Data protection Regulation (GDPR) and Data Protection Act 2018.

Actions for the Audit Committee

The Audit Committee should:

- Review the findings set out in this report, including the draft letter of representation and audit certificate at Appendices one and two respectively.

2. Audit Scope

We have completed our audit of the 2024-25 financial statements in accordance with International Standards on Auditing (UK) (ISAs) issued by the Financial Reporting Council; with Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'; and with the Audit Strategy presented to the Audit Committee in February 2025.

There are no new matters to communicate concerning the planned scope and timing of the audit.

3. Significant Risks

The significant risks identified in our Audit Strategy have been addressed as follows:

Significant Risk 1

Management override of controls

Under ISA (UK) 240, there is a presumed significant risk of material misstatement due to fraud through management override of controls.

Audit Response

As required by ISA (UK) 240, we have carried out the following procedures:

- Tested the appropriateness of journal entries recorded in the general ledger and other adjustments made in the preparation of the financial statements;
- Reviewed accounting estimates for biases and evaluate whether the circumstances producing the bias, if any, represent a risk of material misstatement due to fraud;
- Considered significant transactions that are outside the normal course of business for the entity, or that otherwise appear to be unusual;
- Tested that the recognition of expenditure is appropriate and included in the correct financial period; and
- Included elements of unpredictability in testing while maintaining high levels of professional scepticism throughout the audit.

Outcome

No issues in relation to management override of controls were identified during the audit.

No additional significant risks were identified during our audit fieldwork

4. Findings from the Audit

Financial Reporting

As part of our audit, we evaluate the qualitative aspects of accounting practices and financial reporting. In this section we draw to your attention any significant changes or issues in respect of accounting policies; accounting estimates; and financial statement disclosures.

The Public Health Agency has robust processes in place for the production of the accounts and continue to produce good quality supporting working papers. Officers dealt efficiently with audit queries, effectively prioritising them, and the audit process has been completed within the planned timescales.

Accounting Policies

There have been no significant changes in accounting policies from the prior year. We are content with the appropriateness of the judgements made by the Public Health Agency on accounting policies.

Accounting Estimates

Accounting estimates made by the Public Health Agency within the financial statements are deemed to be appropriate. The accounting estimates made by the Public Health Agency are not complex or highly subjective and are not subject to a high level of inherent risk. Our substantive testing on the financial statement areas impacted by accounting estimates has provided us with sufficient assurance over the accuracy of the estimates adopted. With regard to employer and public liability claims, we have placed reliance on the expertise of the Directorate of Legal Services (DLS).

The Public Health Agency have followed guidance from the Department of Health in relation to the calculation of the PSNI Holiday Pay Provision, and we are content that it has been correctly applied.

Financial Statement Disclosures

We have made a number of suggestions to improve narrative disclosures and to ensure completeness of the disclosures required under the FReM and other relevant guidance.

Going Concern

No events or conditions were identified from our audit work that cast significant doubt about Public Health Agency's ability to continue to adopt the going concern basis of accounting.

Annual Report

The Annual Report was considered to be consistent with our understanding of the business, and was in line with the other information provided in the financial statements.

Accountability Report

The parts of the Accountability Report to be audited were considered to be properly prepared in accordance with Department of Health directions issued under the Health and Social Care (Reform) Act (Northern Ireland) 2009. We requested a number of amendments to the disclosures in the Remuneration Report to ensure compliance with the FreM and other relevant guidance.

Governance Statement

The Governance Statement was considered to reflect compliance with the Department of Finance's guidance. We made a number of suggestions to improve narrative disclosures and ensure completeness of the same.

Regularity, Propriety and Losses

We found no issues in relation to irregularity, impropriety or losses during our audit.

One loss was identified during the year in relation to the write off of unused vaccine stock which amounted to £1,412,883. The write off was approved by the Department of Health on 6th May 2025 and the loss has been appropriately disclosed in the Financial Statements. An associated recommendation has been made.

Internal Control

No material weaknesses in the design and implementation of the PHA's internal control systems have come to our attention during the audit.

An overall limited assurance opinion was issued by the internal auditors in relation to the control environment. This related to areas such as the Management of Vaccination Programmes, Staff in Post Report checks, Patient and Public Involvement (PPI) and Trust Commissioned Services. We have considered the findings and tailored our audit testing accordingly. A finding has been raised in relation to vaccine management.

Related Parties

No significant matters were arising during the audit in connection with Public Health Agency's related parties.

Audit Recommendations

This section outlines the findings arising from our audit, as well as management's response and target date for implementation. Our findings are defined as:

- **Priority 1** – significant issues for the attention of senior management which may have the potential to result in material weakness in internal control.
- **Priority 2** – important issues to be addressed by management in their areas of responsibility.
- **Priority 3** – issues of a more minor nature which represent best practice.

Finding 1

Management of Vaccine Stock Levels

In both 2024/25 and 2023/24 the level of influenza vaccine wastage was high. Whilst the vaccine order was reduced in 2024/25, there was also a decline in vaccine uptake rates. The financial statements include a write-off of unused influenza vaccine stock which amounted to £1,413k in 2024/25 (£1,442k 2023/24).

We also note there is a high inventory balance in 2024/25 of £1,088k in relation to shingles vaccines.

During the year Internal Audit provided limited assurance in relation to the management of vaccines. The Internal Audit findings and the loss are appropriately disclosed in the financial statements.

Priority Rating

2

Recommendation

Whilst we recognize the importance of the vaccination programmes and the need for the Public Health Agency to have sufficient vaccines available, the level of influenza vaccine wastage is high. We also acknowledge the higher stock levels are due to the holding of shingles vaccines which are expected to be used in the 2026 financial year.

We recommend that the Public Health Agency addresses the issues identified by Internal Audit and takes steps to further strengthen the identification of trends and uptake of vaccines to reduce wastage.

Management Response (including target date)

Management acknowledge the high levels of unused Flu vaccine written off in the last 2 years. This is driven by falling vaccine uptake rates across Northern Ireland. PHA reduced the number of doses ordered in 24-25, however the rate of decline in uptake has outstripped expectations and a loss resulted, even though orders were significantly reduced. The order has been further reduced for 25-26 based on the latest trends and expectations of uptake.

It is important that there is never a shortage of vaccine procured, and therefore there will always be some level of wastage arising from unused doses. Nonetheless, PHA will continue to take steps to minimise this loss through close monitoring and forecasting of vaccines requirement and reflecting this in doses ordered.

5. Misstatements and Irregular Expenditure

Adjusted misstatements

There were no adjusted misstatements identified during the audit process which exceeded our clearly trivial threshold of £98,229.

Uncorrected misstatements

There were no unadjusted misstatements identified during the course of our audit which exceeded our clearly trivial threshold of £98,229.

Irregular Expenditure

There was no irregular expenditure identified during the course of our audit.

Appendix One – Letter of Representation

[Client Letterhead]

The Comptroller and Auditor General
Northern Ireland Audit Office
106 University Street
BELFAST
BT7 1EU

Letter of Representation: Public Health Agency Year Ended 31 March 2025

As Accounting Officer of the Public Health Agency I have fulfilled my responsibility for preparing accounts that give a true and fair view of the state of affairs, net expenditure, cash flows, Changes in Taxpayers' Equity; and the related notes of the Public Health Agency for the year ended 31 March 2025.

In preparing the accounts, I was required to:

- observe the accounts direction issued by the Department of Health (DoH), apply appropriate accounting policies on a consistent basis in accordance with International Financial Reporting Standards;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards have been followed and disclosed and explain any material departures in the accounts; and
- make an assessment that the Public Health Agency is a going concern and will continue to be in operation throughout the next year; and ensure that this has been appropriately disclosed in the financial statements.

I confirm that for the financial year ended 31 March 2025:

- neither I nor my staff authorised a course of action, the financial impact of which is that transactions infringe the requirements of regularity as set out in Managing Public Money Northern Ireland;
- having considered and enquired as to the Public Health Agency's compliance with law and regulations, I am not aware of any actual or potential non-compliance that could have a material effect on the ability of the Public Health Agency to conduct its business or on the results and financial position disclosed in the accounts;

- all accounting records have been provided to you for the purpose of your audit and all transactions undertaken by the Public Health Agency have been properly recorded and reflected in the accounting records. All other records and related information, including minutes of all management meetings which you have requested have been supplied to you; and
- the information provided regarding the identification of related parties is complete; and the related party disclosures in the financial statements are adequate.

All material accounting policies as adopted are detailed in note 1 to the accounts.

Internal Control

I have fulfilled my responsibility as Accounting Officer for the design and implementation of internal controls to prevent and detect error and I have disclosed to you the results of my assessment of the risk that the financial statements could be materially misstated.

I confirm that I have reviewed the effectiveness of the system of internal control and that the disclosures I have made are in accordance with DoF guidance on the Governance Statement.

Fraud

I have fulfilled my responsibility as Accounting Officer for the design and implementation of internal controls to prevent and detect fraud and I have disclosed to you the results of my assessment of the risk that the financial statements could be materially misstated as a result of fraud.

I am not aware of any fraud or suspected fraud affecting the Public Health Agency and no allegations of fraud or suspected fraud affecting the financial statements has been communicated to me by employees, former employees, analysts, regulators or others.

Assets

GENERAL
All assets included in the Statement of Financial Position were in existence at the reporting period date and owned by the Public Health Agency and free from any lien, encumbrance or charge, except as disclosed in the

accounts. The Statement of Financial Position includes all tangible assets owned by the Public Health Agency.

NON CURRENT ASSETS
All assets over £5,000 are capitalised. They are revalued annually using indices from Land and Property Services. Depreciation is calculated to reduce the net book amount of each asset to its estimated residual value by the end of its estimated useful life in the Public Health Agency's operations.

OTHER CURRENT ASSETS
On realisation in the ordinary course of the Public Health Agency's operations the other current assets in the Statement of Financial Position are expected to produce at least the amounts at which they are stated. Adequate provision has been made against all amounts owing to Public Health Agency which are known, or may be expected, to be irrecoverable.

Liabilities

GENERAL
All liabilities have been recorded in the Statement of Financial Position.

There was one loss in the year amounting to £1,412,883. There were no other significant losses in the year and no provisions for losses were required at the year end.

All litigation and claims have been disclosed to you and correctly accounted for.

PROVISIONS
Provision is made in the financial statements for:

- PSNI holiday pay (£909,246); and
- Senior executive pay (£155,795).

CONTINGENT LIABILITIES
Except as disclosed in the accounts, I am not aware of any pending litigation which may result in significant loss to Public Health Agency. I am not aware of any action which is or may be brought against the Public Health Agency under the Insolvency (Northern Ireland) Order 1989 and the Insolvency (Northern Ireland) Order 2005.

Other Disclosures

RESULTS
Except as disclosed in the accounts, the results for the year were not materially affected by transactions of a sort not usually undertaken by the Public Health Agency, or circumstances of an exceptional or non-recurring nature.

UNCORRECTED MISSTATEMENTS
In the course of the audit there were no uncorrected misstatements identified.

EVENTS AFTER THE REPORTING PERIOD
Except as disclosed in the accounts, there have been no material changes since the reporting period date affecting liabilities and commitments, and no events or transactions have occurred which, though properly excluded from the accounts, are of such importance that they should have been brought to notice.

ACCOUNTING ESTIMATES
The methods, significant assumptions and the data used in making the accounting estimates and the related disclosures are appropriate to achieve recognition, measurement or disclosure that is in accordance with the financial reporting framework.

Management of Personal Data
There have been no personal data related incidents in 2024-25 which are required to be reported.

Mr Aidan Dawson

Accounting Officer

[Date]

Appendix Two – Audit Certificate

PUBLIC HEALTH AGENCY

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

Opinion on financial statements

I certify that I have audited the financial statements of the Public Health Agency for the year ended 31 March 2025 under the Health and Social Care (Reform) Act (Northern Ireland) 2009. The financial statements comprise: The Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes including significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by the Government Financial Reporting Manual.

I have also audited the information in the Accountability Report that is described in that report as having been audited.

In my opinion the financial statements:

- give a true and fair view of the state of Public Health Agency's affairs as at 31 March 2025 and of the Public Health Agency's net expenditure for the year then ended; and
- have been properly prepared in accordance with the Health and Social Care (Reform) Act (Northern Ireland) 2009 and Department of Health directions issued thereunder.

Opinion on regularity

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

Basis for opinions

I conducted my audit in accordance with International Standards on Auditing (ISAs) (UK), applicable law and Practice Note 10 'Audit of Financial Statements and Regularity of Public Sector Bodies in the United Kingdom'. My responsibilities under those standards are further described in the

Auditor's responsibilities for the audit of the financial statements section of my certificate.

My staff and I are independent of the Public Health Agency in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK, including the Financial Reporting Council's Ethical Standard, and have fulfilled our other ethical responsibilities in accordance with these requirements. I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my opinions.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that Public Health Agency's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Public Health Agency's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the Board and the Accounting Officer with respect to going concern are described in the relevant sections of this certificate.

Other Information

The other information comprises the information included in the annual report other than the financial statements, the parts of the Accountability Report described in that report as having been audited, and my audit certificate and report. The Board and the Accounting Officer are responsible for the other information included in the annual report. My opinion on the financial statements does not cover the other information and except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon.

My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there

is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

In my opinion, based on the work undertaken in the course of the audit:

- the parts of the Accountability Report to be audited have been properly prepared in accordance with Department of Health directions made under the Health and Social Care (Reform) Act (Northern Ireland) 2009; and
- the information given in the Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

In the light of the knowledge and understanding of the Public Health Agency and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance Report and Accountability Report. I have nothing to report in respect of the following matters which I report to you if, in my opinion:

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

Responsibilities of the Board and Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer Responsibilities, the Board and the Accounting Officer are responsible for:

- the preparation of the financial statements in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- ensuring such internal controls are in place as deemed necessary to enable the preparation of financial statements to be free from material misstatement, whether due to fraud of error;

- ensuring the annual report, which includes the Remunerations and Staff Report, is prepared in accordance with the applicable financial reporting framework; and
- assessing the Public Health Agency's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer anticipates that the services provided by the Public Health Agency will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

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

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error and to issue a certificate that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulation, including fraud.

My procedures included:

- obtaining an understanding of the legal and regulatory framework applicable to the Public Health Agency through discussion with management and application of extensive public sector accountability knowledge. The key laws and regulations I considered included governing legislation and any other relevant laws and regulations identified;
- making enquires of management and those charged with governance on Public Health Agency's compliance with laws and regulations;
- making enquiries of internal audit, management and those charged with governance as to susceptibility to irregularity and fraud, their assessment of the risk of material misstatement due to fraud and irregularity, and their knowledge of actual, suspected and alleged fraud and irregularity;
- completing risk assessment procedures to assess the susceptibility of the Public Health Agency's financial statements to material misstatement, including how fraud might occur. This included, but was not limited to, an engagement director led engagement team

discussion on fraud to identify particular areas, transaction streams and business practices that may be susceptible to material misstatement due to fraud. As part of this discussion, I identified potential for fraud in the following areas: revenue recognition, expenditure recognition, posting of unusual journals;

- engagement director oversight to ensure the engagement team collectively had the appropriate competence, capabilities and skills to identify or recognise non-compliance with the applicable legal and regulatory framework throughout the audit;
- documenting and evaluating the design and implementation of internal controls in place to mitigate risk of material misstatement due to fraud and non-compliance with laws and regulations;
- designing audit procedures to address specific laws and regulations which the engagement team considered to have a direct material effect on the financial statements in terms of misstatement and irregularity, including fraud. These audit procedures included, but were not limited to, reading board and committee minutes, and agreeing financial statement disclosures to underlying supporting documentation and approvals as appropriate;
- addressing the risk of fraud as a result of management override of controls by:
    - performing analytical procedures to identify unusual or unexpected relationships or movements;
    - testing journal entries to identify potential anomalies, and inappropriate or unauthorised adjustments;
    - assessing whether judgements and other assumptions made in determining accounting estimates were indicative of potential bias; and
    - investigating significant or unusual transactions made outside of the normal course of business;

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

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

Report

I have no observations to make on these financial statements.

Dorinnia Carville

Comptroller and Auditor General

Northern Ireland Audit Office

106 University Street

BELFAST

BT7 1EU

[Date]

Appendix Three – Implementation of Prior Year Priority One Recommendations

There were no prior year priority one recommendations.

item 9

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	19 June 2025
Title of paper	PHA Annual Compliments and Complaints Report 2024/25
Reference	PHA/03/06/25
Prepared by	Alastair Ross / Ashley Stoney
Lead Director	Aidan Dawson

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

1 Purpose

The purpose of this paper is for the Board to note the Annual Report on Compliment and Complaints for 2024/25.

2 Background Information

In May 2023, BSO Internal Audit carried out an audit of Complaints and Claims Management within the PHA.

Recommendation 2.2 of the Audit recommended that,

'*There should be an annual report on complaints produced and presented to Agency Board. This should include detail as laid out in the DoH guidance.'*

As part of the PHA management response, the Agency's first Annual Complaints Report was produced for the 2023/24 fiscal year.

The Annual Report for the 2024/25 fiscal year has now been prepared and in accordance with DoH guidance, it sets out detail in respect of the number of complaints, response times and the learning achieved by the organisation. The Report has been updated for 2024/25 to include compliments received by the Agency.

3 Key Issues

During 2024/25 a total of three complaints were made against PHA and PHA received a total of 12 compliments. Further information on these is contained within the Report.

4 Next Steps

The Compliments and Complaints Report is an external facing document and upon approval by AMT, GAC and PHA Board it will be uploaded to the ‘Compliments and Complaints’ section of the PHA website.

PHA ANNUAL

COMPLIMENTS AND COMPLAINTS REPORT

2024/2025

HSC Public Health Agency

HSC Public Health Agency

12 Compliments received by the PHA

Between 1 April 2024 and 31 March 2025

3 Complaints made to the PHA

Between 1 April 2024 and 31 March 2025

On average it took us 25 working days to issue a complaint response

Key Performance Indicators

All complaints acknowledged in writing within 2 working days of being received

One complaint response letter issued within 20 working days of the complaint being received - all other complainants updated every 20 days until the issue of each complaint response letter

Compliments

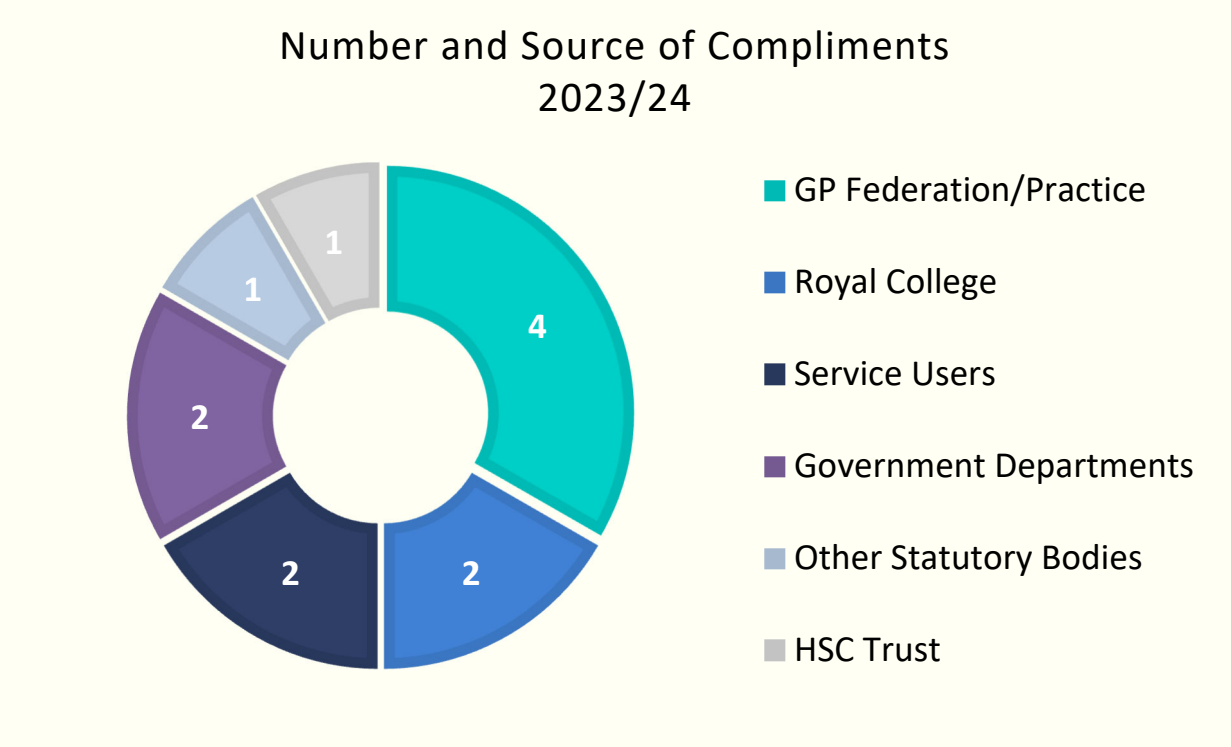
Definition

A compliment is an expression of appreciation felt by service users, carers, relatives, members of the public and/or external professional bodies for the work undertaken by the PHA.

Number of Compliments

During the period 1 April 2024 to 31 March 2025, the Agency received twelve compliments.

Our compliments came from a variety of sources - the following graphic provides further detail on this.



Types of Compliments

We receive compliments relating to a wide variety of subject areas - by way of example, we have included some of our compliments received this year in the following graphic.

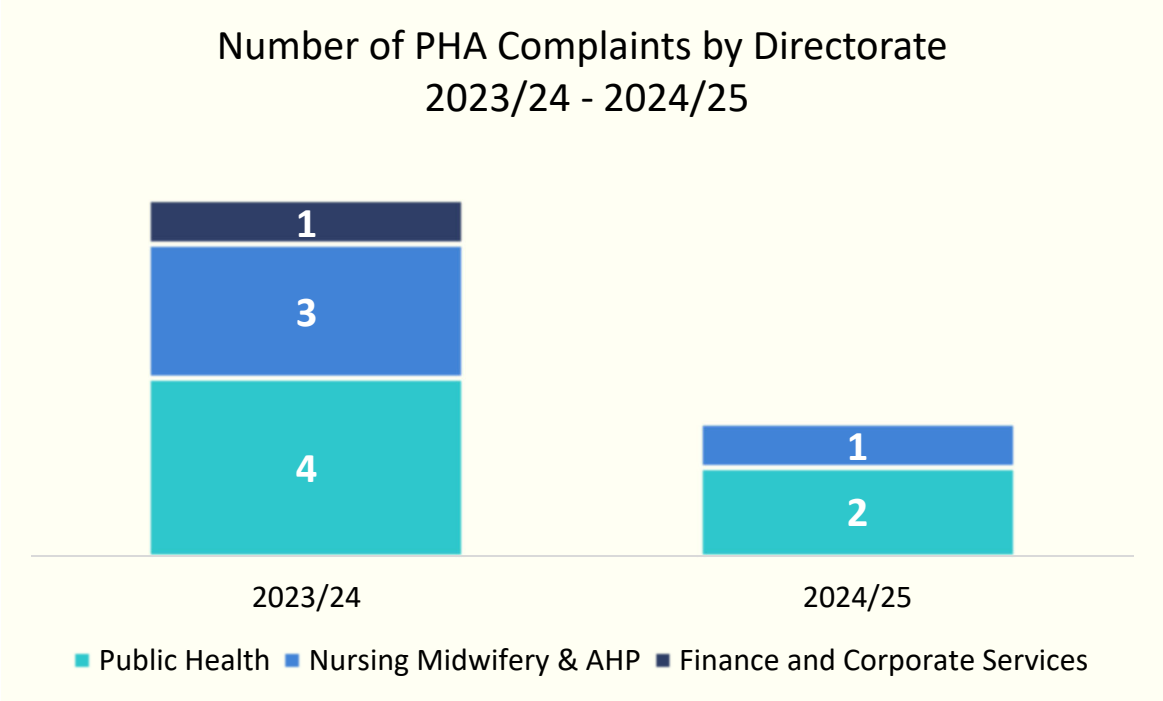
Complaints

Definition

In line with the guidance set out in the Health and Social Care Complaints Procedure a complaint is 'an expression of dissatisfaction that requires a response'.

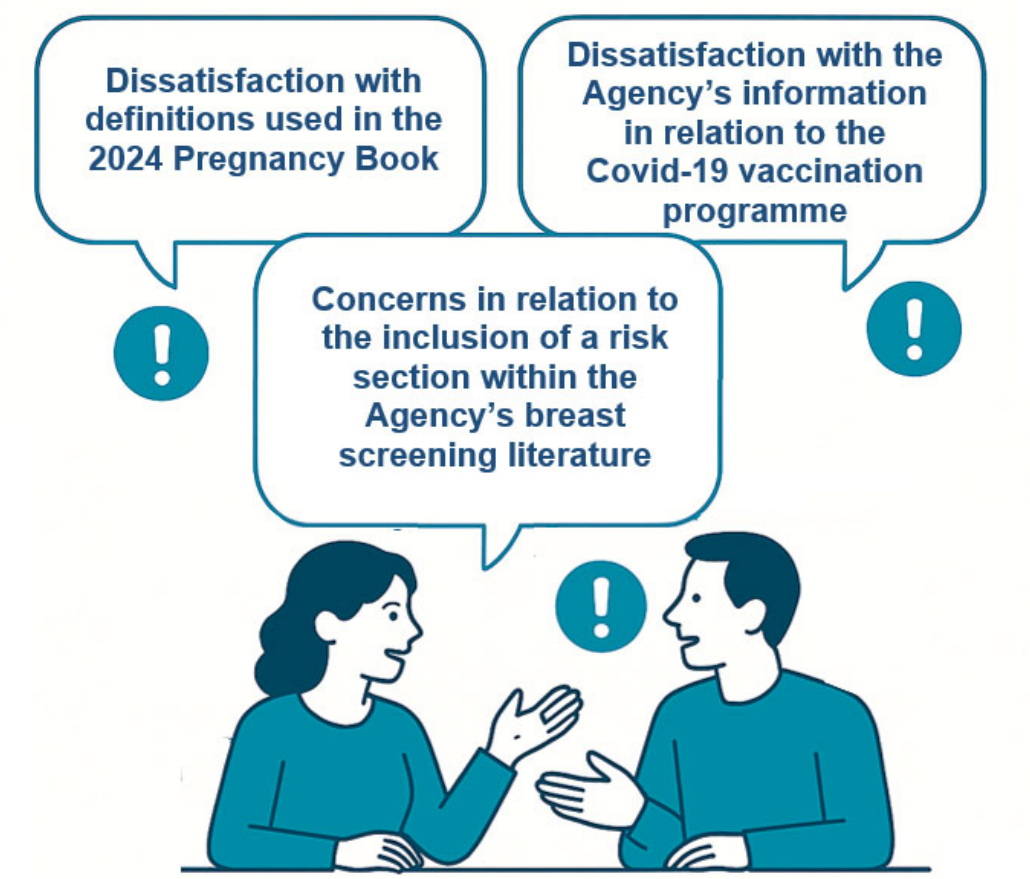
Number of Complaints

During the period 1 April 2024 to 31 March 2025, the Agency received three complaints - *this was a reduction of five compared to the previous year.*



Types of Complaints

Given the breadth of work undertaken by the PHA, any complaints we receive are varied in nature. The following graphic provides some detail on each complaint received in 2024/25.



Responding to Complaints

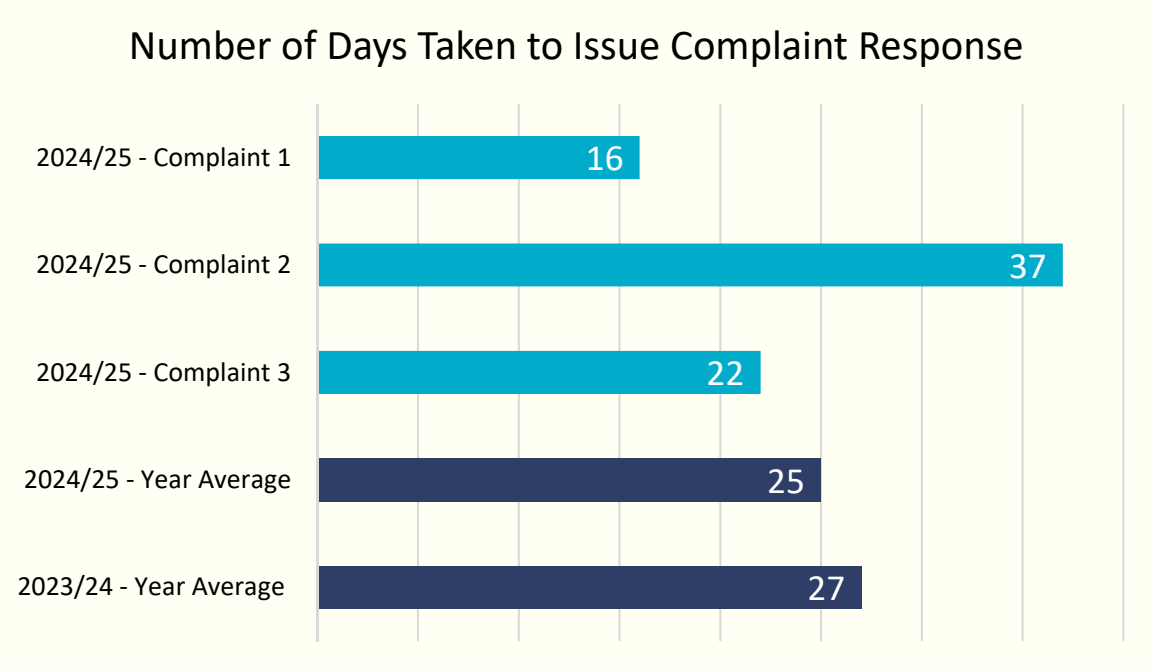
We aim to send an acknowledgement within two working days of a complaint being received.

During 2024/25, we acknowledged each of our three complaints within two working days.

We aim to investigate and issue a response for each complaint within twenty working days of its receipt. Sometimes this is not possible, especially when a complaint is complex and requires us to undertake investigatory work across multiple teams within the PHA.

During 2024/25, we were able to issue a response within twenty working days for one of our three complaints.

The bar chart below shows how long it took us to issue a response to each complaint received during 2024/25 - *on average it took the Agency 25 working days to conclude a complaint.*



Learning from Complaints

Complaints provide us with an opportunity to put things right for our service users and make improvements to the work we undertake.

During the year, as a result of a complaint we updated our public facing information on the Covid-19 vaccine to ensure that it accurately set out the eligibility requirements in relation to the 2024 autumn and winter vaccination programme.

The role of the Ombudsman

If a complainant isn't satisfied with our response, they can refer their complaint to the Northern Ireland Public Services Ombudsman. Upon receipt of a referral, the Ombudsman's office will assess the complaint and decide whether any further investigation is needed.

The PHA was not approached by the Ombudsman in relation to any complaints during 2024/25.

ANNUAL COMPLIMENTS AND COMPLAINTS REPORT

2024/2025

PHA Complaints Office

compliments.pha@hscni.net
complaints.pha@hscni.net

Complaints Office
Public Health Agency
12-22 Linenhall St
Belfast
BT2 8BS

HSC Public Health Agency

item 10

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	19 June 2025
Title of paper	PHA Annual Report and Accounts 2024/25
Reference	PHA/04/06/25
Prepared by	Stephen Wilson / Stephen Bailie / Leah Scott
Lead Director	Leah Scott

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

1 Purpose

The purpose of this paper is to seek approval from the PHA Board for the Chair and the Accounting Officer to sign the PHA's Annual Report and Accounts for 2024/25.

2 Background Information

The Public Health Agency is required to produce an Annual Report and Accounts (ARA). The draft ARA document for 2024/25 was submitted to the Northern Ireland Audit Office (NIAO) and DoH on 2 May 2025.

Following audit, the final draft ARA were brought to the Governance and Audit Committee for consideration and recommendation to the Board for approval on 12 June 2025.

Following approval by the PHA Board the ARA will be signed by the Chair and Chief Executive and the Letter of Representation will be signed by the Accounting Officer and submitted to NIAO. The final accounts will be certified and the audit certificate issued by 25 June 2025 prior to submission to the Department with final accounts being laid before the Assembly by 4 July 2025.

3 Actions Required

Following approval by the Board, in line with Section 2 above;

- The ARA should be signed by the Chair and Chief Executive; and
- The PHA Letter of Representation should be signed by the Accounting Officer.

The Director of Finance will then arrange submission to NIAO and DoH in line with the required timescales.

PUBLIC HEALTH AGENCY

ANNUAL REPORT & ACCOUNTS

FOR THE YEAR ENDED 31 MARCH 2025

PUBLIC HEALTH AGENCY

ANNUAL REPORT & ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2025

Laid before the Northern Ireland Assembly under Schedule 2, para 17(5) of the Reform Act for the Regional Agency, by the Department of Health on xx July 2025

Using this report

This report reflects progress by the Public Health Agency (PHA) in 2024/25 in delivering our corporate priorities and highlights examples of work undertaken during this period. It shows how this work has contributed to meeting our wider objectives and fulfilling our statutory functions.

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

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

Other formats

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

Any enquiries regarding this document should be sent to us at:

Public Health Agency
12/22 Linenhall Street
Belfast
BT2 8BS

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

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PUBLIC HEALTH AGENCY

ANNUAL REPORT & ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2025

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PUBLIC HEALTH AGENCY

ANNUAL REPORT & ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2025

Contents **Page**

A year across the Public Health Agency

April 2024	**Bowel Cancer Awareness Month** In April, the PHA highlighted the two key actions people can take to help combat bowel cancer – act when you notice symptoms, and take part in screening if eligible. Bowel cancer is one of the most common cancers for both men and women, so the Agency wanted to remind everyone that being alert to the symptoms of and attending for screening when invited could save your life.	
May 2024	**Farm families hits 25,000 milestone** In May, the Farm Families Health Checks Programme, which offers on-the-spot health checks to rural communities through a mobile unit attending marts and community-based events, celebrated the 25,000th client to avail of the service. The PHA partners with the Department of Agriculture, Environment and Rural Affairs (DAERA) to develop and co-fund this programme, and it has been successfully delivered by the Northern Trust since March 2012 to help improve the health and social wellbeing of farmers and farm families across Northern Ireland.	

	Measles awareness In May, the PHA emphasised the importance of getting both doses of the MMR (measles, mumps and rubella) vaccine following a number of linked cases of measles being identified in Northern Ireland, and a significant rise in cases in England and across Europe.	
June 2024	**Improving lives of people with swallowing difficulties** In June, the PHA and Hospitality Ulster launched a new factsheet to help the food and drink industry understand and improve the lives of people with swallowing difficulties.	
July 2024	**HPV and mpox vaccination** In July, healthcare professionals from the PHA and vaccinators from the South Eastern Trust were at Custom House Square in Belfast offering people who were eligible for the HPV and mpox vaccinations at the Belfast Pride Festival.	
	World Breastfeeding Week During World Breastfeeding Week the PHA shared stories from mums on their breastfeeding journey to help encourage other mothers to seek support if they need it.	

August 2024	For Cycle to Work Day in August the PHA encouraged everyone to leave the car at home and hop on their bike to work. By switching up your daily commute and choosing to cycle you can reap many benefits for your physical and mental health, and it is also better for the environment.	
September 2024	**Organ donation at 30** During Organ Donation Week in September, the PHA celebrated 30 years of the Organ Donor Register, which was set up in 1994 to promote organ donation and allow people to record their decision to donate. Since its creation, thousands of lives have been saved thanks to people agreeing to donate their organs after death.	
October 2024	**National Bereavement Care Pathway (NBCP)** In partnership with Sands, the PHA announced the appointment of the NBCP Project Manager for Northern Ireland, who will manage the development, delivery and review of the NBCP and embed its standards across Health and Social Care Trusts in Northern Ireland to help improve standards of bereavement care.	

	Awards success In October, the PHA won the Best Use of Social Media in Healthcare Award, and runner-up for Best Social Media Campaign in Public Sector/ Charity/ Education/Not For Profit, at the 2024 Northern Ireland Social Media Awards.	
	Live Better In October, Health Minister Mike Nesbitt announced the first locations for Live Better, a new initiative on addressing health inequalities. The initial phase of the programme will involve neighbourhoods in Belfast and Derry/Londonderry, and aims to reduce the unfair differences in health outcomes that are experienced by some of our most vulnerable individuals and communities.	
November 2024	**Stay well** In November, a new Living Well campaign rolled out which saw community pharmacies across Northern Ireland offering advice and support on a wide range of winter illnesses and actions people could take to help protect their health over the winter months.	
December 2024	**'Dying for Change' conference** The PHA brought together policymakers, academics and professionals from across health and social care to focus on what needs to be urgently improved in the care of people with a learning disability.	

	Safer sleeping Ahead of the Christmas holidays, the PHA reminded parents and carers of young babies of the importance of following safer sleep advice to reduce the risk of sudden infant death. At that time of year, with festivities and celebrations, normal routines and sleeping arrangements for young babies may be changed, so the advice was for babies to sleep is in their own cot or Moses basket, in the same room as an adult.	
January 2025	**Cervical Cancer Prevention Week** During Cervical Cancer Prevention Week in January, the PHA reminded women of the importance of going for cervical screening.	
February 2025	**Talking really helps** In February, the PHA highlighted the importance of having conversations about our true feelings in a campaign that showed people that 'Talking really helps'. The campaign aimed to encourage anyone with feelings of anxiety or distress, or who is in crisis, to start the conversation about their thoughts and feelings.	

March 2025	**Abdominal Aortic Aneurysm (AAA) screening** In March, the AAA Screening Programme's twelfth annual service user event in Belfast brought together a wide range of healthcare professionals and men who have, or had, an AAA detected through screening. The aim of the event was to encourage service users to share their experiences of the screening programme and for the programme to consider future developments.	

Performance Report

Overview

The purpose of the Performance Overview is to provide a brief summary of the role, purpose, activities and values of the PHA.

The Public Health Agency – our role, purpose and activities

The PHA is the statutory body responsible for improving and protecting the health of our population and an integral part of the Health and Social Care (HSC) system, working closely with the Strategic Planning and Performance Group (SPPG) of the Department of Health (DoH), local Health Trusts (HSC Trusts), the Business Services Organisation (BSO) and the Patient Client Council (PCC).

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

The PHA was set up with the explicit agenda to:

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

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

Our purpose

- 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.

Our vision

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

HSC values

In addition, we subscribe to the values and associated behaviours that all staff working within Health and Social Care (HSC) are expected to display at all times.

HSC Value	What does this mean?	What does this look like in practice? - Behaviours
Working Together 	We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.	• I work with others and value everyone's contribution • I treat people with respect and dignity • I work as part of a team looking for opportunities to support and help people in both my own and other teams • I actively engage people on issues that affect them • I look for feedback and examples of good practice, aiming to improve where possible
Compassion 	We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.	• I am sensitive to the different needs and feelings of others and treat people with kindness • I learn from others by listening carefully to them • I look after my own health and well-being so that I can care for and support others
Excellence 	We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high-quality, compassionate care and support.	• I put the people I care for and support at the centre of all I do to make a difference • I take responsibility for my decisions and actions • I commit to best practice and sharing learning, while continually learning and developing • I try to improve by asking 'could we do this better?'
Openness & Honesty 	We are open and honest with each other and act with integrity and candour.	• I am open and honest in order to develop trusting relationships • I ask someone for help when needed • I speak up if I have concerns • I challenge inappropriate or unacceptable behaviour and practice

Chair's Foreword

This is the second annual report under my tenure as Chair of the PHA and I want to begin by acknowledging the passing of my predecessor, Andrew Dougal who died following a short illness in June 2024. Andrew's death came as a shock to so many including his former colleagues in the PHA.

Andrew was Chair of the PHA until May 2023 having served for eight years in the role. Not only did be bring his vast experience and knowledge of a broad range of health issues to the job, but he was also a source of great encouragement and support for the agency and its staff, including during the pandemic. We all benefitted in so many ways from having known and worked with Andrew and pass our best wishes onto Andrew's wife Fiona, and Jack his son.

Under Andrew's leadership as Chair, the agency embarked upon its 'Reshape and Refresh' organisational transformation programme and I can report that the process has moved on significantly during the year with the establishment of a new operating model and leadership structure. I am confident that over the course of the years ahead we will see the benefits of this work in ensuring that the PHA as a fit for purpose organisation is able to shape, influence and deliver through partnership, better outcomes for public health in Northern Ireland – a fitting tribute to Andrew's lifelong passion.

Critical to the success of our endeavour is the need for clear focus and efficient application of limited resources. In this context I am pleased to note the work and contribution of both our staff and stakeholders in taking forward the challenge of developing a new Corporate plan during the year which is to be published shortly.

Given the breadth and complexity of challenges facing public health, particularly our enduring health inequalities which, in many cases are the most pronounced across the home nations, it is vitally important that we focus in on our priorities. With the support of a 'refreshed' organisation and a new draft corporate plan we are better placed to deliver on our statutory responsibilities. Our outcomes will rely in no small measure on the contribution from partner bodies across both the public and private sector and the agency is committed to developing closer ties going forward through a renewed focus on our stakeholder engagement.

As Chair I have been impressed by the focus of our Minister on making public health a top priority during his term of office. At Board level we have had the opportunity to have regular meetings with the Minister, Permanent Secretary and Chief Medical Officer Professor Sir Michael McBride during the year and we were delighted to partner with the Minister in establishing his new Live Better pilots, designed to create new ways by which the health family can better work together to support local communities. This initiative was a clear indication of the Minister's commitment to addressing health inequalities and we look forward to the learning from this pilot programme.

During the year Professor Nichola Rooney took up a new post with the Department of Health as Chief Psychological Professions Officer obliging her to stand down as a PHA Non-Executive Director. Nichola has served on the Board for 7 years and has brought a significant wealth of expertise and undoubted passion for public health to the role over that period. She will be sadly missed by her many colleagues and friends at Board and staff level alike and we thank her for her support and critical advice over the years. We look forward to replacement Non-Executive Board members being announced in the near future to ensure continuity in oversight, scrutiny and stewardship of the work of the PHA.

In concluding I want to thank my fellow Board members including our Chief Executive and Senior Management Team, and all of our staff colleagues for their energetic commitment to delivering the priorities of the Agency's Annual Business plan.

Colin Coffey

Chair of the Board

Public Health Agency for Northern Ireland

Chief Executive's Report

I am pleased to present the Public Health Agency's Annual Report and Accounts for 2024/25. The Agency has had a positive year overall with encouraging signs of progress along with some challenges to overcome in the future.

During 2024/25, the Health Sector in Northern Ireland has faced some tough financial circumstances. PHA continues to work with the Department of Health to ensure that investment in Public Health is continued at current levels and I am pleased that the PHA achieved its financial targets during 2024/25. However, in order to improve health and wellbeing for our population and mitigate the future demands on healthcare services, sustainable funding will be required.

The Agency has strengthened relationships across all our external stakeholders to understand how we can work to address the health needs of our population and reduce health inequalities. During 2024/25 we developed a Draft Corporate Plan for 2025-2030 to deliver services for Health Protection, Health Improvement and support Healthcare Public Health across the Health and Social Care sector. We undertook a public consultation which received over 100 responses from people all over Northern Ireland. I am pleased with the progress made and looking forward to implementing the Plan during 2024/25 and beyond.

During the year our work programmes have ensured that the health of the population has been protected through surveillance activity and a range of vaccination services. We introduced the Respiratory Syncytial Virus (RSV) vaccination and extended the flu vaccination to 50 to 65 year-olds during February 2025. However, there is still work to do as the uptake of vaccines continues to decline.

Our screening programmes continue to save lives and we have overseen improvements to Cervical Screening programmes. I am proud of the success we have had, leading a number of Health improvement programmes across a range of themes in partnership with Trusts and Community and Voluntary partners.

I am mindful of how precious people's health is, particularly as we participate in the Infected Blood Inquiry, COVID-19 Inquiry, Muckamore Hospital Inquiry and Urology Inquiry along with the review taking place into Cervical Screening. I am determined that this work will make improvements to ensure that people in Northern Ireland have confidence in the Healthcare services.

Our people are our biggest asset and I wish to pay tribute to the staff of PHA as they continue to work towards new ways of working. The implementation of the Reshape and Refresh programme has continued to develop throughout the year with the appointment of a number of senior positions who will lead the organisation to a new model of delivery.

The Agency now has its own Finance team to support the achievement of its objectives and a new Chief Executives office has been established to ensure that strategic matters are taken forward effectively. The People Plan has been designed to ensure that all our staff are equipped to play their part in the success of the organisation. I am already seeing the benefits of these changes in the design and delivery of the Agency's work.

The work of the PHA Board and in particular of Non-Executive Board members is essential. I wish to acknowledge the significant contribution made by all members, and in particular Professor Nichola Rooney, who left to take up post as Chief Psychological Professions Officer in the Department of Health. I also wish to thank the HSC Quality Improvement team and Dr Aideen Keaney for their contribution to the PHA as they continue this important work in new organisations.

I am pleased to share the successes in the Annual Report and Accounts, however I acknowledge we have much work to do. We will need the support of the entire population and I am looking forward to working together to ensure that we will see a "Healthier Northern Ireland".

Aidan Dawson HMFPH

Chief Executive

Public Health Agency for Northern Ireland

Performance analysis

The PHA Annual Business Plan 2024–2025 sets out the key actions for the year commencing 1 April 2024 and ending 31 March 2025 to meet ministerial priorities and deliver on outcomes set out in the extant PHA Corporate Plan.

The Annual Business Plan is broken down under the following key priority areas that align with the extant PHA Corporate Plan and are reflected under the current Organisational Refresh and Reshape programme:

- Protecting Health
- Starting Well
- Living Well
- Ageing Well
- HSC Research & Development
- Our Organisation and People

The Annual Business plan is monitored on a quarterly basis and update reports across all KPIs are provided to the PHA Board. The figures in the following table set out the position achieved at 31 March 2025.

	Action completed	14
	Slight delay in completing Action	12
	Action significantly delayed/unable to be completed.	7
	TOTAL	**33**

The following pages highlight some of the key actions taken forward during 2024/25 and the progress achieved.

1. Protecting health

Pandemic preparedness

2024/25 has been a busy year for PHA's core responsibilities for pandemic preparedness. The Agency has been contributing extensively to the review of the COVID-19 pandemic through the UK Public Inquiry and we have been acting on the lessons learned and helping to shape and agree plans for dealing with future pandemics.

Together with partners in SPPG and BSO, draft plans have been completed for all services. These will be further developed in alignment with national planning and capability for the following:

- surveillance, modelling forecasting;
- acute health protection response;
- contact tracing;
- diagnostics and testing;
- infection prevention and control including personal protective equipment;
- digital requirements;
- prison healthcare;
- health improvement;
- population screening programmes;
- communications; and
- vaccine storage and distribution/deployment.

In addition, we continue to work in partnership with health protection partners in the Republic of Ireland and the PHA is represented on a number of preparedness planning groups.

Following an all-island avian influenza exercise during 2023/24, a planning workshop to review draft pandemic preparedness plans was held in August 2024, and in March 2025 the PHA participated as observers in the HSE Exercise Pandora, the purpose of which was to assess the Republic of Ireland's preparedness for the next pandemic. Planning has commenced for participation in a similar UK national exercise commencing in September 2025.

Reporting on preparedness is completed on a quarterly basis to the HSC Pandemic Resilience Oversight Group which is jointly chaired by the Northern Ireland Department of Health and the SPPG.

Vaccination programmes

Getting vaccinated is the single most important thing we can do to protect our health. Vaccination starts before birth with pregnant women being offered vaccines to protect them and their unborn babies and continues after the baby is born though their pre-school

years, teenage years and then as an older adult. While there have been some successes through the introduction of new programmes in response to life-threatening infections, it has been concerning to note a recent decline of vaccine uptake across all of the public vaccination programmes in Northern Ireland.

Against this backdrop, and the ongoing cases of measles in Northern Ireland, the PHA was tasked with taking forward an MMR catch-up campaign, delivered through GP practices and HSC Trust facilities ending in June 2024.

A Respiratory Syncytial Virus (RSV) vaccination programme was implemented in September 2024. The programme saw eligible older adults (aged 75 to 79) and those who are pregnant being offered immunisation against a virus which can cause significant morbidity, mortality and additional pressure on the HSC system. In the first seven months of the programme, 36,426 older adults received an RSV vaccine (achieving an uptake of 47.2%) and 3,647 vaccinations were administered as part of the pregnancy programme.

The pertussis (whooping cough) vaccine is routinely offered to those who are pregnant from 16 weeks of gestation to provide protection to babies in the first few weeks of their life. Following increased cases of pertussis (whooping cough) at the beginning of 2024, the PHA sought to improve uptake in pregnant women from a baseline of 54.4% during 2023/24. In addition to the routine offer via GP practices, HSC Trust vaccination teams attended antenatal clinics to offer patients the chance to get vaccinated. In total since July, 4,087 pertussis vaccinations were given in pregnancy across the HSC network.

The core Autumn vaccination campaign to offer protection against influenza (flu) and COVID-19 commenced in October 2024. In general, uptake for the COVID-19 programme has decreased in comparison to previous campaigns (achieving an uptake of 55.5% in the 65+ age group, 73.5% in care home residents and 22.7% in the clinical at-risk group age 18-64). Flu vaccine uptake is higher than COVID-19 vaccine uptake in all comparable groups, but has seen a general decline in comparison to the previous year. While the programme is not yet complete, uptake for the 65+ age group, care home residents and primary school age children is lower than in 2023/24. However, uptake in post primary school and for the clinical at risk has seen an increase compared to 2023/24.

Maintaining high levels of vaccine uptake is proving to be a significant challenge across the UK and Ireland and will therefore increasingly be a top priority for the PHA. A programme of work is currently underway to promote vaccination, particularly in the most vulnerable and hard to reach groups, and to reverse the decline of vaccine uptake across public vaccination programmes. Behavioural science and mass media-led social marketing are just two tools that we anticipate will need to be optimised to support better outcomes going forward.

Population screening programmes

A range of development and quality improvement projects have been progressed in

population screening programmes during 2024/25, albeit a considerable focus has been required to support the cervical screening programme in particular. Within cervical screening, the PHA supported the completion of the cervical cytology review in the Southern HSCT and the associated reports were published in December 2024.

NHS England has also commenced a peer review of quality assurance processes. The outcome of this is expected in early 2025/26 and will inform how we can strengthen those processes going forward, with learning applied across all our screening programmes. As part of the next phase of the implementation of primary HPV testing, the PHA led a management of change project to reconfigure services to provide one cervical screening laboratory in Northern Ireland. As a result, all laboratory services moved to the Belfast HSCT from 1 November 2024.

The breast screening programme completed a procurement exercise to replace and add to the mammography equipment used by the service, including the purchase of new mobile trailers. A new static screening unit also opened at the Ards Hospital in May 2024. The breast screening programme in England published updated protocols in early 2023 for the surveillance of women at higher risk of developing breast cancer. The new protocols were implemented in Northern Ireland during 2024/25.

The PHA has led the development of a newborn bloodspot screening programme competency pack for newly qualified staff, as well as a competency refresher pack for qualified staff. A pilot of the competency assessment pack is underway with a cohort of QUB Midwifery students.

A health equity audit within the infectious diseases in pregnancy screening programme previously identified concerns about delays in some women attending for timely specialist review after testing positive for hepatitis B. To improve the information available and aid understanding of how important this review is, the PHA has been collaborating with HSC Trusts to develop a video for women with hepatitis B in pregnancy.

These activities demonstrate a culture of continuous improvement in the population screening programmes, ensuring that they continue to deliver against the aims of detecting disease earlier and improving health outcomes for the population.

Antimicrobial resistance

In response to the second UK National Action Plan (NAP) on Antimicrobial Resistance (AMR) launched in May 2024, the joint PHA/SPPG AMR-Strategic Implementation Group (AMR-SIG) has successfully developed the Northern Ireland AMR Implementation Plan for human health. The human health plan will be merged with the equivalent animal and environmental response and submitted to the Strategic Antimicrobial Resistance and Healthcare-associated Infection group for final approval and ratification.

During 2024/25, as a result of the extensive activity across each of the workstreams, the

AMR-SIG has successfully:

- launched the Northern Ireland IPC manual, a nationally recognised resource hosting peer reviewed evidence and guidance on the principles of IPC;
- developed a comprehensive communication strategy incorporating many of the public health awareness days such as World Hand Hygiene Day and Penicillin Allergy Day;
- developed an algorithm to support early detection of substantial increases in selected healthcare associated infections (HCAI) indicators which, once implemented, will facilitate rapid action against outbreaks; and
- contributed to the development of a nationally aligned AWaRe antibiotic classification which supports antibiotic prescribing using a list recommended as access, watch and reserve - this classification has been implemented into regional prescribing practice in primary and secondary care.

While we are at the very early stages of the roll out of the AMR Implementation plan, we are encouraged by the response of our partners and the work that has been successfully undertaken in both developing the plan and the early activities outlined above which will undoubtedly be important in helping to achieve successful outcomes going forward.

The roll-out of Encompass has provided a great deal of data on antimicrobial consumption in HSC Trusts and the PHA is working closely with stakeholders to validate this data. The PHA is also supporting HSC Trusts to reduce HCAI and achieve the commitments outlined in the UK National Action Plan.

Three HSC Trusts have met the annual target for Clostridioides difficile infection and four have met the annual target for Methicillin-resistant Staphylococcus aureus (MRSA) infection. If this performance is maintained, the HSC Trusts are on track to successfully deliver a reduction in HCAI over the five years of the UK National Action Plan.

Health protection surveillance

The last year has seen a number of significant developments in the area of surveillance, which have delivered a step-change in the Agency's ability to detect and monitor incidences of infectious disease. During 2024, a new Health Protection Situational Awareness report was developed collaboratively by the health protection surveillance (HPS) and acute response teams.

The HPS also introduced a detection algorithm to detect unseasonal increases in infectious diseases. It was developed with an interactive application that allows staff to simultaneously process and monitor infectious diseases through a user-friendly interface.

The health protection acute response service also established weekly activity reporting to allow for accurate and timely monitoring of service capacity and demand. Bespoke reports describe in-hours and out-of-hours activity and inform workforce needs and use of agreed

escalation to routine response, standard response or enhanced response.

Collectively these developments facilitate early preparedness and support the work of the Director of Public Heath, Department of Health and regional healthcare providers, while simultaneously providing wider visibility of the PHA’s surveillance and preparedness work.

2. Starting well

Supporting children and families from the earliest stages of life is critical to improving long-term health and wellbeing across the population. The PHA's Starting Well initiatives in 2024/25 focused on addressing key early-life challenges through evidence-based, collaborative approaches.

Together these initiatives demonstrate the PHA's commitment to giving every child the best start in life – laying the foundations for healthier families, stronger communities, and more resilient population across Northern Ireland.

Social complexity in pregnancy

Between July and December 2024, the Agency carried out a review of unmet need and risk factors associated with social complexity in pregnancy in Northern Ireland.

This work is essential to set priorities, identify effective approaches to support families and develop an action plan to address social complexity in pregnancy. This will integrate with relevant work already underway by the PHA, such as Family Nurse Partnership and Early Intervention and Support Teams.

Regional Perinatal Mental Health Care Pathway and Conference

The first Regional Perinatal Mental Health Conference was hosted by the PHA on March 5 2025, during which the *Regional Perinatal Mental Health Care Pathway* was formally launched.

At the heart of this care pathway is the PHA's commitment to improve the care, experience and outcomes for those women with antenatal or postnatal mental health needs, as well as their children and families.

Safer sleeping resources and regional guidance

The PHA has updated the regional guidance on *Promoting Safer Sleeping for Infants* in consultation with key stakeholders, including service users. The guidance fully reflects the current body of evidence in relation to the key safer sleeping messages, and now includes clearer advice in relation to safer bedsharing in line with recently published NHS guidelines.

Continuity of Midwifery Carer

The PHA leads on 'Continuity of Midwifery Carer' (CoMC) implementation. CoMC provides a woman with care from the same midwife/small team of midwives through pregnancy, birth and the early parenting period. The PHA has worked in close partnership with the HSC Trusts to oversee, and support the implementation of this model of care.

Review of routine enquiry into domestic abuse

In response to *the Domestic Abuse Strategy (2024-2031)* Action 4 Pillar 2 – Prevention, the PHA have completed a review of the existing routine enquiry domestic abuse screening processes by midwives, family nurses and health visitors across Northern Ireland. The review consisted of a mixed methodological approach incorporating four research design elements:

- literature review;
- clinical audit;
- service evaluation; and
- survivor focus groups.

A number of recommendations will be implemented under the key themes of policy, training, practice and information.

Early Intervention Support Service

The Early Intervention Support Service (EISS) delivers and coordinates person-centred, evidence-based intervention for **800+ families per year with children 0-18 years**. During 2024/25, the EISS participated in a pilot aimed at identifying opportunities the service could play in providing support regarding substance use. The evaluation is due early 2025.

Infant mental health

The PHA Infant Mental Health Framework Implementation Plan has enabled considerable workforce skills and knowledge development, enhanced parent infant support across sectors and the creation of parent-infant resources. A refreshed Infant Mental Health Action Plan is scheduled for launch in late 2025.

In October 2024, National Children's Bureau hosted an Infant Mental Health virtual conference on behalf of the PHA around the theme of 'Speak up for babies: giving our most vulnerable the best start'. Over 450 people from across sectors joined the event to celebrate and share learnings to improve outcomes on infant mental health in Northern Ireland.

Evidence-based parenting programmes

The PHA commissioned child development interventions coordinators within each HSC Trust to increase access to and improve quality of support for evidence-based parenting programmes from pre-birth to 18 years.

Special educational needs and disability

The PHA is commencing needs assessment across the **39 special schools** to understand the therapeutic and nursing needs of the children and young people. The AHP team is

working to capture the voices of children and young people with complex disabilities who are non-verbal and 'seldom heard' through applying Lundy's model of child participation by using of music, art and play therapies.

Service user and carer involvement

The Starting Well Public Health Planning Team (PHPT) engaged with service users and carers through focused group work to inform the Starting well action plan. The PHPT engaged with over **100 service users and carers across eight organisations** discussing what matters to them with regards to Starting well.

Mental health early intervention and prevention

During 2024/25 the PHA has continued to take forward the implementation of the *Mental Health Strategy Early Intervention and Prevention Action Plan*. The steering group, which consists of 30 partners, met on a quarterly basis to oversee implementation of the work plan, and a number of sub-groups and working groups have been meeting and delivering a range of outputs.

Healthy settings: universities, colleges and training providers

The PHA administered a small grants programme to support one off initiatives in these settings. Seventeen projects were supported, two within universities, four within further education colleges and eleven within training provider organisations. Projects included enhanced training for staff, wellness days, one to one counselling services, awareness raising workshops, meaningful activities, connecting with nature trips and resilience programmes and toolkits.

Communications and public awareness

A digital discovery exercise was carried out in April and May to explore the role of digital tools to support mental health promotion, early intervention and prevention in Northern Ireland. More than 110 stakeholders were engaged in the process through one-to-one interviews, focus groups and workshops.

The PHA and HSC Trusts launched a mental health and emotional wellbeing campaign which ran in September and October urging people to prioritise workplace mental health and to take 10 minutes each day for self-care using the 'Take 5 steps to wellbeing'.

Public mental health learning network

A virtual learning network for anyone with an interest in public mental health has been established on the Project ECHO (Extension of Community Healthcare Outcomes) platform. Network members connect on a monthly basis via Zoom and have discussed issues such as; inequalities in public mental health, mental health interventions in schools and developing community-based interventions.

3. Living Well

Live Better

Live Better has been designed to help address health inequalities by bringing targeted health support to communities which need it most. Live Better is delivered by the PHA and, following a process to identify the areas in which to initially pilot the approach, the programme launched in October in the Fountain, Bogside, Brandywell and Creggan areas in Derry/Londonderry and the Lower Shankill, Lower Falls and Grosvenor Road areas in Belfast.

Priority health issues have been identified for these areas by the local stakeholders. The primary goal is to deliver tailored health interventions and engage the local population to address health inequalities and help improve health and wellbeing.

Suicide prevention

During the year the PHA took several actions to increase public awareness and access to information around suicide including:

- The Minding your head website was redesigned and launched in December 2024.
- A mass media campaign ***Talking really helps*** was delivered from 3 February to 30 March 2025. Provisional performance indicators show a 20% increase in call volume to the Lifeline service, an increase in total talk time and a 25% increase in referrals.

Service provision, development and improvement

- **Lifeline** is Northern Ireland's crisis response helpline for people experiencing distress or despair. Each year there are approximately 40,000 active calls to Lifeline.
- The new Self Harm Intervention Project (SHIP) service was commissioned across Northern Ireland in November 2024. Each year approximately 3,600 people who self-harm are referred to the SHIP service and around 13,000 sessions of therapy are delivered, as well as additional support provided to their carers.
- The annual short-term funding programme for mental health emotional wellbeing and suicide prevention has invested £1.5 million in approximately 500 local projects, benefiting around 25,000 people across Northern Ireland.

2024/25 has seen the conclusion of the review of the *Protect Life 2 Suicide Prevention Strategy Action Plan*. The PHA has worked with the Department of Health on collating the consultation feedback and developing a reviewed action plan for the next three years.

Substance use

2024/25 has been a significant period of progress for the PHA health improvement substance use team. Approximately £10.2 million has been invested in substance use

early intervention and prevention services and treatment support services.

The team, in partnership with the Department of Health and SPPG, published the *Substance Use Commissioning and Implementation Plan* in November 2024 and since have continued to deliver against the actions of the implementation plan.

The first Needle and Syringe Exchange Conference in Northern Ireland was hosted in October 2024. The conference was attended by over 120 representatives including statutory, community and voluntary sector, community pharmacists and public health consultants.

An independent review of the role and function of Drug and Alcohol Co-Ordination Teams across Northern Ireland commenced in 2023 and has recently been completed and published.

Finally, the team was recognised by an award at the Northern Ireland Trauma Conference held in January 2025.

Obesity, physical activity and nutrition

The obesity prevention team leads the implementation of the non-departmental actions aligned to the 'A Fitter Future for All' framework to prevent and address overweight and obesity. Examples include commissioning of the following;

1. An early years obesity prevention programme – HENRY
2. Weigh to a Healthy Pregnancy programme
3. A Food in Schools (FIS) Coordinator to implementation the FIS policy
4. The Public Health Dietitians Group (PHDG) to deliver evidence-based nutrition education programmes
5. Active Travel (AT) programmes

The Active School Travel programme showed that the number of children travelling actively to school increased from 36% at the baseline to 40% at the end of the school year. At the same time, the number of pupils being driven to school fell from 53% to 48%.

One part of the commissioning of PHDG is the development of evidence-based nutrition videos hosted on the PHDG YouTube channel - overall there are nearly 1000 subscribers with 25.8k views and 240.6k impressions which has been a 200% increase from the previous year.

Towards a smoke-free generation

In Northern Ireland, around 13% of the population are current smokers. Smoking is recognised as a major driver of health inequalities and prevalence remains significantly higher among socially disadvantaged groups.

The development of legislation on tobacco, tobacco related products and e-cigarette sales, supply and use, in line with the UK Tobacco and Vapes Bill, is a landmark step which will provide the PHA with an enhanced opportunity to reduce preventable deaths and health inequalities across Northern Ireland.

The Tobacco and Vapes Bill will create a smoke-free generation by making it an offence for anyone born on or after 1 January 2009 to be sold tobacco products and ban the sale of non-nicotine vapes and other nicotine products to under 18s.

4. Ageing well

Ageing Well is a critical part of the PHA's corporate plan for Northern Ireland. As populations age, prioritising older adults' health ensures dignity, equity and sustainability in public health practice.

Home accident prevention

Preventable home accidents remain one of Northern Ireland's most serious public health challenges. In response, coordinated actions have been taken to reduce risk, promote safety, and support healthy ageing.

In November 2024, the Home Accident Prevention Strategic Implementation Group (HAPSIG) reissued 34,000 updated safety leaflets for children under five and adults over 65, distributed through councils and community networks.

Safer mobility

Across 2024/25 the Ageing Well Public Health Planning Team (PHPT) have worked to improve safer mobility/falls prevention services across Northern Ireland. There is significant variation across the five trusts and different services offered in different postcodes. In November the PHA hosted a workshop to show these findings to the relevant stakeholder and we now have agreement from the HSC Trusts, Northern Ireland Ambulance Service and community and voluntary representatives that a regional model is the best way forward.

Service user and carer involvement

The Ageing Well PHPT engaged with service users and carers through focused group work to inform the Ageing well action plan. As an outcome the Ageing Well planning team have key guidance statements to shape their work to ensure it aligns with the views of service users and carers.

Age-friendly Northern Ireland

The PHA has invested in a five-year business plan from 2021–2026 to develop an age-friendly Northern Ireland by commissioning each of our 11 councils to push forward an age-friendly agenda through our age friendly officers (AFOs).

In Armagh, Banbridge and Craigavon Council, a group of local adults were mentored over six weeks by Year 13 A-Level pupils from St Patrick's Grammar in Armagh on a range of IT skills from email to social media as well as important settings on their devices.

5. HSC Research & Development Division

During 2024/25, HSC R&D Division completed a review of the current 10-year R&D Strategy – Research for Better Health and Social Care. The review included an autumn workshop attended by over 100 R&D stakeholders.

Our focus on equity, diversity and inclusivity has continued throughout 2024/25, with the launch of our partnership and manifesto with the Oxford Centre for Research Equity at Stormont in June. Throughout the year, a vibrant group of researchers has been meeting regularly to take forward a proposal for a mobile recruitment unit, with the aim of broadening participation in research to include people who have not previously been involved.

Part of the Belfast Region City Deal, the Institute of Research Excellence for Advanced Clinical Healthcare (iREACH Health) is a £64m integrated clinical research innovation centre led by QUB in partnership with Belfast Trust, jointly funded by HM Treasury, the NI Executive (via HSC R&D Division, PHA) and QUB.

Through the Voluntary Scheme for Branded Medicines Pricing, Access and Growth (VPAG) Investment Programme, the Association of the British Pharmaceutical Industry has signed an agreement with the four UK administrations to invest over £300m into clinical trials across the UK for the next five years, of which Northern Ireland will receive £12.3m.

Both of these new initiatives will build on the longstanding investments made by HSC R&D Division.

6. Our Organisation and People

Reshape and Refresh Programme

The PHA continues to implement a major transformation programme entitled Reshape and Refresh. This will ensure the PHA is well placed to deliver its functions and to deal with ongoing and future public health needs of the population. Last year there were notable achievements across a range of areas including:

- A review of the PHA organisational structures was undertaken with the establishment of a new Assistant Director structure in December/January 2025 and progress is underway to support the design of tier 4 roles within the new organisational structure.
- Establishment of a new Directorate – Population, Data and Intelligence. Work has been progressing to develop this Directorate alongside its Director role.
- A number of functions were identified as being better aligned with other parts of the HSC and in November 2024 HSC Quality Improvement (HSCQI) successfully transferred from PHA to RQIA.
- Work to develop a range of public health planning teams across the PHA was progressed last year.
- In June 2024 the PHA launched their first People Plan which provided a platform of improvements relating to staff development and engagement.

Corporate Plan 2025-30

During 2024/25 the PHA has worked to develop its next corporate plan, setting the strategic direction for the next five years, 2025-2030.

A significant programme of consultation and engagement with external stakeholders, DoH sponsor branch, staff and PHA board members was in place throughout the development process. A 13-week consultation (28 November 2024 – 28 February 2025) invited internal and external stakeholders to engage through surveys, email and workshops to discuss their thoughts and inputs to the direction set out in the draft plan.

A total of **102 responses** were received from internal and external stakeholders during the consultation period via online survey and email. The draft Plan was then reviewed and amended in line with all comments and views shared by stakeholders during the consultation period before its submission to PHA board for final approval in March 2025.

The corporate plan is structured around four strategic areas and is supported by a more detailed implementation plan that sets out the key actions to be progressed in delivering the priorities. A fifth area, focusing on our organisation and how we work, has been added to reflect the importance of both what we do as an organisation and how we do it.

The strategic areas of the plan are themed as follows:

- Protecting health
- Starting well
- Living well
- Ageing well
- Our organisation

Reporting against this corporate plan will take place through annual business plans and corporate monitoring.

Business Continuity

This year the PHA undertook a major review of the Business Continuity arrangements that are in place. Business Impact Assessments were completed by each Directorate and reviewed by the Agency Management Team. From this Directorate Business Continuity Plans were developed. A Business Continuity Plan Project Team has been established to coordinate and take forward this work and to plan for the continual review and testing of Business Continuity Plans within the PHA.

Procurement

During 2024/25, PHA has progressed a number of tenders:

- The Self Harm Intervention Programme Tender process was concluded and five new contracts were awarded and commenced on 1 November, with an annual value of £1.0m.
- Phase 1 of the Alcohol and drug re-tender programme has been progressed with tenders for Adult Step 2 services and workforce development issued to the market in January 2025. The applications are currently being assessed with the intention that new contracts are awarded in July 2025. Pre-planning work for phase 2 of the re-tender programme has been progressed and it is anticipated new contracts will be in place by October 2025.
- A new tender was awarded for the Reader groups in prison to the Verbal Arts Centre and the contract commenced in January 2025.
- Tenders for the workplace Health service and the community development ELEVATE programme were issued to the Market in January 2025 with applications due to be returned by the end of March 2025.
- A business case for a new regional Bereavement support service for children has also been approved and the tender documentation is now being developed, with the intention of issuing this to the market in 2025/26.

Health Intelligence

The Health Intelligence unit provides research and information within the PHA. The team also provide ongoing support to commissioning processes. Examples of work undertaken by the Health Intelligence unit in 2024/25 include:

- Children's Health in Northern Ireland 2022/23 Report
- Director of Public Health Core Tables 2022 and 2023
- Development of the Lifeline 72-hour follow-up pilot evaluation framework and implementation
- Development of evaluation framework for the NIAS Hear and Treat pilot
- Evaluation of the alcohol/drug enhancement of the EISS
- Evaluation of the Ministerial Live Better Initiative

Annual reports and other data outputs

- Breastfeeding in Northern Ireland, Health Intelligence Briefing 2024
- Family Nurse Partnership (FNP) International Annual Report 2024 and five HSCT Annual Review Reports 2024
- Area profiles for each council area working to a whole systems approach to obesity
- Northern Ireland data for the WBTi UK report

Evidence and desktop reviews

- Evidence review of best practice in delivering Weigh to Healthy Pregnancy programmes
- Review of smoking and vaping campaigns: effectiveness, stop smoking service uptake and successful quit rates
- UK four nations tobacco evidence stock take
- Seeking safety as a trauma-based intervention for substance use

The team has carried out work during the year to support PHA activities on various strategy working groups including mental health, substance use, tobacco, sexual health, breastfeeding and suicide prevention. Members are also represented in academic and international research groups including FNP, Lifeline and Euro-Peristat.

Partnership and engagement

The PHA's Reshape and Refresh programme set out an objective of merging the Patient and Client Experience (PCE) and Personal and Public Involvement (PPI) teams into a new structure, the Partnership and Engagement Division.

Regional Patient Client Experience Programme

The Regional Patient Client Experience (PCE) Programme led on Care Opinion through a revised regional implementation and impact framework and the development of Regional Training Framework which included establishment of E-learning modules built through Learn HSCNI.

Through the 10,000 More Voices initiative, the PHA has codesigned a project to assess the experience of service users, families and carers in shared decision making (linked to

NICE Guidance NG197).

As part of 10,000 More Voices initiative the PHA supports the voice of residents in care homes through phase 1 of the project “My experience of living in a Care Home”.

Personal and Public Involvement

PHA Personal and Public Involvement provides professional involvement leadership, advice and guidance to high profile, strategic, or cross-organisation initiatives in the HSC.

Support and encouragement for the integration of involvement into the core work of the PHA has been a key objective.

Communications

The communications team worked closely with colleagues internally, in HSC Trusts and in the Department of Health as well as with other key stakeholders on issues of regional significance. This took the form of campaigns, including the Living Well campaign programme in community pharmacies, printed information for the public and professionals, online information including social media, news releases, briefing journalists and facilitating interviews. We also provided advice and support to colleagues across directorates on sensitive and high-profile issues including vaccination, screening, mental health, and drugs and alcohol.

A number of websites were redeveloped in year which included reviewing the corporate website to make the information more accessible and bring it in line with web content accessibility guidelines.

It was pleasing to note the quality of the PHA’s communications outputs were recognised at the Northern Ireland Social Media awards with a first place in the Healthcare section.

Organ donation

A programme of work to raise awareness and understanding of organ and tissue donation and transplantation was rolled out across 2024/25, and continued to make audiences aware of the change in law. The programme consisted of outreach and engagement activities across Northern Ireland, as well as a range of initiatives for both mass and targeted audiences. A strong partnership approach continued, working closely with HSC Trusts, local councils, community and voluntary sector, education, and private sector. Key initiatives included Organ Donation Week and the new Living Donation Week, and a pilot of post-primary resources.

Public inquiries

The PHA continues to actively support a number of longstanding public inquiries established to investigate issues of serious public concern.

During 2024/25, the main focus of the PHA's public inquiry response has been in relation to the UK COVID-19 Inquiry.

The COVID-19 Inquiry response has also necessitated the provision of oral evidence and both the PHA's Director of Public Health and Chief Executive have made personal attendances at the Inquiry.

The PHA has also worked to meet the demands placed upon it by the other 'active' modules of the COVID-19 Inquiry, with draft witness statements having been prepared and submitted in respect of both Module 6 (Care Sector) and Module 7 (Test, Trace and Isolate).

Human resources

During 2024/25 the PHA has continued to have Human Resources (HR) input through a Service Level Agreement with BSO, including a nominated senior HR Business Partner.

The People Plan which was launched in year has ensured a structured approach to development of culture, staff experience and workforce matters. Working with the Organisational Development Engagement Forum (ODEF), this has seen key areas of development being led by the HR Team:

- Development of 'Our People Portal' for all HR policies, procedures and resources to support managers and staff.
- Hybrid Working Scheme regularised.
- Release of the working effectively resource pack, a wide range of practical tools aimed at supporting teams to rebuild collaboration in the modern world.
- Through ongoing collaboration, the HR team have led on the development and release of a monthly Team Briefing highlighting key actions required of managers.
- A range of existing policies were updated in year in line with regional agreements.

Organisational Development Engagement Forum

The PHA Organisational Development Engagement Forum (ODEF) is the delivery model for the PHA People Plan. Upwards of 50 staff have engaged in various elements of delivery covering a range of key outputs including:

- Staff engagement and communications – continued development of a range of communications channels to ensure regularity of corporate messaging and information from weekly staff news to monthly virtual events led by a member of the Agency Management Team, to quarterly in person engagement events to 'Chat with the Chief'.
- Staff recognition event looking at the past, the present and the future which allowed all staff some time to collaborate and network ensuring time out to reflect and hear from a range of speakers to promote team cohesiveness.

- Health and wellbeing baseline survey completed with the development of an action plan both locally and corporately.
- Learn HSC was introduced with the PHA being the highest performing in terms of staff engagement and usage across the HSC. This tool has facilitated the promotion of a wide range of available training including mandatory training and promotion of continuous professional development tools.

In the area of retention, the ODEF is now established with a clear workplan split into 3 key workstreams:

Staff Experience (Looking after our people) – Following on from the Health & Wellbeing (HWB) survey in the first half of 2024, we now have 12 staff members who have been trained as HWB Champions and are actively engaged in promoting a range of HWB plans both corporately and locally. A full HWB Calendar has been developed with key topics being promoted each month. We are currently developing a full-time job role within the Reshape Refresh programme which will support the co-ordination of this work, as well as the culture champions activity.

Staff Development opportunities have been a key feature area for progress with appraisals now embedded with at least 95% of staff having an appraisal over each of the past two years.

Workforce Development (Growing and Developing our People) – within this group there is a continuous focus on supporting learning and development of staff. This has been underpinned during 2024/25 with the development of a bespoke Skills Development Framework which has been shared over the past year by way of initial familiarisation and feedback. This will now be formally aligned to the Appraisal scheme during the 2025/26 year. In addition, the Corporate Induction programme has been further developed with a range of tools now available to support managers and staff in the early weeks alongside an in-person Corporate Welcome programme which takes place every quarter. An e-learning programme is currently being finalised to support with an introduction to 'What is Public Health'.

Culture (our People as Leaders) – supporting all of the above is the culture workstream who have supported the development of mechanisms to support the organisation's communication systems with staff to ensure clarity, engagement and effectiveness. This includes improved internal communication such as weekly staff news, revised connect platform and regular site visits led by the chief executive. Work relating to recognition and celebration was a key focus of the 2024 Staff event where staff were asked to submit posters for recognition of their teams work as well as on the day providing their input as to what they would like to see going forward. The posters for celebrating the work of individual teams is a feature of the First Tuesday during 2025. In addition, an action plan for 2025/26 based on the feedback has now been developed.

Activity across these three workstreams is progressed through the engagement of a wide

range of staff from across the PHA under the leadership of 2 sponsors per workstream with 3 underpinning targets being to ensure staff:

- are inspired with a shared sense of purpose, to improve and protect Public Health;
- feel valued, supported and engaged in all they do; and
- are knowledgeable, skilled and competent.

The PHA People Plan continues to be monitored with developments reported live in the People Plan Progress hub available on the PHA People Portal. All targets are expected to be delivered on time with a fresh People Plan to be developed during 2025/26 for the next four-year period.

Financial Performance Report

Financial Planning

The PHA newly constituted Finance team, led by the Director of Finance & Corporate Services, is responsible for the delivery of finance functions, including Financial Planning, Financial Governance, Financial Management and Financial Accounting Services.

The team worked with senior leaders in the organisation and Department officials to develop a balanced Financial Plan for 2024/25, which was approved by the Board in June 2024. Financial performance was closely monitored to the opening financial plan assumptions throughout the year.

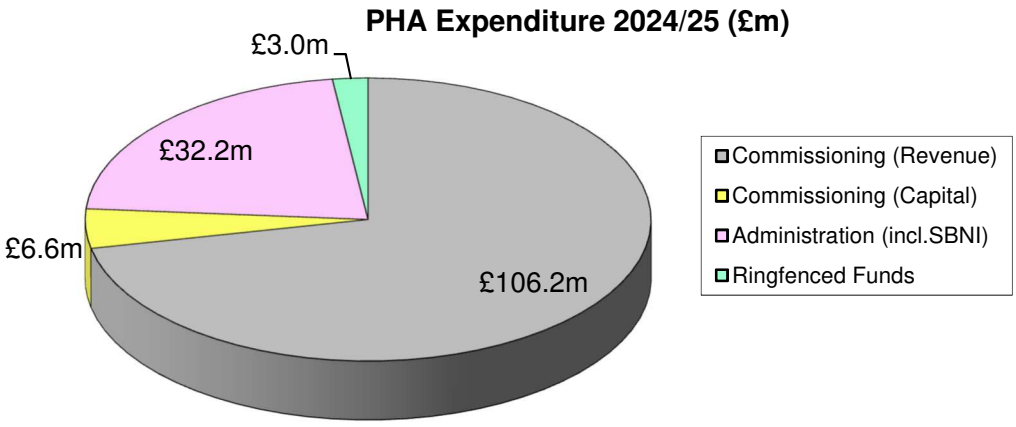
The financial context in the Health and Social Care sector remains challenging. PHA management team will continue to work closely with partners to ensure that sound financial management continues. PHA will also work with Department of Health officials to prioritise resources to deliver on statutory responsibilities and ministerial priorities.

PHA Financial Management and Stability

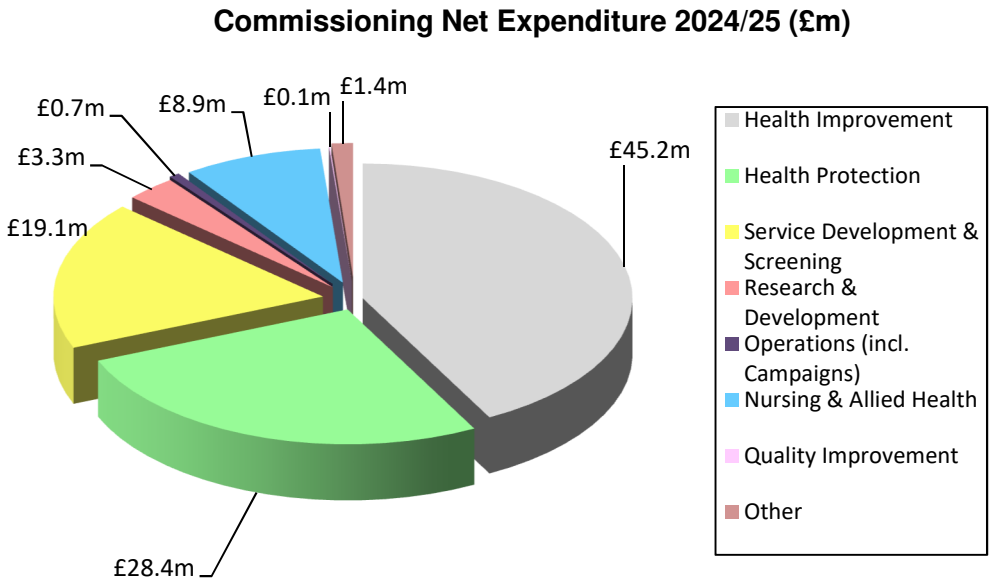
The PHA received a revenue resource budget of £141.5m in 2024/25, along with income from other sources of £1.3m, and a further £6.9m capital funding was allocated to PHA in the year. The financial statements presented in this Annual Report and Accounts highlight that PHA successfully delivered its breakeven duty with a revenue surplus of £77k being reported. This was achieved by significant and diligent efforts on the part of PHA budget holders, supported by the Finance Directorate, in managing the wide range of slippage and pressures across various budgets set against the backdrop of system-wide inflationary pressures and a wide range of operational challenges across the HSC.

The following charts illustrate how the PHA's revenue funds have been utilised during 2024/25.

a. Net Expenditure by Area 2024/25



b. Commissioning Expenditure by Budget Area 2024/25

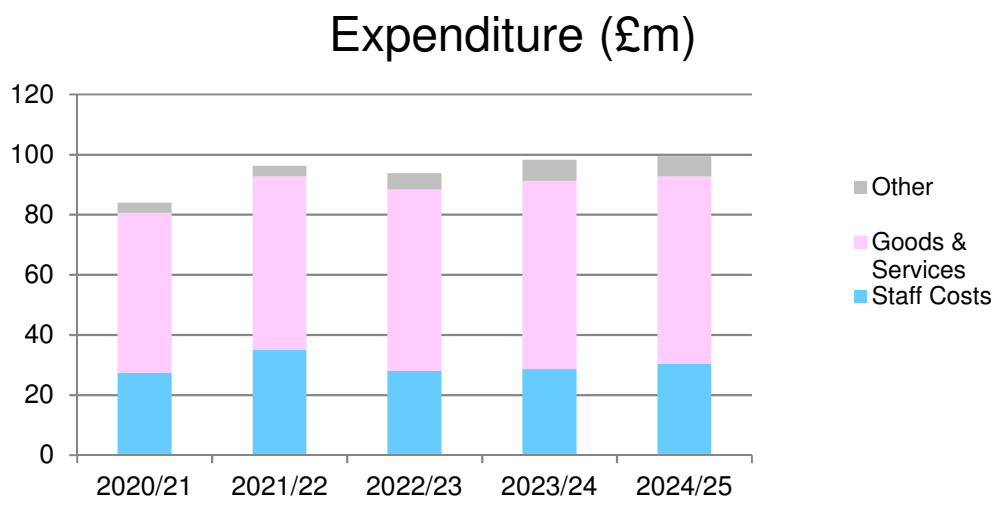


COVID-19 Allocations and Expenditure

During 2024/25, specific ring-fenced allocations earmarked for COVID-19 were allocated to the PHA from DoH. These allocations amounted to £2.3m (2023/24, £4.7m) which allowed the PHA to continue to support the region in its response to the pandemic, primarily through Covid-19 and Flu vaccination programmes.

Long Term Expenditure Trends

The following chart highlights how the main categories of expenditure within the Statement of Comprehensive Net Expenditure (SoCNE) have moved over the last five years. This relates to the revenue expenditure of the PHA excluding allocations to Trusts.



Prompt Payment Performance

a) Public Sector Payment Policy - Measure of Compliance

The Department requires that PHA pay their non-HSC trade payables in accordance with applicable terms and appropriate Government Accounting guidance. The PHA's payment policy is consistent with applicable terms and appropriate Government Accounting guidance and its measure of compliance is detailed in the table below.

	2024-25 Number	2024-25 Value £000s	2023-24 Number	2023-24 Value £000s
Total bills paid	5,786	£85,373	5,184	£77,770
Total bills paid within 30 day target or under agreed payment terms	5,537	£82,969	4,986	£67,436
% of bills paid within 30 day target or under agreed payment terms	**95.7%**	**97.2%**	**96.2%**	**86.7%**
Total bills paid within 10 day target	4,697	£62,803	4,263	£59,456
% of bills paid within 10 day target	**81.2%**	**73.6%**	**82.2%**	**76.5%**

The PHA performed above the 95% target on volume for payments within 30 days, at 95.7% (2023/24, 96.2%) and has performed well above the 70% target of payments within 10 days, at 81.2% (2023/24, 82.2%).

b) The Late Payment of Commercial Debts Regulations 2002

The PHA paid no late payment fees in 2024/25 (£nil for 2023/24).

Sustainability – Environmental, Social and Community Issues

The Northern Ireland Executive Sustainable Development Strategy Everyone's Involved was published in May 2010, setting out a vision for a peaceful, fair, prosperous and sustainable society. The strategy is based on the following principles:

- Living within environmental limits;
- Ensuring a strong, healthy and just society;
- Achieving a sustainable economy;
- Promoting good governance;
- Using sound science responsibly; and
- Promoting opportunity and innovation.

The PHA is committed to the principles of sustainable development and endeavours to integrate these principles into our daily activities. We seek to increase awareness of sustainable development within the PHA generally and to ensure that wherever possible our overall business activities support the achievement of sustainable development objectives. To meet these objectives we will encourage energy and resource efficiency in all our offices, through:

- working with landlords to maximise energy efficiency where possible;
- reminding staff to turn off lights, computers and other electrical equipment when not in use;
- where possible reducing the amount of printing; and
- as and when appropriate, disseminate sustainable development best practice guidelines to staff.

To use our natural resources responsibly, through:

- using recycled materials where possible; and
- promoting recycling of appropriate waste.

To reduce our carbon footprint through how we work, in particular through:

- promoting hybrid working which will reduce travel time to and from work;
- promoting the use of tele-conferencing and video-conferencing to reduce travel;
- supporting the use of travel smart schemes to promote the use of public transport; and
- supporting the cycle to work scheme.

Equality and diversity

Equality and diversity work on the PHA's equality and disability action plans for 2023-28 continued during 2024/25. The equality action plan looks at actions we want to take to

tackle inequalities across all equality categories. The purpose of our disability action plan is to look at things we want to do to promote positive attitudes towards disabled people and encourage their participation in our work areas. We reported progress on year 1 of the equality and disability action plans via the Annual Progress Report 2023/24 to the Equality Commission for Northern Ireland.

Facilitated by the BSO Equality Unit (who provide support to PHA on equality matters), we hold two Disability Awareness Days every year. Staff are invited to suggest topics of interest to them for the Disability Awareness Days and it is encouraging to see staff attendance and participation at these events. Two days were delivered during the year, one in relation to Arthritis and the other in relation to Neurodiversity. The days included a live online session with an expert in the field (a health or social care professional or an individual with lived experience of the condition). Sessions are recorded and then made available on the Tapestry website[1]. This has ensured that staff can access the session at a time convenient to them.

Rural Needs Act (Northern Ireland) 2016

The purpose of the Act is to ensure that public authorities have 'due regard' to the social and economic needs of people in rural areas and to provide a mechanism for ensuring greater transparency in relation to how public authorities consider rural needs when developing, adopting, implementing or revising policies, strategies and plans and when designing and delivering public services.

The Act seeks to help deliver fairer and more equitable treatment for people in rural areas which will deliver better outcomes and make rural communities more sustainable.

The completion of the Rural Needs Impact Assessments has focused minds on the importance of the needs of rural dwellers, so that these are considered from an early stage in any project. In particular, ensuring consultation with rural dwellers when planning services and consideration given to alternative service delivery methods where appropriate to meet their needs.

Complaints and compliments

The PHA received three complaints in 2024/25. Although the number of complaints was low, learning lessons remains a vital aspect of the complaints process and where improvements are identified they are implemented across the PHA on an on-going basis.

The PHA were pleased to receive twelve formal compliments in 2024/25. The general theme from the compliments related to the high quality of the content and user value of a number of PHA publications and wider presentations made across the region.

[1] The Tapestry Disability Staff Network is open to anyone that works in the regional HSC organisations who has an interest in disability; either due to having a disability, caring for someone with a disability or through the nature of their job role

Complaints and compliments are reported quarterly to PHA senior leaders, at both Executive and Non-Executive level. The PHA also publish an annual Complaints and Compliments Report on the PHA public facing website.

Information Requests

Between 1 April 2024 and 31 March 2025, the following requests were made and responded to:

- 59 Freedom of Information Requests;
- 3 Environmental Information Regulations Requests; and
- 7 Subject Access Requests.

On behalf of the PHA, I approve the Performance Report encompassing the following sections:

- Performance Overview.
- Performance Analysis.

Aidan Dawson
Chief Executive
Date: 19 June 2025

ACCOUNTABILITY REPORT

Non-Executive Directors' Report

The primary role of the PHA Board is to establish strategic direction within the policy and resources set by the DoH, monitor performance, ensure effective financial stewardship and ensure high standards of corporate governance are maintained in the conduct of the business of the organisation.

The Board is comprised of a Chair, seven non-executive Directors (one of which was vacant during 2024/25), the Chief Executive and three Executive Directors. The Head of the Chief Executive's Office attends Board meetings. The Department of Health appoints the Non-Executive Directors, with the approval of the Minister of Health. The Chairs and Non- Executive Directors are:

- Mr Colin Coffey (Chair);
- Mr Craig Blaney;
- Mr John Patrick Clayton;
- Ms Anne Henderson OBE;
- Mr Robert Irvine;
- Professor Nichola Rooney (left 28 February 2025); and
- Mr Joseph Stewart, OBE.

The Board and its committees held regular meetings during the year. During 2024/25 the Board held 9 meetings and also held a number of workshops.

The Governance and Audit Committee assists the PHA Board by providing assurance, based on independent and objective review, that effective internal control arrangements are in place within the PHA. The Committee met on five occasions during the year. It is chaired by Mr Joseph Stewart OBE, who provides regular reports to the full Board. The Committee also completes the National Audit Office Audit Committee self-assessment checklist on an annual basis to assess its effectiveness.

The Remuneration Committee is responsible for advising the Board about appropriate remuneration and terms of service for the Chief Executive and other Senior Executives subject to the direction of the Department of Health. The Committee is chaired by Mr Colin Coffey, and met one time during the year.

The Planning, Performance and Resources Committee is responsible for keeping under review the financial position and performance against key non-financial targets of the Board and to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of all resources, and that Corporate/Business Planning arrangements are working effectively. The Committee is chaired by Mr Colin Coffey and met four times during the year.

Corporate Governance Report

The Corporate Governance Report provides information on the composition and organisation of the PHA's governance structures, which support the achievement of the PHA's objectives. It comprises the Director's Report, the Statement of Accounting Officer Responsibilities and the Governance Statement of the organisation.

Director's Report

PHA Board

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

Board Member	Position
Colin Coffey	Chair
Aidan Dawson	Chief Executive
Dr Joanne McClean	Director of Public Health
Heather Reid	Interim Director of Nursing, Midwifery and Allied Health Professionals
Leah Scott	Director of Finance & Corporate Services
Dr Aideen Keaney *(left 30 September 2024)*	Director of the Health and Social Care Quality Improvement and Innovation (HSCQI) Network
Prof Nichola Rooney *(left 28 February 2025)*	Non-Executive Director
John-Patrick Clayton	Non-Executive Director
Joseph Stewart	Non-Executive Director
Robert Irvine	Non-Executive Director
Anne Henderson	Non-Executive Director
Craig Blaney	Non-Executive Director

Further background information on all Board members is available on the PHA website at: https://www.publichealth.hscni.net/pha-board

Related party transactions

The PHA is an arm's length body of the Department of Health and as such the Department is a related party with which the PHA has had various material transactions during the year. In addition, the PHA has material transactions with HSC Trusts. During the year, none of the Board members, members of the key management staff or other related parties have undertaken any material transactions with the PHA.

Register of Directors' interests

Details of company directorships or other significant interests held by Directors, where those Directors are likely to do business, or are possibly seeking to do business with the PHA where this may conflict with their managerial responsibilities, are held on a central register. A copy is available on the PHA website at:
https://www.publichealth.hscni.net/about-us/freedom-information/lists-and-registers

Audit Services

The PHA's statutory audit was performed by CavanaghKelly on behalf of the Northern Ireland Audit Office (NIAO) and the notional charge for the year ended 31 March 2025 was £29,000.

Statement on Disclosure of Information

All Directors at the time this report is approved can confirm:

- so far as each Director is aware, there is no relevant audit information of which the External Auditor is unaware;
- he/she has taken all the steps that he/she ought to have taken as a Director in order to make him/herself aware of any relevant audit information and to establish that the External Auditor is aware of that information; and
- the Annual Report and Accounts as a whole are fair, balanced and understandable and he/she takes personal responsibility for the Annual Report and Accounts, and the judgements required for determining that it is fair, balanced and understandable.

Statement of Accounting Officer Responsibilities

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

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

- Observe the HSC Manual of Accounts issued by the DoH including relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in FReM have been followed, and disclose and explain any material departures in the financial statements;
- Prepare the financial statements on a going concern basis, unless it is inappropriate to presume that the PHA will continue in operation; and.
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The Permanent Secretary of the Department of Health as Principal Accounting Officer for Health and Social Care Resources in Northern Ireland has designated Aidan Dawson as the Accounting Officer for the Public Health Agency. The responsibilities of an Accounting Officer, including responsibility for the regularity and propriety of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the PHA's assets, are set out in the formal letter of appointment of the Accounting Officer issued by the Department of Health, Chapter 3 of Managing Public Money Northern Ireland (MPMNI) and the HM Treasury Handbook: Regularity and Propriety.

As the Accounting Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that PHA's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Governance Statement

1. Introduction/Scope of Responsibility

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

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

A range of processes and systems including Service Level Agreements (SLAs), representation on PHA Board, Governance and Audit Committee, Planning Performance and Resources Committee and regular formal meetings between senior officers are in place to support the close working between the PHA and its partner organisations, primarily the Strategic Planning and Performance Group (SPPG) and the Business Services Organisation (BSO), as they provide essential services to the PHA and in taking forward the health and wellbeing agenda.

Systems are also in place to support the inter-relationship between the PHA and the DoH, through regular meetings and by submitting regular reports. At present the DoH and PHA are currently working through the Refresh and Reshape Organisational Transformation Programme which is designed to enable the PHA to respond effectively to future public health priorities, informed by learning from the COVID-19 pandemic response. It is anticipated that the Implementation phases of the Programme will conclude during 2025/26.

2. Compliance with Corporate Governance Best Practice

The Board of the PHA applies the principles of good practice in Corporate Governance and continues to further strengthen its governance arrangements. The Board of the PHA does this by undertaking continuous assessment of its compliance with Corporate Governance best practice by internal and external audits and through the operation of the Governance and Audit Committee, with regular reports to the PHA Board. The PHA Board also contributes to the strategic leadership of the organisation, ensuring that PHA Agency Management Team are satisfactorily leading on the effectiveness, accountability, sustainability and progressing the vision for PHA. The Board provides strategic support

and challenge on and assesses appropriateness of delivery against the corporate plan and annual business plan which provide the vision for PHA and its key contribution to the wider HSC agenda. This includes risk identification, measurement and monitoring mechanisms and reviewing adequacy of policies to ensure ongoing legal, regularity and code of conduct compliance and ongoing adherence to section 75 equality and good relations requirements in the development of policies and delivery of services. The PHA Board is satisfied that the governance and risk management processes and overall control environment will enable successful delivery of its strategy, policy and objectives.

During 2024/25 the PHA Board completed a self-assessment against the DoH Arm's Length Bodies (ALB) Board Self-Assessment Toolkit relating to the 2023/24 financial year. Overall this shows that the PHA Board functions well, and identifies progress from the previous year. An action plan has been developed to take forward further improvements. Arrangements are in place for an annual declaration of interests by all PHA Board Members and staff; the register is publicly available on the PHA website. Members are also required to declare any potential conflict of interests at Board or committee meetings, and withdraw from the meeting while the item is being discussed and voted on.

The first year of the PHA Equality and Disability five-year Action Plans (2023-28) has been completed. The Equality Action Plan looks at actions we want to take to tackle inequalities across all equality categories. The purpose of our Disability Action Plan is to look at things we want to do to promote positive attitudes towards disabled people and encourage their participation in our work areas. In adherence with the equality and good relations statutory duty, the PHA completed an annual return report to the Equality Commission for the period covering April 2023 to March 2024. Prior to submission, this was approved by PHA Board at its August 2024 meeting.

3. Governance Framework

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

- PHA Board;
- Governance and Audit Committee;
- Remuneration and Terms of Service Committee; and
- Planning, Performance and Resources Committee

The PHA Board is comprised of a Non-Executive Chair, seven Non-Executive members, the Chief Executive and three Executive Directors. One non-executive post was vacant for the whole of 2024/25.

During 2024/25, the PHA Board met on nine occasions. The Board sets the strategic direction for the PHA within the overall policies and priorities of the HSC, monitors performance against objectives, ensures effective financial stewardship, ensures that high standards of corporate governance are maintained, ensures systems are in place to

appoint, appraise and remunerate senior executives, ensures effective public engagement and ensures that robust and effective arrangements are in place for clinical and social care governance and risk management. All Board meetings were quorate.

PHA Board Meeting Attendance Register 2024/25 is summarised in the table below.

Name	Meetings Attended	Meetings Contracted to attend
Mr Colin Coffey (Chair)	9	9
Mr Aidan Dawson (Chief Executive)	9	9
Dr Joanne McClean*	9	9
Ms Heather Reid*	7	9
Ms Leah Scott*	9	9
Dr Aideen Keaney** (left August 2024)	3	4
Mr Craig Blaney***	9	9
Mr John Patrick Clayton***	8	9
Ms Anne Henderson***	9	9
Mr Robert Irvine***	8	9
Professor Nichola Rooney*** (left February 2025)	8	8
Mr Joseph Stewart***	9	9

Executive Director* ***Director* ** Non-Executive Director*

The Governance and Audit Committee (GAC) (chaired by Mr Joseph Stewart) gives an assurance to the PHA Board and Accounting Officer on the adequacy and effectiveness of the PHA's system of internal control. The GAC meets at least quarterly and comprises of four Non-Executive Directors. Representatives from Internal and External Audit are also in attendance. During 2024/25 the GAC met on five occasions and all meetings were quorate.

The Remuneration and Terms of Service Committee (chaired by Mr Colin Coffey) advises the PHA Board about appropriate remuneration and terms of service for the Chief Executive and other senior executives subject to the direction of the DoH. The Committee also oversees the proper functioning of performance appraisal systems, the appropriate contractual arrangements for all staff as well as monitoring a remuneration strategy that reflects national agreement and Departmental Policy and equality legislation. The Committee comprises the PHA Chair and three Non-Executive Directors; it normally meets at least once every 6 months. During 2024/25, the Committee met on one occasion and the meetings were quorate.

The Planning, Performance and Resources Committee, also chaired by Mr Colin Coffey, has responsibility to keep under review the financial position and performance against key non-financial targets of the Board, to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of all resources, and that Corporate/Business Planning arrangements are working effectively. The Committee comprises the PHA Chair and three Non-Executive Directors; it normally meets at least once every three months. During 2024/25, the Committee met on four occasions and the meetings were quorate.

4. Framework for Business Planning and Risk Management

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

The PHA Corporate Plan was rolled forward into 2024/25, as advised by the Department of Health (DoH). The Annual Business Plan 2024/25, which sets out the actions to be taken forward in the PHA Corporate Plan, taking account of DoH guidance and priorities, was approved by the PHA Board. Both documents were developed with input from the PHA Board and staff from all Directorates and engagement with external stakeholders. During 2024/25, PHA has developed a new Corporate Plan for the period 2025-30 which was approved by PHA Board in March 2025.

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

During 2024/25, in keeping with an Internal Audit recommendation, work to re-shape the Corporate Risk Register to reflect the 3 Line Model of Assurance (Assurance Mapping) was completed. The assurance mapping process, using a Board Assurance Framework, improves the evidence provided to the Board in respect of the controls identified in the risk registers and their effectiveness in managing the risk identified.

During 2024/25, the Director of Finance and Corporate Services held responsibility for risk management at Board level. The Corporate Risk Registers are reviewed quarterly by the Agency Management Team (AMT) and Governance and Audit Committee (GAC). Directorate Risk Registers are also reviewed by AMT and the GAC on a rotational basis. The minutes of the GAC are brought to the following PHA Board meeting, and the Chair of the GAC also provides a verbal update on governance issues including risk. The Corporate Risk Register is brought to a PHA Board meeting at least annually, most recently on 27 February 2025.

During 2024/25, guidance and support was provided to staff who are actively involved in reviewing and coordinating the review of the Directorate and Corporate Risk Registers.

All staff are required to complete the PHA risk management e-learning programme. In

addition, staff have also been provided with other relevant training including fire, health and safety, security and fraud awareness.

5. Information Risk

The PHA has robust measures in place to manage and control information risks. The designated Senior Information Risk Owner (SIRO), who is responsible, for the management of information risk at Board level is the Director of Finance and Corporate Services.

The Director of Public Health as the Personal Data Guardian (PDG) has responsibility for ensuring that the PHA processes satisfy the highest practical standards for handling personal data. Assistant Directors/Deputy Directors and other identified senior staff, as Information Asset Owners (IAOs), are responsible for managing and addressing risks associated with the information assets within their function and provide assurance to the SIRO on the management of those assets. The Assistant Director of Planning and Business Services as the Data Protection Officer (DPO) has responsibility for monitoring and advising on data protection.

The PHA's Information Governance Steering Group (IGSG) has the primary role of leading the development and implementation of the Information Governance Framework across the organisation, including ensuring that IG action plans arising from Internal and External Audit reports and the Information Management Checklist are progressed. The Group is chaired by the SIRO and membership includes all the IAOs, PDG, a Non-Executive Board member or their representatives and relevant governance staff. The IGSG is scheduled to meet three times per year and provides a report to the GAC on a regular basis in addition to providing the IGSG Action Plan to GAC annually**.** During 2024/25 the IGSG met three times.

The PHA's Information Governance Strategy (incorporating the Information Governance Framework) 2023-2026 sets out the framework to ensure that the PHA meets its obligations in respect of information governance, embedding this at the heart of the organisation and driving forward improvements in information governance within the PHA.

Alongside this, a range of policies and procedures are in place to ensure compliance with legislation, including Data Protection/Confidentiality Policy, Data Breach Incident Response Policy and a Data Protection Impact Assessment Policy and Guidance.

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

The HSC information governance e-learning programme, incorporating Freedom of Information, Data Protection, Records Management and Cyber Security continues to be rolled out to all staff. Specialised training for SIRO, PDG and IAOs also took place during

2024/25. Uptake of training is monitored by the IGSG. The PHA is represented on the regional HSC Cyber Security Programme Board, and works with BSO ITS, as its IT provider, to take necessary measures in relation to cyber security risks.

During 2024/25, no personal data incidents were reported to the Information Commissioner's Office.

6. Fraud

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

A fraud report is brought to the GAC on a regular basis. During 2024/25 there were no new cases of suspected fraud.

7. Public Stakeholder Involvement

Ensuring the voice of the service user and carer is heard, understood and integrated into the culture and practice of the PHA and indeed the wider HSC, is essential, if we are to ensure that what we are commissioning and delivering, is the truly person-centred health and social care service we are committed to. There are two key ways in which this is achieved, one is through Patient & Client Experience (PCE) and the other is through the connected area of Personal & Public Involvement (PPI).

Through the PHA's Reshape and Refresh programme, these two approaches, will be amalgamated into a new Partnership and Engagement team. This team will work collaboratively, to advance patient experience and service user and care involvement. The PHA actively considers Experience & Involvement in all aspects of the commissioning process, ensuring that the input of service users and carers underpins the identification of priorities; in the development of service models and service planning and in the evaluation and monitoring of service changes or improvements.

The PHA is also cognisant of the ever-evolving policy field in this wider area; including the 'Co-Production Guide for N. Ireland – Connecting and Realising Value through People' (DoH, 2018), which encourages a sustained move towards a coproduction-based approach across the health and social care system, whereby service users and carers are regarded as full partners in health and social care. The Change & Withdrawal of Services Circular (DoH 2023) is a more recent development, which re-affirms HSC commitment to the active involvement of service users and carers in planning and decisions that affect

care. It also references the role of the PHA in regards to the provision of PPI advice to the HSC in line with our leadership role.

In 2024/25 there was a focus by the Regional PPI team on:

- **Leadership, Advice and Guidance** – The provision of advice and guidance on involvement to high profile or cross organisational initiatives in the HSC remains a priority for the PPI team.
- **Training** - Raising awareness, understanding and building skills, knowledge and expertise in Involvement, Co-Production and Partnership Working with HSC staff, service users and carers.
- **Monitoring** - Embedding and streamlining the online, centralised Involvement monitoring system has continued and progressed. It enables the HSC to identify what is happening and the impact / difference that Involvement is making. It does this by utilising quantitative data collected through the HSC wide returns and this is complemented by the roll out of the Human Library model, which captures qualitative information / insight into lived experience of Involvement.
- **Health Literacy –** Staff undertook Health Literacy training and then used that knowledge to design an interactive Health Literacy Training and Support Tool, which is being piloted with the Live Better Demonstration Projects.
- **Service User and Carer Reference Group**. The PHA have developed a new Service User and Carer Reference Group with the aim of further embedding opportunities for service users and carers to inform, influence and shape PHA work and thinking. Some 25 service users and carers were recruited through an open public call, are now members of the Reference Group, supporting strategic involvement work within the PHA and the wider HSC system.

In 2024/25 there was a focus by the Regional PCE team on:

- **Embedding feedback into culture** - Building an informed workforce which supports generation of stories; This included the publication of a Regional Training framework for Regional Patient Client Experience initiatives and development of an E-learning programme. This supports a high standard consistent approach across the region and with a greater reach into the workforce
- **Developing accessible structures** to reach the population of NI – In all initiatives PHA have created mechanisms which key populations of whom feel 'seldom asked'. In 2024/25 the team focused upon reaching out to people with a Learning Disability and non-English speaking communities exploring how to promote Care Opinion and 10,000 MORE Voices.
- **Integrating into a learning system** – The Regional PCE team, in partnership with trust services undertook workshops exploring the model Learning from Excellence, exploring stories which highlighted best practice through the Online User Feedback service, Care Opinion. 10,000 MORE Voices also hosted 18 workshops with services exploring their data through appreciative inquiry and application of learning to practice.

In 2024/25 the Regional PPI & PCE teams have jointly focused on:

- **Strategy Development** - Developing a Partnership and Engagement Strategy that will set out the direction and key areas of work for the next five years for Experience & Involvement work for the PHA internally and in regards to its HSC leadership responsibilities in this area. The PHA 's Corporate Plan for 2025 to 2030 has influenced this work and cognisance is also being taken of the recently launched DoH led Strategic approach to Public Engagement, anticipated to conclude in the first half of 2025/26.
- **Shared Decision Making –** The PPI the PCE teams have supported the regional aspects of the implementation of NICE Guidance NG197, in line with the ask from the DoH Circular HSC (SQSD) (NICE NG197) 19/22. There has been a focus upon developing regional guidelines for person centred clinical letters (recommendation 1.2.20) and on addressing Training and associated Resources / materials related to Shared Decision Making. This work seeks to improve patient experience and embed partnership working at the frontline.

The PHA continues to lead and support cultural and practical change within the HSC, so that the voice of the service user and carer is heard, and the active involvement of and partnership working with people with lived and living experience can become the norm.

8. Assurance

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

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

Internal and External Audit have a vital role in providing assurance on the effectiveness of the system of internal control. The GAC receives, reviews and monitors reports from Internal and External Audit. Internal and External Audit representatives are also in attendance at all GAC meetings. The PHA Assurance Framework sets out a systematic and comprehensive reporting framework to the Board and its committees and is normally reviewed annually.

The PHA continues to ensure that data quality assurance processes are in place across the range of data coming to the PHA Board. Where gaps are identified, the PHA proactively seeks to address these, for example by the development and regular review of the Programme Expenditure Monitoring System (PEMS) to ensure comprehensive and robust information. Information presented to the PHA Board to support decision making, is

firstly presented to, and approved by, the Agency Management Team (AMT) and the Chief Executive, as part of the quality assurance process. Relevant officers are also in attendance at Board meetings when appropriate, to ensure that members have the opportunity to challenge information presented.

The PHA has in place an effective whistleblowing policy based on the HSC Whistleblowing Framework and Model Policy, developed in collaboration with the DoH and HSC organisations in response to the recommendations arising from the RQIA Review of the Operation of HSC Whistleblowing arrangements 2016.

9. Sources of Independent Assurance

The PHA obtains Independent Assurance from the following sources:

- The Regulation and Quality Improvement Authority (RQIA); and
- Internal Audit.

In addition, the PHA receives an opinion on regularity from the External Auditor in the 'Report to those charged with Governance'.

RQIA

Prior to the migration of HSCB to SPPG, the HSCB/PHA had in place a Regional Safety and Quality Alerts Procedure which oversaw the identification, co-ordination, dissemination and assurance on implementation of regional learning issued by the HSCB/PHA/DoH/ RQIA and other independent/regulatory bodies. Safety and Quality Alerts (SQA) were previously issued with joint actions for HSCB/PHA and it was the responsibility of the HSCB/PHA together to ensure adequate responses on assurances to the actions specified within relevant SQAs were implemented accordingly. Recently any S&Q correspondence has been issued with specific actions for each organisation (SPPG and PHA separately). Work is progressing around developing a governance process regarding alerts. Once finalised this will allow PHA to provide specific assurances back to DoH regarding any safety and quality processes. In the interim to maintain governance, any issues regarding processes are overseen by relevant directors (Director of Performance and Planning SPPG and Interim Director of Nursing & Allied Health Professionals, PHA) within the SPPG and PHA by way of weekly Safety Brief Meetings.

Internal Audit

The PHA utilises an Internal Audit function which operates to defined standards and whose work is informed by an analysis of the risk to which the body is exposed and annual audit plans are based on this analysis. Internal Audit work in 2024/25 is provided in the table below.

System Reviewed	Level of Assurance Received*
Financial Review	**Satisfactory** - Financial Reporting to the PHA Board; Non-Pay Expenditure; Budgetary Control & Saving Plan Management and Management of Additional Payments to Staff **Limited** – Staff in Post reports
Management of Vaccination Programme	**Limited**
Board Effectiveness	**Satisfactory**
Trust Commissioned Services	**Limited**
Personal and Public Involvement	**Limited**

Internal Audit's definition of levels of assurance:

Satisfactory*: Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.*

Limited*: There are significant weakness within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.*

Unacceptable: *The system of governance, risk management and control has failed or there is a real and substantial risk that the system will fail to meet its objectives.*

2024/25 Internal Audit Reports with a Limited Assurance

The PHA received a limited level of assurance in relation to three audit reports and also a partially limited assurance in respect of a fourth audit. A summary of the significant findings identified in these reports are provided below.

Financial Review (partially limited in relation to Staff in Post)

Internal Audit provided a satisfactory assurance in relation to Financial Reporting to the PHA Board, Non-Pay Expenditure, Budgetary Control & Saving Plan Management and Management of Additional Payments to Staff however, the review of Staff in Post returns received limited assurance. Internal audit noted that Staff in Post reports are largely reviewed on a regular basis and the Organisational Management structure is updated on HRPTS to reflect the accurate alignment to managers and cost centres. However, it was noted that some business areas had not completed any staff in post checks on a number of occasions during the year, resulting in a number of overpayments. Management has committed to improved monitoring and introduced a system of sign-off by senior officers to

ensure staff in post is reconciled on a monthly basis to reflect an accurate staff in post position.

Management of Vaccination Programme

Internal Audit provided a limited assurance in relation to the Management of Vaccination Programmes. A limited assurance was provided on the basis that there was no overarching formal memorandum of understanding/agreement between stakeholders defining each organisation's roles and responsibilities, assurances and accountability arrangements in respect of vaccines. Internal audit also noted additional checks required for invoices related to the distribution of vaccines prior to approval and a requirement for validation checks to be conducted with vaccine administrators to ensure the stock levels recorded by PHA were accurate. It was noted that the level of influenza vaccine wastage for 2023/24 was high (circa 25%). While the vaccine order was reduced in 2024/25, a fall in vaccine uptake during the year resulted in a similar percentage of the vaccine remaining unused.

Internal audit highlighted that whilst they were providing a limited assurance, that vaccination programmes had been established and arrangements were in place for monitoring and reporting of uptake. In relation to current vaccine programmes in place, internal audit found that PHA was fulfilling its roles in relation to the Management of Vaccination Programmes as per JCVI and DoH guidance. Internal audit noted that the Vaccine Management System is used to monitor the uptake of vaccines and to set future quotas to minimise wastage. Advice is issued by PHA to relevant stakeholders to minimise risk of wastage. Contract management is place with VMS suppliers and annual audits are conducted to ensure the contracted distributer is handling vaccines in an appropriate manner. A number of recommendations have been agreed and will be taken forward as per the timelines in the internal audit report.

Trust Commissioned Services

Internal Audit provided a limited assurance in relation to PHA Management of Trust commissioned services. There were 3 significant findings in this audit: (1) limited assurance was provided on the basis that 1 of 15 trust commissioned services had received no assurance that the service had been delivered for the purpose intended; (2) the commissioning and performance management of Trust Commissioned services (roll-forward arrangement, project evaluation monitoring returns, escalation processes) were inadequate; and (3) two business cases were approved after the start date, with one not being signed as approved. Internal audit recommended further review of commissioned services rolled forward, the need for clear, measurable targets to be set for funding, and strengthening of performance management and accountability arrangements with HSC Trusts. (See section 11 below for further detail on Trust Commissioned Services.)

Personal and Public Involvement

While providing a limited assurance in relation to the Management of Personal and Public Involvement, Internal Audit noted that PHA has led on involvement development, including standards, monitoring arrangements, training and provision for leadership advice and guidance for HSC and a platform for the identification and sharing of best practice and collaboration through the PPI Forum. The PHA also facilitated and co-ordinated relevant training across Trusts; have developed the Engage Website platform to share relevant documents and demonstrated good practice in respect of PPI and created an Involvement Human Library to obtain more qualitative information in respect of involvement across HSC. There have also been presentations to PPI Forum on involvement projects that have helped make a positive contribution to HSC.

Internal audit provided limited assurance on the basis that the PPI Forum was not operating as effectively as it should, with attendance levels often low in recent years and no formal strategy/action plan in place. Further, the PHA systems in place to monitor Trust implementation of PPI requires improvement through the development of SMARTER targets and prioritisation of recommendations. PHA has identified a Directorate Risk in respect of PPI. This audit report will be used to redraft and update the PPI associated risk on the risk register and management will implement Internal Audit recommendations.

Follow Up on Previous Recommendations

The Internal Audit Follow Up report on previous Internal Audit Recommendations, issued 3 April 2025, found that 83 (86%) of the outstanding 97 recommendations examined were fully implemented, a further 14 (14%) were partially implemented. Work will continue during 2025/26 to address those recommendations that have not yet been fully implemented.

Overall Opinion

In her Annual Report, the Head of Internal Audit provided the following opinion on the PHA's system of internal control: *Overall for the year ended 31 March 2025, I can provide* ***Limited*** *assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.*

10. Review of Effectiveness of the System of Internal Governance

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

and a plan to address weaknesses and ensure continuous improvement to the system is in place.

11. Internal Governance Divergences

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

HSCQI

The establishment of the HSC Quality Improvement (HSCQI) function in April 2019 was a key action from 'Health and Wellbeing 2026: Delivering Together'. The DoH established HSCQI within the PHA, providing temporary funding through transformation monies for the Director of HSCQI and a number of additional posts. The Safety Forum, already within the PHA, also became part of the new HSCQI Directorate.

During the PHA Refresh and Reform organisation change programme it was agreed that HSCQI was not aligned with PHA strategy and corporate objectives. Therefore, a recommendation was made that HSCQI should move from hosted arrangement within PHA to an integrated arrangement within an alternative organisation. On 1 November 2024 HSCQI moved from PHA to RQIA, and PHA no longer has any responsibility for HSCQI.

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

Financial Performance

The budget for Health and Social Care in Northern Ireland continues to be challenging. The PHA approved a financial plan in June 2023 on its financial position and direct resources. Financial performance has been monitored against this plan during the financial year and PHA achieved a breakeven financial position in 2024/25.

Budget Position and Authority: The Budget Act (Northern Ireland) 2025, which received Royal Assent on 6 March 2025, together with the Northern Ireland Spring Supplementary Estimates 2024-25 which were agreed by the Assembly on 17 February 2025, provide the statutory authority for the Executive's final 2024-25 expenditure plans. The Budget Act (Northern Ireland) 2025 also provides a Vote on Account to authorise expenditure by departments and other bodies into the early months of the 2025-26 financial year.

Management of Contracts with the Community and Voluntary Sector

In 2023/24 internal audit made a number of recommendations aimed at strengthening the PHA control arrangements relating to procurement when contracting with Community and Voluntary Sector. The PHA has continued to progress these recommendations, working

with providers to review contract activity, agree revised performance measures and considering changes in how services are targeted and delivered. A more detailed review of the current Progress Monitoring Returns (PMR) process is currently being undertaken to ensure that the measures of performance included in contracts are more focused on demonstrating the outcomes being achieved.

The 2023/24 report included a priority one finding relating to the implementation of the PHA Social Care Procurement Plan, which has been partially implemented.

Whilst PHA places a high priority on the delivery of the Procurement Plan, it remains challenging to progress this large programme of work. During 2024/25 the PHA Procurement Board completed a detailed review of all existing contracts and has identified a clear process for how each contract will be reviewed and the funding award process likely to be used to secure a new service. As a result of this review and the introduction of the Public Procurement Policy, it is now anticipated that a significant number of the existing contracts will be more appropriately managed as grant awards. A revised plan has now been developed that sets out the process that will be used to commission new services and the timelines for doing this. This plan now provides a clear pathway for addressing the priority one audit recommendation.

During 2024/25 PHA successfully completed tender awards for the Shared Reading Group service in prisons and the Self Harm Intervention Programme (SHIP).

Good progress has also been made in implementing phase 1 of the Regional Drug and Alcohol service re-tender, which is focused on Adult Step 2 Services and Workforce Development. Tenders were issued to the market in January 2025 and applications are currently being assessed with the intention that new contracts will be in place by 1 July 2025.

Pre-planning work with the Bereavement Support services for Under 18s has also been progressed; the Business case has been approved and work is on-going to develop the tender documentation. Market engagement has been undertaken in April 2025. Tenders for a Workplace Health service and the community capacity building ELEVATE programme were issued to the market in January 2025. Applications were received in March 2025 and the evaluation process is on-going.

There is a recognition that there is limited resources and skills across the organisation to manage the additional scale of work now involved in the pre-planning and completion of tender processes. The PHA is supporting a further 5 staff to complete the post graduate commissioning leadership programme in 2024/25, that aims to build the knowledge and skills of senior staff across HSC in relation to planning, procurement and contract management processes. An assessment of additional resources required to support the delivery of the procurement plan is also being undertaken and will be considered when implementing the new Operational Model for the PHA. The PHA is also continuing to develop new multi-disciplinary planning teams that will oversee the development of

strategic plans for key business areas. These planning teams will help to ensure future procurements are progressed more efficiently, in line with required processes.

The PHA will continue to work closely with colleagues in BSO (Directorate of Legal Services and Procurement and Logistics service), HSC Trusts and the DoH, to ensure that procurement processes continue to meet regional policy and guidance.

PHA Staffing Issues / Staff Resilience

During the 2024/25 year the PHA has continued to consider the workforce requirements both in terms of recruitment and retention in order to fully address the recommendations to enhance the key functions of the PHA as outlined in the 'Rapid, focused external review of the Public Health Agency's resource requirements conducted by Dr R Hussey in December 2020.

Recruitment – Consultant Workforce

PHA continues to face challenges in respect to consultant staffing. Consultant capacity is currently constrained due to a mixture of vacant posts and staff not being available for work due to leave. As a result, locums are being utilised to provide cover for the health protection service both in hours and out of hours.
The permanent recruitment process for both Health Protection Consultants and Generic Public Health consultants has commenced and we are working with communications and recruitment colleagues to develop a recruitment pack to promote the role of the PHA and Northern Ireland as an attractive place to work to reach potential national and international applicants. A range of other measures are in place to mitigate the impact of the reduction in consultant staffing as follows:

- Support from consultants in Public Health whose main area of work has not been health protection are now inputting to strategic areas of health protection work. For example, service development consultants are providing consultant input to areas; blood borne virus, immunisations and avian influenza.
- We are developing a new model for the delivery of 'on call' which will ensure a more robust service model and decrease the requirement of locum cover.
- The development of six senior program manager roles to deliver in a range of areas to ensure consultant expertise is applied where it is most needed.
- Appointment of an Assistant Director for Health Protection and Surveillance to provide senior operational leadership and ensure operational matters are not impacting clinical resource.
- Arrangements have been put in place with the UK Health Security Agency to provide advice and support on health protections matters in and out of hours should that be required.
- In addition, links have been formed with UKHSA teams which have allowed PHA staff to avail of training which previously was not available to our staff.

Hosting of SBNI

The PHA is the corporate host of the SBNI, via arrangements which are governed by a Memorandum of Understanding (MoU). As such, SBNI expenditure is recorded within the accounts of the PHA and whilst the PHA Chief Executive has no day to day responsibility for the operations or expenditure of SBNI, he is the de facto Accounting Officer for SBNI. The SBNI has its own Board and the Chair of the SBNI provides an annual assurance statement to the PHA Chief Executive to attest to the effectiveness of internal control within SBNI. Additional controls are being put in place to oversee this arrangement, principally through a draft revised MOU, however, the ambiguity is unlikely to be fully mitigated and may remain.

Public Inquiries

During 2024/25, the PHA has continued to discharge its responsibilities in respect of the following public statutory inquiries: the Infected Blood Inquiry, the Muckamore Abbey Hospital Inquiry, the Urology Services Inquiry and the UK Covid-19 Inquiry. Each of these inquiries has been established to investigate an issue of serious public concern and necessitates that the PHA responds promptly and thoroughly to every request made of it.

While the live response to a number of inquiries has concluded in-year, the demands placed upon the PHA, particularly in relation to the UK Covid-19 Inquiry, continue to consume significant time, resource and attention of senior staff. Moving into 2025/26, the PHA will also need to devote resourcing to consider the implications of any recommendations from the envisaged outworking's of the Urology Services Inquiry, the Muckamore Abbey Hospital Inquiry and Modules 2C, 3 and potentially 4 of the UK Covid-19 Inquiry.

In order to ensure good governance arrangements are in place, the PHA's collective public inquiry response remains under the direction of a Public Inquiries Programme Management Board comprising of the Chief Executive, Executive Directors and the BSO Directorate of Legal Services. The management board also has Non-Executive Director representation.

Pause on Campaign Programme

As a result of pressures on the HSC budget the DoH introduced a pause on campaign related mass advertising by its ALB's during 2023/24, which continued into 2024/25. Public health campaigns play a significant role and are deployed regularly by Governments and Public Health Authorities worldwide in raising awareness and influencing attitudes and behaviours around a range of key public health issues. As one of its key functions, the PHA has significant experience and expertise in developing successful population wide campaign programs which have proven to be very effective when delivered as part of a wider program of measures including legislative change and other program interventions. Awareness raising campaigns are recommended within a number of current NI health

strategies e.g. Tobacco control, Mental Health and suicide prevention, Fitter Futures and Organ Donation and the PHA is responsible for taking this work forward.

Whilst other communication channels can be deployed the evidence base demonstrates that they are less effective in reaching population wide audiences. The PHA therefore recognises that the pause in its campaign programme is likely to have a detrimental impact on its ability to meet strategic commitments and annual business plan targets.

During 2023/24 PHA submitted a business rationale paper to DoH highlighting the evidence base underpinning the deployment of mass media led campaigns. Notwithstanding, DoH confirmed that the pause on campaign advertising would continue in 2024/25 and is likely to be further extended into 2025/26, therefore the PHA considers it to remain open as a control divergence.

Cervical Screening

Following concerns about the performance of a small number of screening staff in the SHSCT laboratory the Trust asked the Royal College of Pathologists (RCPath) to: undertake a review of laboratory data; assess whether there were any issues with laboratory performance; undertake a risk assessment; and advise of actions that should be taken forward.

The RCPath report was published by SHSCT on 30 September 2023 and contained a number of critical findings relating to performance in the SHSCT laboratory and arrangements to identify and address underperformance within the laboratory over a protracted period of time from 2008 - 2021. The report also recommended that primary HPV screening be implemented as soon as possible.

Staff from the PHA worked intensively with the SHSCT to implement a Review exercise in order to identify women whose last screening samples were processed in the SHSCT by one of the screeners whose performance had been highlighted in the report. The review completed in autumn 2024 and the outcomes report was published in December 2024, alongside a companion report describing cervical cancer cases in the SHSCT during the affected time period. The review found that the vast majority of previous smear results were unchanged and were reconfirmed as normal. An external expert opinion on the findings of the review was commissioned with the report received in March 2025. This report endorsed the robustness of the review process and noted that the rate of abnormalities found at review indicated a relatively high sensitivity of the original result. This area of work has continued to be a draw on senior staff from the Public Health Directorate and was supported by a senior member of staff on loan from the SPPG (DoH).

Primary HPV screening was introduced across Northern Ireland on 11 December 2023. As the next phase of this significant service change, the PHA led a reconfiguration of laboratory services during 2024/25. All cervical screening laboratory services were transitioned to one site within Belfast Trust from 1 November 2024. There is ongoing work

with the BHSCT to manage laboratory turnaround times as a result of this service change and to stabilise the service for the future.

The PHA commissions the provision of three Cancer Screening Programs and oversees Quality Assurance for those programs. Cervical screening is one of these programs. There is a Quality Assurance Structure in place, led by the PHA, the core purpose of which is to maintain national standards and promote continuous improvement in the cancer screening programs to ensure that all eligible people have access to a consistently high quality of service wherever they live and in line with NI Department of Health's population screening policy.

While the RCPath Consulting report was commissioned by and focused on the Southern Trust laboratory, it was considered prudent to review the Quality Assurance function carried out by PHA and how the issues relating to underperformance were present in one of the laboratories carrying out cytology for the screening programme over a 13-year period. Screening experts from NHS England have commenced a detailed peer evaluation of our oversight and QA processes within the cervical screening programme laboratory service. The purpose of this is to identify any areas for improvement and to make recommendations in that regard. This is expected to report in early 2025/26.

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

Management of Vaccine Programme

During 2024/25 the PHA received limited assurance in relation to the management of vaccines where weaknesses in stock management issues, governance arrangements and contract spend oversight were identified.

The PHA immunisation team manages circa 30 public vaccine programmes across NI. One of the main systems used for administration and tracking of the vaccines is the Vaccine Management System (VMS) which transferred to the PHA from the DoH during 2023. During the course of the audit, gaps were identified in the process used for the management and validation of stock levels. The main contributing factor identified was insufficient information being provided by the contracted supplier and the vaccine administrators e.g. GP Surgery. As the VMS system informs the setting of delivery quotas for the following year this is contributing to the level of vaccine which remain unused at the end of the season. The situation is also complicated by the current contractual arrangements in place. Management are implementing a number of Internal Audit recommendations including the introduction of a process to review stock management arrangements and effective reporting to inform planned activity during the year.

Trust commissioned services

During 2024/25 the PHA received limited assurance in relation to the audit of Trust commissioned services where weaknesses in relation to performance management

arrangements with HSC and the lack of a legacy business case register were identified.

The report highlighted the need to standardise and strengthen the approach to performance management with HSC Trusts and the need to develop a framework of accountability to ensure robust monitoring. The establishment of a formal review process by PHA to ensure services, currently commissioned, are sufficiently aligned to population needs was also identified. The report contains a priority one recommendation which relates to a funding stream from PHA to HSC Trust which no longer falls within the PHA remit. Work has commenced on realigning these funds and addressing each of the recommendations made.

12. Conclusion

The PHA maintains a rigorous system of accountability which I can rely on as Accounting Officer to form an opinion on the probity and use of public funds, as detailed in Managing Public Money NI (MPMNI). However, in light of the overall limited assurance from the Head of Internal Audit on the system of operation of internal controls in the Agency during 2024-25, I acknowledge that the system of Internal Control, Risk Management & Governance requires strengthening in a number of areas.

The internal audit review of control systems has resulted in a number of limited assurance opinions in the PHA for the last two consecutive years across some core areas. The findings of these reports have been raised with management and will be extensively examined by the Governance and Audit Committee during 2025/26 to address the weaknesses/gaps in control processes which have been identified.

Remuneration and Staff Report

Section 421 of the Companies Act 2006 requires the preparation of a Remuneration Report containing certain information about the Directors' remuneration in accordance with the requirements of Part 4 and Schedule 8 of Statutory Instrument 2008 No. 410.

Remuneration Policy

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

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

The 2020/21, 2021/22 and 2022/23 Senior Executive's pay awards were set out in DoH Circulars HSC(SE) 1/2023, HSC(SE) 2/2023 and HSC(SE) 3/2023 were paid during 2023/24 in line with the Remuneration Committee's agreement on the classification of Executive Directors' performance, categorised against the standards of 'fully acceptable', 'incomplete' or 'unsatisfactory' as set out within the circulars.

The DoH Circular for the 2023/24 and 2024/25 Senior Executive pay award had not been received by 31 March 2025 and related payments have not been made to Executive Directors.

The salary, pension entitlement and the value of any taxable benefits in kind paid to both Executive and Non-Executive Directors is set out within this report. None of the Executive or Non-Executive Directors of the PHA received any other bonus or performance related pay in 2024/25. It should be noted that Non-Executive Directors do not receive pensionable remuneration and therefore there will be no entries in respect of pensions for Non-Executive members.

Non-Executive Directors are appointed by the DoH under the Public Appointments process and the duration of such contracts is normally for a term of four years. Details of newly appointed Non-Executive Directors or those leaving post have been detailed in the Non-Executive Directors Remuneration tables below. Executive Directors are employed on a permanent contact unless otherwise stated in the following remuneration tables.

Senior Executive Pay Structure Reform

With effect from 1 April 2023, the Department of Health has introduced in 2025 a Senior Executive Pay Structure Reform which impacts all Senior Executives in post at 1 April 2023. An incremental scale has been introduced, initially an 8-point scale, annually reducing by 1 point to achieve a 5-point scale by year 4 (1 April 2026). All incremental

progression is subject to satisfactory performance, as considered by the relevant Remuneration Committee applying the standards as set out in the revised Performance Management Framework. The Department will introduce a new performance framework, setting expectations of organisational and personal objectives which must be met to merit a satisfactory rating. There shall be no further individual performance related pay elements or bonuses. The estimated impact of these changes are reflected within the Senior Employees Remuneration Table on pages 65-66 of this report. It should be noted that these figures are accrued and unpaid at 31 March 2025.

Early Retirement and Other Compensation Schemes

There were no early retirements or payments of compensation for other departures relating to current or past Senior Executives during 2024/25 or 2023/24.

Membership of the Remuneration and Terms of Service Committee:

Mr Colin Coffey – Chair
Professor Nichola Rooney – Non-Executive Director
Ms Anne Henderson – Non-Executive Director
Mr Craig Blaney – Non-Executive Director

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

Non-Executive and Senior Employee's Remuneration and Pension Entitlement

The salary, pension entitlements, and the value of any taxable benefits in kind of the most senior members of the PHA are shown in the following table. It should be noted that there were no bonuses paid to any Director during 2024/25 or 2023/24.

Non-Executive Members (Table Audited)

Name	2024/25				2023/24			
	Salary £000s	Benefits in Kind (to nearest £100)	Pension Benefits (to nearest £1,000)	Total £000s	Salary £000s	Benefits in Kind (to nearest £100)	Pension Benefits (to nearest £1,000)	Total £000s
Mr Andrew Dougal (*Chair*) *(Left 31 May 2023)*	-	-	-	0	5-10 (35-40 FYE)	-	-	5-10
Mr Colin Coffey *(Chair)* *(Started 1 November 2023)*	40-45	-	-	40-45	15-20 (35-40 FYE)	-	-	15-20
Ms Deepa Mann-Kler *(Left 29 February 2024)*	-	-	-	-	5-10 (10-15 FYE)	-	-	5-10
Professor Nichola Rooney *(Left 28 February 2025)*	10-15 (10-15 FYE)	-	-	10-15	15-20	-	-	15-20
Mr John-Patrick Clayton	10-15	-	-	10-15	10-15	-	-	10-15
Mr Joseph Stewart	10-15	-	-	10-15	10-15	-	-	10-15
Mr Robert Irvine	10-15	-	-	10-15	10-15	100	-	10-15
Ms Anne Henderson	10-15	-	-	10-15	10-15	-	-	10-15
Mr Craig Blaney	10-15	-	-	10-15	10-15	-	-	10-15

FYE – Full Year Equivalent

Notes:

- *No Non-Executive Members may have received benefits in kind below £50 which would have been rounded down to nil as specified in the second column of the table above.*
- *Payments to Non-Executive Members are based on DoH Circular HSC(F) 23-2024, with the most recent payments made being effective from 26 November 2024.*

Executive Members (Table Audited)

Name	2024/25				2023/24 Restated			
	Salary £000s	Benefits in Kind (to nearest £100)	Pension Benefits (to nearest £1,000)	Total £000s	Salary £000s	Benefits in Kind (to nearest £100)	Pension Benefits (to nearest £1,000)	Total £000s
Mr Aidan Dawson *Chief Executive*	160-165	-	31,000	190-195	145-150	-	30,000	175-180
Dr Aideen Keaney *Director of HSCQI (Ended 30 Sept 2024)*	60-65 (120-125 FYE)	-	58,000	115-120	100-105	200	31,000	135-140
Mr Stephen Wilson *Interim Director of Operations (Ended 31 March 2024)*	-	-	-	-	100-105	-	57,000	155-160
Ms Leah Scott *Director of Finance & Corporate Services (Started 19 March 2024)*	100-105	-	22,000	120-125	0-5 (90-95 FYE)	-	1,000	0-5
Dr Joanne McClean *Director of Public Health*	160-165	-	90,000	255-260	135-140	1,200	48,000	185-190
Ms Heather Reid *Director of Nursing & Allied Health Professionals (Started 1 May 2023)*	120-125	-	32,000	150-155	100-105 (105-110 FYE)	-	78,000	175-180

FYE – Full Year Equivalent

Notes:

- *No compensation for early retirement or loss of office was paid in the current year.*
- *The value of pension benefits accrued during the year is calculated as (the real increase in pension multiplied by 20) plus (the real increase in any lump sum) less (the contributions made by the individual). The real increases exclude increases due to inflation and any increase or decrease due to a transfer of pension rights.*

Salary

Salary includes gross salary and any other allowance to the extent that it is subject to UK taxation. This report is based on accrued payments made by the PHA and thus recorded in these accounts.

Benefits in Kind

The monetary value of benefits in kind covers any benefits provided by the employer and treated by HM Revenue and Customs as a taxable emolument.

Pensions of Senior Management (Table Audited)

Name	2024/25				
	Real increase in pension and related lump sum at age 60 £000	Total accrued pension at age 60 and related lump sum £000	CETV at 31/03/24 £000	CETV at 31/03/25 £000	Real increase in CETV £000
Mr Aidan Dawson *Chief Executive*	2-2.5 pension Nil lump sum	50-55 pension 135-140 lump sum	1,170	1,270	57
Dr Aideen Keaney *Director of Quality Improvement*	2.5-3.0 pension 8.5-9.0 lump sum	50-55 pension 155-160 lump sum	1,243	1,305	91
Dr Joanne McClean *Director of Public Health*	5-5.5 pension 7-7.5 lump sum	45-50 pension 110-115 lump sum	770	955	104
Ms Leah Scott *Director of Finance & Corporate Services*	1.5-2 pension Nil lump sum	0-5 pension Nil lump sum	1	24	23
Ms Heather Reid *Director of Nursing & Allied Health Professionals*	2-2.5 pension 0.5-1 lump sum	50-55 pension 90-95 lump sum	1,011	1,124	55

The value of pension benefits accrued during the year is calculated as (the real increase in pension multiplied by 20) plus (the real increase in any lump sum) less (the contributions made by the individual). The real increases exclude increases due to inflation or any increase or decreases due to transfer of pension rights, but include actuarial uplift factors and therefore can be positive or negative.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are a member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when a member leaves the scheme and chooses to transfer their benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total service, not just their service in a senior capacity to which disclosure applies.

The CETV figures, and from 2003/04 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the HSC pension scheme. They also include any additional pension benefits accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated in accordance with The Occupational Pension Schemes (Transfer Values) Regulations 1996 (as amended).

CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2025. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2024/25 CETV figures.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase of accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period (which therefore disregards the effect of any changes in factors).

Fair Pay Disclosures Tables (Audited)

The relationship between the remuneration of the highest-paid director and the lower quartile, median and upper quartile remuneration of the workforce is set out below.

Total remuneration includes salary, non-consolidated performance-related pay, and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

	2025	2024 Restated
Band of Highest Paid Director's Remuneration	£160-165k	£145-150k
Percentage Change of Highest Paid Director	10%	24%
Median Total Remuneration	£48,526	£43,806
Ratio	3.35	3.37

The remuneration of the highest paid Director has increased as a result of the Department of Health introducing a Senior Executive Pay Structure Reform in 2025 which impacts all

Senior Executives in post at 1 April 2023. The estimated impact of these changes has been accrued at 31 March 2025. This has also resulted in an increase to the pay ratios in respect of the median remuneration, 25th and 75th percentiles.

The movement in ratio calculations for 2024/25 from 2023/24 is consistent with the pay, reward and progression policies for the PHA taken as a whole.

Further detail on pay ratio information is contained in the tables below;

	2024/25	25th Percentile	75th Percentile
Mid-Point of Top Salary	162,500	37,338	60,504
Ratio		4.35	2.69

	2023/24 Restated	25th Percentile	75th Percentile
Mid-Point of Top Salary	£147,500	£33,706	£55,794
Ratio		4.38	2.64

In 2024/25, no employees received remuneration in excess of the highest paid director. Remuneration ranged from £7,404 to £161,967 in 2024/25 (£7,051 to £145,044 in 2023/24). The lowest salary relates to Safeguarding Board lay members.

For both 2024/25 and 2023/24, the 25th percentile, median and 75th percentile remuneration values consisted solely of salary payments.

Further detail on average salary is contained in the table below;

	2024/25 (£)	2023/24 (£)	Increase/ (Decrease) (£)	Change (%)
Average Salary	52,256	46,815	5,440	11.62%

Staff Report

Staff Costs (Table Audited)

PHA staff costs comprise:

	2025			2024
	Permanently employed staff £000s	Others £000s	Total £000s	Total £000s
Wages and salaries	20,901	1,966	22,867	22,076
Social security costs	2,543	168	2,711	2,287
Other pension costs	4,537	300	4,837	4,249
Total staff costs reported in Statement of Comprehensive Net Expenditure	**27,981**	**2,434**	**30,415**	**28,612**
Less recoveries in respect of outward secondments			(582)	(698)
Total net costs			**29,833**	**27,914**

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

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required with sufficient regularity that the amounts recognised in the financial statements do not differ materially from those determined at the reporting period date. This has been interpreted in the FReM to mean that the period between formal actuarial valuations shall be four years.

The actuary reviews the most recent actuarial valuation at the statement of financial position date and updates it to reflect current conditions. The 2020 scheme valuation was completed by GAD in October 2023. The outcome of this valuation was used to set the level of contributions for employers from 1 April 2024 to 31 March 2027.

Pension benefits are administered by BSO HSC Pension Service. Two schemes are in operation, HSC Pension Scheme and the HSC Pension Scheme 2015. There are two sections to the HSC Pension Scheme (1995 and 2008) which was closed with effect from 1 April 2015 except for some members entitled to continue in this Scheme through 'Protection' arrangements. On 1 April 2015 a new HSC Pension Scheme was introduced.

This new scheme covers all former members of the 1995/2008 Scheme not eligible to continue in that Scheme as well as new HSC employees on or after 1 April 2015. The 2015 Scheme is a Career Average Revalued Earnings (CARE) scheme.

On 1 April 2015, the government made changes to public service pension schemes which treated members differently based on their age. The public service pensions remedy, known as the 'McCloud Remedy' puts this right and removes the age discrimination for the remedy period, between 1 April 2015 and 31 March 2022. Stage 1 of the remedy closed the 1995/2008 Scheme on 31 March 2022, with active members becoming members of the 2015 Scheme on 1 April 2022. For Stage 2 of the remedy, eligible members had their membership during the remedy period in the 2015 Scheme moved back into the 1995/2008 Scheme on 1 October 2023. This is called 'rollback'.

In complying with FReM, for 2024/25 pensions are being calculated using the rolled back opening balance, the rolled back closing balance, calculation of CETV by BSO HSC Pension Service on the rolled back basis and no restatement of prior year figures, where disclosed. All benefits accrued from 1 April 2022 onwards are calculated under the 2015 CARE Scheme. BSO HSC Pension Service will contact retirees with personalised information to assist in making their retrospective choice regarding the remedy period.

Following a public consultation, the DoH introduced changes to the amount members pay towards their HSC pension. The changes include the pensionable pay ranges used to decide how much members contribute to their pension and the percentage of members' pay to be a member of the scheme. The latter change means the amount payable will be based on a member's actual annual rate of pay, rather than their whole-time equivalent. For part-time staff, their contribution rate will now be based on how they are paid, instead of how much they would earn if they worked full-time.

The table below sets out the member contribution rates that apply in both the HSC Pension Scheme and the HSC Pension Scheme 2015 from 1 November 2022.

Pensionable salary range	Contribution rates (before tax relief & based on actual annual pensionable pay)
Up to £13,259	5.2%
£13,260 to £26,831	6.5%
£26,832 to £32,691	8.3%
£32,692 to £49,078	9.8%
£49,079 to £62,924	10.7%
£62,925 and above	12.5%

Average Number of Persons Employed (Table Audited)

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

	2025			2024
	Permanently employed staff	Others	Total	Total
Commissioning of Health and Social Care	382	27	**409**	**391**
Less average staff number in respect of outward secondments	(6)	0	**(6)**	**(9)**
Total net average number of persons employed	**376**	**27**	**403**	**382**

Reporting of Early Retirement and other Compensation Schemes – Exit Packages
There were no exit packages agreed and accounted for in 2024/25 or 2023/24. No exit costs were paid in 2024/25 (2023/24: nil).

Redundancy and other departure costs have been paid in accordance with the provisions of the HSC Pension Scheme Regulations and the Compensation for Premature Retirement Regulations, statutory provisions made under the Superannuation (Northern Ireland) Order 1972. Exit costs are accounted for in full in the year in which the exit package is approved and agreed and are included as operating expenses at Note 3. Where early retirements have been agreed, the additional costs are met by the PHA and not by the HSC pension scheme. Ill-health retirement costs are met by the pension scheme and are not included in the table.

Staff Benefits

The PHA had no staff benefits in 2024/25 or 2023/24.

Retirements Due to Ill-Health

During 2024/25, there were no early retirements from the PHA on the grounds of ill-health (2023/24: nil).

Staff Composition

The staff composition broken down by male/female as at 31 March 2025 is illustrated in the table below;

	Male	Female	Total
Non-Executives	5	1	6
Chief Executive and Directors	1	3	4
Senior Management*	19	43	62
Other	69	275	344
Total	**94**	**322**	**416**

**Senior management is defined as staff in receipt of a basic whole-time equivalent salary of an Agenda for Change Band 8C or above and staff on Medical and Dental grades*

Sickness Absence Data

The corporate cumulative annual absence level for the PHA for the period from 1 April 2024 to 31 March 2025 is 4.02% (2023/24, 4.35%).

There were 30,076 hours lost due to sickness absence (2023/24: 30,754 hours), or the equivalent of 74.25 hours (2023/24: 81.8 hours) lost per employee. Based on a 7.5 hour working day, this is equal to 9.9 days per employee (2023/24: 11 days).

Staff Turnover Percentage

For a given period, the total turnover figure is calculated as the number of leavers within that period divided by the average employee headcount over the period. Voluntary turnover includes leavers classified under the categories of resignation, retirement or ill-health retirement. Involuntary turnover includes leavers classified under the categories of dismissal, end of fixed term contract or ill-health termination.

Staff Turnover %	2025	2024
Total Staff Turnover	9.13%	10%
Split between:		
Voluntary Turnover	6.17%	9.70%
Involuntary Turnover	2.96%	0.30%

Staff Policies / Employment and Occupation

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

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

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

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

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

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

Expenditure on Consultancy

The PHA had no expenditure on External Consultancy during 2024/25 (2023/24: nil).

Off-Payroll Engagements

The PHA is required to disclose whether there were any staff or public sector appointees contracted through employment agencies or self-employed who earn more than £245 per day and lasted longer than 6 months during the financial year, which were not paid through the PHA Payroll. The PHA had 2 such 'off-payroll' staff resource engagements as at 31 March 2025 (2023/24: 3).

The following tables provide further analysis:

Temporary Off-Payroll Worker Engagements	**2025**	**2024**
Number of off-payroll workers engaged during the year ended 31 March	2	3
of which:		
Number determined as out-of-scope of IR35	2	3
Number determined as in-scope of IR35	0	0
Number of engagements reassessed for compliance or assurance purposes during the year	0	0

	2025	**2024**
Number of off-payroll engagements at 31 March	2	3
of which:		
Existed for less than one year at time of reporting	0	2
Existed for between one and two years at time of reporting	1	1
Existed for between two and three years at time of reporting	1	0

These engagements were via a contracted Recruitment Agency and comply with IR35 requirements. No penalty was imposed by HMRC resulting from non-compliance with off-payroll worker legislation.

Assembly Accountability and Audit Report

Funding Report

Regularity of Expenditure (Audited)

The PHA has robust internal controls in place to support the regularity of expenditure. These are supported by procurement experts (BSO PaLS), annually reviewed Standing Orders, Standing Financial Instructions and Scheme of Delegated Authority and the dissemination of new guidance where appropriate. Expenditure and the governing controls are independently reviewed by Internal and External Audit.

During 2024/25 there has been no evidence of irregular expenditure occurring.

Losses and Special Payments (Audited)

Losses Statement	2024/25	2023/24
Total number of losses	1	1
Total value of losses (£)	£1,413k	£1,442k

Individual losses over £300k are shown in the table below:

	2024/25		2023/24
	Number	£'000	£'000
Fruitless Payments (PHA)			
Total number of losses	1	1,413	1,442

Special Payments

There was one special payment made during the year totaling £85k (2023/24: 0).

Other Payments and Estimates

There were no other payments made during the year (2023/24: 0).

Remote Contingent Liabilities (Audited)

In addition to contingent liabilities reported within the meaning of IAS37 shown in Note 19 of the financial statements, the PHA also considers liabilities for which the likelihood of a transfer of economic benefit in settlement is too remote to meet the definition of contingent liability. As at 31 March 2025, the PHA is not aware of any remote contingent liabilities, and there were none in 2023/24.

On behalf of the PHA, I approve the Accountability Report encompassing the following sections:

- Governance Statement.
- Remuneration and Staff Report.
- Assembly Accountability and Audit Report.

_____

Aidan Dawson
Chief Executive
Date: 19 June 2025

The Certificate and Report of the Comptroller and Auditor General to the Northern Ireland Assembly

Opinion on financial statements

I certify that I have audited the financial statements of the Public Health Agency for the year ended 31 March 2025 under the Health and Social Care (Reform) Act (Northern Ireland) 2009. The financial statements comprise: The Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes including significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by the Government Financial Reporting Manual.

I have also audited the information in the Accountability Report that is described in that report as having been audited.

In my opinion the financial statements:

- give a true and fair view of the state of Public Health Agency's affairs as at 31 March 2025 and of the Public Health Agency's net expenditure for the year then ended; and
- have been properly prepared in accordance with the Health and Social Care (Reform) Act (Northern Ireland) 2009 and Department of Health directions issued thereunder.

Opinion on regularity

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

Basis for opinions

I conducted my audit in accordance with International Standards on Auditing (ISAs) (UK), applicable law and Practice Note 10 'Audit of Financial Statements and Regularity of Public Sector Bodies in the United Kingdom'. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my certificate.

My staff and I are independent of the Public Health Agency in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK, including the Financial Reporting Council's Ethical Standard, and have fulfilled our other ethical responsibilities in accordance with these requirements. I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my opinions.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that Public Health Agency's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Public Health Agency's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the Board and the Accounting Officer with respect to going concern are described in the relevant sections of this certificate.

Other Information

The other information comprises the information included in the annual report other than the financial statements, the parts of the Accountability Report described in that report as having been audited, and my audit certificate and report. The Board and the Accounting Officer are responsible for the other information included in the annual report. My opinion on the financial statements does not cover the other information and except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon.

My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

In my opinion, based on the work undertaken in the course of the audit:

- the parts of the Accountability Report to be audited have been properly prepared in accordance with Department of Health directions made under the Health and Social Care (Reform) Act (Northern Ireland) 2009; and
- the information given in the Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

In the light of the knowledge and understanding of the Public Health Agency and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance Report and Accountability Report. I have nothing to report in respect of the following matters which I report to you if, in my opinion:

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

Responsibilities of the Board and Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer Responsibilities, the Board and the Accounting Officer are responsible for:

- the preparation of the financial statements in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- ensuring such internal controls are in place as deemed necessary to enable the preparation of financial statements to be free from material misstatement, whether due to fraud of error;
- ensuring the annual report, which includes the Remuneration and Staff Report, is prepared in accordance with the applicable financial reporting framework; and
- assessing the Public Health Agency's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer anticipates that the services provided by the Public Health Agency will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

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

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error and to issue a certificate that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error

and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulation, including fraud.

My procedures included:

- obtaining an understanding of the legal and regulatory framework applicable to the Public Health Agency through discussion with management and application of extensive public sector accountability knowledge. The key laws and regulations I considered included governing legislation and any other relevant laws and regulations identified;
- making enquires of management and those charged with governance on Public Health Agency's compliance with laws and regulations;
- making enquiries of internal audit, management and those charged with governance as to susceptibility to irregularity and fraud, their assessment of the risk of material misstatement due to fraud and irregularity, and their knowledge of actual, suspected and alleged fraud and irregularity;
- completing risk assessment procedures to assess the susceptibility of the Public Health Agency's financial statements to material misstatement, including how fraud might occur. This included, but was not limited to, an engagement director led engagement team discussion on fraud to identify particular areas, transaction streams and business practices that may be susceptible to material misstatement due to fraud. As part of this discussion, I identified potential for fraud in the following areas: revenue recognition, expenditure recognition, posting of unusual journals;
- engagement director oversight to ensure the engagement team collectively had the appropriate competence, capabilities and skills to identify or recognise non-compliance with the applicable legal and regulatory framework throughout the audit;
- documenting and evaluating the design and implementation of internal controls in place to mitigate risk of material misstatement due to fraud and non-compliance with laws and regulations;
- designing audit procedures to address specific laws and regulations which the engagement team considered to have a direct material effect on the financial statements in terms of misstatement and irregularity, including fraud. These audit procedures included, but were not limited to, reading board and committee minutes, and agreeing financial statement disclosures to underlying supporting documentation and approvals as appropriate;
- addressing the risk of fraud as a result of management override of controls by:
    - performing analytical procedures to identify unusual or unexpected relationships or movements;
    - testing journal entries to identify potential anomalies, and inappropriate or unauthorised adjustments;

- assessing whether judgements and other assumptions made in determining accounting estimates were indicative of potential bias; and
- investigating significant or unusual transactions made outside of the normal course of business.

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

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

Report

I have no observations to make on these financial statements.

Dorinnia Carville
Comptroller and Auditor General
Northern Ireland Audit Office
106 University Street
BELFAST
BT7 1EU
xx June 2025

PUBLIC HEALTH AGENCY

ANNUAL ACCOUNTS

FOR THE YEAR ENDED 31 MARCH 2025

FOREWORD

These accounts for the year ended 31 March 2025 have been prepared in a form determined by the Department of Health (DoH) based on guidance in the Government Financial Reporting Manual (FReM) and in accordance with the requirements of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

Statement of Comprehensive Net Expenditure for the Year Ended 31 March 2025

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

	NOTE	2025 £000	2024 £000
Income			
Revenue from contracts with customers	4.1	728	1,897
Other operating income (excluding interest)	4.2	582	445
Total Operating Income		1,310	2,342
Expenditure			
Staff costs	3	(30,415)	(28,612)
Purchase of goods and services	3	(62,251)	(62,620)
Depreciation, amortisation and impairment charges	3	(1,639)	(1,650)
Provision expense	3	(698)	(182)
Other operating expenditure	3	(4,448)	(5,165)
Total Operating Expenditure		(99,451)	(98,229)
Net Operating Expenditure		**(98,141)**	**(95,887)**
Finance expense	3	(2)	(3)
Net Expenditure for the Year		(98,143)	(95,890)
Revenue Resource Limits (RRLs) and capital grants issued (to)			
Belfast Health & Social Care Trust		(17,372)	(16,618)
South Eastern Health & Social Care Trust		(6,363)	(6,149)
Southern Health & Social Care Trust		(9,123)	(9,002)
Northern Health & Social Care Trust		(10,476)	(10,617)
Western Health & Social Care Trust		(8,902)	(8,465)
NI Ambulance Service		(122)	(177)
Total RRL issued		(52,358)	(51,028)
Total Commissioner Resources Utilised		(150,501)	(146,918)
Adjustment to net expenditure for non cash items	22.1	9,125	7,551
Total Commissioner resources funded from RRL		(141,376)	(139,367)
Revenue Resource Limit (RRL) received from DOH	22.1	141,453	139,447
Surplus / (Deficit) against RRL		**77**	**80**

		2025 £000	2024 £000
OTHER COMPREHENSIVE EXPENDITURE			
Items that will not be reclassified to net operating costs			
Net gain/(loss) on revaluation of property, plant and equipment	5.1/5.2/8	0	1
TOTAL COMPREHENSIVE EXPENDITURE for the Year Ended 31 March		**(98,143)**	**(95,889)**

The notes on pages 88 to 119 form part of these accounts.

Statement of Financial Position for the Year Ended 31 March 2025

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

	NOTE	2025 £000	£000	2024 £000	£000
Non Current Assets					
Property, plant and equipment	5.1/5.2	252		585	
Intangible assets	6.1/6.2	2,821		3,965	
Total Non Current Assets			3,073		4,550
Current Assets					
Inventories	10	1,088		0	
Trade and other receivables	12	636		4,489	
Other current assets	12	274		89	
Cash and cash equivalents	11	417		394	
Total Current Assets			2,415		4,972
Total Assets			**5,488**		**9,522**
Current Liabilities					
Trade and other payables	13	(8,817)		(15,645)	
Other liabilities	13/16	(110)		(109)	
Provisions	14	(156)		(134)	
Total Current Liabilities			(9,083)		(15,888)
Total Assets less Current Liabilities			**(3,595)**		**(6,366)**
Non Current Liabilities					
Provisions	14	(909)		(233)	
Other liabilities	13/16	(55)		(165)	
Total Non Current Liabilities			(964)		(398)
Total Assets less Total Liabilities			**(4,559)**		**(6,764)**
Taxpayers' Equity and Other Reserves					
Revaluation reserve		5,321		5,322	
SoCNE Reserve		(9,880)		(12,086)	
Total Equity			**(4,559)**		**(6,764)**

The notes on pages 88 to 119 form part of these accounts.

The financial statements on pages 84 to 87 were approved by the Board on 19 June 2025 and were signed on its behalf by:

Signed (Chair) 19 June 2025

Signed (Chief Executive) 19 June 2025

Statement of Cash Flows for the Year Ended 31 March 2025

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

	NOTE	2025 £000	2024 £000
Cash flows from operating activities			
Net operating expenditure	SoCNE	(98,143)	(95,890)
Adjustments for non cash transactions	3	2,475	1,966
(Increase)/decrease in trade and other receivables	12	3,668	1,519
(Increase)/decrease in inventories	10	(1,088)	0
Increase/(decrease) in trade and other payables	13	(6,938)	1,767
Less movements in payables relating to items not passing through the Net Expenditure Adjustment (NEA)			
Movements in payables relating to finance leases	13	109	108
Net cash inflow/(outflow) from operating activities		(99,917)	(90,530)
Cash flows from investing activities			
(Purchase of intangible assets)	6	(270)	(39)
Net cash outflow from investing activities		(270)	(39)
Cash flows from financing activities			
Grant in aid		100,320	90,559
Capital element of bringing lease onto Balance Sheet		(110)	(108)
Net financing		100,210	90,451
Net increase/(decrease) in cash & cash equivalents in the period		23	(118)
Cash & cash equivalents at the beginning of the period	11	394	512
Cash & cash equivalents at the end of the period	11	**417**	**394**

The notes on pages 88 to 119 form part of these accounts.

PUBLIC HEALTH AGENCY

Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2025

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

	NOTE	SoCNE Reserve £000	Revaluation Reserve £000	Total £000
Balance at 31 March 2023		**(6,781)**	**247**	**(6,534)**
Changes in Taxpayers' Equity 2023/24				
Grant from DOH		90,559	0	90,559
(Comprehensive expenditure for the year)		(95,889)	1	(95,888)
Transfer of asset ownership		0	5,074	5,074
Non cash charges - auditors remuneration	3	25	0	25
Balance at 31 March 2024		**(12,086)**	**5,322**	**(6,764)**
Changes in Taxpayers' Equity 2024/25				
Grant from DOH		100,320	0	100,320
(Comprehensive expenditure for the year)		(98,143)	(1)	(98,144)
Transfer of asset ownership		0	0	0
Non cash charges - auditors remuneration	3	29	0	29
Balance at 31 March 2025		**(9,880)**	**5,321**	**(4,559)**

The notes on pages 88 to 119 form part of these accounts.

NOTE 1 - STATEMENT OF ACCOUNTING POLICIES

1 Authority

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

The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Public Health Agency (PHA) for the purpose of giving a true and fair view has been selected. The particular policies adopted by the PHA are described below. They have been applied consistently in dealing with items considered material in relation to the accounts, unless otherwise stated.

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

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and liabilities.

1.2 Currency and Rounding

These accounts are presented in UK Pounds (£) sterling. The figures in the accounts are shown to the nearest £1,000, which may give rise to rounding differences.

1.3 Property, Plant and Equipment

Property, plant and equipment assets comprise Buildings, Information Technology, Furniture & Fittings and Assets under Construction.

Recognition

Property, plant and equipment must be capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the PHA;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £1,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building or unit, irrespective of their individual or collective cost.

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

Valuation

All Property, Plant and Equipment are carried at fair value.

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

Assets under Construction (AUC)

Assets classified as “under construction” are recognised in the Statement of Financial Position to the extent that money has been paid, or a liability has been incurred. They are carried at cost, less any impairment loss. Assets under construction are revalued and depreciation commences when that are brought into use.

Short Life Assets

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

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

Revaluation Reserve

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

1.4 Depreciation

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

Otherwise, depreciation is charged to write off the costs or valuation of property, plant and equipment and similarly, amortisation is applied to intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. Assets held under finance leases are also depreciated over the lower of their estimated useful lives and the terms of the lease. The estimated useful life of an asset is the period over which the PHA expects to obtain economic benefits or service potential from the asset. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

The following asset lives have been used.

Asset Type	Asset Life
Freehold Buildings	25 – 60 years
Leasehold property	Remaining period of lease
IT assets	3 – 10 years
Intangible assets	3 – 10 years
Other Equipment	3 – 15 years

1.5 Impairment loss

If there has been an impairment loss due to a general change in prices, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure within the Statement of Comprehensive Net Expenditure. If the impairment is due to the consumption of economic benefits the full amount of the impairment is charged to the Statement of Comprehensive Net Expenditure and an amount up to the value of the

impairment in the revaluation reserve is transferred to the Statement of Comprehensive Net Expenditure Reserve. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited firstly to the Statement of Comprehensive Net Expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.6 Subsequent expenditure

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

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

1.7 Intangible assets

Intangible assets include any of the following held - software, licences, trademarks, websites, development expenditure, Patents, Goodwill and Intangible Assets under Construction. Software that is integral to the operating of hardware, for example an operating system is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

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

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the PHA's business or which arise from contractual or other legal rights. Intangible assets are considered to have a finite life. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the PHA where the cost of the asset can be measured reliably. All single items over £5,000 in value must be capitalised while intangible assets which fall within the grouped asset definition may be capitalised if their individual value is at least £1,000 each and the group is at least £5,000 in value.

The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date of commencement of the intangible asset, until it is complete and ready for use.

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

1.8 Non-current assets held for sale

The PHA had no non-current assets held for sale in either 2024/25 or 2023/24.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value and are included exclusive of VAT. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.10 Income

Income is classified between Revenue from Contracts and Other Operating Income as assessed in line with organisational activity, under the requirements of IFRS 15 and as applicable to the public sector. Judgement is exercised in order to determine whether the five essential criteria within the scope of IFRS 15 are met in order to define income as a contract.

Income relates directly to the activities of the PHA and is recognised on an accruals basis when, and to the extent that a performance obligation is satisfied in a manner that depicts the transfer to the customer of the goods or services promised.

Where the criteria to determine whether a contract is in existence are not met, income is classified as Other Operating Income within the Statement of Comprehensive Net Expenditure and is recognised when the right to receive payment is established.

Income is stated net of VAT.

Grant in aid

Funding received from other entities, including the Department is accounted for as grant in aid and is reflected through the Statement of Comprehensive Net Expenditure Reserve.

1.11 Investments

The PHA did not hold any investments in either 2024/25 or 2023/24.

1.12 Research and Development expenditure

Research and development (R&D) expenditure is expensed in the year it is incurred in accordance with IAS 38.

Following the introduction of the 2010 European System of Accounts (ESA10) and the change in the budgeting treatment (a change from the revenue budget to the capital budget) of R&D expenditure, additional disclosures are included in the notes to the accounts. This treatment was implemented from 2016-17.

1.13 Other expenses

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

1.14 Cash and cash equivalents

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

1.15 Leases

Under IFRS 16 Leased Assets which the PHA has use/control over and which it does not necessarily legally own are to be recognised as a 'Right-Of-Use' (ROU) asset. There are only two exceptions:

- short term assets – with a life of up to one year; and
- low value assets – with a value equal to or below the Department's threshold limit which is currently £5,000.

Short term leases

Short term leases are defined as having a lease term of 12 months or less. Any lease with a purchase option cannot qualify as a short-term lease. The lessee must not exercise an option to extend the lease beyond 12 months. No liability should be recognised in respect of short-term leases, and neither should the underlying asset be capitalised.

Lease agreements which contain a purchase option cannot qualify as short-term.

Examples of short-term leases are software leases, specialised equipment, hire cars and some property leases.

Low value assets

An asset is considered "low value" if its value, when new, is less than the capitalisation threshold. The application of the exemption is independent of considerations of materiality. The low value assessment is performed on the underlying asset, which is the value of that underlying asset when new.

Examples of low value assets are, tablet and personal computers, small items of office furniture and telephones.

Separating lease and service components

Some contracts may contain both a lease element and a service element. DoH bodies can, at their own discretion, choose to combine lease and non-lease components of contracts, and account for the entire contract as a lease. If a contract contains both lease and service components IFRS 16 provides guidance on how to separate those components. If a lessee separates lease and service components, it should capitalise amounts related to the lease components and expense elements relating to the service elements. However, IFRS 16 also provides an option for lessees to combine lease and service components and account for them as a single lease. This option should help DoH bodies where it is time consuming or difficult to separate these components.

The PHA as lessee

The ROU asset lease liability will initially be measured at the present value of the unavoidable future lease payments. The future lease payments should include any amounts for:

- indexation;
- amounts payable for residual value;
- purchase price options;
- payment of penalties for terminating the lease;
- any initial direct costs; and
- costs relating to restoration of the asset at the end of the lease.

The lease liability is discounted using the rate implicit in the lease.

Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the PHA's surplus/deficit.

The difference between the carrying amount and the lease liability on transition is recognised as an adjustment to taxpayer's equity. After transition the difference is recognised as income in accordance with IAS 20.

Subsequent measurement

After the commencement date (the date that the lessor makes the underlying asset available for use by the lessee) a lessee shall measure the liability by;

- increasing the carrying amount to reflect interest;
- reducing the carrying amount to reflect lease payments made; and
- re-measuring the carrying amount to reflect any reassessments or lease modifications, or to reflect revised in substance fixed lease payments.

There is a need to reassess the lease liability in the future if there is:

- a change in lease term;
- a change in assessment of purchase option;
- a change in amounts expected to be payable under a residual value guarantee; or
- a change in future payments resulting from change in index or rate.

Subsequent measurement of the ROU asset is measured in same way as other property, plant and equipment. Asset valuations should be measured at either 'fair value' or 'current value in existing use'.

Depreciation

Assets under a finance lease or ROU lease are depreciated over the shorter of the lease term and its useful life, unless there is a reasonable certainty the lessee will obtain ownership of the asset by the end of the lease term in which case it should be depreciated over its useful life.

The depreciation policy is that for other depreciable assets that are owned by the entity.

Leased assets under construction must also be depreciated.

The PHA as lessor

The PHA did not have any lessor agreements in either 2024/25 or 2023/24.

1.16 Private Finance Initiative (PFI) transactions

The PHA had no PFI transactions during 2024/25 or 2023/24.

1.17 Financial instruments

A financial instrument is defined as any contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

The PHA has financial instruments in the form of trade receivables and payables and cash and cash equivalents.

Financial assets

Financial assets are recognised on the Statement of Financial Position when the PHA becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value. IFRS 9 requires consideration of the expected credit loss model on financial assets. The measurement of the loss allowance depends upon the PHA's assessment at the end of each reporting period as to whether the financial instrument's credit risk has increased significantly since initial recognition, based on reasonable and supportable information that is available, without undue cost or effort to obtain. The amount of expected credit loss recognised is measured on the basis of the probability weighted present value of anticipated cash shortfalls over the life of the instrument, where judged necessary.

Financial assets are classified into the following categories:

- financial assets at fair value through Statement of Comprehensive Net Expenditure;
- held to maturity investments;
- available for sale financial assets; and
- loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial liabilities

Financial liabilities are recognised on the Statement of Financial Position when the PHA becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

Financial risk management

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

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

Currency risk

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

Interest rate risk

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

Credit and liquidity risk

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

1.18 Provisions

In accordance with IAS 37, provisions are recognised when there is a present legal or constructive obligation as a result of a past event, it is probable that the PHA will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

Where a provision is measured using the cash flows estimated to settle the obligation, it's carrying amount is the present value of those cash flows using the relevant discount rates provided by HM Treasury.

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

1.19 Contingent liabilities/assets

In addition to contingent liabilities disclosed in accordance with IAS 37, the PHA discloses for Assembly reporting and accountability purposes certain statutory and non-statutory contingent liabilities where the likelihood of a transfer of economic benefit is remote, but which have been reported to the Assembly in accordance with the requirements of Managing Public Money Northern Ireland.

Where the time value of money is material, contingent liabilities which are required to be disclosed under IAS 37 are stated at discounted amounts and the amount reported to the Assembly separately noted. Contingent liabilities that are not required to be disclosed by IAS 37 are stated at the amounts reported to the Assembly.

Under IAS 37, the PHA discloses contingent liabilities where there is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of

the PHA, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the PHA. A contingent asset is disclosed where an inflow of economic benefits is probable.

1.20 Employee benefits

Short-term employee benefits

Under the requirements of IAS 19: Employee Benefits, staff costs must be recorded as an expense as soon as the organisation is obligated to pay them. This includes the cost of any untaken leave that has been earned at the year end. This cost has been calculated based on the balance remaining in the computerised leave system for all staff as at 31 March 2025. (Untaken flexi leave is estimated to be immaterial to the PHA and has not been included).

Retirement benefit costs

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

The costs of early retirements, except those for ill-health retirements, are met by the PHA and charged to the Statement of Comprehensive Net Expenditure at the time the PHA commits itself to the retirement.

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required with sufficient regularity that the amounts recognised in the financial statements do not differ materially from those determined at the reporting period date. This has been interpreted in the FReM to mean that the period between formal actuarial valuations shall be four years.

The actuary reviews the most recent actuarial valuation at the statement of financial position date and updates it to reflect current conditions. The scheme valuation data provided for the 2020 actuarial valuation will be used in the 2024/25 accounts. The 2020

valuation assumptions will be retained for demographic assumptions apart from the assumption for future longevity improvements. GAD have recommended that the future longevity improvement assumptions are updated in line with the 2022-based population projections for the United Kingdom published by the Office for National Statistics (ONS) on 28 January 2025. Financial assumptions are updated to reflect recent financial conditions.

1.21 Reserves

Statement of Comprehensive Net Expenditure Reserve

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

Revaluation Reserve

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

1.22 Value Added Tax (VAT)

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

1.23 Third party assets

The PHA had no third-party assets in 2024/25 or 2023/24.

1.24 Government Grants

The PHA had no government grants in 2024/25 or 2023/24.

1.25 Losses and Special Payments

Losses and special payments are items that the Assembly would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments.

They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the PHA not been bearing its own risks (with insurance

premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses register which reports amounts on an accruals basis with the exception of provisions for future losses.

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

IFRS 17 Insurance Contracts:

IFRS 17 replaces the previous standard on insurance contracts, IFRS 4. The standard will be adapted for the central government context and updates made to the 2024-25 FReM, with an implementation date of 1 April 2025 (with limited options for early adoption).

Application guidance has been published and is available at: https://www.gov.uk/government/publications/government-financial-reporting-manualapplication-guidance

Management currently assess that there will be no impact on application to the PHA's financial statements.

1.27 Changes in accounting policies

There were no changes in accounting policies during the year ended 31 March 2025.

NOTE 2 - ANALYSIS OF NET EXPENDITURE BY SEGMENT

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

	NOTE	2025	2024
Summary		**£000**	**£000**
Commissioning	2.1	110,739	108,956
FHS	2.2	3,084	2,761
Agency Administration	2.3	35,759	34,315
Safeguarding Board NI	2.4	914	886
Total Commissioner Resources utilised		**150,496**	**146,918**

2.1 Commissioning

		2025	2024
Expenditure		**£000**	**£000**
Belfast Health & Social Care Trust	SoCNE	17,372	16,618
South Eastern Health & Social Care Trust	SoCNE	6,363	6,149
Southern Health & Social Care Trust	SoCNE	9,123	9,002
Northern Health & Social Care Trust	SoCNE	10,476	10,617
Western Health & Social Care Trust	SoCNE	8,902	8,465
NIAS	SoCNE	122	177
Other	3.1	59,109	59,825
		111,467	110,853
Income			
Revenue from contracts with customers	4.1	728	1,897
Commissioning Net Expenditure		**110,739**	**108,956**

2.2 Family Health Service (FHS)

FHS Net Expenditure	3.1	**3,084**	**2,761**

2.3 Agency Administration

		2025	2024
Expenditure		**£000**	**£000**
Salaries and wages	3.2	29,803	27,989
Operating expenditure	3.2	4,068	4,806
Non-cash costs	3.3	722	206
Depreciation	3.3	1,748	1,759
		36,341	34,760
Other Operating Income			
Staff secondment recoveries	4.2	582	445
Agency Administration Net Expenditure		**35,759**	**34,315**

2.4 Safeguarding Board NI

		2025	2024
Expenditure		**£000**	**£000**
Salaries and wages	3.2	612	623
Operating expenditure	3.2	302	263
Safeguarding Board NI Net Expenditure		**914**	**886**

NOTE 3 EXPENDITURE

3.1 Commissioning	2025 £000	2024 £000
General Medical Services	3,084	2,761
Other providers of healthcare and personal social services	49,334	50,050
Research & development capital grants	9,775	9,775
Total Commissioning	**62,193**	**62,586**

3.2 Operating expenses are as follows:-

Staff costs[1]:		
Wages and salaries	22,867	22,076
Social security costs	2,711	2,287
Other pension costs	4,837	4,249
Supplies and services - general	58	34
Establishment	3,616	4,323
Transport	5	2
Premises	628	624
Rentals under operating leases	61	82
Interest charges under IFRS16	2	3
Total Operating Expenses	**34,785**	**33,680**

3.3 Non cash items

Depreciation	225	251
Amortisation	1,414	1,399
Depreciation charges under IFRS16	109	109
Increase / Decrease in provisions	693	181
Cost of borrowing of provisions (unwinding of discount on provisions)	5	1
Auditors remuneration	29	25
Total non cash items	**2,475**	**1,966**
Total	**99,453**	**98,232**

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

During the year the PHA paid its share of regional audit services (£1,382) from its external auditor (NIAO) for the National Fraud Initiative (NFI) and this amount is included in operating costs above.

NOTE 4 - INCOME

4.1 Revenue from Contracts with Customers

	2025 £000	2024 £000
R&D	290	1,145
Other income from non-patient services	104	163
Burdett Income	0	18
Capital Grant Income	334	571
Total	**728**	**1,897**

4.2 Other Operating Income

	2025 £000	2024 £000
Seconded staff	582	445
Total	**582**	**445**

Total Income	**1,310**	**2,342**

NOTE 5.1 - Property, Plant & Equipment - Year Ended 31 March 2025

	Buildings (excluding dwellings) £000	Information Technology (IT) £000	Furniture and Fittings £000	Total £000
Cost or Valuation				
At 1 April 2024	720	1,141	56	1,917
Indexation	6	0	1	7
Transfers	0	(7)	0	(7)
Disposals	0	(5)	0	(5)
At 31 March 2025	**726**	**1,129**	**57**	**1,912**
Depreciation				
At 1 April 2024	448	840	44	1,332
Indexation	5	0	1	6
Transfers	0	(7)	0	(7)
Disposals	0	(5)	0	(5)
Provided during the year	109	222	3	334
At 31 March 2025	**562**	**1,050**	**48**	**1,660**
Carrying Amount				
At 31 March 2025	**164**	**79**	**9**	**252**
At 31 March 2024	**272**	**301**	**12**	**585**
Asset financing				
Owned	0	79	9	88
Finance leased	164	0	0	164
Carrying Amount				
At 31 March 2025	**164**	**79**	**9**	**252**

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

The total amount of depreciation charged in the Statement of Comprehensive Net Expenditure Account in respect of assets held under finance leases and hire purchase contracts is £109k (2023/24: £109k).

The fair value of assets funded from donations, government grants or lottery funding during the year was £nil (2023/24: £nil).

PHA uses Producer Price Indices published by the Office for National Statistics (ONS) in order to apply indexation to the value of non-property assets at year-end. In line with previous years, the December indices have been applied in 2024-25. Ordinarily, an assessment is carried out after the year-end, following the publication of the March indices by ONS, to ascertain that the impact of the movement in the indices between December and March is immaterial. However, in March 2025, ONS issued a statement indicating that they had identified a problem with the chain-linking methods used to calculate these indices, affecting the years from 2008 onwards, and that they would consequently be pausing publication of Producer Price Index data while the issue is rectified. At the time these accounts are being prepared, it has not been possible to ascertain the potential impact of this issue. However, given the value of the non-property assets potentially affected, PHA does not expect an adjustment to indexation to have a material impact on the 2024-25 accounts. It is anticipated that ONS will recommence publication of the Producer Price Indices at some point during the 2025-26 financial year and the indexation of non-property assets will be brought up to date in the 2025-26 accounts.

NOTE 5.2 - Property, Plant & Equipment - Year Ended 31 March 2024

	Buildings (excluding dwellings) £000	Information Technology (IT) £000	Furniture and Fittings £000	Total £000
Cost or Valuation				
At 1 April 2023	713	1,215	55	1,983
Indexation	7	0	1	8
Disposals	0	(74)	0	(74)
At 31 March 2024	**720**	**1,141**	**56**	**1,917**
Depreciation				
At 1 April 2023	333	666	40	1,039
Indexation	6	0	1	7
Disposals	0	(74)	0	(74)
Provided during the year	109	248	3	360
At 31 March 2024	**448**	**840**	**44**	**1,332**
Carrying Amount				
At 31 March 2024	**272**	**301**	**12**	**585**
At 1 April 2023	**380**	**549**	**15**	**944**
Asset financing				
Owned	0	301	12	313
Finance leased	272	0	0	272
Carrying Amount				
At 31 March 2024	**272**	**301**	**12**	**585**
Asset financing				
Owned	0	549	15	564
Finance leased	380	0	0	380
Carrying Amount				
At 1 April 2023	**380**	**549**	**15**	**944**

NOTE 6.1 - Intangible Assets - Year Ended 31 March 2025

	Software Licenses £000	Information Technology £000	Payments on Account & Assets under Construction £000	Total £000
Cost or Valuation				
At 1 April 2024	343	6,847	0	7,190
Additions	0	74	196	270
At 31 March 2025	**343**	**6,921**	**196**	**7,460**
Amortisation				
At 1 April 2024	242	2,983	0	3,225
Provided during the year	75	1,339	0	1,414
At 31 March 2025	**317**	**4,322**	**0**	**4,639**
Carrying Amount				
At 31 March 2025	**26**	**2,599**	**196**	**2,821**
At 31 March 2024	**101**	**3,864**	**0**	**3,965**
Asset financing				
Owned	26	2,599	196	2,821
Carrying Amount				
At 31 March 2025	**26**	**2,599**	**196**	**2,821**

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

The fair value of assets funded from donations, government grants or lottery funding during the year was £nil (2023/24 - £nil).

NOTE 6.2 - Intangible Assets - Year Ended 31 March 2024

	Software Licenses £000	Information Technology £000	Total £000
Cost or Valuation			
At 1 April 2023	343	307	650
Additions	0	39	39
Transfers	0	6,501	6,501
At 31 March 2024	**343**	**6,847**	**7,190**
Amortisation			
At 1 April 2023	167	232	399
Transfers	0	1,427	1,427
Provided during the year	75	1,324	1,399
At 31 March 2024	**242**	**2,983**	**3,225**
Carrying Amount			
At 31 March 2024	**101**	**3,864**	**3,965**
At 1 April 2023	**176**	**75**	**251**
Asset financing			
Owned	101	3,864	3,965
Carrying Amount			
At 31 March 2024	**101**	**3,864**	**3,965**
Asset financing			
Owned	176	75	251
Carrying Amount			
At 1 April 2023	**176**	**75**	**251**

NOTE 7 - FINANCIAL INSTRUMENTS

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

NOTE 8 - IMPAIRMENTS

The PHA had no impairments in 2024/25 or 2023/24.

NOTE 9 - ASSETS CLASSIFIED AS HELD FOR SALE

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

The PHA did not hold any assets classified as held for sale in 2024/25 or 2023/24.

NOTE 10 - INVENTORIES

	2025 £000	2024 £000
Vaccination Supplies	1,088	0
Balance at 31st March	**1,088**	**0**

NOTE 11 - CASH AND CASH EQUIVALENTS

	2025 £000	2024 £000
Balance at 1st April	394	512
Net change in cash and cash equivalents	23	(118)
Balance at 31st March	**417**	**394**

The following balances were held at 31 March:

	2025 £000	2024 £000
Commercial banks and cash in hand	417	394
Balance at 31st March	**417**	**394**

11.1 Reconciliation of liabilities arising from financing activities

		Non-Cash Changes				
	2024	Cash flows	Net cash requirement	Acquisition	Change in valuation	2025
	£000	£000	£000	£000	£000	£000
Lease Liabilities	274	(112)	0	0	2	165
Total liabilities from financing activities	**274**	**(112)**	**0**	**0**	**2**	**165**

NOTE 12 - TRADE RECEIVABLES, FINANCIAL AND OTHER ASSETS

	2025 £000	2024 £000
Amounts falling due within one year		
Trade receivables	187	1,171
VAT receivable	414	461
Other receivables - not relating to fixed assets	35	2,857
Trade and other receivables	**636**	**4,489**
Prepayments	274	89
Other current assets	**274**	**89**
TOTAL TRADE AND OTHER RECEIVABLES	**636**	**4,489**
TOTAL OTHER CURRENT ASSETS	**274**	**89**
TOTAL RECEIVABLES AND OTHER CURRENT ASSETS	**910**	**4,578**

The balances are net of a provision for bad debts of £nil (2023/24: £nil).

NOTE 13 - TRADE PAYABLES, FINANCIAL AND OTHER LIABILITIES

	2025 £000	2024 £000
Amounts falling due within one year		
Trade revenue payables	3,115	7,033
Payroll payables	1,652	3,844
BSO payables	946	963
Other payables	3,105	2,970
Deferred income	0	835
Trade and other payables	**8,817**	**15,645**
Current part of lease liabilities	110	109
Other current liabilities	**110**	**109**
Total payables falling due within one year	**8,927**	**15,754**
Amounts falling due after more than one year		
Finance leases	55	165
Total non current other payables	**55**	**165**
TOTAL TRADE PAYABLES AND OTHER CURRENT LIABILITIES	**8,982**	**15,919**

NOTE 14 - PROVISIONS FOR LIABILITIES AND CHARGES 2025

	Holiday Pay £000	Other £000	Total £000
Balance at 1 April 2024	233	134	367
Provided in year	671	22	693
Cost of borrowing (unwinding of discount)	5	0	5
At 31 March 2025	**909**	**156**	**1,065**

Comprehensive Net Expenditure Account Charges

	2025 £000	2024 £000
Arising during the year	693	210
Reversed unused	0	(30)
Cost of borrowing (unwinding of discount)	5	1
Total charge within Operating expenses	**698**	**181**

Analysis of Expected Timing of Discounted Flows

	Holiday Pay £000	Other £000	Total £000
Not later than one year	0	156	156
Later than one year and not later than five years	909	0	909
Later than five years	0	0	0
At 31 March 2025	**909**	**156**	**1,065**

Provisions have been made for a Senior Executive Pay Award and the Holiday Pay legal case.

Holiday Pay Provision

On 4 October 2023, the Supreme Court handed down the decision in the case of the Chief Constable of the PSNI v Agnew and others. The judgement confirmed that the claimants are able to bring their claims under the 'unlawful deductions' provisions of the Employment Rights (Northern Ireland) Order 1996. The judgement accepted the principle, established by a number of cases in both the European and domestic courts that the claimants were entitled to be paid their normal pay during periods of annual leave, and that "normal pay" is not limited to basic pay but could include elements such as overtime, commission and allowances. The outcome of this case has widespread implications for all public sector bodies in Northern Ireland in respect of both the pay elements that must be included in holiday pay calculations and the period of retrospection which means that some employees may be able to bring claims to be rectified as far back as 1998.

With effect from 1 April 2025, HSC employers have implemented an interim arrangement to ensure employees are paid appropriately for periods of annual leave. This interim arrangement has been agreed with trade unions pending the introduction of the new HR and payroll system in 2026/27. A provision in respect of the retrospective payment is still required for the period 1998/99 to 2024/25. The PHA's provision at 31 March 2025 reflects this retrospective timeframe. In calculating the provision, the PHA has used payroll data available, for all eligible staff, within the current HRPTS system back to 2015, with averaging applied for the prior years and changes in staff numbers. Revised Working Time Directive (14.5%) and Employer costs rates have been factored in, and 8% compound interest applied. A settlement year of 2026/27 has been used and as such the overall value of the provision has been discounted to determine the net present value.

A number of key areas of uncertainty which may impact on the value of the provision remain including:

- The reliability of the data used;
- The terms of settlement is subject to the determination in cases lodged by employees to the Industrial Tribunal;
- The resolution of grievances lodged by employees and any settlement negotiations with trade unions;
- The uptake rate for current or past employees;
- The extent of attrition in the workforce;
- Delays in the time it will take to administer the payments, once agreed; and
- The extent to which interest will apply.

No sensitivity analysis has been undertaken to assess how much the value of the provision would change if the assumptions used were to differ. The reason for this is the possible permutations for any sensitivity analysis are numerous and the value of the provision is already subject to the key areas of uncertainty identified above.

NOTE 14 - PROVISIONS FOR LIABILITIES AND CHARGES 2024

	Holiday Pay £000	Other £000	2024 £000
Balance at 1 April 2023	155	31	186
Provided in year	76	134	210
(Provisions not required written back)	0	(30)	(30)
Cost of borrowing (unwinding of discount)	2	(1)	1
At 31 March 2024	**233**	**134**	**367**

Analysis of Expected Timing of Discounted Flows

	Holiday Pay £000	Other £000	2024 £000
Not later than one year	0	134	134
Later than one year and not later than five years	233	0	233
Later than five years	0	0	0
At 31 March 2024	**233**	**134**	**367**

NOTE 15 - CAPITAL AND OTHER COMMITMENTS

The PHA did not have any capital or other commitments as at 31 March 2025 or 31 March 2024.

NOTE 16 - LEASES

16.1 Quantitative Disclosures around Right of Use Assets

	Land and Buildings	Other	Total
Cost or Valuation	**£000**	**£000**	**£000**
At 1 April 2024	489	0	489
Additions	0	0	0
As at 31 March 2025	**489**	**0**	**489**
Depreciation Expense			
At 1 April 2024	218	0	218
Charged in year	109	0	109
At 31 March 2025	**327**	**0**	**327**
Carrying Amount at 31 March 2025	**162**	**0**	**162**
Interest charged on IFRS 16 leases	**2**		**2**

16.2 Quantitative Disclosures around Lease Liabilities

Maturity Analysis

	2025	2024
	£000	**£000**
Buildings		
Not later than one year	111	111
Later than one year and not later than five years	55	166
Later than five years	0	0
	166	**277**
Less interest element	(1)	(3)
Present Value of Obligations	**165**	**274**
Total Present Value of Obligations	**165**	**274**
Current Portion	110	109
Non-Current Portion	55	165

16.3 Quantitative Disclosures around Elements in the Statement of Comprehensive Net Expenditure

	2025 £000	2024 £000
Other lease payments not included in lease liabilities	61	73
Sub-leasing income	0	0
Expense related to short-term leases	0	0
Expense related to low-value asset leases	0	0
	61	**73**

16.4 Quantitative Disclosures around Cash Outflow for Leases

	2025 £000	2024 £000
Total cash outflow for lease	172	184

NOTE 17 - COMMITMENTS UNDER PFI AND OTHER SERVICE CONCESSION ARRANGEMENTS

17.1 Off balance sheet PFI contracts and other service concession arrangements

The PHA had no commitments under PFI or service concession arrangements in either 2024/25 or 2023/24.

NOTE 18 - OTHER FINANCIAL COMMITMENTS

The PHA did not have any other financial commitments at either 31 March 2025 or 31 March 2024.

NOTE 19 - CONTINGENT LIABILITIES

The PHA has contingent liabilities of £5k.

Clinical negligence

	2025 £000	2024 £000
Total estimate of contingent clinical negligence liabilities	5	5
Amount recoverable through non cash RRL	(5)	(5)
Net Contingent Liability	**0**	**0**

Other litigation claims could arise in the future due to incidents which have already occurred. The expenditure which may arise from such claims cannot be determined as yet.

NOTE 20 - RELATED PARTY TRANSACTIONS

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

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

NOTE 21 - THIRD PARTY ASSETS

The PHA had no third party assets in 2024/25 or 2023/24.

NOTE 22 - FINANCIAL PERFORMANCE TARGETS

22.1 Revenue Resource Limit

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

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

	2025	2024
	£000	£000
Revenue Resource Limit (RRL)		
RRL Allocated from:		
DoH (excludes non Cash)	140,962	138,956
Other Government Departments - NIMDTA	491	491
Total RRL Received	141,453	139,447
Less RRL Issued To:		
RRL Issued	(52,358)	(51,028)
Total RRL issued	(52,358)	(51,028)
RRL to be Accounted For	**89,095**	**88,419**
Revenue Resource Limit Expenditure		
Net Expenditure per SoCNE	98,143	95,890
Adjustments to remove items not funded via RRL		
Capital Grants for R&D	(334)	(570)
Capital Grant for GP Scheme	0	0
Research and Development under ESA10	(6,314)	(5,016)
IT purchase not capitalised	(2)	0
Depreciation	(226)	(251)
Depreciation - IFRS 16	(109)	(109)
Amortisation	(1,414)	(1,399)
Impairments	0	0
Notional Charges	(29)	(25)
Movements in Provisions	(698)	(181)
Total Adjustments	(9,125)	(7,551)
Net Expenditure Funded from RRL	**89,018**	**88,339**
Surplus/(Deficit) against RRL	77	80
Break Even cumulative position (opening)	2,236	2,156
Break Even cumulative position (closing)	**2,313**	**2,236**

Materiality Test:

	2025	2024
	%	%
Break Even in year position as % of RRL	0.05%	0.06%
Break Even cumulative position as % of RRL	1.64%	1.60%

The PHA has met its requirements to contain Net Resource Outturn to within +/- 0.25% of its agreed Revenue Resource Limit (RRL), as per DoH circular HSC(F) 37/2023.

Following the implementation of Review of Financial Process, the format of Note 22.1 has changed as the Department of Health has introduced budget control limits for depreciation, impairments, and provisions, which an Arm's Length Body cannot exceed. The PHA has remained within the budget control limit it was issued. From 2022/23 onwards, the materiality threshold limit excludes non-cash RRL.

22.2 Capital Resource Limit

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

	2025 £000	2024 £000
Capital Resource Limit (CRL)		
CRL Allocated from:		
Department of Health - Investment Directorate	6,920	5,626
Total CRL received	6,920	5,626
Less CRL Issued To:		
Organisation (please specify)	0	0
Total CRL Issued	0	0
Net CRL position	**6,920**	**5,626**
Capital Resource Limit Expenditure		
Capital expenditure per additions in asset notes	270	39
Adjustments to remove items not funded via CRL	0	0
Adjustments to add items not capitalised in accounts (i.e. expensed through SoCNE) but funded via CRL		
Capital grants for R&D	334	571
Research and Development under ESA10	6,314	5,016
IT purchase not capitalised	2	0
Net Capital Expenditure Funded from CRL	**6,920**	**5,626**
Surplus/(Deficit) against CRL	**0**	**0**

NOTE 23 - EVENTS AFTER THE REPORTING PERIOD

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

DATE AUTHORISED FOR ISSUE

The Accounting Officer authorised these financial statements for issue on <DATE>.

HSC Public Health Agency

item 11

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	19 June 2025
Title of paper	Financial Plan 2025/26
Reference	PHA/05/06/25
Prepared by	Stephen Bailie
Lead Director	Leah Scott

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

1 Purpose

The purpose of this paper is to seek approval from the PHA Board for the PHA Financial Plan for 2025/26.

2 Background Information

The attached Plan sets out the allocations made available to PHA and their deployment to providers of HSC services including Trusts.

PHA management have developed a Financial Plan which is balanced and deliverable in the current year but which contains a number of assumptions and risks which are highlighted in the document.

The PHA's opening allocation letter has not been finalised, however in January 2025 the DoH provided a draft allocation to the PHA to support the planning activities of the organisation.

This Plan has been prepared on the basis of the draft allocation and has been informed by subsequent DoH clarification in a number of areas. There is therefore an element of risk in approving the Plan, which will be managed until a formal allocation is issued to PHA. Further funds are expected to be received throughout the year, and updated budgets will be formally reported in the regular monthly financial position to management and the Board.

The following sections of this Plan summarise:

I. The total funding allocation from DoH, as set out in the 2025/26 draft opening allocation letter and projections based on other assumed allocations;
II. Planned application of resources set against high level budget areas;
III. Risks and uncertainties associated with the 2025/26 financial plan;
IV. The opening capital position for the PHA for 2025/26.

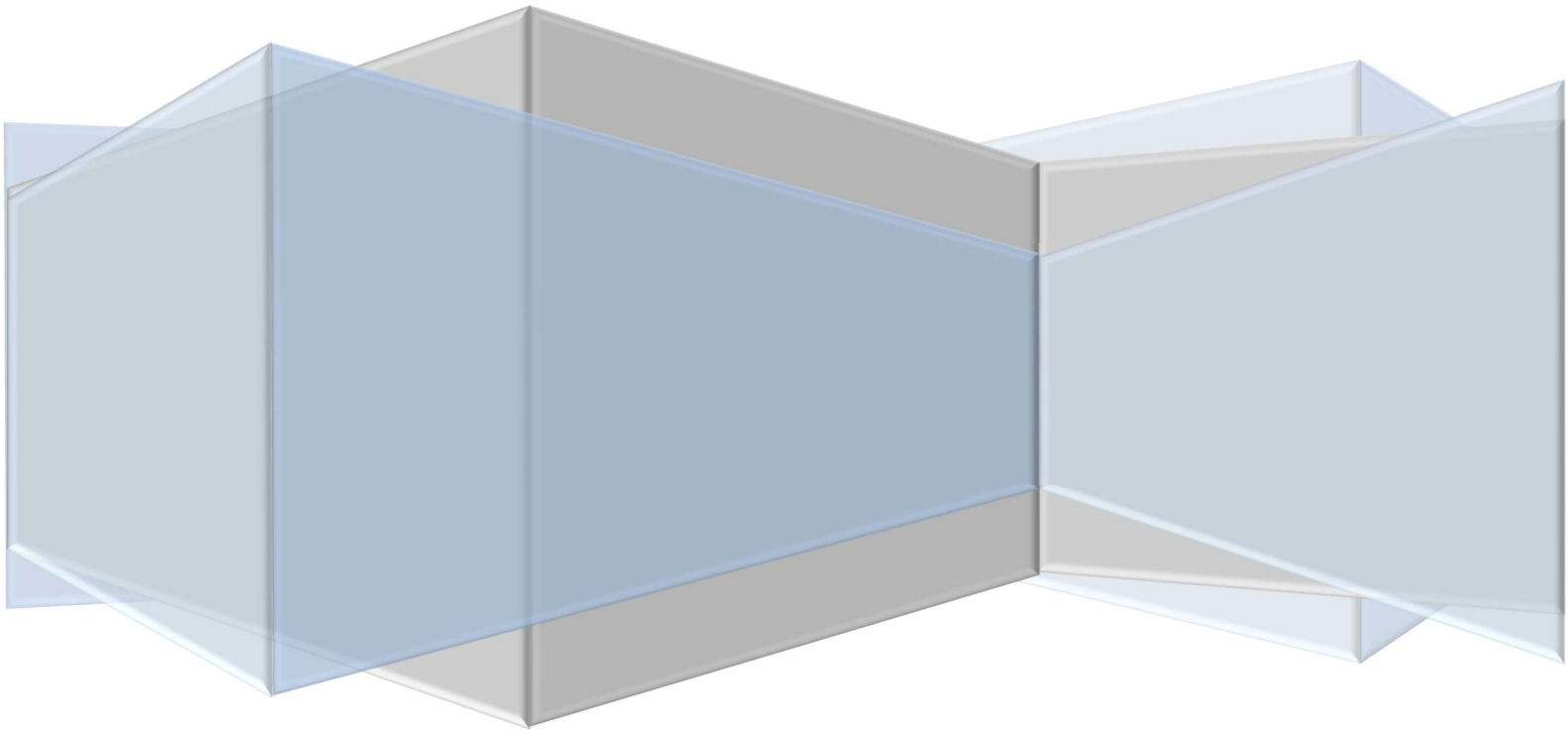
3 Next Steps

PHA Board are asked to consider the assumptions and risks set out and approve the recommendations made in the Financial Plan in respect of the opening revenue and capital budget position for 2025/26. Further updates will be provided in the monthly budget reports throughout the financial year.

HSC Public Health Agency

Financial Plan 2025/26 - Draft for Board approval

Leah Scott
Director of Finance and Corporate Services



Contents

Executive Summary

This document sets out the Public Health Agency's financial plan for 2025/26 and forms the basis of approval for the Board to decide on the adequacy of the allocation and distribution of resources across priorities set out in the Corporate Plan.

The development of the 2025/26 budget plan is set in the absence of a resolved financial budget within the Health sector for the year and aims to meet the demands of the PHA as it implements the Reshape and Refresh programme. There are a range of Risk based assumptions which the PHA Board should approve before accepting the recommendations set out.

Recommendation 1 (p3)

It is recommended that the unallocated savings target from 2023/24 of £1.2m is set against the Administration budget recurrently from 2025/26. The 1.2m will be made up of a 0.7m permanent reduction in the budget with the remaining 0.5m being managed via vacancy controls.

Recommendation 2 (p3)

It is recommended that Board agree that 2025/26 savings target of £1.243m can be managed on a recurrent basis by offsetting savings identified from VMS and HPV vaccination funding allocations.

Recommendation 3 (p5)

It is recommended that £2.2m pressures identified (£0.660m Admin and £1.540m Commissioning) are funded from slippage on an in-year only basis, with recurrent funding for the future costs still to be determined.

Strategic Context & Background

The development of this financial plan is set in the context of the biggest financial crisis facing the NHS in the United Kingdom since its establishment as a result of increasing demand, inadequate funding and lack of long-term planning arrangements to meet future needs.

The Permanent Secretary to the Department of Health, has signalled his intention to focus on mitigating pressures on the health services by reducing demand through early intervention and health improvement. a systems Financial management group has been established to drive forward savings supported by workstreams targeting specific areas of focus.

It is likely therefore, that PHA will be under more scrutiny to report on outcomes associated with the investment and be asked to do more with no additional funding.

The PHA Corporate Plan 2025-2030 has been agreed by the Board and the Department of Health. It sets out the Agency's priorities over the next 5 years to achieve statutory obligations and also the full transition to a new operating model through the Reshape and Refresh programme.

Financial Objectives

The performance measures which are relevant to the Financial Plan and are set out in the Annual Business Plan for 2025/26 and have been and are as follows:

- Effectively manage the PHA financial position to achieve a breakeven [1]position at year-end.

- New Operational Framework for Public Health Planning Teams and performance management framework, aligned to the new PHA operational model, to be developed and approved by PHA board.

A summary of the budget allocation and expenditure for 2025/6 is shown in the following table and shows a balanced budget:

Table 1: Summary of Overall Budget 2025/26	Commissioning		Admin	Ringfenced	Total
	Trust	Non-Trust			
		£'000	£'000	£'000	£'000
Department Revenue Allocation (incl. assumed)	51,218	55,573	32,053	302	**139,146**
Revenue Income from Other Sources			603		**603**
Total Revenue Funding	**51,218**	**55,573**	**32,656**	**302**	**139,749**
Proposed Revenue Budgets:					
Trusts expenditure	51,218				**51,218**
PHA Direct Programme expenditure		55,573		302	**55,875**
PHA Administration - pay			30,503		**30,503**
PHA Administration - non-pay			2,153		**2,153**
In-Year Slippage		(200)	(2,000)		**(2,200)**
In-Year Pressures		1,540	660		**2,200**
Total Revenue Expenditure	**51,218**	**56,913**	**31,316**	**302**	**139,749**
Surplus / (Deficit) - Revenue	**0**	**(1,340)**	**1,340**	**0**	**0**

PHA Board are asked to consider the assumptions and risks set out and approve the Financial Plan in respect of the opening revenue budget position and the opening capital budget position for 2025/26

[1] Breakeven is defined as no overspend and no greater than 0.25% of allocation underspent

1. Management of Recurrent savings targets

A number of savings targets have been applied to the PHA budget in recent years. A summary of how these have been managed is shown in Table 2 below:

Table 2: Recurrent savings targets	2023-24 £'000	2024-25 £'000	2025-26 £'000
Savings target	(5,300)	(1,000)	(1,243)
Savings realised the Progamme efficiencies in 2023-24	4,100		
Uncommitted recurrent Programme funding in 24-25		300	
Efficiency applied to funding uplifts for NonPay and NLW		700	
Balance of recurrent savings target at March 2025	**(1,200)**	**-**	**(1,243)**
Savings target recurrently applied to Admin budget in 25-26	1,200		
Efficiencies on VMS and HPV vaccination funding allocations			916
Uncommitted recurrent Programme funding in 25-26			327
Balance of recurrent savings target at April 2025	**-**	**-**	**-**

Recommendation 1.

It is recommended that the unallocated savings target from 2023/24 of £1.2m is set against the Administration budget recurrently from 2025/26. The 1.2m will be made up of a 0.7m permanent reduction in the budget with the remaining 0.5m being managed via vacancy controls.

Recommendation 2.

It is recommended that Board agree that 2025/26 savings target of £1.243m can be managed on a recurrent basis by offsetting savings identified from VMS and HPV vaccination funding allocations.

2. In-Year Pressures and Priorities

A number of in-year pressures and priorities have been identified by budget managers within the PHA, and these are listed in **Table 3**.

Table 3: In-Year Pressures & Priorities	Recurrent Pressure £'000	2025-26 Unfunded Pressure £'000
Other Pressures:		
Diabetic Eye Screening	400	400
Nicotine Replacement Therapy	350	350
Advanced Care Planning	325	70
Protect Life 2	306	301
SAI Redesign - surveillance support	169	118
Maternity & Neonatal Partnership	162	162
Resilience Workforce (Acute Response)	280	150
Screening postage - price pressure	110	110
Epidemiologist posts - 5 x Band 7	330	60
NI Cancer Registry	91	91
Child Health system	71	71
Digital solutions - specifications for Child Health System and Screening solutions	250	62
Band 7 Vaccines post (changes to childhood schedule)	-	60
Discovery exercise for new PHA Corporate Website	-	40
Band 8a Principal Behavioural Scientist (including overheads)	83	40
Implementation of Hepatitis C elimimation plan	70	35
Breast Assessment Equipment - balance	25	25
Research Support for influenza vaccine uptake behavioural science work	-	25
Electronic Notification of Infectious Disease (eNOIDs)	20	20
Focus groups for social care workers' attitudes to occupational influenza vaccination	-	10
Total Pressure	**3,042**	**2,200**

There is a significant list of mainly recurrent pressures which have no recurrent funding source, but which PHA proposes to cover internally for in-year slippage on a non-recurrent basis

A breakeven position is projected for the year with in-year pressures in the Programme budget expected to be funded from underspends on the Administration

budget and anticipated slippage in the Programme baseline. This Plan shows a balanced recurrent position against the draft allocation as set out in Table 4 below.

Table 4: Summary In-Year Position 2025/26	Commissioning £'000	Admin £'000	Ringfenced £'000	Total £'000
Total Funding (see Table 5)	106,791	32,656	302	139,749
Recurrently committed funding	106,791	32,656	302	139,749
Recurrent funding available / (over-committed)	**0**	**0**	**-**	**0**
In-Year Position:				
Anticipated baseline slippage in 25-26	200	2,000		2,200
In-Year Pressures to be funded (Table 3)	(1,540)	(660)		(2,200)
Forecast 25-26 surplus / (deficit)	**(1,340)**	**1,340**	**-**	**0**

Recommendation 3

It is recommended that £2.2m pressures identified (£0.660m Admin and £1.540m Commissioning) are funded from slippage on an in-year only basis, with recurrent funding for the future costs still to be determined.

PHA finance team continue to work with the Department in achieving allocations in respect of assumptions. Further updates will be provided in the monthly budget reports throughout the financial year.

Income In Detail

The main funding source of revenue expenditure for the PHA is provided by the Department of Health and set out in the draft allocation received in March 2025.

2024/25 Closing Position

In 2024/25 PHA received £141.0m funding which included additional funding of £10.0m of non-recurrent and £3.6m of recurrent funding allocated during the year. This forms the basis for the opening position for 2025/6 allocation.

2025/26 Allocation

A total of £139.7m has been estimated recurrently for the activities of the PHA in 2025/26. The total funds available is been split between Commissioning (£106.8m) and Administration (£32.6m) budgets.

The Department of Health has agreed to allocate PHA funding equivalent to flat cash (excluding funding for pay settlements) through funding in-year pressures equivalent to £1.243m while also applying an equal and opposite savings target to the baseline budget of £1.243m. The PHA will continue to focus on making the best use of resources available through greater levels of efficiency and productivity.

Additional allocations[2] in 2025/26 recurrent funding position have been received included in the opening allocation as follows:

- Recurrent funding of £3.2m for National Institute for Health and Care Research (NIHR) contribution
- an element of funding for price increase due to inflation (£1.066m);
- support for increased costs relating to National Living Wage (£0.78m);
- Increases to Employers National Insurance for Community and Voluntary sector (£0.69m);
- Funding for Additional laboratory costs associated with the implementation of HPV (£1.054m)

In developing this model funding has been **assumed** for:

- funding for pay awards for Consultants and Senior Executives; (£0.359m)
- ringfenced funding for sessional vaccinators and NI Protocol project (£0.302m);
- Assumed funding for 33% of the additional employer's cost of NIC (based on discussion with DoH colleagues.)

[2] Per confirmation by DoH Finance at 24 March 2025

- In the 2025-28 financial planning exercise PHA identified £1.243m pressures and PHA was asked to ensure £1.243m savings will be delivered to cover these and to continue to take this approach to managing pressures during 2025/26.

Other Income

Funding anticipated from other sources has been included in the allocation and relates to:

- Clinical Excellence and Joint Appointment funding (0.098m)
- Macmillan and QUB funding (£0.112m)
- NIMDTA funding received each year for medical trainees. (£0.491M)

Table 5: Funding available in 2025/26	Commissioning £'000	Admin £'000	Ringfenced £'000	Total £'000
Opening Allocation at 1 April 2024	95,904	31,293	-	127,196
New Recurrent Allocations 2024-25:				
Pay Awards 2024-25	2,274	1,432	-	3,705
Other (incl. SBNI recurrent allocation)	197	139	-	335
Reclassifications in 2024-25	(23)	23	-	-
Total recurrent allocation at 31 March 2025	**98,351**	**32,886**	**-**	**131,237**
New recurrent allocations 2025/26:				
R&D funding for NIHR	3,200	-	-	3,200
Price Inflation, NLW, pension uplift	2,413	123	-	2,536
Other recurrent allocations	1,353	200	-	1,553
25-26 Transfers to/from other organisations	400	(714)	-	(314)
Inescapable service pressures	1,243	-	-	1,243
25-26 Savings	(1,243)	-	-	(1,243)
Total allocation at 1 April 2025	**105,716**	**32,496**	**-**	**138,212**
Re-alignment of 23-24 savings target balance	1,200	(1,200)	-	-
Confirmed ringfenced funding - sessional vaccinators	-	-	240	240
Confirmed ringfenced funding - NI Protocol	-	-	62	62
Reclassification of Perinatal MH funding	(125)	125	-	-
Assumed 24-25 pay award allocation for Consultants		250		250
Assumed 24-25 & 25-26 pay award allocation for Senior Execs		109		109
Assumed E'ers NIC uplift (33% to be covered)		175		175
Clinical Excellence & Joint Appointment funding		98		98
Income (MacMillan & QUB)		112		112
NIMDTA funding for medical trainees		491		491
Total Funding	**106,791**	**32,656**	**302**	**139,749**

Expenditure In Detail

The summary of PHA 2025/26 revenue budgets and forecast expenditure is contained in **Table 6** below**:**

Table 6: Forecast Expenditure 2025/26	Commissioning £'000	Admin £'000	Ringfenced £'000	Total £'000
Recurrent Budgets:				
Management & Admin - salaries		31,006		31,006
Management & Admin - Goods & Services		2,153		2,153
Health Improvement	47,735			47,735
Health Protection	25,863		240	26,103
VMS recurrent funding not required	*(500)*			*(500)*
Research & Development	3,252		62	3,313
Service Development & Screening	20,482			20,482
Nursing, Midwifery and AHPs	8,275			8,275
Communications & Knowledge Management	352			352
Early Intervention (Mental Health)	343			343
Funded by DoH - not yet in budgets:				
STEC testing (ecoli)	100			100
Pertussis vaccination	127			127
Screening postage	150			150
Re-tendering of existing contracts	200			200
Nicotine Replacement Therapy (NRT) - additional demand	250			250
25-26 Savings target:				
Savings target	(1,243)			(1,243)
Efficiencies on VMS & HPV vaccination budgets	916			916
Uncomitted recurrent funds (efficiencies on inflation etc.)	489			489
Assumed Slippage for Vacancy & Recyclables		*(503)*		*(503)*
Recurrently committed funding	**106,791**	**32,656**	**302**	**139,749**

The following costs will be explained in further detail in the following sections of the report:

(i) Administration – Salaries
(ii) Administration – Non-Pay
(iii) Programme Costs
(iv) Ringfenced Budgets

(i) Administration – Salaries

Considerable work has been undertaken to develop a costed workforce plan for 2025/6 which reflects the implementation of the Reshape and Refresh Programme and includes realistic timescales.

The Administration - Salaries budget for 2025/26 is analysed by Directorates as set out in **Table 7** below.

Table 7: Provisional Administration – Salaries Budgets	**Salaries & Wages £'000**
Public Health Services	14,434
Population Health & Wellbeing	8,210
Finance & Corporate Services	2,808
Population Data & Intelligence	2,996
Chief Exec Office & Board	2,018
Safeguarding Board	540
Balance to be funded through vacancies	(503)
Total Admin budget - Salaries	**30,503**

The main assumptions in the development of pay budgets for 2025/6 which will apply are as follows:

- Realignment of budgets is on-going and will continue during 2025/26 as the Reshape and Refresh programme is embedded and the new Directorates settle in. This split across Directorates should be considered provisional at this stage and may change as the process develops.
- It is assumed that financial settlement of a pay award will be directed through the Department of Health. These figures do not take account of any 2025/26 pay award which will be notified if approved and updated in the monthly financial reports. No pay award funding has been received for 2025/26 to date, and it is assumed that all pay uplifts will be fully funded in the year. If 2025/26 pay costs are not to be funded centrally, PHA will need to review its ability to award pay increases and any decision to award unfunded pay awards would be made within a regional context. Each 1% of pay award is expected to cost PHA approximately £0.3m.
- An early assessment of the expected slippage on Admin (Salaries) budgets in 2025/26 shows a forecast underspend of approximately £2.0m, after including a range of pressures relating to the Reshape and Refresh programme, various Public Inquiries and Digital staffing resources. The anticipated underspend on Admin (Salaries) budgets is primarily due to vacancies, including a number of consultants and other senior posts, reflecting the continued challenges in recruiting specialist staff and filling posts in general in the current climate. The Reshape & Refresh structure, including new posts identified as being required by Directors and service leads, has been costed and included in this plan.
- The structure is affordable within the existing Administration allocation, after absorbing the £1.2m balance of the 23-24 savings target which had not yet been recurrently achieved until this point and assuming funding gap of £0.5m is resolve achieved through management of vacancies in year. It is assumed that the balance

of funding of £503k, will be achieved by slippage in budgets relating to normal delays in recruitment and appointment at salary point below estimate.

It is expected that the Scrutiny Committee will continue to exercise oversight of and financial rigour over recruitment activity, as was the case in 2024/25.

(ii) Administration – Non-Pay

The Administration- Non-Pay budget for 2025/26 is analysed by Directorates as set out in **Table 8**, below.

Table 8: Provisional Non-Pay Budgets	Goods & Services £'000
Public Health Services	181
Population Health & Wellbeing	242
Finance & Corporate Services	1,129
Population Data & Intelligence	81
Chief Exec Office & Board	264
Safeguarding Board	256
Total Admin budget	**2,153**

The main assumptions in the development **of Non-Pay budgets** for 2025/26 which will apply are as follows:

- Pressures arising from Inflation are assumed to be 2% which will be funded by an allocation by the Department of Health;
- Costs of existing Shared Services through BSO will be carried forward to 2025/26 with no unfunded increases;

(iii) Programme Budgets

The main assumptions in the development of Programme budgets for 2025/6 which will apply are as follows

- Programme budgets are based on an assessment of current programmes and commitments rolled forward from 2024/25. Additional Programmes for example expansion of Screening or Vaccination programmes will be subject to Policy arrangements through the Department of Health and a commensurate recurrent funding package.

- Expenditure assumed to be funded by DoH shown “not yet in budgets” will only take place if funding is available;

PHA received additional recurrent allocation for a number of pressures, including STEC testing, Pertussis vaccinations and additional Nicotine Replacement Therapy demand and totalling £1.243m. However, the Department applied an equal and opposite savings target of £1.243m which the Agency is required to achieve on a recurrent basis moving forward. This savings target has been delivered using efficiencies on a number of allocations from previous years including VMS, HPV vaccinations and non-pay inflation funding.

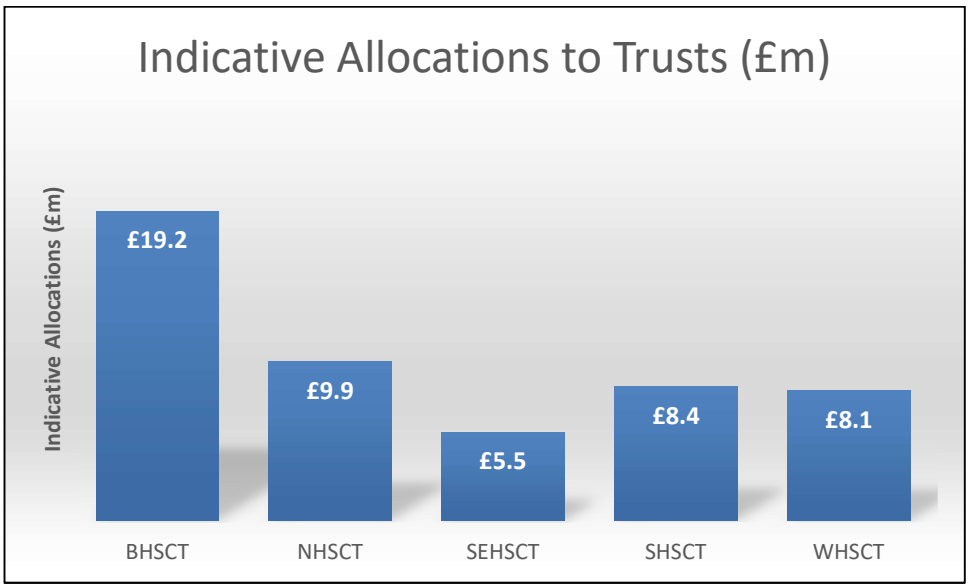
Budgets have been rolled forward within the PEMS delegated areas, as in previous years. These budgets are now being held against Reshape & Refresh Directorates and budgetary areas, and will be reported in this structure. However, it is acknowledged this will take some time to bed in during the year. Programme funding of **£106.8m** has been allocated across programme areas, as outlined in **Table 9**, below. Further detail is provided in Appendix 1.

Table 9: Analysis of Baseline Programme Budget 2025/26	**Trust £'000**	**Non-Trust £'000**	**Total £'000**
Health Improvement	14,762	32,973	47,735
Health Protection	10,221	15,642	25,863
Research & Development	-	3,252	3,252
Service Development & Screening	18,507	1,975	20,482
Nursing & AHP	7,728	547	8,275
Communications	-	352	352
Early Intervention (Mental Health)	-	343	343
Funding not recurrently committed	-	489	489
Total Recurrent allocation	**51,218**	**55,573**	**106,791**

The majority of the existing baseline programme budget is allocated on a recurrent basis to providers (Trusts or external organisations, primarily in the Community and Voluntary sector) under long-term SLAs.

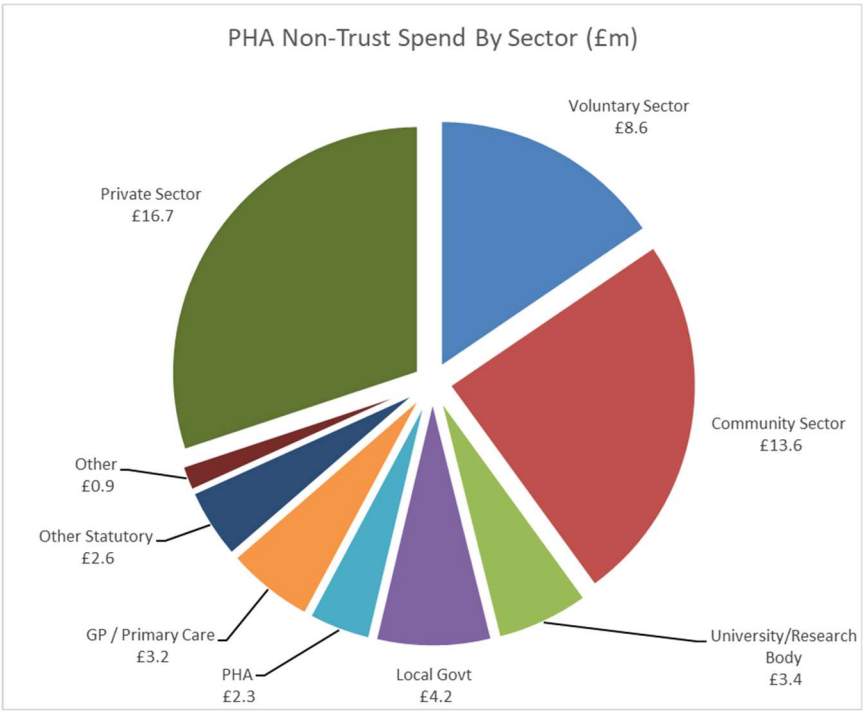
A. Indicative Allocations to Trusts

The opening recurrent allocations to Trusts for 2025/26 (£51.2m) are set out in the chart below and have rolled forward based on allocations made recurrently in prior years:



B. Non-Trust Budgets

A summary of the recurrent allocations of £55.5m to Non-Trust budgets is set out in the chart below:



Further detail of the recurrent Programme allocation and full analysis by theme of £106.8m has been set out in the following Tables and also in **Appendix 1**.

(iv) Ringfenced Budgets

Ringfenced funding has been provided by the Department for two programmes and expenditure will offset income. They are:

- sessional vaccinators (£0.240m); and
- NI Protocol (£0.062m).

Other Issues

Programme funds for the HSC Quality Improvement team were transferred to RQIA in 2024/25 and no longer form part of the PHA budget.

The Safeguarding Board NI (SBNI) is hosted by PHA who have responsibility for financial oversight, employment of staff and the provision of accommodation as set out by the Memorandum of Understanding. Funding of £0.8m for the Safeguarding Board has been allocated recurrently, and this has been included in the in-year budget for 2025/26.

Capital

The PHA has received an indicative allocation letter from the Department of Health, providing an opening capital position as detailed in **Table 10**, below.

Table 10: PHA opening Capital position (2025/26)

	£m
R&D - Trusts	8.5
R&D - Other Bodies	2.2
Capital Receipts	0.0
Total R&D allocation	*10.7*
Congenital Heart Disease (CHD) Network	0.7
NICOLA	0.8
i-REACH Project	0.7
Total CRL allocation	**12.9**

The majority of the PHA's indicative Capital Resource Limit (CRL) of £12.9m relates to the regional allocation for HSC Research & Development (R&D). This 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.

PHA has received three smaller capital allocations in respect of the Congenital Heart Disease (CHD) Network (£0.7m), the NICOLA project (£0.8m), both of which are managed through the PHA R&D team, and for the iREACH project (£0.7m). These projects are a continuation of funding received by the PHA in 2024/25.

The PHA has been informed by DoH that no general capital funding is available for use on schemes of a more minor nature, therefore no bids have been submitted for 2025/26. This represents a significant risk for the Agency, with the potential that IT equipment such as laptops cannot be refreshed when required.

The monthly Finance Report to the Agency Management Team (AMT) and the PHA Board in 2025/26 will provide information on the financial position for capital schemes. It is currently projected that capital schemes will breakeven, but will be subject to careful monitoring throughout the year.

Risk assessment

PHA finance team will maintain careful financial control on all budgets throughout the year, and the Scrutiny Committee will continue to exercise a challenge function on all recruitment activity. This position will be kept under close review and regular monthly updates will be provided to both AMT and PHA Board throughout the year. This opening financial plan has a number of assumptions, risks and uncertainties built in and the management of these elements are set out below.

i. Reshape & Refresh review

The PHA is currently undergoing a significant review of its structures and processes, and the full impact of this on staffing structures will not be fully known until later in the year. Through this process the Agency has considered where new posts may be required (e.g. to resource Strategic Planning Teams) in the longer term and where modernisation will enable new operational structures.

A costed budget based on the outcomes of the Reshape and Refresh process has been developed and is incorporated into this Plan.

There are risks associated with implementing the outcomes of this review in a savings context, and careful management will be required at all stages of the process. Risks will be regularly discussed and reviewed as part of the overall management of the Programme through the Implementation Team and Programme Board.

ii. Administration Slippage

In recent years there has been significant slippage on the Administration budget, which is expected to continue in 2025/26 as the Agency moves to substantive structures. The budget will be closely monitored during the year to ensure that slippage is monitored, and AMT and Board will be alerted at an early stage if it appears the assumptions in this Plan need reviewed.

An early estimate of slippage on the Administration - salaries budget has identified that approximately £2m will be available in-year to fund known pressures. This figure will be kept under close review as the year develops and new staffing structure settle in, and any revision to this figure will be shared with AMT and Board at an early stage.

iii. Demand led services

There are a number of demand-led budgetary areas that are more difficult to predict the funding requirements and therefore manage the budgets. These include Nicotine Replacement Therapy (NRT) and various vaccination budgets. These will be kept under close review throughout the year; however, a significant amount of funding has been removed from the opening budget to address the savings requirement.

iv. Policy Development

This financial plan may evolve as a number of other initiatives develop and have not been included as details are not yet clear on the budget requirements for 2025/6. The funding allocation is based on indicative figures which may be subject to review at final approval or agreements with Sponsor Branch on measures required through the Departments Systems Financial Management Group as commissioned by the Permanent Secretary.

Appendix 1: PHA Programme Budget 2025/26 (detail)

1.1. Health Improvement

The opening budget for the Health Improvement area is set out in its Thematic areas in **Table Aa** below:

Table Aa - Health Improvement by Thematic Area	£
Drugs & Alcohol	11,002,500
Early Years	3,256,489
Health Inequalities	7,432,346
Later Years	2,646,384
Mental Health & Suicide Prevention	12,196,501
Obesity	4,811,086
Sexual Health	2,377,201
Tobacco	4,012,732
Total - Health Improvement	**£47,735,239**

As in previous years, almost half of the total budget for Health Improvement is allocated to Drugs & Alcohol and various Mental Health / Suicide Prevention initiatives. Other key priorities in this area include Smoking Cessation and Physical Activity programmes, along with schemes tackling issues associated with inequality.

1.2. Health Protection

The opening budget for the Health Protection area is set out in **Table Ab** below:

Health Protection	
HCAI	215,771
Rotavirus	901,852
HPV	1,977,971
Men ACWY	567,857
Shingles	1,597,622
Men B	2,371,789
Hexavalent	178,629
Pertusis	393,389
Mpox	118,538
RSV	525,166
Immunisation Other	259,024
Vaccine Management System	1,500,000
Seasonal Flu	6,355,392
Child Flu	8,137,280
Storage & Distribution	407,961
National Poisons Information Service	163,323
Support to Hep C Clinical Network	111,497
HIV Surveillance	79,873
Total - Health Protection	**£25,862,934**

Vaccines funding allocation by DoH

Vaccination programmes and in particular the flu vaccination budget of £14.5m make up the majority of this area of work. Since the impact of COVID experience, the application and management of vaccines are continuing to adapt and improve.

This Plan assumes that the funding allocated, along with further allocations expected in-year from DoH for Flu and Shingles, will be sufficient to cover the costs of the vaccination programme in 2025/26. Any additional activity beyond this will be separately funded on a non-recurrent basis by DoH during the year.

1.3. Research & Development

The opening budget for the Research & Development area is set out in Table Ac below:

Table Ac - R&D	£
Research & Development	3,251,661
Research & Development	**£3,251,661**

This budget includes £3.2m for the PHA's participation in the National Institute for Health and Care Research. The Research & Development team also manages approximately £13m of capital grant funding which is included in the capital section of this Financial Plan.

1.4. Service Development & Screening (SDS)

The opening budget for the Service Development & Screening area is set out in Table Ad below:

Service Development & Screening	
Abdominal Aortic Aneurysm	657,956
Ante Natal Screening Programme	29,626
Cervical Screening Programme	1,094,493
Bowel Cancer Screening Programme	5,584,264
Breast Screening Programme	8,124,577
Digital mammography	172,704
High Risk Breast Screening	311,179
Diabetic Retinopathy Screening Prog	961,369
New Born Bloodspot Screening	712,054
New Born Hearing Screening	257,928
Cancer Registry	1,157,884
HPV – PHA laboratory costs	1,054,250
SDS - Other	363,847
Total - Service Development & Screening	**20,482,131**

Breast and Bowel Cancer screening programmes make up the largest part of this budget (£13.7m), with the balance consisting of various other screening and service development activity.

1.5. Nursing & Allied Healthcare Practitioners (AHP)

The opening budget for the Nursing & AHP area is set out in Table Ae below:

Table Ae- Nursing & AHP	£
Ward Sister Initiative	2,712,018
Family Nurse Partnership	1,993,572
Nursing & AHP (Other)	59,699
Public Health Nursing	286,453
Transformation Fund/ Delivering Care	504,376
Older People	35,000
Cerebral Palsy	125,888
Nursing Home In-reach	748,561
Holistic H&W Assessment for LAC	401,505
Dysphagia Project	725,075
Partnership Working Officers	276,915
Real Time User Feedback	380,580
Chest Drain Insertion Training	25,041
Total - Nursing & AHP	**£8,274,683**

It is proposed that Ward sister Initiative, Chest Drain Insertion and Nursing Home In – reach projects may transfer to SPPG during the year but are included pending approvals.

PHA funds a number of specific Nursing and AHP programmes in Trusts that are aimed at modernising or transforming services such as the Family Nurse Partnership and Dysphagia. As regional lead for Personal & Public Involvement (PPI), PHA also funds programmes that promote patient and client involvement.

1.6. Communications & Knowledge Management (KM)

The opening budget for the Communications & KM area is set out in Table Af below:

Table Af - Campaigns	£
Organ Donation	58,886
Deemed Consent Organ Donation	293,519
Total - Campaigns	**£352,405**

On 30 March 2023 the Department advised PHA of a freeze on campaign advertising expenditure for 2023/24. This continued into 2024/25 and is still the case for 2025/26,

with the only campaign approved to progress in the current year being organ donation. There is continued uncertainty around the delivery of campaign programmes and the agency will continue to engage with DoH on the agreement.

1.7. Other Budgets

The opening budget allocation to other areas is shown in Table Ag below:

Table Ag - Other Budgets	£
Operations - Early Intervention & Prevention (Mental Health)	342,612
Funding not recurrently committed	489,175
Total - Other Budgets	**831,787**

PHA received an allocation of £0.3m for Early Intervention & Prevention in the area of Mental Health in 2024/25. This funding is recurrent and will be managed by the Finance and Corporate Services team to take forward implementation of the agreed multi-agency Action Plan.

A balance from miscellaneous allocations totalling £0.489m is held centrally and has not been allocated to date. A savings target of £1.243m has been applied by DoH in 2025/26 and this funding has been identified to achieve this.

Health Improvement (by Thematic area)		£
Drugs & Alcohol	Substance Use	9,704,028
Drugs & Alcohol	Youth Engagement Service	1,298,472
Drugs & Alcohol		**£11,002,500**
Early Years	Starting Well - Breastfeeding	749,993
Early Years	Starting Well - Early Years	2,506,496
Early Years		**£3,256,489**
Health Inequalities	Geography (inc Workplace)	1,351,952
Health Inequalities	Inclusion Health	914,127
Health Inequalities	Protected Characteristics	56,542
Health Inequalities	Socio-Economic Deprivation	4,843,793
Health Inequalities	Shankill & Beechall HWIC	265,932
Health Inequalities		**£7,432,346**
Later Years	Ageing Well - Accident Prevention	901,192
Later Years	Ageing Well - Age Friendly	683,380
Later Years	Ageing Well - Health and Wellbeing	1,061,812
Later Years		**£2,646,384**
Mental Health/Suicide Prev	Lifeline	3,623,663
Mental Health/Suicide Prev	Mental Health	1,954,608
Mental Health/Suicide Prev	Suicide	6,618,230
Mental Health/Suicide Prev		**£12,196,501**
Obesity	Nutrition	991,429
Obesity	Obesity	1,530,070
Obesity	Physical Activity	2,289,587
Obesity		**£4,811,086**
Sexual Health	Sexual Health	2,377,201
Sexual Health		**£2,377,201**
Tobacco	Cancer Prevention	82,128
Tobacco	Smoking Cessation Regional	3,930,604
Tobacco		**£4,012,732**
Total - Health Improvement		**£47,735,239**
Service Development & Screening		
Abdominal Aortic Aneurysm		657,956
Ante Natal Screening Programme		29,626
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Total - Nursing & AHP		**£8,274,683**
Campaigns		
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Total - Campaigns		**£352,405**
R&D		
Research & Development		3,251,661
Research & Development		**£3,251,661**
Operations - Early Intervention & Prevention (Mental Health)		**£342,612**
Funding not recurrently committed		**£489,175**
TOTAL PROGRAMME BUDGET		**£106,790,840**

item 12

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	19 June 2025
Title of paper	Draft PHA Implementation Plan
Reference	PHA/06/06/25
Prepared by	Julie Mawhinney
Lead Director	Leah Scott

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

1 Purpose

The purpose of this paper is to share the current draft of the Implementation plan with PHA board before it is finalised as part of the implementation of new structures.

2 Background Information

The Implementation Plan 2025-2028 sets out more detail on how PHA will implement the outcomes and priorities set out in Corporate Plan 2025-2030.

This Implementation Plan should be considered alongside the Corporate Plan 2025-2030 and the Annual Business Plan 2025/26. The plan, alongside the Annual Business Plan, provides further details on actions to be taken forward in the immediate three year period in delivery of the Corporate Plan priorities and ambitions. As a live document, it will be reviewed and updated annually to consider the next three year cycle of delivery within the timeframe of the Corporate Plan.

This draft has been developed with the Senior Leadership Forum to set out the expected actions to be delivered in 2026-28. The actions included within the implementation plan are organised by Corporate Plan priority and span the domains of public health, our statutory and strategic responsibilities and include a focus on inequalities.

Work is underway to provide a baseline of the indicators for 2025 that will also be reviewed on an annual basis.

This document is still considered draft until the new structures have been implemented and the new teams, who will be driving the actions within the plan, have been able to review and finalise the document as one of their first tasks in their new roles.

3 Key Issues

This plan is being developed during a period of reform both for our organisation and for Health and Social Care (HSC) and in a time of significant financial constraint. However, we have embraced the opportunity provided by this time of change and constraint to set out our actions and intentions for the work to be progressed in the coming years.

The document is structured around the Corporate Plan ambitions and priorities and includes the outputs and anticipated impact from the work on its delivery. Each thematic area also includes a section that will detail the current data for the relevant indicators.

We commit to reviewing this plan in line with any future programme for government framework and departmental strategies to be developed during the period of this plan.

4 Next Steps

Following approval from PHA Board and implementation of the new structures, this Plan will be reviewed by the new teams and finalised.

The plan will be reviewed annually to ensure it remains up to date and relevant in line with strategic direction, funding priorities and best practice.

HSC Public Health

HSC Public Health Agency

[Year]

DRAFT Public Health Agency Implementation Plan 2025-2028

JUNE 2025

HSC Public Health Agency

Contents

Implementation Plan 2025-2028 for PHA Corporate Plan 2025-2030

Introduction

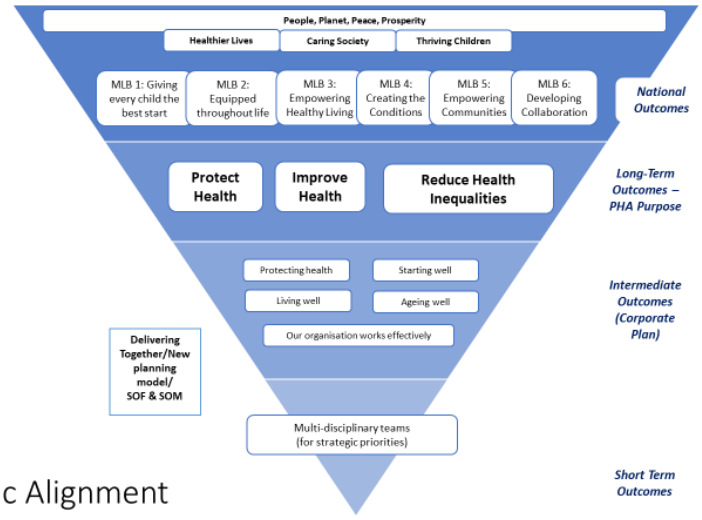
The Implementation Plan 2025-2028 sets out more detail on how PHA will implement the outcomes and priorities set out in Corporate Plan 2025-2030.

The Implementation Plan should be considered alongside the Corporate Plan 2025-2030 and the Annual Business Plan for each year. The document will be reviewed annually to consider the coming three years within the timeframe of the Corporate Plan.

The Implementation Plan is collated by the Planning and Performance Team on behalf of the Leadership Team.

Strategic alignment

As an organisation, PHA has a number of legislative and strategic drivers. The key foundations of our work are reflected across the draft Programme for Government framework 2024-2027 and the wide range of departmental policies and strategies that influence and determine the work of PHA, including Making Life Better public health framework, and Health and Wellbeing 2026: Delivering Together. The PHA also has lead responsibility for implementing a number of strategies across key areas of work, including maternity and early years; mental health, emotional wellbeing and suicide prevention; obesity; tobacco use; alcohol and drugs; and long-term conditions, including cancer. The strategic alignment for each outcome can be

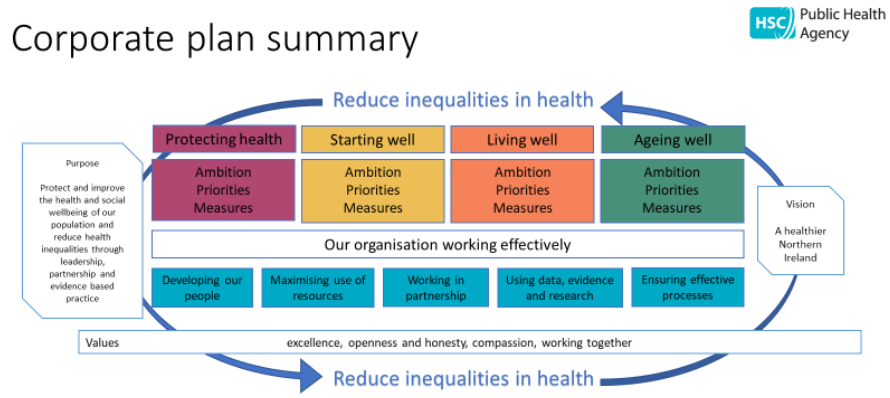


Strategic Alignment

mapped through each of these strategies. The diagram below illustrates the overall corporate plan strategic alignment.

Corporate Plan Population Accountability

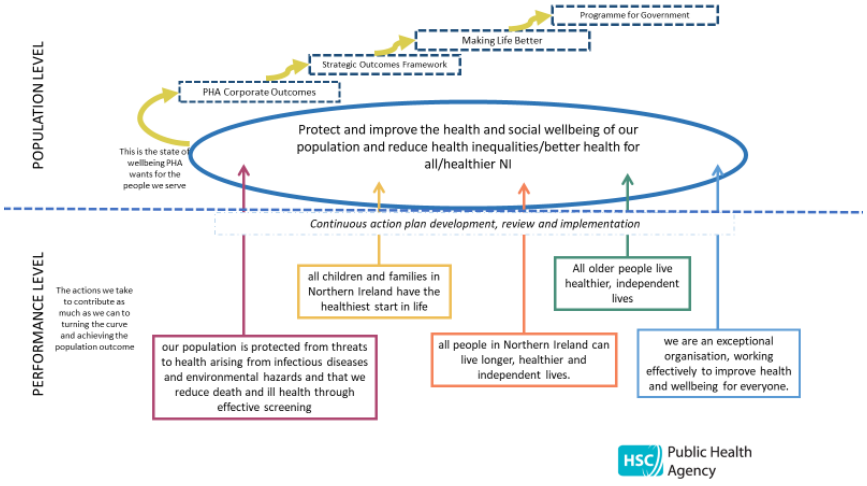
The PHA Corporate Plan 2025-2030 sets out the outcomes, ambitions and priorities for the next 5 years for PHA. The implementation plan alongside the Annual Business Plan provides further details on actions to be taken forward in the coming three year period in delivery of those priorities and ambitions.



Preventing, Protecting, Improving; Better health for everyone!

The following diagram illustrates the outcome PHA wishes to work towards in the coming 5 years and the areas of work it will focus on, as well as highlighting the key strategic drivers:

The actions noted in the diagram below are also the ambitions stated in the corporate plan.



HSC Public Health Agency

Protecting health

Protecting the population from serious health threats, such as infectious disease outbreaks or major incidents

Population Outcome and Ambition

That our population is protected from threats to health arising from infectious diseases and environmental hazards and that we reduce death and ill health through effective screening.

Population indicators

- vaccination uptake;
- notification rates of vaccine preventable diseases;
- rates of healthcare associated infections;
- bloodborne virus elimination targets;
- waste water surveillance;
- stage of cancer diagnosis.

HSC Public Health Agency

Action Plan

Priority 1: develop emergency response plans to support readiness to respond to incidents that may have an impact on public health for Northern Ireland

CP	Action No	Year	Action	Output	Impact	Lead Director
1	1.	2026/27 2027/28	To develop an enhanced Surge Response service – this should include a suite of capabilities and services, to enable a flexible and scalable response to hazards to health.	**Output** **November 2026** – developed detailed costed option paper to outline options available **March 2027** – submit to DoH for consideration Pending outcome and required funding progress with implementation of Enhanced surge response service. **2027-2028** – full implementation of chosen option and testing of surge response capabilities.	Enhanced surge response model developed and in place and staff trained in its use within existing resources. Identification of any additional required resources Response plan developed and in place. Any solution should provide technology capabilities in testing, case, contact and outbreak management, and advice and guidance in the 'contain' and 'delay' phases of a pandemic. bacteraemia's and reduce use of antibiotics.	DPH
1 (2,3)	2.	2026/27 2027/28	Replace HP Zone with an effective Case Management and Surveillance System.	**Output** **March 2026** – submit detailed costed plan for relacment of HPZone to DoH for consideration.	Improved integration with surveillance platforms and hospital laboratory systems Improved functionality and scalability	DPH

CP	Action No	Year	Action	Output	Impact	Lead Director
				Dependent on funding and approval from DOH: **April 2026** - Establish PHA implementation group to oversee development and delivery of new system. **April 2026** - **March 2028** - Work with case management system providers to ensure system meets the needs of service and can interface effectively with existing NI electronic systems e.g. Encompass, LIMS etc March 2028- New system in place. Staff trained.	to allow the PHA to respond more effectively to an outbreak/pandemic.	

HSC Public Health Agency

Priority 2: work collaboratively to minimise the impact of infectious disease, with a focus on antimicrobial resistance and our elimination targets for blood- borne viruses

CP	Action No	Year	Action	Output	Impact	Lead Director
2 (4,8)	3.	2026/27	Implement UTI focused programmes in care homes across Northern Ireland	Leading the development and delivery of: **Output** Leading the development and delivery of: (1) **June 2026** - UTI hydration programme in care homes; (2) **September 2026** - UTI patient pathways and decision aids; (3) **March 2027** - Catheter care in care homes. (4) .	Reduction in incidence of UTI in care homes and a subsequent effect of reduced gram negative bacteraemia's and reduce use of antibiotics. This is not routinely collected information and would be difficult to collate.	DPH
2	4.	2026/27	Co-Develop a regional toolkit, business case and policy with SPPG guidance for penicillin allergy de-labelling services	**Output** Number of individuals managed within service and number of individuals delabelled via current regional service. (June 2025) Regional guidance in place- **March 2026**	will help to promote the antimicrobial stewardship; avoids unnecessary Developing a safe pathway to facilitate the de-labelling of individuals with an inappropriate penicillin allergy status will help to	DPH

CP	Action No	Year	Action	Output	Impact	Lead Director
				Business case submitted – **May 2026** Toolkit in place. – **September 2026** Training in place - **September 2026**	promote the antimicrobial stewardship; avoids unnecessary prescribing of alternative / second line treatments and reduces the impact on antimicrobial resistance. Also have an impact on WHO AWaRe, as patients are delabelled.	
2	5.	2027/28	Developing a TB 'toolkit'	Toolkit developed. Single repository for public resources. Training available - TB awareness programs in all sectors.	Increase awareness amongst professionals responsible for diagnosis and treatment of TB to promote earlier diagnosis (time from onset of symptoms to diagnosis). Updated resources and easier access to raise awareness for the public to promote earlier presentation.	DPH
2	6.	2026/28	Implementation of the 2026-2030 Hepatitis C Elimination Action Plan	2026-2030 Hepatitis C Elimination Action Plan in place – December 2026. Implement recommendations aligned to PHA.	Aligns with the UK goal and the WHOs commitment to eliminate Hepatitis C as a major public health threat by 2030.	DPH

CP	Action No	Year	Action	Output	Impact	Lead Director
					Aim to reduce incidence of Hepatitis C	
2	see also action 2					

Priority 3: deliver a high-quality and responsive health protection surveillance and epidemiology programme

CP	Action No	Year	Action	Output	Impact	Lead Director
3	7.	2026/27	Work with SPPG to develop a business case for pathogen genomic sequencing within the Northern Ireland Laboratory Service.	Pathogen genomic sequencing business case developed – **June 2026** Pathogen genomic sequencing commissioned in NI Laboratory service - **December 2026** (funding dependent). Enhanced ability to swiftly identify and respond to pathogen-specific outbreaks.	Improved accuracy of tracking pathogen evolution and transmission dynamics, facilitate predictive modelling, and support thorough outbreak investigations. More timely access to results.	DPH
3	8.	2027/28	Scope a surveillance delivery mechanism to regionally monitor Latent TB Infection	Prepare report by March 2027	Improve surveillance of active and latent TB will inform service development towards mitigating against active TB disease	DPH

Priority 4: strengthen the multidisciplinary coordinated approach to infection prevention and control across the wider HSC system though the established infection, prevention and control forums

CP	Action No	Year	Action	Output	Impact	Lead Director
4	See action 3					

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Priority 5: ensure the delivery of high-quality screening programmes

CP	Action No	Year	Action	Output	Impact	Lead Director
5 (12, 23,32)	9.	2026/27 2027/28	Phased implementation of action plan to reduce inequalities in screening participation.	Improved knowledge of, and access to, population screening programmes,	increased participation among groups known to experience inequalities.	DPH
5	10.	2026/27	Phased implementation of the extended age range of the bowel screening programme	Increased detection of early stage bowel cancer	improved clinical outcomes for individuals	DPH
5	11.	2026-28	Work towards implementation of targeted lung cancer screening	Increase in detection of lung cancer at earliest stage	Increase in detection of lung cancer at earliest stage	DPH
5	12.	2025/26 2026/27	Design and deliver digital solutions for screening programmes	August 2025 – Screening Digital Modernisation Programme Board to decide on strategic implementation route (NHSE/Encompass/NIDIS) November – requirements gathering complete December 2025 – Phasing order and approach agreed with stakeholders		DPH

CP	Action No	Year	Action	Output	Impact	Lead Director
		2027/28 2027/28	Phased introduction of new digital systems (subject to funding)	March 2025 – Engagement with chosen route vendor on requirements complete December 2026 – Digital Build complete (dependent on chosen route) April 2027 – Testing complete July 2027 – training and delivery underway		

Priority 6: lead the development and commissioning of vaccine programmes to ensure they are accessible to all, addressing the associated barriers and inequalities and ensure there is a key focus on seldom heard groups

CP	Action No	Year	Action	Output	Impact	Lead Director
6 (12)	13.	2026/28	Implement changes to the childhood immunisation schedule by offering delayed selective catch up of MMRV to the eligible cohort.	Output – the number of children in the eligible cohort offered a single dose of MMRV vaccine. The offer of varicella vaccine aims to decrease the number of cases of varicella seen in childhood.	All eligible children are offered a single dose of MMRV vaccine. Prevention of severe cases of varicella, and other serious complications which while rare may have otherwise resulted in hospitalisation or other serious outcomes.	DPH

Priority 7: scope existing evidence for public health approaches to protect people and communities from the public health impacts of the environment, including climate change, and develop a PHA climate action plan

CP	Action No	Year	Action	Output	Impact	Lead Director
7	14.	2026/27	Scoping available evidence for public health impacts of the environment, including climate change.	Complete scoping exercise of existing evidence for public health approaches	Evidence in place to allow action plan to be developed	DPH
7	15.	2027/28	Develop a PHA climate action plan relating to rise in temperatures and increased risk of Vector Borne Diseases.	Action plan in place to mitigate against the PH threats raised by climate change.	Protect people and communities from the public health impacts of the environment, including climate change.	

Priority 8: build public confidence and trust in public health advice, information and messaging through improving health literacy via education and engagement with the public

CP	Action No	Year	Action	Output	Impact	Lead Director
8	See action 3					

Starting Well

Laying the foundations for a healthy life from pre-birth, infancy, early years, childhood to adolescent years

Population Outcome and Ambition

That all children and families in Northern Ireland have the healthiest start in life.

Population Indicators

- screening and vaccination in pregnancy uptake;
- childhood vaccination uptake;
- percentage of children living with obesity or overweight in Year 1 and Year 8;
- percentage of babies born at low birth weight;
- avoidable child death rates;
- percentage of mothers breastfeeding on discharge and at 6 months;
- breastfeeding welcome here scheme membership;
- percentage of young people who drink alcohol;
- percentage of young people who smoke cigarettes;
- percentage of young people who currently use e-cigarettes;
- number of people under 18 years attending emergency departments for self harm;
- percentage of women smoking during pregnancy.

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Action Plan

Priority 9: Support families to take care of their physical and mental health, with a particular focus on the first 1,001 days

CP	Action No	Year	Action	Output	Impact	Lead Director
9 (10, 13, 17, 20, 21)	**16.**	**2027/ 28**	Work in collaboration across a wide range of bodies and departments including statutory, voluntary and community sectors to address the root causes of domestic abuse.	Develop PHA action plan to support the implementation of recommendations from the Review of Routine Enquiry (RE) in relation to Domestic Abuse (DA) in line with Domestic and Sexual Abuse Strategy **(March 2026)** Develop an agreed PHA communication plan to raise public awareness regarding Domestic Abuse as a Public Health issue (**March 2026**) Model of Routine Enquiry to be further expanded to other disciplines and service areas. **(March 2027)**	Increased opportunities for victims to disclose Domestic Abuse and avail of additional support thus reducing impact of DA on victims and children	Director Pop Health
9 (16)	**17.**	2027/ 28	Deliver on the commissioned childhood obesity prevention programme – HENRY	Implementation of the HENRY service	Reduced % of children with obesity in Yr 1&8.	Dir Pop Health

CP	Action No	Year	Action	Output	Impact	Lead Director
9 (10, 20,24)	**18.**	2027/28	Reduce the impact of Adversity in early childhood and Social Complexity in Pregnancy	Broadening and strengthening existing evidence-based interventions supporting Mothers, infants, children, young people and families.	Giving specific focus to social complexity expand and innovate on a number of key interventions to optimise impact.	Dir Pop Health
9 (14)	**19.**	2027/28	Work with SPPG on the regional implementation of the Saving Babies Lives Care Bundle Initiative	The Care bundle has six elements to target including: 1. Reduce smoking in pregnancy 2. Fetal Growth 3. Raising awareness of reduced fetal movement 4. Effective fetal monitoring 5. Reducing preterm birth 6. Managing pre-existing diabetes	Reduction of stillbirth, neonatal death and intrapartum brain injury.	Dir Pop Health

Priority 10: reduce the impact of social complexity in pregnancy

CP	Action No	Year	Action	Output	Impact	Lead Director
10	**See also actions 18,19,21,23**					

Priority 11: promote the health benefits of breastfeeding and encourage support for breastfeeding mothers

CP	Action No	Year	Action	Output	Impact	Lead Director
11	**20.**	2027/28	Work collaboratively with key stakeholders to update Breastfeeding action plan	To identify key strategic priorities in order to protect, promote, support and normalise breastfeeding. Identify a key target group based on existing intelligence and develop an action plan to improve breastfeeding rates for that cohort	Increase uptake of breastfeeding rates across NI	Dir Pop Health

Priority 12: protect the health of children and young people through antenatal and newborn screening programmes and childhood vaccination programmes

CP	Action No	Year	Action	Output	Impact	Lead Director
12	**21.**	2027/28	Optimising data systems and intelligence to inform maternity and early years decision making. This includes the transfer of CHS system move to encompass	Transfer for CHS to encompass Optimised data systems and information to inform decision making	Provide assurance that the right children are scheduled for the right treatment/surveillance at the right time and that any significant results or outcomes are suitably followed up	Dir Pop Health

Priority 13: deliver universal and targeted support programmes, including Healthy Child Healthy Future, Family Nurse Partnership, and Northern Ireland New Entrants service (NINES)

CP	Action No	Year	Action	Output	Impact	Lead Director
13	**22.**	2027/28	Review and lead oversight over the refreshed Healthy Child Healthy Futures pending approval from Department of Health	Co-chairing of the new NI Implementation Group and establishment of its functions.	Key influence of departmental action plan and costing of the rollout of the extended HCHF programme	Director Pop Health

Priority 14: work together to reduce stillbirth, neonatal and avoidable child deaths through improved use and application of data and evidence

CP	Action No	Year	Action	Output	Impact	Lead Director
14	**23.**	2027/28	Better understand the key reasons for Child Deaths in Northern Ireland to address preventable cause	Undertake a comprehensive review and analysis of existing child death databases and develop a detailed report and associated cross departmental action plan to address key modifiable factors	Improved understanding of the key reasons or child deaths in Northern Ireland	Dir Pop Health

Priority 15: support children and young people with additional needs, their families and carers in addressing the unique health challenges and disparities they face

CP	Action No	Year	Action	Output	Impact	Lead Director
15	**24.**	2027/28	Co-lead the development of improved multisectoral collaboration between sectors and disciplines to optimise access to the educational curriculum and improve outcomes for children with special education needs (SEN)	Co-lead with education the development and implementation of an action plan to take forward learning and recommendations from the review of AHP/Nursing Need's Assessments and Engagement work with CYP in partnership with Dept of Health and Dept of Education.	improve health and wellbeing outcomes for this vulnerable group	Dir Pop Health
15	**25.**	2027/28	Ensuring a multisectoral and multi-disciplinary approach, develop new and updated pathways for children with special educational needs (SEN), based on the *AHP/Nursing Recommendations Report*	Update existing pathways to ensure wraparound therapeutic and nursing input supports are in place for children with Special Educational Needs (SEN) Drive a project to establish cross-sector improvements cross-for data collection to facilitate more accurate needs assessment and effective decision making	Develop improved partnership working between disciplines and across sectors Working towards improved joined up working between AHPs and Nursing within agency to improve outcomes for SEN children.	Dir Pop Health

CP	Action No	Year	Action	Output	Impact	Lead Director
				PHA will take forward the recommendations relevant to them in partnership with Dept of Health and Dept of Education. Offer influence and professional advice to other organisations were appropriate.		

Priority 16: support adolescents to establish patterns of behaviour that can protect their mental and physical health

CP	Action No	Year	Action	Output	Impact	Lead Director
16 (24)	**26.**	2026/27	Review the delivery model for Youth Engagement Services (YES) for Substance Use and seek to develop a universal youth prevention service of support for children and young people	Agreement on a youth prevention service model Agreement on a joint procurement process with PHA and the Education Authority (others as appropriate) that will inform future business case and procurement processes.	Reduction of harm caused by substance use in children and young people	Dir Pop Health
16 (21,22)	**27.**	Q4 2025/26	Procure the community-based Substance Use Step 2 Youth Treatment service and the	Procurement process completed and services operational	Reduction of harm caused by substance use in children and young people	Dir Pop Health

CP	Action No	Year	Action	Output	Impact	Lead Director
			Problematic Parental Substance Use service in line with the Substance use Procurement Plan			
16	See also actions 37, 40					

Priority 17: work with others to promote the safeguarding and protection of children and young people

CP	Action No	Year	Action	Output	Impact	Lead Director
17	See also action 16					

Living Well

Ensuring that people have the opportunity to live and work in a healthy way

Population Outcome and Ambition

That all people in Northern Ireland can live longer, healthier and independent lives

Population Indicators

- percentage of people with a high GHQ-12 score, indicating a possible mental health problem;
- number of people who die by suicide or undetermined intent;
- percentage of adults smoking and vaping;
- percentage of adults living with overweight or obesity;
- percentage of adults meeting physical activity guidelines;
- percentage of adults drinking above weekly limits
- alcohol and substance use-related hospital admissions;
- age standardised mortality rate for alcohol-related deaths and substance use-related deaths;
- percentage self-reporting a physical or mental health condition or illness expected to last 12 months or more;
- registrations to the NHS Organ Donor Register;
- percentage of those living with long-term conditions reporting a reduced ability to carry out daily activities.

Action Plan

Priority 18: create the conditions for people to adopt healthier behaviours and reduce the risks to health caused by low physical activity, smoking and vaping, poor diet and sexual risk behaviours

CP	Action No	Year	Action	Output	Impact	Lead Director
18 (19)	**28.**	2026/27	Scope options for Tier 2 community weight management programmes in line with NICE and PHE guidance	-Prepare a report by March 2027. -Plan to implement recommendations from the report from April 2027. Any service developed would report activity and outcomes.	Evidence based service in place which supports those referred to lose weight to improve their heatlh.	DPH TBC Planning Team
18 (19, 24)	**29.**	2025-28	Continue to implement a Whole System Approach to Obesity	Over the next 3 years work with a further 3-5 councils on implementing the six phases of Whole Systems Approach. (resource dependant)	Reduction in levels of overweight & obesity and increase in levels of physical activity in line with CMO guidelines.	
18 (20, 24, 25)	30.	2026/27 2027/28	Making every service contact count for prevention to equip wider HSC workforce with the knowledge, skills and evidence base	Complete scoping exercise on identifying opportunities for frontline staff to ensure the delivery of PH messaging through a MECC approach.	The HSC workforce is uniquely placed to influence large numbers of people using our services. Equipping the workforce with the tools	DPH TBC Planning Team

Commented [JM1]: Should we be caveating things with resource dependent – if we take that approach would apply to everything? Is there something about us prioritising what goes into the plan?

CP	Action No	Year	Action	Output	Impact	Lead Director
			to maximise primary and secondary prevention opportunities along with their easy access to signposting information.	-Develop bespoke communication approaches for staff considering a pilot in 2026/27 with a view to full roll-out in 2027/28.	to make the most of every opportunity to support people to improve their health could have a significant benefit at population level in terms of increasing physical activity, stopping smoking and reducing alcohol intake.	
18 (20, 22,23,24 ,25, 27,28)	31.	2026/27 2027/28	Work jointly with SPPG to identify and review both commissioned inequality specific services (such as NINES; Homelessness, Traveller and Prison Health), and general services to identify where there are greater opportunities to reduce health inequalities. (by March 2027)	-By Sept 2026, develop an interim report for AMT. -By March 2027- complete a final report with an action plan for completion by March 2028	Health inequalities will be central to decisions about service development. Healthcare inequalities will be reduced through the development of equitable service models. Services for inclusion health groups will be strengthened to address the huge health inequalities seen in inclusion health groups.	TBC
18 (25)	32.	2026/27 2027/28	Implementation of the developed regional service specification (to be completed by Feb 26) for pharmacy and Trust Stop smoking	-Continue roll-out to pharmacies across NI alongside a workforce training programme aiming for 95% of pharmacies by Mar 2028.	Continue to reduce smoking prevalence across NI by a minimum of 1% annually to reduce deaths caused by smoking related illnesses	DPH TBC Planning Team

CP	Action No	Year	Action	Output	Impact	Lead Director
			Programmes, aiming to significantly modernise both, with increased emphasis on reducing inequalities. Implement learning from the review of all Stop Smoking services commissioned via PHA (to be completed by Feb 2026), to ensure regionally consistent and comparable, measurable services are in place to meet population needs in each Trust.	-ensure and maintain that at least 5% of the smoking population in NI access stop smoking services to improve quit rates.	(Ref: NI Tobacco Control Strategy)	

Priority 19: support those living with long-term conditions to live well

CP	Action No	Year	Action	Output	Impact	Lead Director
19 (20)	33.	2026/27 2027/28	Lead and work jointly with partners (SPPG; Councils; Trusts) to	Review the PARS scheme by March 2027 -Implement recommendations of review by March 2028	There is a wealth of evidence showing that increasing physical activity reduces risk of various	TBC

CP	Action No	Year	Action	Output	Impact	Lead Director
			commission services based on the completed (March 26) enhanced service specification for the physical activity referral scheme, (PARS), which will include those for people living with cancer and other chronic conditions. Including cancer pre-hab and rehabilitation, using the cancer toolkit produced in conjunction with NICaN (by Feb 2026)		health issues. There is also evidence showing the beneficial impact it has on outcomes for long term conditions and cancer. Optimising how physical activity is used across the heatlh service to improve the health of patients will have a benefit at a population level given. Physical activity levels will reduce and improvements will be seen in heatlh and outcomes from various long term conditions.	
19 (20,21, 22 23,24, 27)	34.	Ongoing	Continue to provide professional advice to SPPG and Trusts to support commissioning of high quality, effective and efficient services for	Annual report to AMT and PHA Board on major subject areas	Health services in northern Ireland are developed based on the best evidence of effectiveness at individual and population level.	DPH TBC Planning Team

CP	Action No	Year	Action	Output	Impact	Lead Director
			physical / mental health /substance use issues			
19	See also actions 28, 29					

Priority 20: deliver high-quality programmes and initiatives, including prevention and early intervention approaches, to protect and improve physical and mental health and emotional and social wellbeing

CP	Action No	Year	Action	Output	Impact	Lead Director
20 (16,21, 24)	35.	Ongoing	Continued development of the Minding Your Head website to provide information for general population and targeted information for higher risk groups	Development of Minding Your Head website	Improved access to information to promote mental health and wellbeing for all	
20 (22, 24)	36.	2026/27	Scope with SPPG, how to embed evidence-based preventative actions in both primary and secondary care	Establish a joint forum with SPPG by April 2026	Opportunities to improve health, detect ill health earlier and improve outcomes will be realised for the population.	DPH TBC Planning Team

CP	Action No	Year	Action	Output	Impact	Lead Director
20 (21)	37.	2025-2028	Facilitate delivery of the revised Protect Life 2 Action Plan including procurement of new suicide prevention services in line with procurement plan to include targeted services for at risk groups and postvention services for those bereaved by suicide (across the life course)	Actions with Protect Life 2 action plan being progressed and addressed. Procurement process completed and new services in place across all Trust areas.	Intended to achieve reduction in suicide and self-harm rates over long term.	Dir Population Health & Wellbeing MH Planning Team
20	See also actions 30, 31, 33, 34, 37					

Priority 21: continue to work in partnership across government and with communities, services, and families across society to reduce suicides and the incidence of self-harm

CP	Action No	Year	Action	Output	Impact	Lead Director
21	See actions 34, 35					

Priority 22: reduce harm caused by substance use by improving access to high-quality prevention and early intervention, harm reduction, treatment and recovery services to ensure people can access the right service at the right time delivered in the right place to best meet their needs

CP	Action No	Year	Action	Output	Impact	Lead Director
22 (16)	38.		Procure new substance use services in line with Phases 3 and 4 of the Substance Use Procurement plan (across the life course)	Provision of high-quality prevention, early intervention and treatment and recovery services within each HSC Trust area. Improved access and uptake of substance use services across the region	Reduction of harm caused by substance use	Dir Population Health & Wellbeing MH Planning Team
22	See also actions 31, 36					

Priority 23: support prevention and early detection of illness through vaccination and screening programmes

CP	Action No	Year	Action	Output	Impact	Lead Director
23	See actions 33, 36					

Priority 24: provide targeted information and support to help everyone, including those who experience multiple barriers to health, to adopt healthy behaviours, avail of preventative services and access high- quality care

CP	Action No	Year	Action	Output	Impact	Lead Director
24 (28)	39.	2026/27 2027/28	Work jointly with the Major Trauma Network and other partners to prevent morbidity and mortality from avoidable accidents	Develop an agreed action plan by Sept 2026		DPH TBC Planning Team
24	See also actions 29, 30, 31, 34, 35, 36,					

Priority 25: continue working towards a tobacco-free society

CP	Action No	Year	Action	Output	Impact	Lead Director
25	See actions 30, 31, 32,					

Priority 26: improve public awareness and understanding of organ donation and transplantation, and the change in legislation on consent, encouraging positive actions and behaviours in relation to organ donation across society

CP	Action No	Year	Action	Output	Impact	Lead Director
26	See actions					

Priority 27: continue working to implement and enhance shared decision making, accessibility and health literacy

CP	Action No	Year	Action	Output	Impact	Lead Director
27	See actions 31, 34					

Priority 28: strengthen the role of communities within the public health system, by embedding community-centred approaches to reduce health inequalities and build healthier communities.

CP	Action No	Year	Action	Output	Impact	Lead Director
28	See actions 31, 39					

HSC Public Health Agency

Ageing Well

Supporting people to age healthily throughout their lives

Population Outcome and Ambition

That people live healthier, independent lives for longer.

Population Indicators

- percentage of people aged 65+ with a high GHQ-12 score, indicating a possible mental health problem;
- percentage of people who report feeling lonely 'often/always' or 'some of the time';
- adults aged 65+ stating health is good or very good;
- emergency hospital admissions due to falls in people aged 65+;
- number of deaths from falls in people aged 65+;
- percentage of older people who are living with overweight or obesity;
- percentage of older people who do not meet physical activity guidelines;
- percentage uptake of flu and shingles vaccinations;
- frequency of alcohol use by age;
- percentage of people who die at home, in hospital or other setting

HSC Public Health Agency

Action Plan

Priority 29: implement the World Health Organization (WHO) Age-friendly movement across Northern Ireland

CP	Action no	Year	Action	Output	Impact	Lead Director
29	**40.**	2026/27	Working with 11 local councils and other key stakeholders, develop a regional age friendly model and strategy for Age Friendly implementation with a focus on the determinants of health and improving outcomes across NI	A regional age friendly strategy for NI and consistent regional approach Determinants approach, framed around 8 domains Established baseline in community of the services available	Population approach to improving health and wellbeing Influencing policy change through lens of older people Collaboration across depts Increased regional consistency Improved outcomes and quality of life for older people across NI	Dir Pop Health

Priority 30: reduce and prevent falls and home accidents, including the development and implementation of a regional model for safer mobility

CP	Action no	Year	Action	Output	Impact	Lead Director
30	**41.**	2026 - 2027	Development and implementation of a Regional Safer Mobility Model across Northern Ireland to include a focus on: • Understanding the burden of falls on HSC activity, associated costs of falls and the human impact • Prevention – understanding current provision and prevention work underway, any gaps, the evidence base for what works and system readiness to act • Influencing improved collation and understanding	Improved regional consistency through deployment of a regionally consistent safer mobility model. Address regional gaps in service model in community, acute and care home settings Improved understanding of falls in NI and the burden of falls on our population and on HSC	Enhanced primary and secondary prevention of falls. Improved recording in acute and community settings. Better decision making and commissioning of appropriate services based on need	DNMAHP TBC Planning Team

CP	Action no	Year	Action	Output	Impact	Lead Director
			of current GP data relating to older people and ageing and the ability to identify those at high risk of falls			

Priority 31: reduce the impact of frailty by raising awareness and increase early detection

CP	Action no	Year	Action	Output	Impact	Lead Director
31, 34	**42.**	2026/27	Working collaboratively with Age NI and QUB and we will engage with older adults in Northern Ireland to better understand their experience of a stay in hospital, from admission through to discharge to support quality	A regional group will be developed to focus on areas for quality improvement by end of June 2026 and will report by December 2026. Review the current system against the recommendations	Improved understanding of key issues for older people and the issues which impact on their experience of hospital. Further development of knowledge on engagement methodology in this population group. This new learning will inform how we improve	DNMAHP TBC Planning Team

Commented [HR2]: Will QUB and Age NI be commissioned to do the work?
Might be helpful to get PPI/PCE input into designing the work.

CP	Action no	Year	Action	Output	Impact	Lead Director
			and service improvement. This will develop into an outcomes report with recommendations for the system.		the experience of the service user through our ongoing commissioning, service development and redesign.	
31	**43.**	**Year 2 2026/27** Standards and KPIs will be adopted and implemented across the HSC system. **Year 3 2027/28** Improved experience of older adults attending hospital.	Develop evidence-based standards for the identification, recording and management of delirium in hospital settings. Using behavioural science approaches, identify best approach to raise awareness on this issue with patients, families and staff.	Scope best practise in behavioural science approaches. Develop best practise implementation plan based of learning.	Improved identification, recording and understanding of impact of delirium in hospital settings. Improved methods of raising public awareness System clarity on service standard.	DNMAHP TBC Planning Team

CP	Action no	Year	Action	Output	Impact	Lead Director
		Improve system flow through shorter lengths of stay				
31	**44.**	2026/27	Influencing the improved identification and recording of frailty in primary care using Electronic Frailty Index (EFI in GP settings) and secondary care using the Clinical frailty score (Rockwood tool through encompass) Initial focus on moderate frailty	Embed EFI in core practise with GPs for patients over 65. Rework where possible Encompass to create ways of working so that the Rockwood assessment is a core parts of the pathway for people over 65.	Early identification and risk stratification of frailty. Early focussed intervention and prevention. Better QoL	

Commented [HR3]: Whilst a good thing to do - PHA will have very limited influence over implementing this. Need to consider escalation and/or exit plan

Is there a LES in existence?

Priority 32: support prevention and early detection of illness through vaccination and screening programmes for older adults

CP	Action no	Year	Action	Output	Impact	Lead Director
32	**45.**	**See actions 10, 11**				

Priority 33: increase levels of physical activity and promote opportunities to stay active

CP	Action no	Year	Action	Output	Impact	Lead Director
33	**See action 41**					

Priority 34: work with key partners to identify and reduce levels of loneliness and social isolation and to improve wellbeing

CP	Action no	Year	Action	Output	Impact	Lead Director
34	**See action 42**					

Priority 35: champion the voice of older people and the issues that impact on their health and wellbeing

CP	Action no	Year	Action	Output	Impact	Lead Director
35	**46.**	2026/27	Develop and implement a plan	Employing the PHA Health Inequalities Framework use	Better identification of needs and effective	

CP	Action no	Year	Action	Output	Impact	Lead Director
			to ensure the needs of older people in marginalised communities are fully integrated into all other work areas.	data and evidence systematically to identify root causes, effective solutions and assess progress within the ageing well population.	solutions for this population Improved outcomes and reduced inequalities for older people in marginalised communities	
35	**47.**	2027/28	Work with stakeholders to clarify the scope of PHA involvement and responsibility as it relates to adult safeguarding	Clarity on roles and responsibilities	Improved governance	

Commented [JM4]: Edit TBC

Priority 36: lead and implement initiatives to ensure people who live within care homes have good health and wellbeing and improved quality of life

CP	Action no	Year	Action	Output	Impact	Lead Director
36	**48.**	2027/28	Develop and test a pathway to improve 'best interest' decision making in a Care Home setting	Evidence base for different approach to prevent admissions to hospital	improved care planning across care home settings	

CP	Action no	Year	Action	Output	Impact	Lead Director
			including advance care planning and recommendations from the Big Discussion	Inform work to redesign community services Implementation of advance care planning in care home settings	improved decision making in care home settings	

Priority 37: work with partners to support individuals and families at the end of their life through advance care planning

CP	Action no	Year	Action	Output	Impact	Lead Director
37	**See action 48**					

Priority 38: build and develop a strong research and evidence base to support ageing well programmes in Northern Ireland

CP	Action no	Year	Action	Output	Impact	Lead Director
38	49.	2027/28	Begin the development of a state of ageing report in Northern Ireland through close working with partners and utilising existing data,	State of ageing report for NI Participatory mapping (PPI, the voice of older people)	Improved links with academia and research Better understanding of ageing in NI and ability to visualise and predict health trends	

CP	Action no	Year	Action	Output	Impact	Lead Director
			approaches and systems		Reduce unnecessary health care costs by targeting high-risk zones proactively	
38	50.	2027/28	Influence/co-lead Geospatial mapping of long term conditions including dementia prevalence and dementia services	Geospatial map relating to; dementia and dementia services	Allocate resources more efficiently, target high-risk zones proactively Help reduce health inequalities	
38	51.	2026/27	Review existing PHA spend related to ageing well initiatives in terms of: • Corporate plan objectives • Priority • Addressing health inequality • Value for money	Review of tendered contracts Agreed commissioning priorities and clarity of spend.	Improved efficiency and best use of resources	

Our Organisation

How we work: our processes, governance, culture, people and resources

Population Outcome and Ambition

That we are an exceptional organisation, working effectively to improve health and wellbeing for everyone.

INSERT INDICATORS - TBD

HSC Public Health Agency

Action Plan

O1: People

CP	Action No	Year	Action	Output	Impact	Lead Director
O1	1.	2026/27 2027/28	Delivery of the People Strategy	Implementation of recommendations within each year of the strategy	To attract and retain the highest calibre of staff who are equipped to deliver on the PHA Corporate Strategy	DFCS
O1	2.	2026/27 2027/28	Review of HR Metrics post the Reshape Refresh programme and new system implementation.	Available metrics which allow the organisation to benchmark performance.	Ability to benchmark performance	DFCS

O2: Partnership

CP	Action No	Year	Action	Output	Impact	Lead Director
O2	3.	2027/2028	Develop and implement an organisational stakeholder engagement strategy	2026/27 (develop strategy) 2027/2028 (implement strategy)	Improved stakeholder engagement	HoCxO
O2 (24)	4.	2027/28	All Public Health messages and campaigns will include accessible information, including ensuring PHA	Guidance for developing accessible information	Improved health literacy for people with learning	DNMAHP

CP	Action No	Year	Action	Output	Impact	Lead Director
			public facing website hosts accessible information.	Accessible information produced for each campaign and message as it is produced	disabilities in Northern Ireland in regards to targeted Public Health messages.	TBC Planning Team
O2	5.	2026/27 & 28	Develop a Partnership & Engagement Strategy, to deliver on the PHA's regional leadership role in Experience & Involvement, and which embeds these approaches into the culture and practice of the PHA. This will also take into account evolving key priorities, including the Strategic Review of Public Engagement and Shared Decision Making, amongst others.	Partnership & Engagement Strategy developed & implemented. Experience & Involvement evident in structures, processes and approaches of the PHA including SU/C membership of / contribution to PHPTs, Joint Commissioning Groups etc Evidence identified, collated and reported of the SU/C voice & Shared Decision Making, influencing commissioning, planning & delivery of services. Identification, replication and upscaling of good practice in Experience & Involvement	Increased partnership and engagement with informed Service Users, Carers (SU/C) their Families & the Public in PHA & HSC. associated better public health outcomes for SU/C, their families & the wider public	DNMAHP

HSC Public Health Agency

O3: Process

CP	Action No	Year	Action	Output	Impact	Lead Director
O3	6.	2026/27	Implementation of new organisational contract management processes	Improved quality of performance information provided when reporting against agreed KPIs New processes implemented	Improved oversight and compliance with Contract T&Cs Improved use of resources	DFCS
O3	7.	2026/27	Planning Teams to complete induction programmes by November 2026	Induction process developed and rolled out	PHPTs have skills and knowledge to operate effectively	DFCS
O3	8.	2026/27	Procurement plan 2026/7 implemented	All procurement scheduled for 26/27 implemented	Clients accessing services have improved health and wellbeing outcomes Services are delivering best value in terms of quality and cost	DFCS
O3	9.	2026/27 2027/28	Development of 3 year strategic plans for 3 PHPTs completed by	Agreed plan in place setting out the specific priorities that PHA	Strategic direction set for key areas of work	

CP	Action No	Year	Action	Output	Impact	Lead Director
			March 2027 to include review of evidence base for commissioning programmes.	will focus on delivering over the coming 3 year period		
O3	10.	2025 - 2028	Review, refresh and embed key corporate and information governance policies and procedures, ensuring that staff across the PHA understand their responsibilities and implement these ensuring good governance in how we do our business.	Via the Information Governance Steering Group as per actions on its annual Action Plan, disseminate key messages and information to all staff throughout the year	Increased understanding of corporate and information governance responsibilities across the organisation	DFCS
O3	11.	2027/28	Implement Safety and Quality Framework for PHA to include: • enhanced surveillance of adverse incidents and • improved structures for internal and external work to support safety and quality initiatives	Implementation of Safety and Quality Framework Enhanced surveillance of adverse incidents Implementation of supportive structures	Enhanced support for safety and quality across agency	DNMAHP
O3	12.	2027/28	NILIS Replacement integrated into NIHAP	Integration of NILIS into NIHAP	Improved surveillance through a new	DPH

CP	Action No	Year	Action	Output	Impact	Lead Director
					system that automates the transfer, validation, and integration of laboratory data from Core LIMS to the new lab surveillance system.	
O3	13.	2027/28	HPS will identify appropriate datasets and develop aggregate count data tables for submission to OpendataNI for all surveillance workstreams.	Data submitted to Opendata NI for all surveillance workstreams	HP surveillance will provide statistics; published at a sufficient level of detail; in an open and transparent manner that promotes confidence.	DPH
O3 (O4)	14.	2026/27	Implementation of a new integrated Finance, Procurement and HR System (EQUIP) with a wide range of self-service options aimed at modernisation and improved user experience	Implementation of (EQUIP) with a wide range of self-service options aimed at modernisation and improved user experience.	Modernised HR and Finance software	DFCS

HSC Public Health Agency

O4: Digital

CP	Action No	Year	Action	Output	Impact	Lead Director
O4	15.	2026/27	Using the **Population Health Model** to Design & Evaluate Interventions	Model-based scenario planning to identify the most effective public health interventions	Improved planning and identification of effective public health interventions	Director of Population Data and Intelligence
O4	**16.**	**2026/27**	Survey and scope PHA's data, epidemiology, research and intelligence needs, and create a plan to resource and deliver these.	A delivery plan to create sustainable and integrated data, intelligence and research functions to support the work of the rest of PHA.	Sustainable and integrated data, research and intelligence supporting and embedded across PHA work	Director of Population Data and Intelligence

O5: Research and Evidence

CP	Action No	Year	Action	Output	Impact	Lead Director
O5	17.		To develop and submit a business case for a	Approved business case	Ability to design health	

CP	Action No	Year	Action	Output	Impact	Lead Director
			principal behavioural scientist to develop in-house capability to design health behaviour interventions.	Recruited behavioural scientist	behaviour interventions	
O5	18.		To convene and jointly lead a behavioural science research and practice forum of PHA, policy and academic stakeholders to leverage expertise in behavioural change, to support PHA's delivery and evaluation of health behaviour interventions	Established behavioural science research and practice forum	Improved organisational ability and access to expertise in the delivery and evaluation of health behaviour interventions	
O5	19.	2026/27	Develop and launch the new HSC R&D Strategy 2025-2030 and corresponding implementation plan	Approved HSC R&D Strategy 2025-2030 Approved implementation plan	Ensure HSC can support delivery of relevant high-quality health and social research	DPH/ AD R&D
O5	20.	2026-2028	Support and enable the delivery of relevant high-quality HSC R&D across the HSC by providing: • Funding for essential infrastructure for	Fund and support the delivery of relevant high-quality health and social research across the HSC	Promote the need for health and social care services (including those delivered to	DPH/ AD R&D

CP	Action No	Year	Action	Output	Impact	Lead Director
			research such as information databanks, tissue banks, clinical research facilities, clinical trials units and research networks • Opportunities for local researchers to access HSC R&D funding (including NI's allocation from the Voluntary Scheme for Branded Medicine Pricing, Access and Growth (VPAG) Investment Programme) or other externally sourced research funding on a wider UK or international basis • The HSC R&D Approvals Service streamlining the research approval		children, young people, and older adults) to be informed by the best available and up-to-date evidence.	

CP	Action No	Year	Action	Output	Impact	Lead Director
			process for NI applicants in line with coordinating functions in other UK Nation • The HSC Industry Engagement Unit to build industry and HSC relationships and partnerships to develop and increase levels of commercially sponsored clinical trials across the NI clinical research delivery infrastructure including the Commercial Research Delivery Centre NI			

Year 5 Position

The following table sets out the indicators and measures detailed within the PHA Corporate Plan 2025-2030 and the change that is expected over the next 5 years as the organisation works to deliver on its priorities. These indicators are at population level and the tables below show the long term change PHA hopes to see. However, PHA recognises there are many factors that impact on these indicators, and many of these are outside PHA's control. PHA will also monitor the delivery and success of its work programmes, which should translate into the longer term change identified below. An updated table of figures will be provided annually to PHA board.

Overall

Theme	Measure/ Indicator	Expected trend
Overall	Healthy life expectancy	↑
	Gap in healthy life expectancy	↓
	Preventable deaths	↓

Protecting Health

Theme	Measure/ Indicator	Expected Trend
Protecting Health	Vaccination uptake	
	Notification rates of VPD	
	Rates of HCAI	
	Bbv elimination targets	
	Screening uptake	
	Waste water surveillance	
	Stage of cancer diagnosis	
	climate change activity	
	IPC	

Starting Well

Theme	Measure/ Indicator	Expected Trend
Starting Well	Screening and vaccination in pregnancy uptake	↑
	Childhood vaccination uptake	↑

Theme	Measure/ Indicator	Expected Trend
	Percentage of children living with obesity or overweight in year 1 and year 8	↓
	Percentage of babies born at low birth weight	↓
	Avoidable child death rates	↓
	Percentage of mothers breastfeeding on discharge and at 6 months	↑
	Breastfeeding welcome here scheme membership	↑
	Percentage of young people who drink alcohol	↓
	Percentage of young people who smoke cigarettes	↓
	Percentage of young people who currently use e-cigs	↓
	Number of people under 18 years attending emergency departments for self harm	↓
	Percentage of women smoking during pregnancy	↓

Living Well

Theme	Measure/ Indicator	Expected Trend
Living well	Percentage of people with a high GHQ-12 score, indicating a possible mental health problem	↓
	Number pf people die by suicide or undetermined intent	↓
	Percentage of adults smoking and vaping	↓
	Percentage of adults living overweight or obese	↓
	Percentage adults meeting physical activity guidelines	
	Percentage adults drinking above weekly limits	↓
	Alcohol and substance use related hospital admissions	↓
	Age standardised mortality rate for alcohol related deaths and substance use related deaths	↓
	percentage self-reporting a physical or mental health condition or illness expected to last 12 months or more	↓
	percentage of those living with long-term conditions reporting a reduced ability to carry out daily activities.	↓

Theme	Measure/ Indicator	Expected Trend
	Percentage of people with a high GHQ-12 score, indicating a possible mental health problem DUPLICATED	↓
	Number of people die by suicide or undetermined intent	↓

Ageing Well

Theme	Measure/ Indicator	Expected trend
Ageing Well	percentage of people aged 65+ with a high GHQ-12 score, indicating a possible mental health problem	↓
	percentage of people who report feeling lonely 'often/always' or 'some of the time'	↓
	adults aged 65+ stating health is good or very good	
	Emergency hospital admissions due to falls in people aged 65 and over	↓
	Nos of deaths from falls in people over 65 yrs	↓
	'percentage of older people who are overweight or obese	↓
	percentage of older people who do not meet physical activity guidelines	↓
	percentage uptake flu and shingles vaccinations	
	frequency of drinking by age	
	percentage of people who die at home, in hospital or other setting	

Our Organisation

TBC

Theme	Measure/ Indicator	Expected trend
Our organisation		
	climate change activity	
	public comms?	
	our people?	

Public Health Agency

Appendices

A: performance accountability template for reporting

C: alignment cover sheet?

Appendix A: performance accountability template for reporting

Action

Delivery Outcome

Customers

Story behind the baseline

Partners

What we will do/Action plan & performance measures

Performance Matrix

BLURB

How much did we do?	How well did we do it?
Is anyone better off?	

HSC Public Health Agency

Appendix B: Implementation Plan Actions by Public Health Domain 03/06/2025 (DRAFT)

Healthcare public health	Health Protection	Health Improvement
	Protecting Health Actions 1-14	
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C:

MENTAL HEALTH and SUICIDE PREVENTION STRATEGIC DRIVERS