HSC Public Health Agency

# Meeting agenda

## PHA Board Meeting

| Date and time | Venue |
|---|---|
| 27 March 2025 at 1.30pm | Fifth Floor Meeting Room, 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 27 February 2025 | Chair |
| 4 | Actions from Previous Meeting / Matters Arising | Chair |
| 5 | Reshape and Refresh Programme | Chair |
| 6 | Reports of New or Emerging Risks | Chief Executive |
| 7 | Raising Concerns | Chief Executive |
| 8 | Updates from Committees:<br>• Governance and Audit Committee<br>• Remuneration Committee<br>• Planning, Performance and Resources Committee<br>• Screening Programme Board<br>• Procurement Board<br>• Information Governance Steering Group<br>• Public Inquiries Programme Board | Committee Chairs |
| 9 | Draft PHA Corporate Plan 2025-30 **[PHA/01/03/25] (For approval)** | Ms Scott |

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| 10 | PHA Business Plan 2025-26 **[PHA/02/03/25] (For approval)** | Ms Scott |
| 11 | Chief Executive's and Executive Directors' Report | Chief Executive/ Executive Directors |
| 12 | Finance Report **[PHA/03/03/25]** | Ms Scott |
| 13 | Chair's Remarks | Chair |
| 14 | Any Other Business | Chair |
| 15 | Details of next meeting:<br>*Thursday 24 April 2025 at 1.30pm*<br>*Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast* | Chair |

# PHA Board Meeting Minutes

| Date and Time | Venue |
|---|---|
| 27 February 2025 at 1.30pm | Fifth Floor Meeting Room, 12/22 Linenhall Street |

| Member | Title | Attendance status |
|---|---|---|
| Mr Colin Coffey | Chair | Present |
| Mr Aidan Dawson | Chief Executive | Present |
| Dr Joanne McClean | Director of Public Health | 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 |
| Ms Anne Henderson | Non-Executive Director | Present |
| Mr Robert Irvine | Non-Executive Director | Present |
| Professor Nichola Rooney | Non-Executive Director | Present |
| Mr Joseph Stewart | Non-Executive Director | Present |
| Mr Stephen Wilson | Head of Chief Executive's Office | In attendance |
| Ms Emily Roberts | Designated Nurse for Safeguarding Children and Young People | In attendance (on behalf of Ms Reid) |
| Mr Robert Graham | Secretariat | In attendance |
| Ms Heather Reid | Interim Director of Nursing, Midwifery and Allied Health Professionals | Apologies |
| Ms Meadhbha Monaghan | Chief Executive, Patient Client Council | Apologies |

## 17/25 - Item 1 – Welcome and Apologies

**17/25.1** The Chair welcomed everyone to the meeting. Apologies were noted from Ms Heather Reid and Ms Meadhbha Monaghan.

## 18/25 - Item 2 – Declaration of Interests

**18/25.1** The Chair asked if anyone had interests to declare relevant to any items on the agenda.

**18/25.2** Mr Clayton declared an interest in relation to Public Inquiries as Unison is engaging with the Inquiries.

## 19/25 - Item 3 – Minutes of previous meeting held on 30 January 2025

**19/25.5** The minutes of the Board meeting held on 30 January 2025 were **APPROVED** as an accurate record of that meeting, subject to three amendments proposed by Mr Clayton. He indicated that in paragraph 8.25/10, "Procurement Board" should read, "Information Governance Steering Group" and the penultimate line should read "…Scoring Social Value…". In paragraph 11.25/7, he asked that the wording be clarified to indicate that the Board had previously asked to see the terms of reference.

## 20/25 - Item 4 – Actions from Previous Meeting / Matters Arising

**20/25.1** An action log from the previous meeting was distributed in advance of the meeting and members were content with the progress noted.

## 21/25 - Item 5 – Reshape and Refresh Programme

**21/25.1** The Chair advised that there has not been a meeting of the Programme Board since the last Board meeting, but noted that the leadership group at Tier 3 continues to be established. The Chief Executive reported that there are now monthly meetings of that group and a development day has been arranged at which Professor Phil Glasgow will be in attendance to facilitate a session on teamworking which will then be carried out with other teams. He added that the planning teams are also being worked on. The Chair asked when the Board can expect to receive the first presentation from one of the Strategic Planning Teams and the Chief Executive replied that he and Ms Scott had discussed this, and the aim is to bring a presentation from the Mental Health Strategic Planning Team to the Board in April.

**21/25.2** Ms Henderson asked if there will be an opportunity to look at what that team may require in terms of resources, and a look at funding around key themes, but the Chief Executive said that it is too early for this and that the current ask is that the team

ensures that its work is aligned to the Corporate Plan. The Chair noted that the Board will receive the Implementation Plan at the March Board, but Ms Scott explained that while progress is being made to collate this, it is a challenge because the structures are not yet fully in place and that a draft Plan may be available. The Chair said that the Plan needs to be approved by 1 April, but Ms Scott clarified that the Business Plan will be ready but the Implementation Plan may not. The Chair said that there needs to be a link between the Corporate Plan and activities on the ground, and there needs to be a Plan that the Board can approve. The Chief Executive pointed out that quite often, the formal budget is not signed off until after 1 April. Mr Stewart advised that he had attended a meeting of Audit Committee Chairs and at that meeting, Ms Brigitte Worth had outlined that the financial outlook is one of a "flat cash" scenario. The Chief Executive said that his understanding is that it will be "flat cash" or less because there remains a £100m funding gap.

**21/25.3** Professor Rooney asked for an update on the new Digital directorate. The Chief Executive reported that the job description for the Director post is currently with the Department of Health for evaluation. However, he added that the Department is currently reviewing the structures of all HSC organisations but said that PHA had put forward representation that it should not be included as it is currently undergoing a restructuring. Professor Rooney asked about the work of the new directorate. The Chief Executive outlined that PHA currently has good information systems and there is work happening in that space. He advised that he and Ms Scott had met with Mr Paul McWilliams to look at a digital health model. Professor Rooney asked if there is a directorate in place. The Chief Executive replied that there is not, but explained that each of the Directors currently looks after an element of its work.

**21/25.4** Professor Rooney said that the Board should write to the Department because it was part of the meetings with EY to look at a new structure for PHA and now this is on hold. The Chief Executive advised that he has raised this with both Mr Jim Wilkinson and PHA's Sponsor Branch because he would like to see this progressed. He added that BSO has also raised it and reiterated that PHA is not the only organisation affected. Professor Rooney pointed out that PHA is the only organisation where the Department has paid for it to go through a restructuring exercise. The Chief Executive reiterated that he would continue to raise the matter.

*At this point Dr McClean joined the meeting.*

**21/25.5** Ms Henderson asked whether not getting this directorate in place will mean that PHA has not fulfilled the Reshape and Refresh programme. The Chief Executive replied that a lot of progress has been made with new structures in place and that progress will continue to be made. The Chair suggested that there should be a presentation for the Board on this **(Action 1 – Chief Executive)**.

**21/25.6** Mr Stewart commented that PHA is no further on than it was two years ago and agreed that a letter should go to Mr Peter Toogood because the Department, like PHA, is committed to the Reshape and Refresh programme and this issue needs to be sorted. The Chief Executive reiterated that good progress has been made, but added that element was always going to be difficult. He added that he did not think that writing a letter was the best way forward. The Chair noted that there is also an issue in terms of being able to recruit for the post, but Mr Stewart said that was a totally different issue. The Chair suggested that PHA should obtain a timeline from the Department about how

this will be resolved, and if this timeline is not satisfactory, then PHA should write to the Department.

**21/25.7** Professor Rooney noted that at the start of the pandemic, a major issue for PHA was information, and the establishment of this new directorate was crucial. The Chief Executive said that in terms of whether PHA has advanced in how it uses information, progress has been made. He added that he would be content to bring Dr Declan Bradley to present on this. He advised that there will also be digital pieces of work developed so the foundations of that directorate are being put in place. He noted that there will be challenges in relation to Encompass, but he would mention these later. He reiterated that in terms of surveillance, PHA is in a better place than it was in 2019. Professor Rooney said that it would be useful to have that assurance for the Board. The Chair said that he and the Chief Executive would speak to the Department concerning this **(Action 2 – Chair/Chief Executive)**.

**21/25.8** Ms Henderson asked if this should be placed on PHA's Corporate Risk Register. She asked if the population health modelling work carried out by Gartner has been completed. The Chief Executive replied that this is the work he described earlier. The Chair asked Dr McClean for her thoughts. Dr McClean said that how PHA works with information has been transformed since the pandemic and that the population health model work and the digital pieces are the way forward.

## 22/25 - Item 6 – Reports of New or Emerging Risks

*Corporate Risk Register as at 31 December 2024* ***[PHA/01/02/25]***

**22/25.1** The Chief Executive advised that one new risk has been added to the Corporate Risk Register and there would be a briefing on this in the confidential session.

**22/25.2** Mr Stewart said that the Corporate Risk Register is brought to the Board can be satisfied. He noted that the Chair had previously suggested that there should be a session for the Board to take a detailed look at the Register and advised that at last week's Governance and Audit Committee meeting, he had spoken to Mrs Catherine McKeown regarding a session for members on the 3 Lines Assurance model.

**22/25.3** Mr Stewart advised that the Committee had gone through the Register in considerable detail and he drew members' attention to risk 74 around the Integrated Care System (ICS) and the prospect of PHA acting *ultra vires*. He said that this links to the lack of progress on the development of a new HSC Framework Document and that this risk lies with the Department and needs to be moved up the agenda. He added there is also the issue around joint commissioning and that there is not an urgency to resolve these.

**22/25.4** Mr Clayton agreed that PHA is exposed and felt that the mitigating actions are operational in nature. He added that there is a wider governance piece about roles and responsibilities so clarity is needed.

**22/25.5** Mr Clayton said that there was a substantive discussion around risk 55 which relates to staffing and how this risk has morphed over time given it began as a risk

around public health consultants. He suggested that it may be useful for the full Board to receive an update so it is sighted **(Action 3 – Dr McClean)**.

**22/25.6** Ms Henderson asked about the new risk on the Child Health System (risk 74) and if this has been escalated to the Department and if it is on its Risk Register. The Chief Executive said that PHA would need to ask the Department. Mr Stewart advised that the Committee recommended that PHA should write to the Department and point out these gaps. Mr Wilson noted that there was a Departmental representative at the Committee meeting and they would have heard this discussion so he agreed to follow up with them **(Action 4 – Mr Wilson)**. The Chair advised that he is meeting Ms Tracey McCaig on Monday afternoon.

**22/25.7** Professor Rooney said that for Risk 71, relating to Public Inquiries, the original risk was around PHA's capacity to respond, but as the Inquiries are coming to an end, the risk is now around potential criticism for PHA. She added that the Muckamore Inquiry may be a difficult one, and asked if the wording reflects the risk. The Chief Executive noted that it is difficult to know what is in the Inquiry reports until they are published. He added that when the COVID Inquiry recommendations came out, they were for the Government rather than PHA, and that although there is an Oversight Board for the implementation of recommendations in the Department, PHA is not a member and was told it was not required.

**22/25.8** Mr Stewart stated that the Corporate Risk Register is about potential risks, and he has a concern that the rating has been changed from "high" to "medium". He said that the wording needs to be revised as the risk is about potential impact and reputational impact and that the Agency Management Team (AMT) should review it. The Chair added that AMT needs to bring an update to the Board on lessons learned from Inquiries as the Board needs an assurance that PHA is in a better position. The Chief Executive said that Mr Wilson and the Inquiries Group is undertaking a piece of work looking at the recommendations from previous Inquiries.

## 23/25 - Item 7 – Raising Concerns

**23/25.1** The Chief Executive advised that there were no new concerns to report on.

## 24/25 - Item 8 – Updates from Board Committees

*Governance and Audit Committee* ***[PHA/02/02/25]***

**24/25.1** Mr Stewart said that the Governance and Audit Committee had met on 13 February and it was an extensive meeting. He reported that two Internal Audit reports relating to Trusts had been considered and PHA had received limited assurances on both and this is an area that PHA needs to be concerned about. He advised that the Committee had considered a paper on recruitment, which should be shared with all members **(Action 5 – Secretariat)**, and it showed that while BSO is meetings its timelines, there are issues in terms of PHA meeting its targets.

*Remuneration Committee*

**24/25.2** The Chair advised that the Remuneration Committee had met prior to the Board meeting to discuss pay awards for 2022/23 and recommendations have now been made.

*Planning, Performance and Resources Committee* ***[PHA/03/02/25]***

**24/25.3** The Chair said that the minutes of the November meeting of the Planning, Performance and Resources Committee were available for members and that the Committee had met last week.

**24/25.4** The Chair advised that there had been discussions about structures aligning to outcomes and the need for these to be a link between corporate outcomes, Strategic Planning Teams and with SPPG commissioning teams. He said that there is a lot of work going on in the background.

**24/25.5** The Chair said that the Committee had gone through the Performance Management Report and he would like to see how it links with the Corporate Plan and how its activities are taking the organisation forward. He added that PHA needs to ensure that what it is working on will deliver what the organisation needs, which is pertinent given that funding continues to be tight.

**24/25.6** The Chair advised that there was a discussion on procurement and this will now become a standing item on the Committee's agenda. He said that PHA needs a plan to take this forward as it links to work on commissioning and how PHA ensures that it is reviewing what it is doing and making the right decisions.

**24/25.7** Mr Stewart said that the Governance and Audit Committee had received a copy of the External Audit Strategy and as part of its audit, there will be a review of Direct Award Contracts.

**24/25.8** The Chair advised that the PPR Committee had discussed commissioning and working with SPPG, and said that PHA needs to look at how it can make a difference and review what it is doing to get out of the habit of doing what it has always done.

*Screening Programme Board*

**24/25.9** The Chair noted that the Screening Programme Board has not met since the last Board meeting.

*Procurement Board*

**24/25.10** The Chair noted that the Procurement Board has not met since the last Board meeting.

*Information Governance Steering Group*

**24/25.11** The Chair noted that the Information Governance Steering Group has not met since the last Board meeting.

**24/25.12** Professor Rooney gave an overview of the work of the Public Inquiries Programme Board and said that there is a number of modules upcoming that PHA will have to attend to give evidence. Dr McClean advised that she will be giving evidence for the module on Test on Trace, and explained that while PHA had not considered itself as a core participant for the module on Children and Young People, it has received a lengthy Rule 9 request. Ms Roberts said that there will be meetings with a number of key people to look at the request. Dr McClean added that there is a module on Care Homes that Ms Reid will have to attend to give evidence on. Professor Rooney said that it is very stressful for staff having to appear at these Inquiries and it is important that they receive support. She commended the work of the Programme Board to date.

## 25/25 - Item 9 – Performance Management Report [PHA/04/02/25]

**25/25.1** Ms Scott advised that the Performance Management Report was discussed at the PPR Committee and that AMT also went through the Report in detail. She explained that AMT was quite strict in marking targets "red" if the timescale for them had not been met.

**25/25.2** The Chair said that his only concerns related to some of the targets which were rated "red", for examples those pertaining to the new structure. He also highlighted KPI23 around procurement and said that there should be more detailed information. He expressed disappointment that the targets are not linked to corporate outcomes. Ms Henderson advised that the PPR Committee had looked at KPI32 on commissioning teams and noted that this is a strategic risk which is outside PHA's control.

**25/25.3** Mr Clayton asked about KPI6 on vaccinations and the reference to the migration to Encompass and being able to access records. He also asked for clarity in terms of how PHA is dealing with inequalities. With regard to KPI14 on cancer networks, he asked how far apart PHA and the Department are in terms of seeing this as a priority area.

**25/25.4** Dr McClean replied that for KPI6, there was a catch-up campaign for the MMR vaccine and PHA mapped geographical areas and focused on areas where there was a large migrant community. She added that PHA also ranked schools with the lowest uptake. She advised that there is an evaluation report which can be shared with members **(Action 6 - Dr McClean)**.

**25/25.5** Dr McClean explained that when there was a pertussis outbreak, there was a focus on getting pregnant women vaccinated as it can make babies sick. However, she outlined that there was an issue with Encompass and getting data out of the system.

**25/25.6** Dr McClean advised that, with regard to the Cancer Strategy, this was published in 2022, but the actions that were prioritised related to service. She explained that information from Health Intelligence would indicate that the number of people who will be diagnosed is going to increase and the system will not be able to cope with the treatment needed. She advised that PHA is writing a business case for an extension of the bowel cancer screening programme. Ms Henderson asked how much this would

cost. Dr McClean replied that she did not know the exact cost, but explained that if there are more tests, there needs to be more colonoscopy capacity. Ms Henderson noted that Northern Ireland is out of step with the rest of the UK in this area.

**25/25.7** Professor Rooney asked if there are any charities raising this issue. Dr McClean clarified that both PHA and the Department deem this as a priority and once the business case has been completed there will be a review of where the capacity issues are. The Chair asked if PHA has carried out any research. Dr McClean explained that the bigger concern is how to fit this into the service as there are already long waiting times for colonoscopy. Mr Wilson advised that PHA has a partnership with Cancer Research UK to raise awareness.

**25/25.8** Ms Henderson asked if the Board could get an update on the age extension for bowel cancer screening **(Action 7 – Dr McClean)**. The Chair asked how PHA can better influence the prioritisation of the Department saying that delivery experts and policy experts need to work together. Dr McClean said that in the same way as reducing the risk of getting any other condition, cancer can be reduced by improved diet etc. Professor Rooney asked if there is any financial modelling. Dr McClean replied that she believed that there is modelling which looks at the long-term cost of more people getting cancer.

**25/25.9** The Board noted the Performance Management Report.

## 26/25 - Item 10 – Operational Updates

*Chief Executive's and Executive Directors' Report*

**26/25.1** The Chief Executive advised that PHA has produced a Health Protection report which gives improved information across a range of areas. He said that next week there is a session with the Department to discuss winter pressures and Dr Bradley has produced a paper. He explained that there is an ageing population, with more co-morbidities which creates pressures on health and social care services. He added that there is increased poverty with people having less access to the tools they need to live a healthy life.

**26/25.2** The Chair asked if PHA will make reference to the fact that it does not have the funding to influence behavioural change which would have an impact. The Chief Executive said that this is part of an ongoing discussion. Dr McClean advised that the workshop will have a clinical focus and will look at how to improve flow in hospitals. She said that there will be information about how many people presented at hospitals and how this leads to congestion in Emergency Departments. The Chair asked who is leading the session and Dr McClean replied that it is being jointly led by the Chief Medical Officer and the Chief Nursing Officer.

*Finance Report* ***[PHA/05/02/25]***

**26/25.3** Ms Scott reported that at the end of December, PHA has slippage of around £1m. She explained that as £250k of this is unlikely to be spent, PHA has returned it to the Department to fund the pay award. Mr Clayton declared an interest noting his union's involvement with the pay award.

**26/25.4** Ms Scott advised that PHA is funding a series of projects within R&D which will help improve access to clinical trials over the next 5 years. She said that the PPR Committee had scrutinised this Report at its last meeting.

**26/25.5** The Chair asked if PHA will have a balanced budget at the year end. Ms Scott replied that PHA is on target and it has a good relationship with both the Department and SPPG and there remain a lot of moving parts.

**26/25.6** The Chair asked about the outlook for 2025/26. Ms Scott replied that PHA has received an indicative allocation. She explained that PHA had highlighted £1.243m of pressures and that it has been asked to meet these pressures from savings. She advised that the allocation is for £133m, which is broadly a flat cash scenario.

**26/25.7** Ms Henderson said that she would work with Ms Scott to look at how this Report can be shortened as the format has been unchanged for a number of years.

**26/25.8** Mr Clayton noted that PHA has had slippage within its management and administration budget and asked if it would be possible to get a breakdown of what this has been allocated against as there is not a clear sense of that within the Report. Ms Scott said that PHA is looking at realigning budgets and develop a thematic approach to how it organises its business and this exercise will take a bit of time, but is the direction of travel as the PPR Committee wishes to see this.

**26/25.9** The Board noted the Finance Report.

## 27/25 - Item 11 – Complaints, Compliments and Claims Quarterly Report [PHA/06/02/25]

**27/25.1** Mr Wilson advised that this Report is for the period up to December 2024 and by that time PHA had received three complaints, compared to six for the same period last year. He said that the Report shows the origin of any complaints and details of those which are closed. He advised that there are currently no open complaints and no cases ongoing with the Northern Ireland Public Services Ombudsman.

**27/25.2** Mr Wilson reported that PHA is starting to collate information on compliments. With regard to claims, he advised that one claim has been closed while a further claim, in respect of an employment law issue, remains open.

**27/25.3** The Board noted the Complaints, Compliments and Claims Quarterly Report.

## 28/25 - Item 12 – PHA Complaints Policy [PHA/07/02/25]

**28/25.1** The Chair noted that this Policy was brought to the Governance and Audit Committee. Mr Wilson explained that the extant Complaints Policy had been in place for some time and this was flagged up by Internal Audit. He said that PHA put together this new Policy based on reviewing processes across the HSC and good practice, but he pointed out that there is going to be a launch of a new HSC policy following work undertaken by the Ombudsman and once this has been completed, PHA will amend its policy accordingly.

**28/25.2** Mr Clayton welcomed that there is now clarity that the Policy covers both PHA staff and the Board, but noted there are parts of the Policy where it indicates that decisions lie with the Chief Executive. He said that if there is a complaint about a Board member, that would go to the Chair and this should be indicated here. The Chief Executive pointed out that he is a member of the Board so any complaint should go to the Chair. Mr Wilson explained that this has been clarified on page 5. Mr Clayton asked if this is line with the Partnership Agreement and Mr Wilson said that he would need to check that **(Action 8 – Mr Wilson)**.

**28/25.3** Mr Blaney asked how complaints come into the organisation, and Mr Wilson advised that it can be through a variety of ways. Mr Blaney noted that an individual in an organisation may wish to submit a complaint anonymously.

**28/25.4** Mr Blaney noted that he is the Non-Executive Director with responsibility for whistleblowing and he asked at what stage he would become involved in any complaints. Mr Wilson replied that they would be two different processes. Mr Clayton commented that this a good question, but felt that internal complaints would be dealt with through the grievance process. Professor Rooney noted that the Belfast Trust was criticised by Judge O'Hara because it did not deem people raising concerns as complaints. The Chief Executive said that the complaints process is a learning process, but noted that some people who submit complaints are seeking retribution. Professor Rooney said that for PHA, it is about how it deals with concerns and how it can learn.

**28/25.5** Mr Blaney asked again about how much information he would need to know about complaints, but the Chair said that the Board's role is to ensure that processes are carried out correctly. Mr Blaney asked if his e-mail address should be published. Mr Stewart said that it should be and added that when it comes to grievances, complaints or raising concerns, a matter could fall into any of those. He said that if an individual feels they cannot speak to anyone in the organisation they should be able to speak to Mr Blaney. The Chair agreed that this process needs to align with what it is in the Partnership Agreement.

**28/25.6** Ms Scott said that it can depend on the nature of the issue and that whistleblowing is more about a systemic issue and it may be appropriate to either go to the Chief Executive's office, the Department or the Board. The Chair agreed and said that if an issue is raised he, and the Chair of the Governance and Audit Committee, should be made aware of it. He added that the organisation has a duty of care to the individual who raises an issue.

**28/25.7** Mr Wilson said that he would be happy to discuss this further with Mr Blaney outside of the meeting **(Action 9 – Mr Wilson)**.

**28/25.9** The Board **APPROVED** the Complaints Policy.

## 29/25 - Item 13 – Final Partnership Agreement between Department of Health and Public Health Agency [PHA/08/02/25]

**29/25.1** The Chair said that he continues to have an issue with the Agreement in that it needs to be more specific in terms of his capability of meeting with the Minister.

**29/25.2** Ms Scott noted that this Agreement came to the Board last August. The Chair said that he wished to draw out this point. Ms Scott explained that this is an Agreement and not a legal document and that there are still concerns around some legislative issues. She said that she intends to submit these concerns alongside the Agreement. She advised that with regard to the reference to a meeting with the Minister, it indicates "either/or", but she undertook to highlight this again **(Action 10 – Ms Scott)**.

**29/25.3** Mr Clayton said that part 9 deals with the Department and it is there that there should be reference to the powers that the Department has to direct the PHA, and that if it applies those powers, this should be notified to the Chair of the Board. The Chair said that he has raised this issue with Mr Toogood and there has been an acceptance that previously the Board was not treated properly.

**29/25.4** Mr Stewart suggested that rather than redrafting the section of the Agreement, there should be a covering letter highlighting the issues raised.

**29/25.5** Ms Scott advised that this version has been sent to the PHA as a final version for approval. The Chair noted that there are issues around SBNI, but Ms Scott said that the SBNI MOU will be included in the final document once it is finalised. The Chair said that the MOU needs to come to the Board.

**29/25.6** The Chair suggested that the caveats around the powers to direct PHA should be included, noting that the role of the Board has to be respected. The Chair said that final approval of the Partnership Agreement should be done by correspondence.

**29/25.7** Professor Rooney asked if Section 5.3 will be updated to reflect the new Directors' titles. Ms Scott replied that at present these are the correct titles. Professor Rooney suggested highlighting the fact that these will be changed.

**29/25.8** Ms Henderson asked if the Board could see the cover letter before it is issued and the Chair said that it will be shared **(Action 11 – Chair)**.

## 30/25 - Item 14 – Establishment of PHA Working Group [PHA/09/02/25]

**30/25.1** Mr Wilson said that PHA has built up capacity within the Public Inquiries team and it now wishes to focus on the recommendations from Inquiries and bringing any learning to the Board. At an operational level, he explained that there is a directorate-wide working group.

**30/25.2** Mr Wilson said that the Public Inquires Programme Board has benefitted from having Professor Rooney so this new group should report through AMT and the Governance and Audit Committee. He advised that the intention is to have this group up and running at the start of the next financial year.

**30/25.3** The Chair noted that there had been a previous discussion about having a presentation to the Board in June 2025, although he acknowledged that a lot of the learning from Inquiries has already been implemented. The Chief Executive advised that Dr McClean and he have gone through the Neurology Report and he would be content to bring a SITREP to the Board in June **(Action 12 – Chief Executive)**. He added that PHA will continue to learn from other Inquiries.

**30/25.4** Professor Rooney said that she was pleased with this development. She added that some of the learning from the Muckamore Inquiry will likely be around the quality assurance of the commissioning process. Dr McClean noted that PHA has to be cognisant of the complexity of some of the recommendations.

**30/25.5** Mr Irvine said that Professor Rooney has undertaken good work in this area, and it is appropriate that is now sits under the purview of the Governance and Audit Committee as its role is to question and challenge. He added that the establishment of this working group shows that the organisation is learning. Mr Stewart commented that it is important that PHA records what it can do, and what it cannot do when it comes to Inquiry recommendations as recommendations are not absolute, so it is possible to say that they cannot be accepted.

**30/25.6** The Board noted the paper on the establishment of a PHA Working Group.

## 31/25 - Item 15 – Items for Information

*Our People Report* ***[PHA/10/02/25]***

**31/25.1** The Chair said that he felt that members should see this Report and although it was in a slightly different format, it was still an important for members to have it.

## 32/25 - Item 16 – Chair's Remarks

**32/25.1** The Chair paid tribute to Professor Rooney as this was her last PHA Board meeting. He said that she was a stalwart and provided great assistance to PHA as it came out of the COVID pandemic. He acknowledged her contributions to the Reshape and Refresh Programme Board, as well as the Remuneration Committee and the Public Inquiries Programme Board. He said that she was a great member to work with and was sad to see her go.

## 33/25 - Item 17 – Any Other Business

**33/25.1** There was no other business.

## 34/25 - Item 18 – Details of Next Meeting

*Thursday 27 March 2025 at 1.30pm*

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

Signed by Chair:

Colin Coffey

Date: 27 March 2025

item 9

# PHA Board Meeting

| | |
|---|---|
| **Title of Meeting** | PHA Board Meeting |
| **Date** | 27 March 2025 |
| **Title of paper** | Draft PHA Corporate Plan 2025-2030 |
| **Reference** | PHA/01/03/2025 |
| **Prepared by** | Julie Mawhinney |
| **Lead Director** | Leah Scott |

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

## 1 Purpose

The purpose of this paper is for the Board to approve the final draft of the new PHA Corporate Plan 2025-2030.

## 2 Background Information

This Corporate Plan 2025–2030 sets out the strategic direction for the Public Health Agency (PHA) for the next five years, taking account of 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 corporate plan has been developed through review of existing strategic documents (e.g. Corporate Strategy 2017–2021), engagement with internal and external stakeholders, in cognisance of changing context e.g. ICS implementation and alignment with the recommendations of the Reshape and Refresh programme**.** Furthermore, we have also undertaken a significant programme of consultation and engagement with external stakeholders, DoH sponsor branch, staff and PHA board members.

This document presents the **final** draft of the PHA Corporate Plan 2025-2030 pending PHA board and DoH approval. The Plan went out to public consultation on the 28th November 2024 for a 13-week period and closed on 28th February 2025.

A total of **102 responses** were received from internal and external stakeholders during the consultation period via online survey and email. To further support the consultation process we successfully organised three stakeholder engagement events, two in person

and one online. Collectively **85 external** and **17 internal** responses were received. Further insight on consultation response and feedback can be found within the supporting papers provided. Following consultation, comments and views of all stakeholders have been collated and considered. Amendments to the plan were made for review and approved by the Corporate Plan Oversight Group on Tuesday 11th March 2025 and subsequently further approved by AMT on the 18th March 2025.

Equality screening of the draft Plan has been completed; a S75 screening template alongside an accompanying equality paper with additional supporting information have been shared with the Equality Unit. A full Rural Needs Impact Assessment has also been completed.

All items enclosed in support of Board approval of the new corporate plan include:

- **Copy of the draft Plan**
- **Full Consultation Report**
- **S75 Equality Screening Template**
- **Additional Equality Paper with supporting evidence.**
- **Rural Needs Assessment Template**

## 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 vision and ambitions for health and wellbeing in Northern Ireland for the next five years and reiterate our call for a continued focus on improving health and reducing health inequalities across HSC and wider society.

Aligned with recommendations from Reshape and Refresh programme, the corporate plan is structured around 4 strategic areas. A 5th 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 planned are themed as follows:

1. Protecting Health
2. Starting Well
3. Living Well
4. Ageing Well
5. Our Organisation

The first is focused on protecting health and the others adopt a life course approach. Whilst taking a life course approach, it is recognised there are a number of cross-cutting areas, including for example mental health, learning disability and inclusion health. Each theme sets out our ambition and a number of priorities for the years ahead. These are

aligned with the strategic direction outlined in key departmental strategies. Population level indicators have been included to accompany each ambition to support regular evaluation.

In working to achieve the priorities set out in this plan, we commit to:

- tackling and reducing health inequalities being at the heart of our work

- championing a ‘whole system’, cross-government approach to tackle the challenges and barriers to improving health and reducing health inequalities

- providing professional public health advice to the planning and commissioning of safe, effective, equitable, high-quality healthcare

- listening to, involving, and working together with individuals, families, local communities, HSC and other key partners in all our work

- ensuring planning, guidance and decisions are based on best available evidence and driven by data, research and experience

- improving equity of access to prevention and early intervention information and services for those who need them.

Reporting against this corporate plan will take place through annual business plans and corporate monitoring. In addition, a more detailed implementation plan is being developed that will set out the actions to be taken forward and appropriate measures within each of the themes. 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.

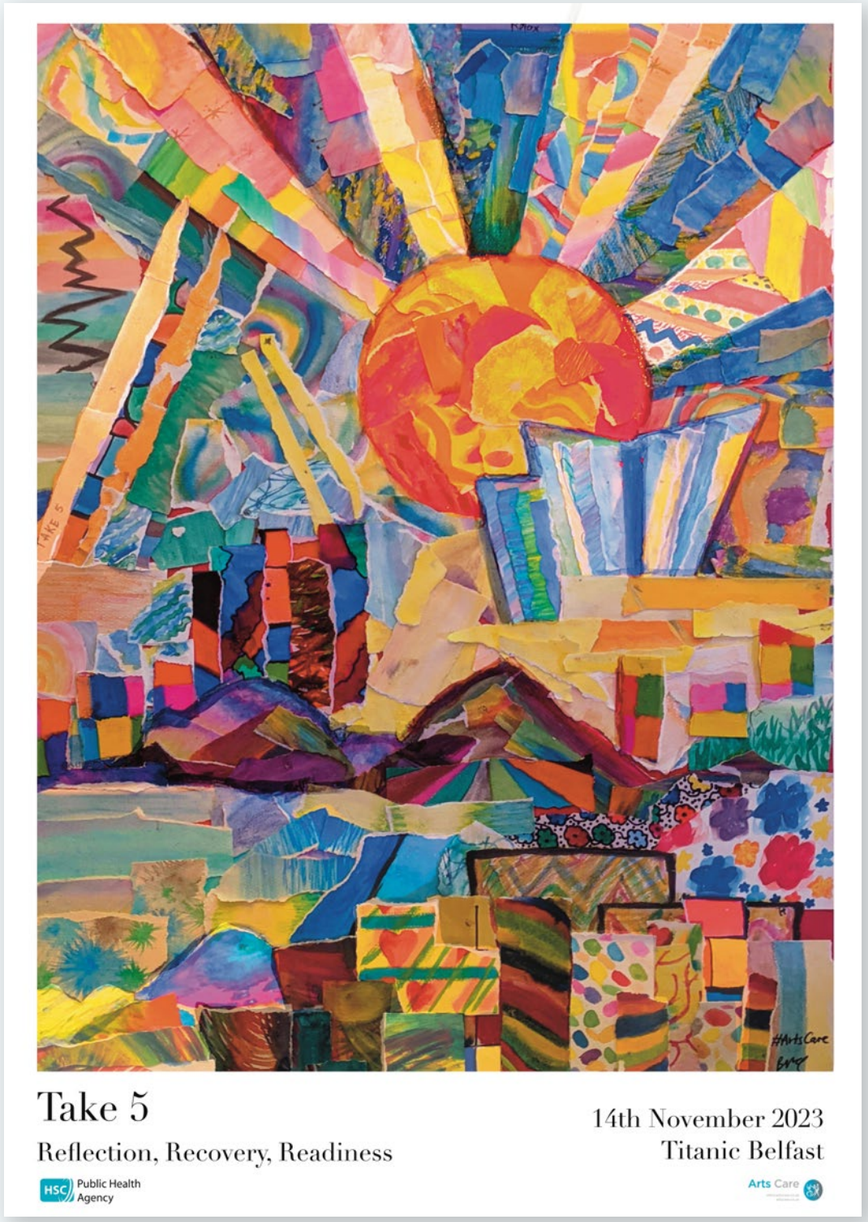
## 4 Next Steps

As part of the approval process, the draft Plan if approved today by Board will be shared with sponsor branch for review. The Plan, subject to approval by sponsor branch, will be published as soon as possible in early/mid-April 2025.

Public Health Agency

# Corporate Plan 2025–2030

Preventing, protecting, improving:
Better health for **everyone**




Collage of artwork from PHA all staff event 2023.

# Contents

# Foreword



## Foreword

**This Public Health Agency (PHA) Corporate Plan 2025-2030 sets out our strategic direction for the next five years: where we will target our work, based on evidence and informed by engagement with our partners, the public, key stakeholders and aligned to Programme for Government and Department of Health (DoH) strategies and priorities.**

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 vision and ambitions for health and wellbeing in Northern Ireland and reiterate our call for a continued focus on improving health and reducing health inequalities across HSC and wider society.

Over the period of our previous corporate plan (2017-2021), the PHA has continued to take forward work to improve and protect health and wellbeing, reduce health inequalities, improve the quality and safety of care services, and support research and development.[1] Much has been achieved, but much is yet to be done to deliver better health for everyone in Northern Ireland.

Our society has faced many difficult challenges in recent years, most notably the COVID-19 pandemic and its impact. This has shaped many of our priorities and work areas over recent years and the lessons learned continue to influence our work: pandemic preparedness and a re-energised focus on stubborn and systemic inequalities in health that we continue to experience. These unfair and avoidable differences in health impact our ability to lead healthy lives and too many people in Northern Ireland still die prematurely or live with preventable conditions. We must do all that we can to prevent this from being the case. Our commitment to work to reduce health inequalities is at the core of this plan and our work over the next five years.

The priorities set out in the following pages (and summarised on pages 40-41) relate to everyone in Northern Ireland including those of every age, gender, ethnicity, sexual orientation, ability, disability; whether you are a service user, a carer, independent or needing care. Our outcomes are ambitious, and will require energy, courage, commitment and creativity to deliver them – all against the backdrop of increasing demands and financial constraints, as well as structural reform. We must take a 'whole system' approach and make partnership, involvement and engagement central to our work, to make the best use of our combined resources. We must work collaboratively with service users and carers, the community and voluntary sector and across government to have a positive, lasting impact on health and wellbeing.

It is also critical as we grow as an organisation that we focus on our people. We have a highly skilled and committed multidisciplinary workforce across a range of professions and we must strive to ensure they feel valued, equipped and enabled in their work. In particular, we must ensure that all staff are supported and given opportunities to develop both professionally and personally.

We must continue to develop as a learning organisation and build on significant developments in digital capacity in recent years. Embracing innovative, digital solutions and maximising the use of data will enable us to work more effectively to meet the current and future needs of the population.

This plan, supported by a more detailed implementation plan, sets out our next steps as we look forward. This will be a period of change and adaptation but also of great opportunity where we endeavour, as the lead organisation for public health, to be an organisation where people want to work, where we nurture collective and compassionate leadership.

Above all, this plan represents our unwavering commitment to improving health and wellbeing for everyone in Northern Ireland.

**Aidan Dawson**
Chief Executive

**Colin Coffey**
Chair

# Purpose, vision and values





## Purpose:

Protect and improve the health and social wellbeing of our population and reduce health inequalities through leadership, partnership and evidence-based practice.

## Vision:

A healthier Northern Ireland.

## Values:

The PHA endeavours to translate the Health and Social Care values into its culture by putting individuals and communities at the heart of everything we do, acting with **openness and honesty** and treating people with dignity, respect and **compassion; working together** in partnership to improve the quality of life of those we serve, listening to and involving individuals and communities; valuing, developing and empowering our staff and striving for **excellence** and innovation; being evidence led and outcomes focused.

# Our context and the health profile of Northern Ireland





**Since its establishment in 2009, the PHA has worked to improve and protect health and wellbeing, reduce health inequalities, promote healthy behaviours and reduce barriers to good health, improve the quality and safety of care services, and support related research and innovation.**

There have been many developments and advances in recent years in respect of interventions and programmes to improve and protect health and wellbeing, and reduce health inequalities. The graphics on pages 10-15 show a snapshot of health in 2022-23. In general, the health of our population has been improving over time, as seen in increases in life expectancy (the number of years a person can expect to live) and healthy life expectancy (the number of years lived in good health). However, in recent years, improvements in life expectancy and healthy life expectancy have slowed and health inequality remains a major issue (see page 10).

### Determinants of health

Health is determined by many factors: social, political, environmental and economic. Changes in these can have significant impacts on the health and wellbeing of the population and in recent years, society has experienced many significant events of this nature: the COVID-19 pandemic, cost of living crisis, climate change,the outworking of EU exit and other political change.[2-4] The pandemic also highlighted both the stubborn and systemic inequalities in health that Northern Ireland continues to experience. Health inequalities remain and continue to divide our society. While this situation is not unique to Northern Ireland, it remains a major issue with significant differences in health outcomes between the most and least disadvantaged.

### A time of change

The challenges facing our health and social care system, and indeed health systems worldwide, are also well documented, and Northern Ireland's health and social care system remains under immense and growing pressure.[3] Further change is also underway both in the development and implementation of the Integrated Care System for Northern Ireland (ICSNI). The current economic climate and constrained financial environment for HSC continues to impact on population health and requires creative, innovative and collaborative ways of working,

and making best use of available resources to deliver better health outcomes and help people to stay well.

It is well documented that long-lasting and significant improvements in health and wellbeing can only be achieved through a 'whole system' approach.[2, 5-7] Our current context, compounded with the additional challenges to health and wellbeing further strengthen the need for a population health approach, a focus on prevention and early intervention and strong cross-sectoral, multi-agency collaboration.

### Regional strategic frameworks

These key foundations for 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.[2,3] 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.[8-14]

There are many DoH and indeed other departmental strategies and policies that are relevant to the setting of priorities for the PHA. The outcomes and priorities for the PHA for the next five years reflect and align with these key strategic documents, and our contribution to progressing this agenda and our commitment to working collaboratively with others, will help ensure that these outcomes are realised.

Snapshot of health in Northern Ireland, 2022-2023.

## Population of Northern Ireland[15]

**1.9m**

## People aged[15]

**17.8%**

**65+**

up from **13.1%** in 1998

## Life expectancy and Healthy life expectancy[16]

### Males

**Most** deprived areas

**Ill health** for **19.2 years**

Age at death **74.0**

**Good health** until the age of **54.8 years**

**Least** deprived areas

Age at death **81.2**

**Ill health** for **14.2 years**

**Good health** until the age of **67 years**

### Females

**Most** deprived areas

**Ill health** for **26.4 years**

Age at death **79.3**

**Good health** until the age of **52.9 years**

**Least** deprived areas

Age at death **84.1**

**Ill health** for **17 years**

**Good health** until the age of **67.1 years**

Adults who **smoke**[17]

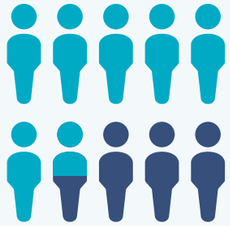
**13%**

This is 23% in the most deprived areas; 7% in the least deprived areas.

**19%**
of people may have a mental health difficulty[17]

Adults living with overweight or obesity[19]

**64%**



**1 in 5**

P1 children living with overweight or obesity[17]

Babies **breastfed** (at discharge)[17]

**51%**

This is 38% in the most deprived areas; 66% in the least deprived areas.

**MMR** uptake at 5 years old[18]

**85.9%**

**179** preventable deaths

per 100,000 of the population[16]

**96.6%** White

**3.4%** Ethnic minority

Northern Ireland population[15]

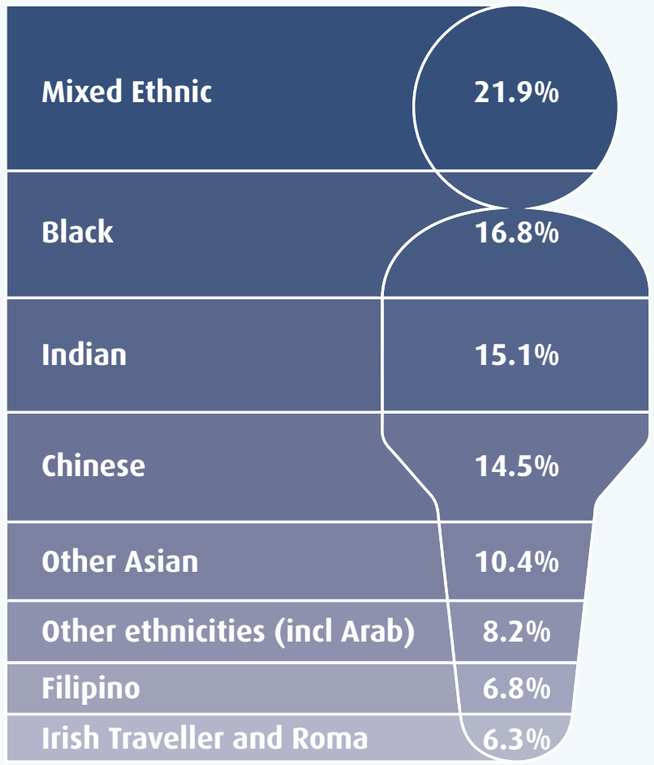
**220.3**

# Deaths

by suicide[21]

**2%** of adults

have a learning disability[22]




**65,600**

Ethnic minority population

# What is public health?



## What is public health?

**Public health works to protect communities and has a strong focus on equity.**

There are three key domains of public health practice:[23]

### 1. Health protection

This involves protecting the population from threats to their health from infectious diseases and other hazards. It involves both proactive preventative actions (such as vaccination) as well as reactive response to incidents such as disease outbreaks.

### 2. Health improvement

This involves wide ranging actions working with a variety of stakeholders to improve health and wellbeing. It includes influencing other sectors to address the wider determinants of health, as well as working with the general public and specific vulnerable or marginalised groups, to improve health literacy and promote healthy lifestyle choices. There is a heavy focus on addressing health inequalities.

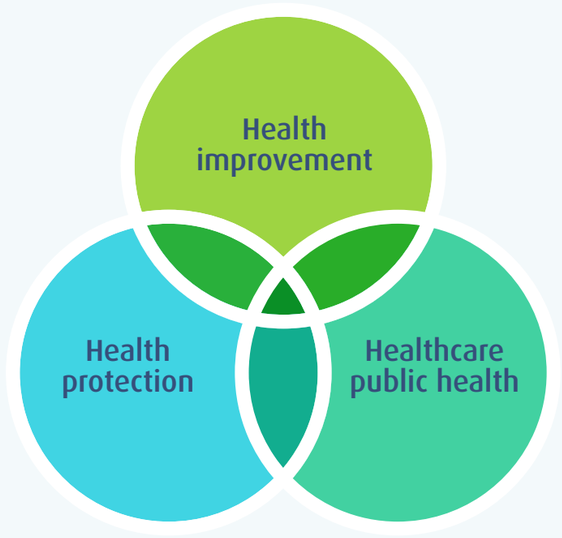
### 3. Healthcare public health

This involves actions in the planning, commissioning and development of healthcare services working with partners across the HSC and related services to ensure provision of high quality, safe and effective services, while working to reduce inequalities.

As set out in the diagram, these three aspects of public health practice are not stand-alone and overlap with each other, requiring a skilled workforce that can work across these various domains to address complex issues.

HSC services make a significant contribution to the health of individuals and the population. The PHA has a statutory responsibility to work with the Strategic Planning and Performance Group (SPPG) and provide professional input to commissioning healthcare services. We work with SPPG and colleagues across HSC to ensure that people in Northern Ireland have access to high-quality and effective health services no matter where they live.

Three key domains of public health practice




The work of the PHA in each of these three domains is underpinned by a strong basis in science, with evidence informing all of our work. We cannot deliver improvements to public health in isolation, so partnership working and building relationships with our partners is a key element of our work.

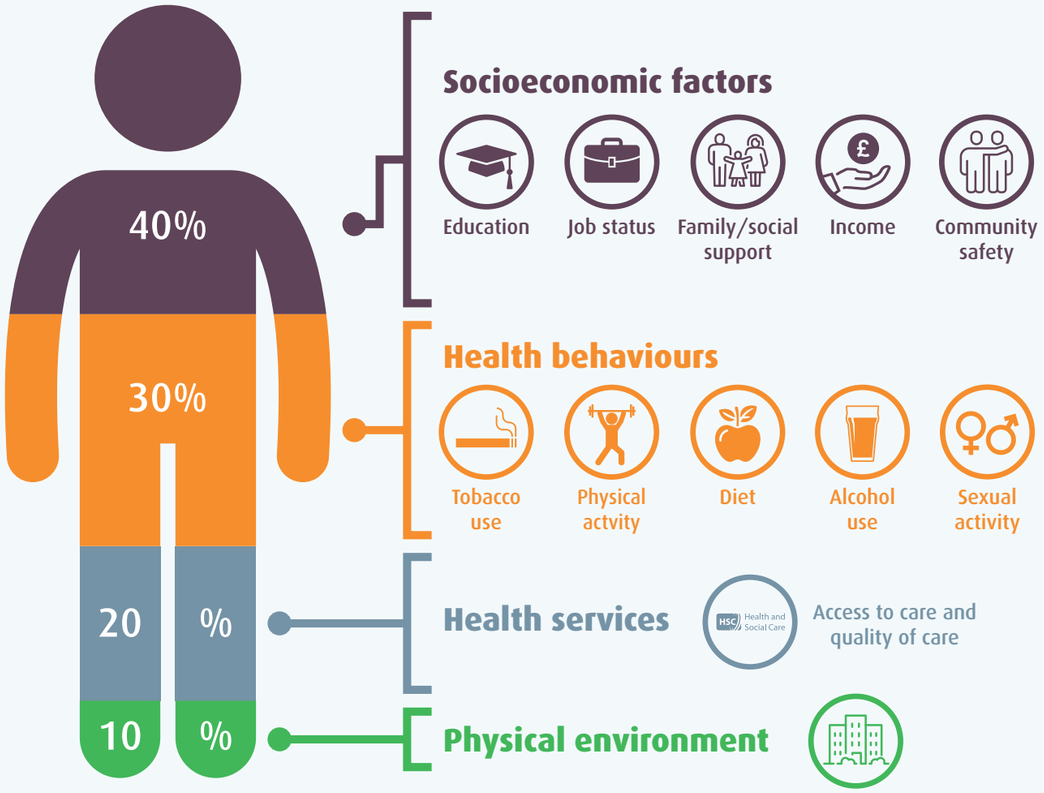
> *"Public health is the science and art of preventing disease, prolonging life and promoting health and wellbeing, through the organised efforts of society.[24]"*

## What factors impact on our health and wellbeing?

**Many factors, known as the 'wider determinants of health' affect our health and wellbeing. These include social, economic and environmental conditions such as income, education, access to green space, healthy food, work and living conditions.[2, 25] It is widely recognised that, taken together, these factors are the principal drivers of how healthy people are.[2, 26]**

The PHA works with various sectors to influence these wider determinants of health, aiming to make it easier for our population to have healthy lifestyles and make healthy choices.

As well as working with partners to address the wider determinants of health, the PHA has a key role in encouraging healthy behaviours and ensuring equitable access to high quality, safe and effective preventative and treatment services.




Source: Institute for Clinical Systems Improvement. Going beyond clinical walls: solving complex problems (October 2014)

## What are health inequalities?

**Health inequalities are "avoidable differences in health status between different population groups" and are influenced by variation in the determinants of health referred to above.[5-8] Health inequalities are evident in terms of differences in the prevalence of certain health conditions among certain groups in society or differences in outcomes (like life expectancy or cancer survival, for example) for certain population groups.[27]**

Some groups are disproportionately impacted by the determinants of health, which can lead to health inequalities.

Factors impacting on health inequality:

- socioeconomic factors, for example living in socioeconomically deprived areas;
- geography, for example, region or whether urban or rural;
- specific characteristics including those protected in law, such as sex, gender identity, sexual orientation, ethnicity or disability;
- socially excluded groups, for example, people experiencing homelessness.

The determinants of health interact with each other and can often have a cumulative effect with people often experiencing challenges across multiple determinants contributing to inequalities in health and health outcomes.[27]

# Our focus

## Our focus

**These strategic themes encompass core areas of focus for our organisation as we work towards our vision of a healthier Northern Ireland.**

### Protecting health

Protecting the population from serious health threats, such as infectious disease outbreaks or major incidents

### Starting well

Laying the foundations for a healthy life from pre-birth, infancy, early years, childhood to adolescent years

### Living well

Ensuring that people have the opportunity to live and work in a healthy way

### Ageing well

Supporting people to age healthily throughout their lives

The first is focused on protecting health and the others adopt a life course approach. Whilst we have taken a life course approach, we recognise there are a number of cross-cutting areas, including for example mental health, learning disability and inclusion health.

Each theme sets out our ambition and a number of priorities for the years ahead. These are aligned with the strategic direction outlined in key departmental strategies. Population level indicators are also provided for each ambition to support regular evaluation.

In working to achieve the priorities set out in this plan, we commit to:

- tackling and reducing health inequalities being at the heart of our work;
- championing a 'whole system', cross-government approach to tackle the challenges and barriers to improving health and reducing health inequalities;
- providing professional public health advice to the planning and commissioning of safe, effective, equitable, high-quality healthcare;
- listening to, involving, and working together with individuals, families, local communities, HSC and other key partners in all our work;
- ensuring planning, guidance and decisions are based on best available evidence and driven by data, research and experience;
- improving equity of access to prevention and early intervention information and services for those who need them.

Reporting against this corporate plan will take place through our annual business plans and corporate monitoring. In addition, a more detailed implementation and action plan will be developed setting out the actions to be taken forward and appropriate measures within each of the themes.

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.

# Protecting health

*Protecting the population from serious health threats, such as infectious disease outbreaks or major incidents*





## Our 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.**

Protecting our population's health is one of our core functions. We do this through surveillance, identification and timely response to threats to public health; providing advice and support; monitoring of threats to health; and education, training and research. This includes the prevention of infectious diseases through vaccination and early detection of disease through population screening programmes. Our focus is also on preparing and planning for potential future pandemics and other potential threats to the population's health and wellbeing. We will work effectively across the organisation to ensure a robust coordination of the overall public health response. We will ensure that we learn from and implement recommendations from inquiries and incidents.

Our people will have the necessary knowledge, skills and experience to deliver an effective and efficient service, using evidence-informed approaches to mitigate the impact of inequalities on prevention and control of infectious diseases and other defined hazards.

The PHA has responsibility for commissioning, coordinating and quality assuring a number of population screening programmes: infectious diseases in pregnancy, newborn blood spot and hearing; diabetic retinopathy; bowel, breast and cervical cancer; and abdominal aortic aneurysm (AAA).

## Priorities 2025-2030

- develop emergency response plans to support readiness to respond to incidents that may have an impact on public health for Northern Ireland;
- work collaboratively to minimise the impact of infectious disease, with a focus on antimicrobial resistance and our elimination targets for blood-borne viruses;
- deliver a high-quality and responsive health protection surveillance and epidemiology programme;
- strengthen the multidisciplinary coordinated approach to infection prevention and control across the wider HSC system though the established infection, prevention and control forums;
- ensure the delivery of high-quality screening programmes;
- 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;
- 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;
- build public confidence and trust in public health advice, information and messaging through improving health literacy via education and engagement with the public.

## Indicators

**We will measure success through the following:**

- vaccination uptake;
- notification rates of vaccine preventable diseases;
- rates of healthcare associated infections;
- bloodborne virus elimination targets;
- waste water surveillance;
- stage of cancer diagnosis.

# Starting well

*Laying the foundations for a healthy life from pre-birth, infancy, early years, childhood to adolescent years*





## Our ambition

**That all children and families in Northern Ireland have the healthiest start in life.**

What happens during pre-conception, pregnancy, the early years, the school years and adolescence is key to what happens in later life. This includes having an adequate standard of living, a secure family environment, good physical and mental health and wellbeing and being protected from harm.

We will support and empower families to create and provide a safe and nurturing home environment and to make good decisions about their physical and mental health and wellbeing. We recognise that adolescence is a unique stage of development and an important time for laying the foundations of good health.

Health inequalities can have a profound impact on a child's start in life. All children and young people, including those who have additional needs, should have the opportunity for better health and wellbeing.

Adverse childhood experiences can have long-term impacts on health and wellbeing. We will embed a trauma-informed approach and work with partners to reduce adversity and trauma, support recovery and increase resilience.

The challenges faced by families are complex and multifaceted and we cannot improve their health in isolation. We must work together in strong partnerships with families and across society in a whole system, holistic approach to make a meaningful difference.

## Priorities 2025-2030

- support families to take care of their physical and mental health and emotional wellbeing, with a particular focus on the first 1,001 days;
- reduce the impact of social complexity in pregnancy;
- promote the health benefits of breastfeeding and encourage support for breastfeeding mothers;
- protect the health of children and young people through antenatal and newborn screening programmes and childhood vaccination programmes;
- deliver universal and targeted support, including Healthy Child Healthy Future, Family Nurse Partnership, and Northern Ireland New Entrants service (NINES);
- work together to reduce stillbirth, neonatal and avoidable child deaths through improved use and application of data and evidence;
- support children and young people with additional needs, their families and carers in addressing the unique health challenges and disparities they face;
- support adolescents to establish patterns of behaviour that can protect their mental and physical health;
- work with others to promote the safeguarding and protection of children and young people.

## Indicators

**We will measure success through the following:**

- 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.

# Living well

*Ensuring that people have the opportunity to live and work in a healthy way*





## Our ambition

**That all people in Northern Ireland can live longer, healthier and independent lives.**

Adults now generally enjoy better health and wellbeing and can expect to live longer than previous generations. However, in recent years life expectancy rates have been stalling and there are still many challenges and significant health needs within our population that impact the ability of people to experience good physical and mental health and wellbeing.

There are many factors that impact our health and wellbeing during our adult lives. These include where we live, our environment, access to education and employment, health services and the effects of poor diet, smoking, drug and alcohol use, low levels of physical activity, homelessness and food, fuel and financial poverty.

Many of the challenges that impact our physical health, also impact our mental health and emotional wellbeing. Too many people in our communities are struggling with mental ill health, which is impacting their ability to make healthy choices. It is important that we support and promote good mental health and emotional wellbeing across society.

Health inequalities continue to compound challenges to health and prevent many from experiencing good health and wellbeing. We must ensure that we provide targeted approaches where needed for those more vulnerable in our society.

As well as equipping people to live longer, healthier lives, we must also help protect them from becoming ill or needing health interventions. Promoting healthy choices and healthier environments and communities, including within workplaces, will also be a key focus.

Supporting everyone to adopt healthier behaviours, avail of preventative services and access high-quality care throughout our lives can make a significant contribution to improving the health of the population. This is not about placing the responsibility on the individual but working together to support people and create supportive environments and opportunities for good health for all.

## Priorities 2025-2030

- 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;
- support those living with long-term conditions to live well;
- deliver high-quality programmes and initiatives, including prevention and early intervention approaches, to protect and improve mental health and emotional and social wellbeing;
- continue to work in partnership across government and with communities, services, and families across society to reduce suicides and the incidence of self-harm;
- 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;
- support prevention and early detection of illness through vaccination and screening programmes;
- 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;
- continue working towards a tobacco-free society;
- 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;
- continue working to implement and enhance shared decision making, accessibility and health literacy;
- strengthen the role of communities within the public health system, by embedding community-centred approaches to reduce health inequalities and build healthier communities.

## Indicators

**We will measure success through the following:**

- 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.

**55% of all adults**

**exercise at least 150 mins a week**

# Ageing well

*Supporting people to age healthily throughout their lives*





## Our ambition

**That people live healthier, independent lives for longer.**

As a population, we are living longer and many older adults enjoy good health and make significant contributions to their communities.

For others, however, older age brings a risk of poor physical and mental health, social isolation and complex health problems. Poor health, dementia and frailty should not be inevitable outcomes as we age. As well as living longer, we also want to live healthier for longer so that we can continue to participate in activities we enjoy and live fulfilled, independent lives.

There are many factors that impact our health and wellbeing throughout our lives. These include the environment we live in, access to health services and the impact on our health and wellbeing of poor diet, smoking, drug and alcohol misuse, low levels of physical activity and food, fuel and financial poverty.

As our older population continues to grow, we want to support and promote healthy, positive ageing both for individuals and as a society. We must enable people to live longer, healthier more fulfilling lives but also create environments and communities that enable healthy behaviours and also support, value, respect and protect our older population.

Working with partners, we will support and advocate for delivery of healthcare that is wrapped around the person, be that in their own home, hospital or care home.

We will take a life course approach to positive health and active ageing and work to reduce the impact of health inequalities through education and support for people to improve their health.

## Priorities 2025-2030

- implement the World Health Organization (WHO) Age-friendly movement across Northern Ireland;
- reduce and prevent falls and home accidents, including the development and implementation of a regional model for safer mobility;
- reduce the impact of frailty by raising awareness and increase early detection;
- support prevention and early detection of illness through vaccination and screening programmes for older adults;
- increase levels of physical activity and promote opportunities to stay active;
- work with key partners to identify and reduce levels of loneliness and social isolation and to improve wellbeing;
- champion the voice of older adults and the issues that impact on their health and wellbeing;
- lead and implement initiatives to ensure people who live within care homes have good health and wellbeing and improved quality of life;
- work with partners to support individuals, carers and families at the end of their life through advance care planning;
- build and develop a strong research and evidence base to support ageing well programmes in Northern Ireland.

## Indicators

**We will measure success through the following:**

- 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.

**Almost 1 in 2 over 75s**

**report good or very good health**

# Our organisation

*How we work: our processes, governance, culture, people and resources*



## Our organisation

The PHA is a multidisciplinary, multi-professional body with a strong regional and local presence and was set up with the explicit agenda to protect and improve the health and wellbeing of people in Northern Ireland.

Since its establishment in 2009, we have worked to improve and protect health and wellbeing, reduce health inequalities, promote healthy behaviours, reduce barriers to good health, improve the quality and safety of health and social care services and support related research and innovation.

As part of the health and social care family, we work 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).

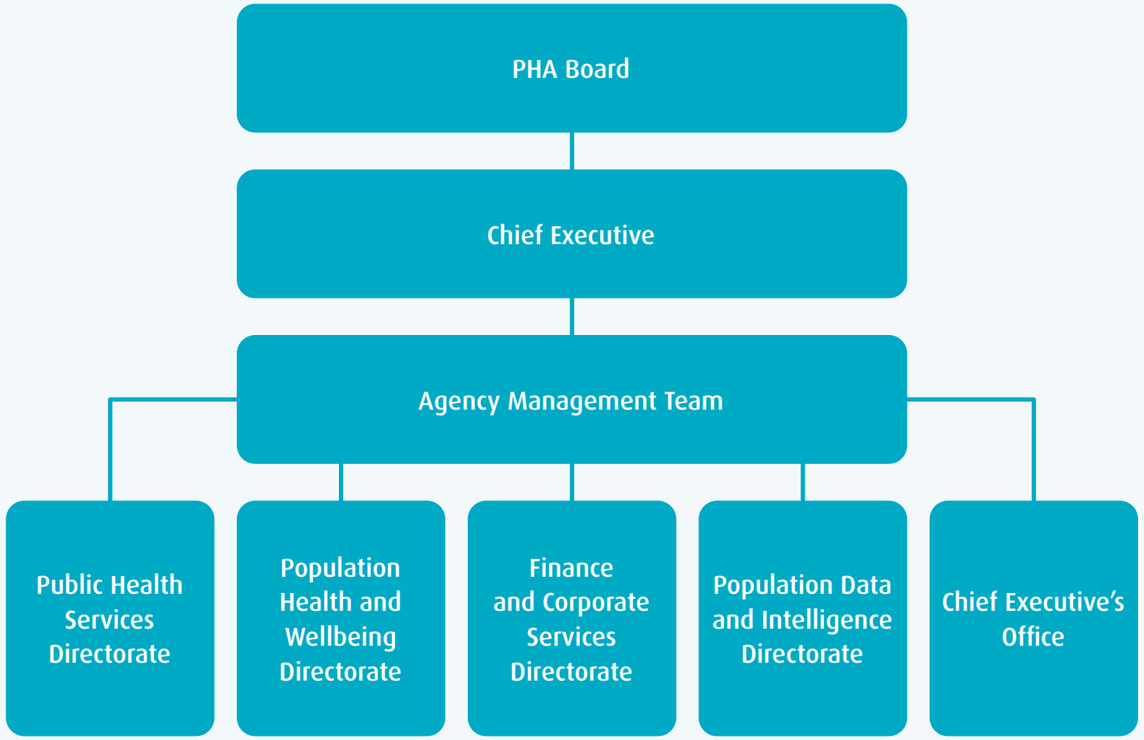
Central to our main responsibilities is working in close partnership with individuals, groups and organisations from all sectors – community, voluntary and statutory.

Through our organisational 'Reshape and Refresh' programme to design and implement a new operating model for the organisation, we continue to evolve as an organisation to ensure we can continue to meet the public health needs of the people of Northern Ireland.

As part of this programme, our organisational structure has changed and is outlined below.

Our legislation determines that we should hold two distinct professional roles: Director of Public Health and Director of Nursing and AHP. These will be encompassed within the Public Health Services and Population Health and Wellbeing directorates.

### PHA organisation chart



## Staff at 31 March 2024


## Budget

**Revenue resource budget in 2023/24**

**£139.4m**

## Our ambition

**That we are an exceptional organisation, working effectively to improve health and wellbeing for everyone.**

Our progress towards this ambition over the next five years depends on our people. We must therefore ensure that our staff feel supported, equipped and empowered in their work. We will continue to develop our staff and make use of their expertise, building on their experience, to make sure we achieve the greatest impact and can effectively respond to new challenges.

In fulfilling this ambition, we are committed to:

- **People**
- **Partnership**
- **Process**
- **Digital**
- **Research and evidence**

## People

Our people are our greatest asset and we must strive to ensure staff feel valued, are equipped and enabled in the work they do and given opportunities to develop both professionally and personally. We want to be an organisation where people want to work and are proud to be part of. All staff working in PHA should have a common understanding of public health and have a shared sense of purpose, feel valued and supported and have opportunities to upskill, develop and progress in their career.

We must ensure a multidisciplinary workforce which is highly skilled in the area of public health to ensure effective and appropriate preparation for future threats and that we are agile, designed to deliver and able to manage emerging risks to health. The PHA currently is the lead organisation in the delivery of the Public Health Specialty Training Programme for people wishing to become Consultants in Public Health. It is important that the quality and standards of this training programme are maintained in order to safeguard the future workforce.

As we work to implement the 'Reshape and Refresh' programme, we must remain focused on valuing and supporting our people, recognising that periods of change and uncertainty are difficult for everyone and ensuring that staff are equipped and enabled to adapt to any new structures and to continue to take forward the important work set out in this plan.

Culture is key to the success of any organisation. We must continue to develop into an organisation where:

- our culture and values are clear in everyone's experience of the PHA;
- we are agile and adaptive to changes and challenges;
- we attract and retain high calibre staff;
- we are leaders in our field and strive to learn from research and evidence;
- we embrace collective and compassionate leadership, nurturing collaboration, continuous improvement and empathetic care and support.

### Priorities 2025-2030

- implement the Reshape and Refresh recommendations and restructure;
- deliver Our People Plan and develop subsequent plans encompassing culture, staff experience, health and wellbeing and workforce development. This will include a wide range of targets with the overall aim of supporting the underlying goals that our staff:
  - are inspired with a shared sense of purpose to improve and protect the health of our population
  - feel valued, supported and engaged in all they do
  - are knowledgeable, skilled and competent;
- develop a professional governance framework;
- provide an improved working environment maximising flexible, modern ways of working to enhance staff engagement and wellbeing.

## Partnership

Improving the health and wellbeing of the population is the work of not just one single organisation but requires collaborative cross-society efforts. This includes ensuring that our communities, service users and carers are not only the focus of our work but that their voices are heard and listened to.

We are committed to working collaboratively with others, to help ensure the best outcomes for the population of Northern Ireland. This will include working with and across government departments, local government, other statutory bodies (such as housing and education), community and voluntary organisations and commercial and private providers and organisations as we create and distribute knowledge and information, interventions and services to improve health and wellbeing.

We will continue to engage and collaborate with partners with public health expertise locally, regionally, nationally and internationally. to maximise our combined resources to improve health and wellbeing. In line with the PHA's regional leadership role across the HSC in lived experience and involvement and in keeping with statutory and policy responsibilities in this area, we are committed to actively listening to and meaningfully involving service users, carers and the public who we serve.

### Priorities 2025-2030

- carry out a comprehensive stakeholder mapping and relationship profiling and collaborate with leaders in key sectors to implement improvements, enhance partnership working and target messaging;
- develop our communications and engagement strategy and resources to support the implementation of the corporate plan priorities;
- engage with key structures and foster partnerships focused on improving health and wellbeing including through SPPG Planning and Performance Teams, ICS Area Integrated Partnership Boards and Local Government Community Planning Partnerships;
- develop a partnership working strategy that embeds lived experience and involvement into the culture and practice of the PHA;
- use expertise and data from other sources to develop a comprehensive joined up approach to planning public health investment and programmes across government.



## Process

We know the importance of demonstrating good organisational and professional governance in how we conduct our work, ensure good stewardship of all our resources and accountability for the use of public monies. In the volatile and continuing changing environment in which we are working, with organisational, sectoral and strategic change, increasing demand on health services and ongoing financial and economic constraints, it is essential that we have strong accountability and dynamic processes to enable effective delivery and achieve the greatest impact possible within organisational resources. We must also ensure our processes allow us to be agile, designed and able to manage any emerging risks.

The PHA will continue to look at creative, innovative and collaborative ways of working to make best use of available resources to achieve maximum impact. Strong planning and multidisciplinary ways of working as well as strong governance processes will be crucial to our success as an organisation.

### Priorities 2025-2030

- establish and embed robust financial governance in line with new financial management arrangements as part of the ongoing transformative restructure;
- 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;
- develop the planning and procurement arrangements in the PHA, ensuring the necessary skills, expertise and capacity to work alongside programme leads and together progress these, to meet the health and wellbeing needs of the population ensuring best use of public monies;
- continue to implement the multidisciplinary public health planning structure.

## Digital

In recent years, we have made rapid and significant development around digital capacity, embracing innovative ways of working and harnessing the potential of new technology.

Technology is continually changing the way we live, interact, learn play and work, offering new opportunities to connect and engage with people and communities in different ways. Digital tools offer new ways to gather and analyse data, collaborate within the PHA and with external partners to improve public health, support our core functions and build capabilities. Embracing new technology requires new thinking about public health provision models, data, governance, partnership and engagement. The PHA will take a 'digital first' approach to its work and develop an open data approach that supports openness and transparency.

### Priorities 2025-2030

- strengthen public health leadership in digital innovation through development and implementation of innovative public health models, positioning PHA as a leader in digital health provision;
- enhance digital awareness and understanding across PHA; building digital literacy and fostering a shared understanding of digital opportunities and challenges;
- embed a digital first approach in planning by integrating digitalisation into the design of external and internal products, services and business processes;
- build and continuously improve the accessibility and functionality of underpinning digital platforms for the PHA;
- increase digital skills across the PHA, embed learning and development for digital ways of working and design new digital roles.

## Research and evidence

The availability, analysis and interpretation of good data and evidence is essential for effective planning and delivery of services. As an organisation, we will bring together evidence and learning from both national and international sources and continually seek to develop and improve our data sources and analytic capability. We have a wealth of experience and knowledge in health intelligence, data management and surveillance, and it is essential that we invest in and further develop this over the next five years. This will inform not only PHA policy and actions but crucially also the policy, actions and plans of our partners, to improve the health and wellbeing of the population.

HSC Research and Development (R&D) division works to support research that provides high quality evidence to improve care for patients, clients and the general population, and adds to our understanding of health, disease, treatment and care. A new HSC R&D strategy is in development for launch in 2025, building on the existing strategy with an enhanced focus on equality, diversity and inclusion (EDI), sustainability and the safe and appropriate use of data in HSC research.

Developing as an organisation and enabling innovative, data-driven approaches to the planning and delivery of our services will enable the organisation to deliver a public health service that meets the current and future needs of the population and respond to emerging challenges or threats.

We will become a more research active organisation, both in identifying research questions and encouraging staff to engage in active research and collaborate with the Northern Ireland Public Health Research Network.

### Priorities 2025-2030

- establish a new directorate focused on health intelligence, research and digital approaches;
- implement the new HSC R&D strategy;
- develop research literacy and capacity in research within the PHA workforce, through training and development opportunities such as critical appraisal and evidence synthesis training and R&D fellowships;
- build strategic partnerships with clear data-sharing agreements to ensure access to a comprehensive range of data sources, enabling robust modelling, planning and public health response capabilities;
- strengthen our reputation as a leader in evidence-based decision-making, using data to drive public health policy, inform practices and guide resource allocation;
- expand analytical capabilities by further developing skills in areas such as behaviour change analysis, data science, health economics and modelling and equipping the organisation for in-depth programme evaluation;
- use high-calibre modelling and evaluation techniques to assess equality impacts and effectiveness of interventions and programmes;
- be recognised as a leader in health intelligence, predictive modelling and scenario planning, driving insights for proactive public health strategy.



# Summary table

# Summary table

**Summary of PHA priorities for 2025-2030 and indicators for each strategic theme**

## Protecting health

| Priorities | Indicators |
|---|---|
| • develop emergency response plans to support readiness to respond to incidents that may have an impact on public health for Northern Ireland;<br>• work collaboratively to minimise the impact of infectious disease, with a focus on antimicrobial resistance and our elimination targets for blood-borne viruses;<br>• deliver a high-quality and responsive health protection surveillance and epidemiology programme;<br>• strengthen the multidisciplinary coordinated approach to infection prevention and control across the wider HSC system though the established infection, prevention and control forums;<br>• ensure the delivery of high-quality screening programmes;<br>• 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;<br>• 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;<br>• build public confidence and trust in public health advice, information and messaging through improving health literacy via education and engagement with the public. | • vaccination uptake;<br>• notification rates of vaccine preventable diseases;<br>• rates of healthcare associated infections;<br>• bloodborne virus elimination targets;<br>• waste water surveillance;<br>• stage of cancer diagnosis. |

## Starting well

| Priorities | Indicators |
|---|---|
| • support families to take care of their physical and mental health, with a particular focus on the first 1,000 days;<br>• reduce the impact of social complexity in pregnancy;<br>• promote the health benefits of breastfeeding and encourage support for breastfeeding mothers;<br>• protect the health of children and young people through antenatal and newborn screening programmes and childhood vaccination programmes;<br>• deliver universal and targeted support programmes, including Healthy Child Healthy Family, Family Nurse Partnership, and Northern Ireland New Entrants service (NINES);<br>• work together to reduce child deaths through improved use and application of data and evidence;<br>• support children and young people with special education needs, their families and carers in addressing the unique health challenges and disparities they face, by enhancing access to services, resources and support systems that contribute to their physical, mental, and social wellbeing;<br>• support adolescents to establish patterns of behaviour that can protect their mental and physical health;<br>• work with others to promote the safeguarding and protection of children and young people. | • screening and vaccination in pregnancy uptake;<br>• childhood vaccination uptake;<br>• percentage of children living with obesity or overweight in Year 1 and Year 8;<br>• percentage of babies born at low birth weight;<br>• avoidable child death rates;<br>• percentage of mothers breastfeeding on discharge and at 6 months;<br>• breastfeeding welcome here scheme membership;<br>• percentage of young people who drink alcohol;<br>• percentage of young people who smoke cigarettes;<br>• percentage of young people who currently use e-cigarettes;<br>• number of people under 18 years attending emergency departments for self harm;<br>• percentage of women smoking during pregnancy. |

## Living well

| Priorities | Indicators |
|---|---|
| • 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;<br>• support those living with long-term conditions to live well with disease<br>• deliver high-quality programmes and initiatives, including prevention and early intervention approaches, to protect and improve mental health and emotional and social wellbeing;<br>• continue to work in partnership across government and with communities, services, and families across society to reduce suicides and the incidence of self-harm;<br>• 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;<br>• support prevention and early detection of illness through vaccination and screening programmes;<br>• 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.<br>• continue working towards a tobacco-free society;<br>• 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;<br>• continue working to implement and enhance shared decision making, accessibility and health literacy;<br>• strengthen the role of communities within the public health system, by embedding community-centred approaches to reduce health inequalities and build healthier communities. | • percentage of people with a high GHQ-12 score, indicating a possible mental health problem;<br>• number of people who die by suicide or undetermined intent;<br>• percentage of adults smoking and vaping;<br>• percentage of adults living with overweight or obesity;<br>• percentage of adults meeting physical activity guidelines;<br>• percentage of adults drinking above weekly limits;<br>• alcohol and substance use-related hospital admissions;<br>• age standardised mortality rate for alcohol-related deaths and substance use-related deaths;<br>• percentage self-reporting a physical or mental health condition or illness expected to last 12 months or more;<br>• registrations to the NHS Organ Donor Register;<br>• percentage of those living with long-term conditions reporting a reduced ability to carry out daily activities. |

## Ageing well

| Priorities | Indicators |
|---|---|
| • implement the World Health Organization (WHO) Age-friendly movement across Northern Ireland;<br>• reduce and prevent falls and home accidents, including the development and implementation of a regional model for safer mobility;<br>• reduce the impact of frailty by raising awareness and increase early detection;<br>• support prevention and early detection of illness through vaccination and screening programmes for older adults;<br>• increase levels of physical activity and promote opportunities to stay active;<br>• work with key partners to identify and reduce levels of loneliness and social isolation and to improve mental health and emotional wellbeing;<br>• champion the voice of older people and the issues that impact on their health and wellbeing;<br>• lead and implement initiatives to ensure people who live with long-term conditions and those who live in care homes have good health and wellbeing and improved quality of life;<br>• work with partners to support individuals and families at the end of their life through advance care planning;<br>• build and develop a strong research and evidence base to support ageing well programmes in Northern Ireland. | • percentage of people aged 65+ with a high GHQ-12 score, indicating a possible mental health problem;<br>• percentage of people who report feeling lonely 'often/always' or 'some of the time';<br>• adults aged 65+ stating health is good or very good;<br>• emergency hospital admissions due to falls in people aged 65+;<br>• number of deaths from falls in people aged 65+;<br>• percentage of older people who are living with overweight or obesity;<br>• percentage of older people who do not meet physical activity guidelines;<br>• percentage uptake of flu and shingles vaccinations;<br>• frequency of alcohol use by age;<br>• percentage of people who die at home, in hospital or other setting. |

# Glossary of useful terms



## Glossary of useful terms

| Term | Definition |
|---|---|
| **AAA** | Abdominal aortic aneurysm. A swelling in the abdominal aorta, the main artery that supplies blood to your body, which can be fatal. |
| **Age-friendly** | An WHO initiative to create liveable communities that are inviting and accessible for people of all ages – especially older adults. |
| **Area Integrated Partnership Board (AIPB)** | A local planning body with the overarching aim of improving health and social care outcomes and reducing health inequalities for its local population. |
| **Collaboration** | The action of working with someone to produce something. |
| **Coronavirus disease/ COVID-19** | An infectious disease caused by the SARS-CoV-2 virus. |
| **Delivering Together 2026** | Approach launched by the then Minister of Health, Michelle O'Neill, on 25 October 2016 and driven by the Northern Ireland Executive's draft Programme for Government, setting out an ambition to support people to lead long, healthy and active lives. |
| **Department of Health (DoH)** | A devolved government department in the Northern Ireland Executive. |
| **Diabetic retinopathy** | Diabetic retinopathy occurs when diabetes damages the small blood vessels in the part of the eye called the retina, affecting vision. |
| **Digital first** | The use of digital and online solutions first and more traditional solutions as needed. |
| **EDI** | Equality, diversity and inclusion. |
| **Epidemiology** | The study of how often diseases occur in different groups of people and why. |
| **GHQ-12** | General Health Questionnaire (Goldberg & Williams, 1988) consisting of 12 items, each one assessing the severity of a mental problem. |
| **Health and wellbeing** | The combination of factors contributing to a person's physical, mental, emotional and social health. |
| **Health inequalities** | Unfair and avoidable differences in health across the population and between different groups within society. |
| **Health intervention** | A treatment, procedure or other action taken to prevent or treat disease, or improve health in other ways. |
| **Health literacy** | The ability to access, understand, appraise and use information and services in ways that promote and maintain good health and wellbeing. |

| Term | Definition |
|---|---|
| **Healthy life expectancy** | The average number of years of full health that a newborn could expect to live. |
| **Health and Social Care (HSC)** | Publicly funded healthcare system in Northern Ireland. Although created separately to the National Health Service, it is nonetheless considered a part of the overall national health service in the United Kingdom. |
| **Incidence** | The rate of new cases of a disease occurring in a specific population over a particular period of time. |
| **Integrated Care System Northern Ireland (ICS NI)** | The new (2024) commissioning framework for Northern Ireland. It is a single planning system that will help us to improve the health and wellbeing of our population. |
| **Life course approach** | An inclusive approach that considers people's health needs and opportunities across all age groups. |
| **Live Better initiative** | A series of planned initiatives set out by the Health Minister in October 2024 to help tackle health inequalities in Northern Ireland and bring targeted health support to communities that need it most. |
| **Making Life Better, the NI Public Health Framework** | A strategic framework for public health designed to provide direction for policies and actions to improve the health and wellbeing of people in Northern Ireland and to reduce health inequalities. |
| **MMR Vaccine** | Vaccine against measles, mumps and rubella. |
| **Mortality** | In medicine, a term also used for death rate, or the number of deaths in a certain group of people in a certain period of time. |
| **Most and least deprived areas** | The 20% most and 20% least deprived areas are defined according to the Northern Ireland Multiple Deprivation Measures (2017), which provides a mechanism for ranking geographical areas within Northern Ireland in the order of the most deprived to the least deprived based on a number of distinct types of deprivation, including income, employment, quality of environment, health, education and housing. |
| **Personal and Public Involvement (PPI)** | Active and meaningful involvement of service users, carers, their advocates and the public in the planning, commissioning, delivery and evaluation of Health and Social Care (HSC) services, in ways that are relevant to them. |
| **Programme for Government (PfG)** | The Draft Programme for Government 2024-2027 Our Plan: Doing What Matters Most outlines the Executive's priorities for making a real difference to the lives of people here. |
| **Public Health** | The science and art of preventing disease, prolonging life and promoting health through the organised efforts of society. |



| Term | Definition |
|---|---|
| **Public Health Agency (PHA)** | Established in April 2009 as part of the reforms to Health and Social Care (HSC) in Northern Ireland, responsible for providing health protection and health and social wellbeing improvement to every member of every community in Northern Ireland. |
| **Prevalence** | The number of cases of a disease in a specific population at a particular time point or over a specified period of time. |
| **Smoking cessation** | The process of discontinuing tobacco smoking. |
| **Social complexity in pregnancy** | Vulnerable women are women who are exposed to physical, psychological, cognitive and/or social risk factors such as poverty, homelessness, substance use, recent arrival as a migrant, asylum seeker or refugee status, difficulty speaking or understanding English, being a young parent (age under 20), experience of domestic abuse, member of an ethnic minority group, mental ill-health, social isolation/lack of social support, human trafficking and exposure to criminal or antisocial behaviour. |
| **SPPG** | Strategic Planning and Performance Group. |
| **Surveillance** | Continuous process of collection, analysis and interpretation of data. |
| **Whole system approach** | A strategic integrated approach to planning and delivering services. |
| **World Health Organization** | (WHO) The World Health Organization sets standards for disease control, healthcare and medicines; conducts education and research programs; and publishes scientific papers and reports. |

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03/25

# Public Health Agency Corporate Plan 2025-2030
# Public Consultation Report

## Introduction

The Public Health Agency (PHA) undertook a public consultation on the draft PHA Corporate Plan 2025-2030 between November 2024 and February 2025. This document provides a report on the consultation.

The Corporate Plan is by its nature a high level document, setting out the role, direction, strategic themes and priorities for the PHA from 2025-2030 and states our commitment to working collaboratively with others. The content of the Plan was informed by internal and external engagement with our partners, the public and key stakeholders during the course of its development.

The Plan considers key factors including responsibility for implementing a number of strategies across significant areas of work as well as challenges facing our health and social care system, which are detailed within the context section of the Corporate Plan. A number of key policy drivers including the draft Programme for Government (PFG) 2024-2027; Making Life Better, the public health framework; and Health and Wellbeing 2026: Delivering Together were considered when laying the key foundations for our work, as well as the current economic climate and constrained financial environment for HSC. A full list of all policies considered can be found in the References section of the Corporate Plan.

The Corporate Plan will be supported by an Implementation Plan as well as our Annual Business Plan, which will enable us to incorporate new priorities and respond to new challenges that may arise over the five year period.

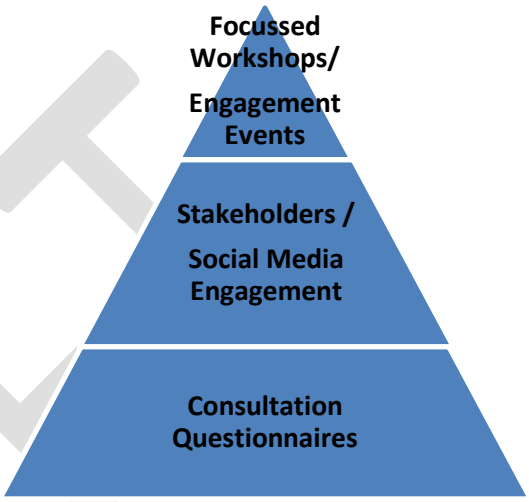
As well as summarising communications with internal and external stakeholders, this report summarises responses and feedback received from internal and external stakeholders during the consultation period and outlines the amendments made to the draft Corporate Plan as a result.

## Consultation Methodology

The draft PHA Corporate Plan 2025-2030 was issued for consultation for a 12 week period and was launched on Thursday 28 November 2024, closing on Friday 28 February 2025.

In order to reach as many people and maximise the number of responses a number of different engagement approaches were used, as follows:

1. Consultation questionnaires
2. Stakeholder and social media engagement
3. Focussed workshops and engagement events




The following sections describe each of the methods and how they were responded to.

### Consultation Questionnaires, Documentation and Communications

Consultation questionnaires were the main mechanism used to consult on the draft PHA Corporate Plan 2025-2030. A questionnaire was created for external stakeholders to respond via Citizen Space, the recommended online consultation and survey tool available via the NI Direct website. MS Forms was used to create a survey to enable staff to respond anonymously.

External stakeholders were invited to participate in the consultation with a letter from the PHA Chief Executive and draft documentation issued via email by the Head of PHA Chief Executive's Office and Strategic Engagement. Correspondence was issued to over 600 stakeholders following a comprehensive internal stakeholder mapping exercise undertaken from July 2024. Questionnaires were also made available in Word format with responses being able to be submitted via post or by email to phacorporateplan@hscni.net.

All documentation was published on the PHA Website with hyperlinks and QR codes provided for ease of access to the consultation questionnaire. Documentation issued is summarised below:

- Letter from PHA Chief Executive
- PHA Draft Corporate Plan 2025-2030
- PHA Draft Corporate Plan 2025-2030 easy read version

- PHA Draft Corporate Plan 2025-2030 large print accessible Word format version
- PHA Draft Corporate Plan 2025-2030 Initial Equality Screening Draft
- PHA Draft Corporate Plan 2025-2030 Initial Rural Screening Draft
- PHA Draft Corporate Plan 2025-2030 Public Consultation questionnaire online link (Citizen Space)
- PHA Draft Corporate Plan 2025-2030 Public Consultation questionnaire Word format

The PHA was committed to providing various options for communication and engagement with external stakeholders as well as alternative methods for responding to the consultation, summarised as follows:

1. Draft Corporate Plan for consultation including draft easy-read and large print accessible versions.
2. Consultation questionnaire available for completion online via Citizen Space, or Word format for return by post or the phacorporateplan@hscni.net email.
3. Communication updates, hyperlinks and QR codes issued to external stakeholders by the Head of PHA Chief Executive's Office and Strategic Engagement with updated information available via the PHA Website.
4. The phacorporateplan@hscni.net email for any queries to be responded to at any time.
5. Social media conversations including videos by the Chief Executive, Directors and various nominated staff during the consultation period, which continued until the end of the consultation period. Please refer to further details in Appendix A and Appendix B.
6. Smaller group meetings held by request.

Staff also had the opportunity to submit their comments and feedback via the online staff questionnaire (MS Forms). They were provided with regular communications via:

- Team meetings discussions
- Updates via PHA Connect (intranet)
- Weekly staff news/email
- PHA Website
- PHA monthly 1st Tuesday staff engagement sessions
- Staff engagement events and NICON
- Staff engagement evaluation report
- Consultation questionnaire available via MS Forms or Word format for staff to respond via post or the phacorporateplan@hscni.net email
- Regular updates throughout whole process

A timeline of staff communications and engagement can be found in Appendix C.

## Engagement Events

External stakeholder engagement consultation events were held during January 2025 and February 2025. Two in-person consultation events were held in Magherafelt and Lisburn to consider geographical spread to give external stakeholders the opportunity to discuss the draft corporate plan content. A third online event was also held to accommodate any organisations who were unable to attend in person.

Stephen Wilson, Head of PHA Chief Executive's Office and Strategic Engagement and Julie Mawhinney, Senior Operations Manager facilitated the events. As well as close engagement with the Communications/Publications teams and PPI team, PHA Directors had the opportunity to provide details of nominees from any of their teams to facilitate and contribute to discussions.

The events took place as follows:

1. 2.00pm to 4.00pm on Monday 13 January 2025 - in Involve NI (C&V Sector), Involve House Magherafelt, 16-18 Queen Street, Magherafelt, BT45 6AB.

2. 10.30am to 12.30pm on Tuesday 21 January 2025 - in Lagan Valley Island (Castlereagh & Lisburn Council), The Island, Lisburn, BT27 4RL.

3. 12.30pm to 2.00pm on Thursday 06 February 2025 - online session held via MS Teams, which accommodated a wider audience over the lunchtime period to give additional opportunity for external stakeholders to join.

The focus of these events was to provide informal working sessions, considering the plan as a whole and providing an opportunity for conversation around the strategic themes and priorities over the next five years.

Feedback from all of these events was collated along with all responses received via the online consultation questionnaires and summarised within this document below.

The project team also offered smaller individual meetings to stakeholders. One organisation took up the offer and this also led to collaboration for the development of the draft accessible version of the Corporate Plan 2025-2030.

## Social Media

Social media was used to promote the consultation and also as an alternative method for response and engagement. The consultation was promoted on Facebook, Instagram, X and LinkedIN with a full External Engagement and Communications Plan prepared to execute all content and communications seamlessly.

Due to the consultation falling over the Christmas period, a focussed social media campaign was agreed for January and February 2025, following a consultation launch video from the PHA Chief Executive as well as some promotional content in December 2024. Social media posts focused on the strategic themes and priorities of the Corporate Plan with further details provided via video content from Directors and various nominated staff (Appendix A).

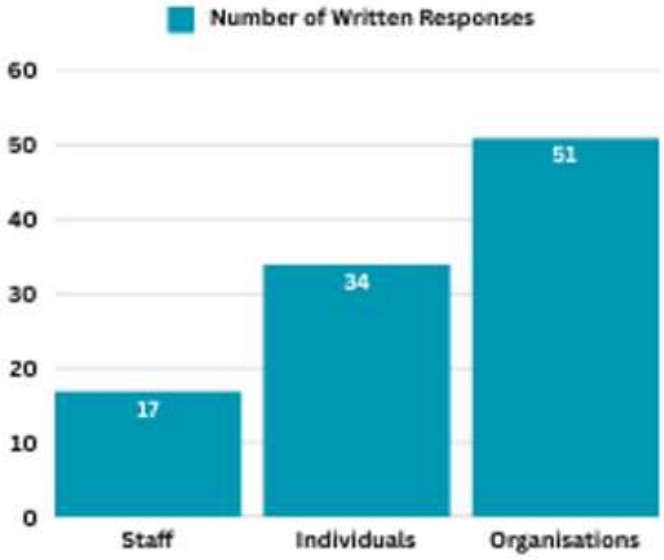
| **Week Commencing** | **Examples/Strategic Theme** |
|---|---|
| 07 January 2025 | **Starting Well** - laying the foundations for a healthy life from pre-birth, infancy, early years, childhood to adolescent years |
| 13 January 2025 | **Ageing Well** - supporting people to age healthily throughout their lives |
| 06 February 2025 | **Living well** – ensuring that people have the opportunity to live and work in a healthy way.<br><br>Promotional video with Dr Hannah McCourt discussing how the corporate plans aims to create supportive environments and opportunities for good health. |
| 14 February 2025 | **Protecting Health** - protecting the population from serious health threats, such as infectious disease outbreaks or major incidents |

## Summary of Engagement and Participation

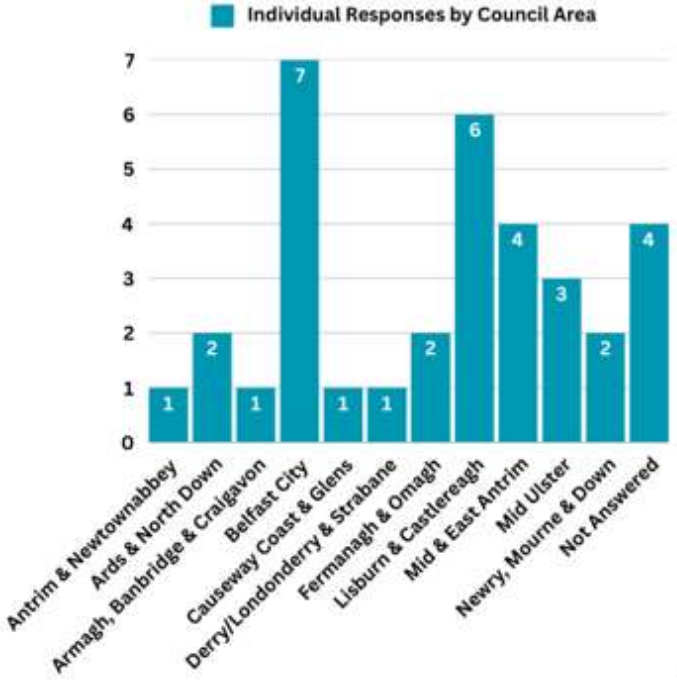
### Consultation Questionnaire Responses

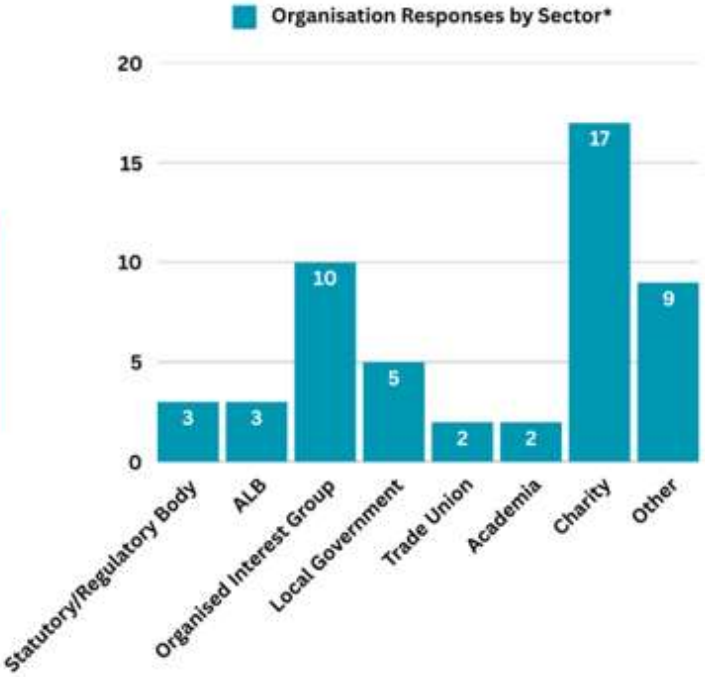
PHA received 102 written responses to the Draft Corporate Plan 2025-2030 Consultation.

**Overall - Number or Written Responses**




**External: Individual and Organisation Responses**

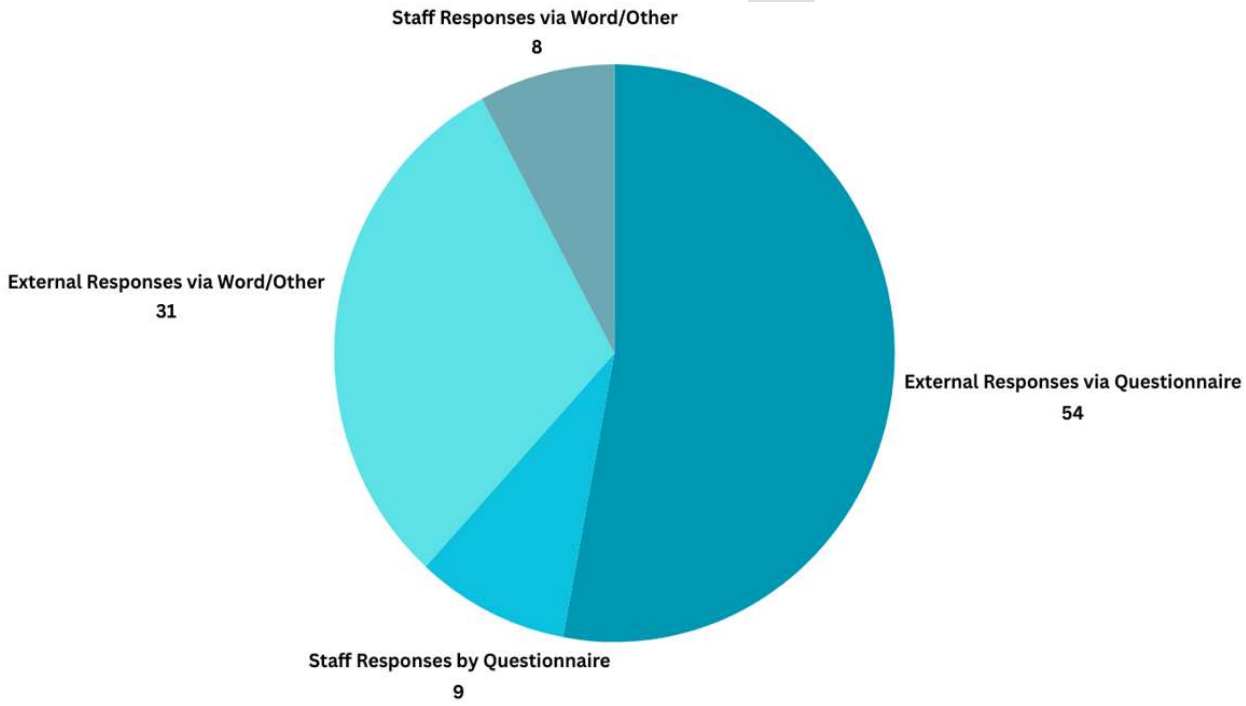



**no response from Business Operators, Church or Faith Groups, Government Depts, Media or Political Party sectors*

Of the 17 staff responses 9 completed the MS Forms questionnaire and 8 used the Word format questionnaire or their own format/report which was submitted via the phacorporateplan@hscni.net email.

Of the 85 external stakeholder responses, with 51 from organisations and 34 from individuals - 54 used the questionnaire via Citizen Space and 31 used the Word format questionnaire or their own format/report, again submitting via the corporate plan email address. A list of the organisations who responded is attached within Appendix D and a copy of the questions is included at Appendix E.




Not all respondents who used the questionnaire answered all of the questions, and this is also true of those responses that opted not to use the questionnaire at all. This needs to be considered when taking account of any quantitative analysis. Some responses were from organisations covering a wide range of interests, others were from organisations with a particular or single interest. All responses were valuable and considered when reviewing the draft Corporate Plan following consultation.

Indications of Agreement

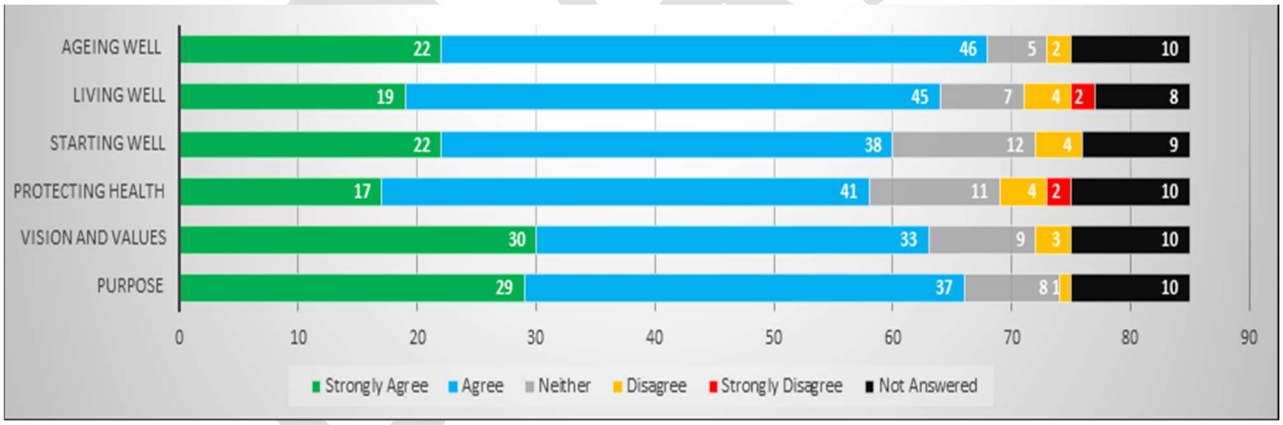
Not everyone indicated their level of agreement within their response with details for staff and external responses set out follows:

**External: Percentage Responses Data***

| Outcome | Strongly Agree | Agree | Neither | Disagree | Strongly Disagree | Not Answered | Total Responses |
|---|---|---|---|---|---|---|---|
| Purpose | 29 | 37 | 8 | 1 | 0 | 10 | 85 |
| | *34%* | *44%* | *9%* | *1%* | *0%* | *12%* | |
| Vision & Values | 30 | 33 | 9 | 3 | 0 | 10 | 85 |
| | *35%* | *39%* | *11%* | *4%* | *0%* | *12%* | |
| Protecting Health | 17 | 41 | 11 | 4 | 2 | 10 | 85 |
| | *20%* | *48%* | *13%* | *5%* | *2%* | *12%* | |
| Starting Well | 22 | 38 | 12 | 4 | 0 | 9 | 85 |
| | *26%* | *45%* | *14%* | *5%* | *0%* | *11%* | |
| Living Well | 19 | 45 | 7 | 4 | 2 | 8 | 85 |
| | *22%* | *53%* | *8%* | *5%* | *2%* | *9%* | |
| Ageing Well | 22 | 46 | 5 | 2 | 0 | 10 | 85 |
| | *26%* | *54%* | *6%* | *2%* | *0%* | *12%* | |

*% rounded to whole number

**External: Responses Comparison Data**

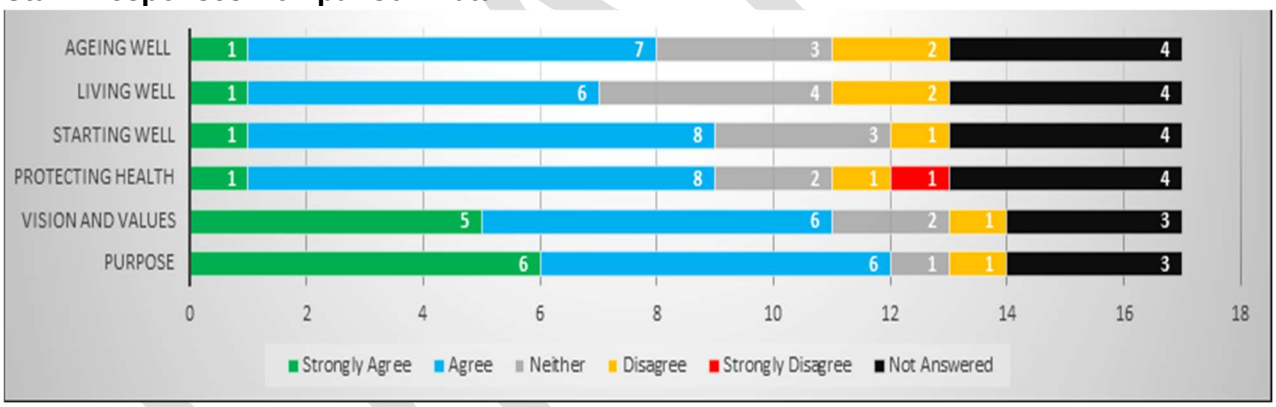


## Staff: Percentage Responses Data*

| Outcome/ Strategic Theme | Strongly Agree | Agree | Neither | Disagree | Strongly Disagree | Not Answered | Total Responses |
|---|---|---|---|---|---|---|---|
| Purpose | 6 | 6 | 1 | 1 | 0 | 3 | 17 |
| | 35% | 35% | 6% | 6% | 0% | 18% | |
| Vision & Values | 5 | 6 | 2 | 1 | 0 | 3 | 17 |
| | 29% | 35% | 12% | 6% | 0% | 18% | |
| Protecting Health | 1 | 8 | 2 | 1 | 1 | 4 | 17 |
| | 6% | 47% | 12% | 6% | 6% | 24% | |
| Starting Well | 1 | 8 | 3 | 1 | 0 | 4 | 17 |
| | 6% | 47% | 18% | 6% | 0% | 24% | |
| Living Well | 1 | 6 | 4 | 2 | 0 | 4 | 17 |
| | 6% | 35% | 24% | 12% | 0% | 24% | |
| Ageing Well | 1 | 7 | 3 | 2 | 0 | 4 | 17 |
| | 6% | 41% | 18% | 12% | 0% | 24% | |

*% rounded to whole number

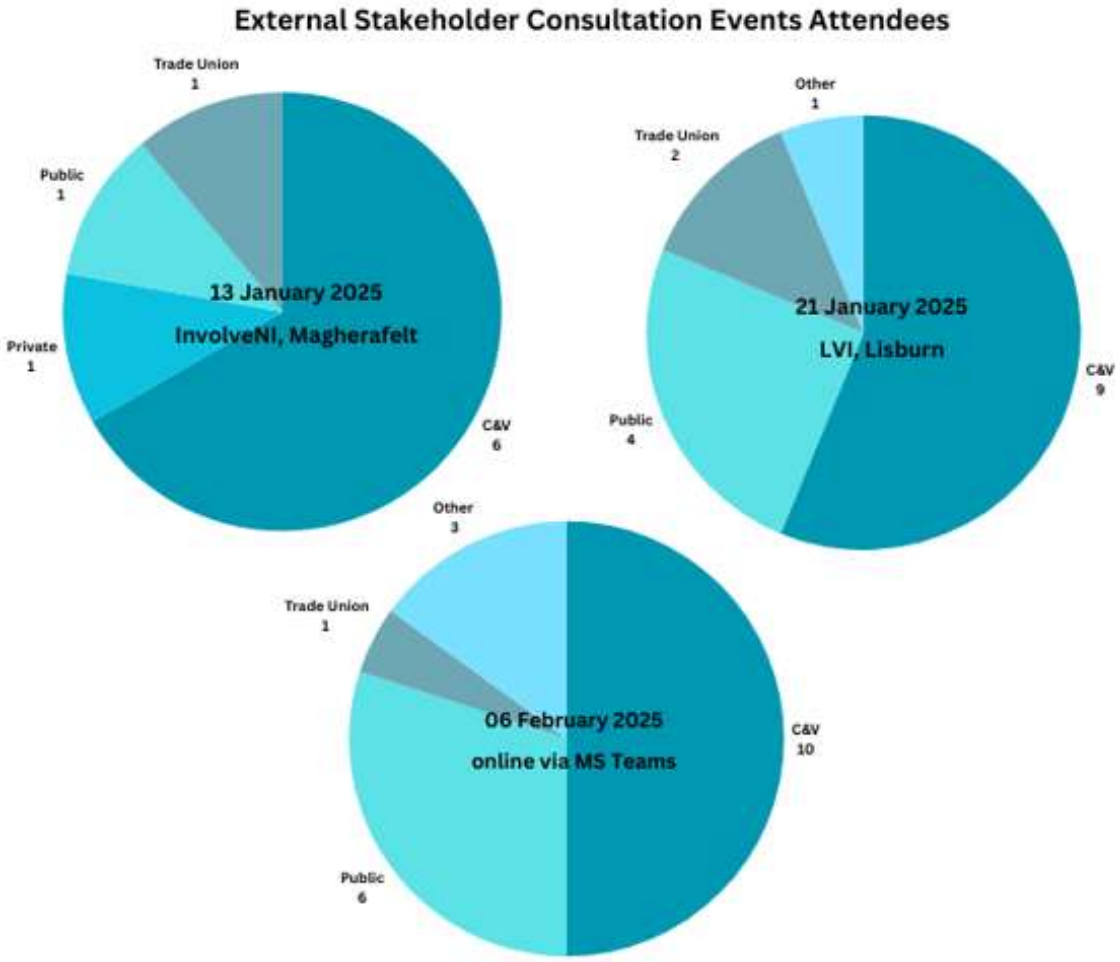
## Staff: Responses Comparison Data



## External Stakeholder Consultation Events

Over the 3 external stakeholder consultation events there was representation from 45 organisations with 52 people in attendance.

With 9 organisations in attendance at the event in Magherafelt on 13 January 2025, 16 in Lisburn on 21 January 2025 and 20 joining the online session on 06 February 2025, there was participation from a wide range of areas.




The events were very well received, with a number of attendees commenting positively on the format and that this had enabled them to actively participate. The events programme is attached at Appendix F and a list of organisations who attended included at Appendix G.

The information gathered during these events was collated with the written responses for analysis and consideration in agreeing the PHA Corporate Plan 2025-2030.

## Social Media and PHA Website Performance

The total number of social media posts throughout the campaign period was 25, with 138,190 unique users seeing the posts at least once. There were over 14,000 views of video posts with 2,009 link clicks throughout the campaign period – a key call to action for the campaign.


Full details of social media performance and PHA website performance, including top performing posts, can be found in Appendix B.

A summary and examples of social media posts are also provided in Appendix A: Draft Corporate Plan 2025-2030: Sample External Stakeholder Consultation - Social Media Communications.

## Overall Feedback from Responses

The overall feedback from responses was overwhelmingly positive with high levels of agreement indicated overall and for each section of the draft plan, as confirmed by the level of agreement scores summarised above.

For those who indicated agreement within their responses the majority strongly agreed or agreed overall with the purpose, vision and values as well as the strategic themes and the ambitions, priorities and focus set for each within the draft Corporate Plan. As well as suggesting constructive changes and amendments, a wide range of additional information was also shared by some respondents.

All feedback and suggested changes were taken onboard for consideration and implemented into the Corporate Plan where relevant and possible. While some of the information and suggestions provided are too detailed for the Corporate Plan, it will be used to finalise the Implementation Plan and made available to staff to inform individual plans and projects.

### Overall

Many respondents found the document impressive and well-structured with some suggesting minor improvements for clarity and additional detail on certain topics. Most of the suggested changes were focussed on wording amendments, clarification, some structural changes, an increased focus on health inequalities and partnership working and there were some suggestions focussed on specific services and treatments.

A number of structural changes were suggested including removing screening priorities from the Protecting Health section and removing the life course approach. These changes were considered but it was decided that the life course approach would remain in line with the approach in other strategic documents and recommendations from the restructuring programme in the organisation. The screening priorities will also remain within the Protecting Health section, noting that this section is about protecting health and not focused only on the specific health protection function of the organisation.

There were a number of suggestions proposing the specific inclusion of various groups/communities of people including those with caring responsibilities, learning disabilities and autism. While we have made these amendments where this has been appropriate, it would not be feasible to name every different client group that the Corporate Plan relates to. Therefore, rather than name a few and risk excluding others, we have also noted at the beginning of the document that the Plan is for all

people inclusive of age, gender, ability, disability, ethnicity, sexual orientation, caring responsibility and location.

Wording throughout the document has been revised where appropriate to ensure that the importance of, and PHA commitment to, partnership working and reducing health inequalities is clear. Health inequalities has also been further emphasised with more statistics added within the health profile detailing the differences faced across Northern Ireland and additional mention within the 'Our Focus' section.

A numer of respondents suggested increased or enhanced access to services or treatments. While these are outside the scope of the organisation's statutory repsonsibility, these responses have been provided to senior staff across the organisation with a role in supporting commissioning of services through the provision of professional and public health advice to ensure the information is shared with relevant departments.

Where responses related to specifc actions, these have been shared with the PHA Senior Team for consideration within the draft Implementation Plan that accompanies the Corporate Plan 2025-2030.

**Purpose, Vision and Values**

This section had one of the highest agreement levels with minimal disagreement, reflecting strong alignment with respondents expectations.

There were minimal changes suggested to this section and the majority of proposed amendments suggested rewording or re-ordering the wording within the purpose, vision and values. None of the proposed amendments changed the meaning or direction of the draft purpose, vision and values. As the proposed amendments did not change the meaning or direction set out in this section and in recognition of the collaborative work with staff across the organisation to develop and agree the purpose, vision and values, no changes were made to this section.

**Protecting Health: Protecting the population from serious health threats, such as infectious disease outbreaks or major incidents**

Protecting Health had mostly strong agreement from internal and external stakeholders but there were a small number of respondents who disagreed.

The main feedback for this section was focussed on structure and the need to clarify the inclusion of screening priorities. Responses also noted the need to include clear and specific indicators within this section.

Where a response disagreed with the set direction, this was linked to the structure of the overall document or due to a preference to focus this section on health protection

duties only. Where possible suggested amendments have been included within the Plan including the agreement and inclusion of a number of indicators; additional definitions added and increased focus on health inequalities within the priorities.

**Starting Well: Laying the foundations for a healthy life from pre-birth, infancy, early years, childhood to adolescent years**

There was strong support for this section and the direction it sets. Where there was disagreement, it related to the structure of the overall document or where respondents felt something was missing or required further clarification.
There were a number of suggested amendments including changes to indicators, the need to ensure inclusion of pre-conception within the focus of this section. Responses also highlighted the use of nicotine and the need for an indicator that would show vaping use. Where possible suggested amendments have been included within the Plan including suggested rephrasing, a definition of social complexity and the addition of more indicators.

**Living Well: Ensuring that people have the opportunity to live and work in a healthy way**

This section had a mixed response across internal and external responses. While most responses agreed, there was some reflection that this section was too focussed on substance use, diet, obesity and mental health and a broader focus was required. Some respondents felt the section read negatively and there was a need for further emphasis on the communities and environments in which people live and work.

There were a number of responses requesting increased focus on poverty. The impact of different types of poverty have been considered within this section as noted within the information. Tackling poverty is not within the statutory remit of the organisation but where possible and in recognition of the impact poverty can have on health, PHA works with partners to mitigate its impact on health and wellbeing. Where possible suggested amendments have been included within the Plan including some rewording, a review of the indicators and inclusion of additional priorities.

**Ageing Well: Supporting people to age healthily throughout their lives**

This section was well received within consultation responses and received high levels of agreement from internal and external stakeholders. There were opposing views within the responses on whether this section had a positive or negative slant on ageing. Responses also felt that dementia and cognitive health were significant gaps within this section.

Where there was disagreement, it related to the structure of the overall document or where respondents felt something was missing or required further clarification.

Where possible suggested amendments have been included within the Plan including a review of the language used, amended wording, the inclusion of dementia, specific indicators on falls have been included and a further indicator added on loneliness.

## Our Organisation Works Effectively

The focus on the organisation and how it develops over the next 5 years was strongly welcomed with a particular welcome on the inclusion of partnership and research and evidence as key pillars. The comments returned included ensuring appropriate communication with stakeholders, the importance of the community and voluntary sector and the need to look after staff health and wellbeing.

Further clarity was requested on PHA's internal structure and the role of particular health professions and their contributions.

Where possible the suggested amendments were made including a review of language to ensure inclusion and a stronger focus on employee health and wellbeing. The development and agreement of appropriate organisational measures will also be taken forward throughout the life of the Plan.

## Any Other Comments or Suggestions

Responses overall considered the document well-presented and easy to read and noted the importance of the easy read version for accessibility for all. Other comments noted that implementation of ambitious, population focussed outcomes will require partnership working, integration with other strategies and policies and a focus on health inequalities. Where possible, these comments have been used to improve the document.

## Monitoring

The PHA is committed to the ongoing monitoring of the Corporate Plan 2025-2030 aided by the development of an Implementation Plan. This plan will provide more detail on the implementation of the Corporate Plan and set out specific programmes of work to be taken forward within the 5 years.

The PHA Annual Business Plan will also act as the annual action plan towards the outcomes.

## Equality Screening and Rural Needs Impact Assessment

Draft Equality screening and Rural Needs Impact Assessment (RNIA) papers, shared during the consultation were updated to reflect feedback provided, with Equality Screening submitted to the Equality Unit for their input.

The RNIA paper was updated to reflect comments received and help inform the RNIA. Examples of important factors highlighted were included such as; farm families who experience barriers to accessing healthcare services and exhibit low help-seeking behaviour or do not prioritise their health and wellbeing. These rural groups are also referenced as a priority when considering reducing the levels of loneliness and social isolation as well as consideration for older people and those facing digital poverty when considering development within digital capacity.

These are just a few of the examples from the responses received which will be shared with the relevant teams and staff within the PHA to consider these factors when individually screening actions, work and programmes.

## Conclusion

Overall the responses to the consultation were positive and supportive of the proposed strategic direction of the PHA.  They also made many helpful comments, provided additional information and suggested changes that have been incorporated into the final draft and will be included in the easy read and accessible versions, where possible.

While it would be impractical to make individual replies to each consultation response, this consultation report summarises the points made and sets out the key changes that have been made to the draft PHA Corporate Plan 2025-2030 as a result. We would like to acknowledge the contribution of everyone involved and thank all those who have supported the consultation process, provided responses and/or attended the staff engagement workshops and external stakeholder consultation events.

## Appendices

**Appendix A**: Draft PHA Corporate Plan 2025-2030: External Stakeholder Consultation - Summary/Examples of Social Media Communications

**Appendix B:** Draft PHA Corporate Plan 2025-2030: External Stakeholder Consultation - Social Media Performance

**Appendix C:** Draft PHA Corporate Plan 2025-2030: Staff Communications and Engagement Timeline

**Appendix D**: Draft PHA Corporate Plan 2025-2030: External Stakeholder Consultation - List of Organisations who Responded to the Consultation

**Appendix E**: Draft PHA Corporate Plan 2025-2030: External Stakeholder Consultation - List of Questionnaire Questions

**Appendix F:** Draft PHA Corporate Plan 2025-2030: External Stakeholder Consultation - Engagement Events Programme and Discussion Questions

**Appendix G**: Draft PHA Corporate Plan 2025-2030: External Stakeholder Consultation – List of Organisations who attended Consultation Events

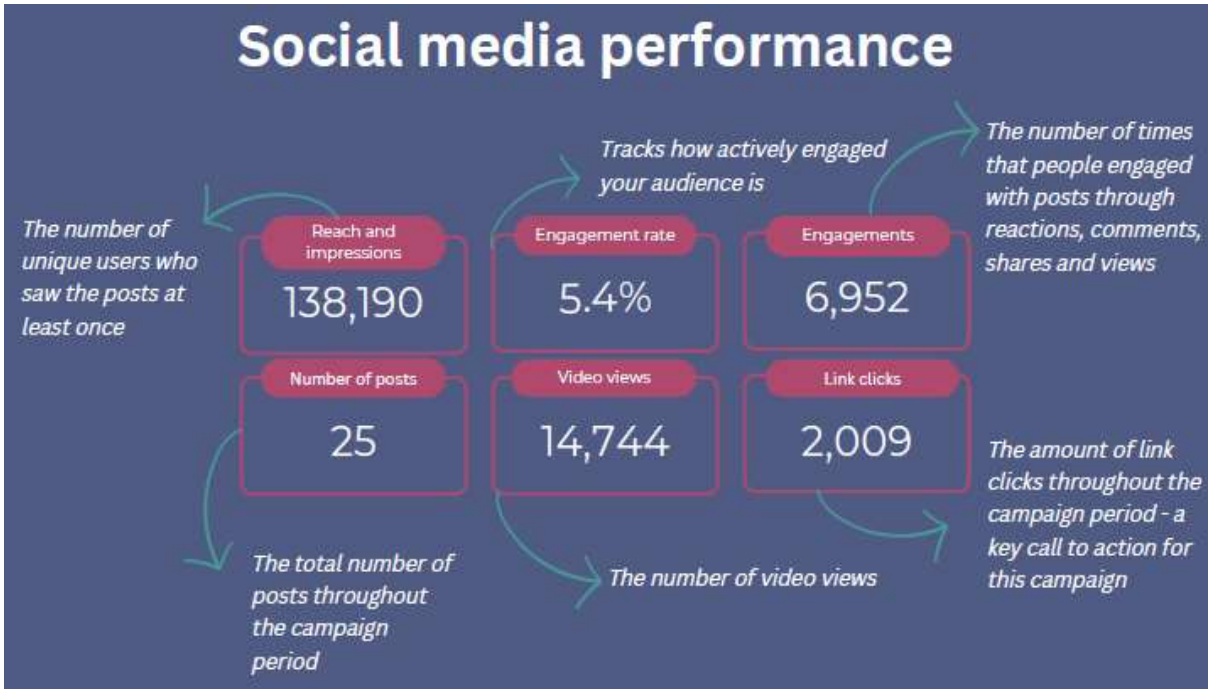
**Appendix H:** Draft PHA Corporate Plan 2025-2030: Staff Engagement Evaluation Report Draft Corporate Plan – copy for AMT reference

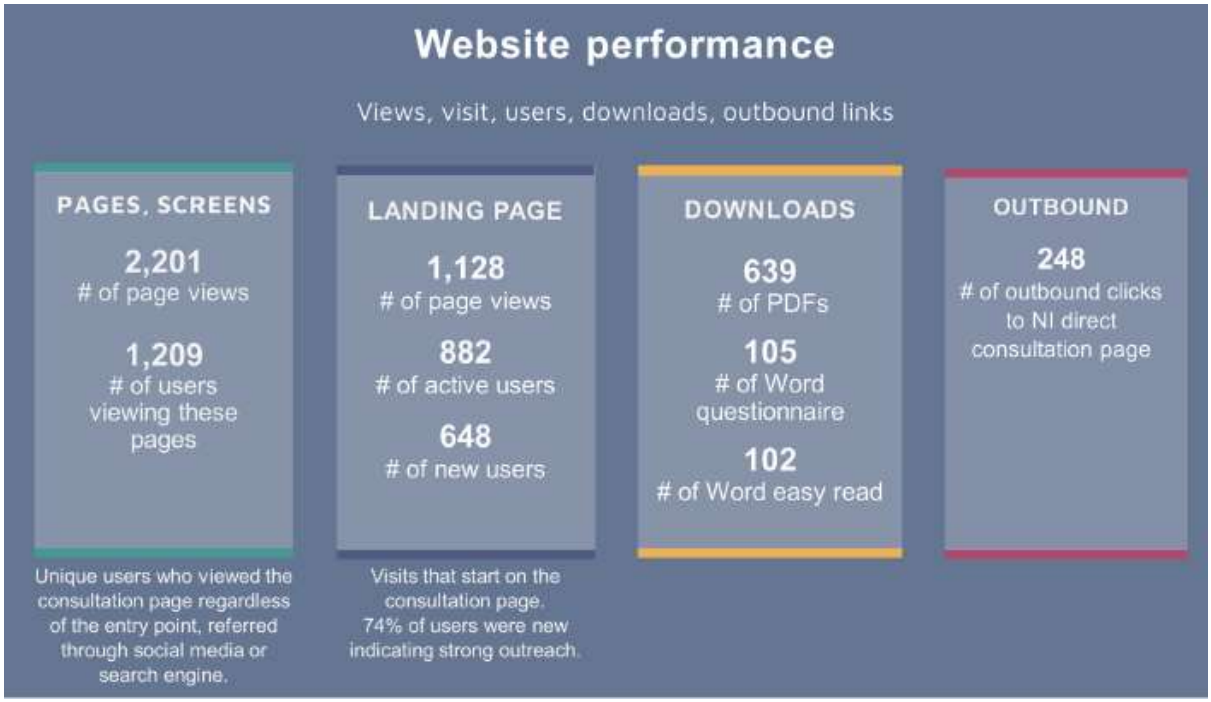
## Appendix A: Draft PHA Corporate Plan 2025-2030: External Stakeholder Consultation - Summary/Examples of Social Media Communications

| Date | Focus | Social Media | Sample |
|---|---|---|---|
| 28/11/2024<br>18/12/2024 | Consultation launch and promotion | Video content from PHA Chief Executive Aidan Dawson |  |
| 04/12/2024<br>15/12/2024<br>09/01/2025<br>15/01/2025<br>21/02/2025 | Promotion and consultation link | Link to PHA Website – Draft Corporate Plan consultation |  |
| 10/12/2024<br>26/01/2025<br>16/02/2025 | What is Public Health? | Public Health diagram |  |
| 07/01/2025<br>24/01/2025<br>12/02/2025 | **Starting Well** - laying the foundations for a healthy life from pre-birth, infancy, early years, childhood to adolescent years | Starting Well content |  |
| 09/01/2025 | In-person external stakeholder consultation events dates/information | External stakeholder consultation events info/registration link |  |
| 13/01/2025<br>11/02/2025 | **Ageing Well** - supporting people to age healthily throughout their lives | Ageing Well content |  |

| | | | |
|---|---|---|---|
| 29/01/2025 | Consultation promotion and protecting/improving health and wellbeing information | Video content from PHA Director of Public Health Dr Joanne McClean |  |
| 06/02/2025<br>19/02/2025 | Consultation promotion and creating supportive environments and opportunities for good health information | Video content from PHA Health & Social Wellbeing Improvement Manager Dr Hannah McCourt |  |
| 14/02/2025 | **Protecting Health** - protecting the population from serious health threats, such as infectious disease outbreaks or major incidents | Protecting Health content |  |
| 21/02/2025 | Consultation promotion and Nursing, Midwifery and Allied Health Professionals (NMAHP) information | Video content from PHA Director of NMAHP Mrs Heather Reid |  |

## Appendix B: Draft PHA Corporate Plan 2025-2030: External Stakeholder Consultation - Social Media Performance



## Appendix C: Draft PHA Corporate Plan 2025-2030: Staff Communications and Engagement Timeline

**Staff Communications/Engagement Timeline**

| Date Commenced | Details |
|---|---|
| **August 2024** | Corporate plan process announced and teams asked to discuss at team meetings |
| | Weekly Staff News/Connect (PHA Intranet) updates began |
| **September 2024** | Corporate plan development updates at every 1st Tuesday staff engagement session |
| **October to November 2024** | Two in-person staff engagement workshops |
| | NICON event |
| | Request for inputs and teams to help with writing and editing content |
| | Development of content with colleagues and teams |
| | Draft for consultation to be discussed with Corporate Plan Oversight Group, AMT, PPR and PHA board for approval |
| **22 November 2024** | Staff engagement evaluation report and copy of draft Corporate Plan issued to staff *prior* to consultation 'Go Live'. |

## Appendix D: Draft PHA Corporate Plan 2025-2030: External Stakeholder Consultation - List of Organisations who Responded to the Consultation

| | | | | | | |
|---|---|---|---|---|---|---|
| **Individual Responses by Council Area** | **Antrim and Newtownabbey** | **Ards North Down** | **ABC** | **Belfast CC** | **Causeway Coast and Glens** | **Derry and Strabane** |
| | 1 | 2 | 1 | 7 | 1 | 1 |
| | **Fermanagh Omagh** | **Lisburn and Castlereagh** | **Mid East Antrim** | **Mid Ulster** | **Newry Mourne Down** | **Not Answered** |
| | 2 | 6 | 4 | 3 | 2 | 4 |

| | | |
|---|---|---|
| **Organisation Respondents** | AGE NI | Lisburn and Castlereagh City Council |
| | AHPFNI | Mental Health Champion Office |
| | AIIHP | Mid and East Antrim |
| | ARC NI | NEA NI |
| | Ards and North Down Borough Council | NIAS |
| | Auditory Verbal UK | NIHE |
| | Belfast Health Cities | NSPCC |
| | Breast Cancer Now | Outscape |
| | Causeway Coast and Glens DC | PBNI |
| | Centre for Effective Services | Peninsula Healthy Living Partnership Ltd |
| | Chest Heart and Stroke | PHA (Health Protection) |
| | Child Health Partnership | Positive Futures |
| | Clanrye Group | Prostate Cancer Uk |
| | Comm Dev and Health Network | PWSA |
| | COPNI | Queens University Belfast |
| | County Down Rural Community Network | RCN (Trade Union) |
| | Derry and Strabane DC | Research Data Scotland |
| | East Belfast Community Dev Agency | Resurgam Trust |
| | Extern | RNIB |
| | Faculty of Public Health | Royal College of Psychiatrists NI |
| | Healthy Living Alliance | Rural Support |
| | Heart Project Belfast | Stroke Association |
| | HIRA NI | The Chartered Society of Physiotherapy |
| | HSC NI (PHA) | The Safeguarding Board NI |
| | IPA | Ulster University |
| | Kidney Care UK | |

## Appendix E: Draft PHA Corporate Plan 2025-2030: External Stakeholder Consultation - List of Questionnaire Questions

Q1: Do you agree with our purpose? If not, what alternative do you suggest?

Q2: Do you agree with our vision and values? If not, what alternative do you suggest?

Q3: Referring to the draft plan, do you agree with Outcome 1: Protecting Health and the priorities listed? If not, what alternative do you suggest?

Q4: Referring to the draft plan, do you agree with Outcome 2: Starting Well and the priorities listed? If not, what alternative do you suggest?

Q5: Referring to the plan, do you agree with Outcome 3: Living Well and the priorities listed? If not, what alternative do you suggest?

Q6: Referring to the plan, do you agree with Outcome 4: Ageing Well and the priorities listed? If not, what alternative do you suggest?

Q7: Referring to the plan, do you agree with our organisation ambition and priorities listed? If not, what alternative do you suggest?

Q8: Is there an outcome you feel is missing or is not sufficiently reflected?

Q9: Have you any other comments or suggestions to improve the document as a whole? If so, please outline these in the box below.

## Appendix F: Draft PHA Corporate Plan 2025-2030: External Stakeholder Consultation - Engagement Workshop Programme and Discussion Questions

### Stakeholder Engagement Event Programme

| In-Person Stakeholder Consultation Events | | | |
|---|---|---|---|
| Date:<br>Time:<br>Venue: | **Mon 13 January 2025**<br>2.00pm to 4.00pm<br>**Involve NI***<br>16-18 Queen Street<br>Magherafelt, BT45 6AB | **Tue 21 January 2025**<br>10.30am to 12.30pm<br>**Lagan Valley Island***<br>1 The Island<br>Lisburn, BT27 4RL | **The 06 February 2025**<br>12.30pm to 2.00pm<br>**via MS Teams/Zoom** |

### Agenda

| Day | Time | Item |
|---|---|---|
| 1 | 2.00pm | **Registration, Tea and Coffee*** |
| 2 | 10.30am | |
| 3 | 12.30pm | |
| 1 | 2.15pm | **Welcome and Setting the Scene**<br>*Stephen Wilson, Julie Mawhinney* |
| 2 | 10.45am | |
| 3 | 12.45pm | |
| 1 | 2.40pm | **Burning Issues** |
| 2 | 11.10am | |
| 3 | 1.10pm | |
| 1 | 2.45pm | **Outcomes Themed Discussion**<br>*Stephen Wilson, Stephen Murray, Julie Mawhinney, Martin Quinn, Bronagh Donnelly, Emmett Lynch* |
| 2 | 11.15am | |
| 3 | 1.15pm | |
| 1 | 3.45pm | **Next Steps** |
| 2 | 12.15pm | |
| 3 | 2.15pm | |
| 1 | 4.00pm | **Close** |
| 2 | 12.30pm | |
| 3 | 2.30pm | |

### Areas/Questions for Discussion

Strategic Themes Focussed Discussions:

1. Does this strategic them set out the right direction and right priorities/indicators?
2. Is anything missing?
3. What would success look like?
4. How can we work better together?

Overall Corporate Plan Questions:

1. Do you agree with the direction set out by the corporate plan as a whole? Consider the purpose, vision and values, strategic themes, ambitions, priorities and suggested indicators.
2. What would successful implementation of the plan look like?

## Appendix G: Draft PHA Corporate Plan 2025-2030: External Stakeholder Consultation – List of Organisations who attended Consultation Events

| | 13 January 2025<br>InvolveNI, Magherafelt | 21 January 2025<br>LVI, Lisburn | 06 February 2025<br>Online via MS Teams |
|---|---|---|---|
| 1. | Compassionate Communities NI | Age Friendly Alliance | Age NI |
| 2. | CWSAN | AHPFNI | Aware NI |
| 3. | Impact Network NI | All Ireland Institute of Hospice and Palliative Care | Ballynahinch Counselling Service |
| 4. | Mid Ulster Agewell | Chinese Welfare Association NI | Bogside & Brandywell Health Forum |
| 5. | Mid Ulster District Council | Clinical Education Centre | British Dental Association |
| 6. | Mid Ulster Volunteer Centre | Community Development and Health Network | Citizen |
| 7. | MSD | Department of Education | Derg Valley Care Healthy Living Centre |
| 8. | Northern Area Community Network | East Belfast Community Development Agency | Dunlewey Addiction Services |
| 9. | Royal College of Nursing | MindWise | Equality and Human Rights Unit, Department of Health |
| 10. | | New Lodge Duncairn Community Health Partnership | Kidney Care UK |
| 11. | | PIPS Hope & Support | Medicines and Healthcare Products Regulatory Authority (MHRA) |
| 12. | | PWSA UK (Prader Willi Syndrome Association) - Northern Ireland Regional Office | NHSCT Recovery College |
| 13. | | Rosie's Trust | NICON |
| 14. | | Royal College of Nursing | NIPHRN, Ulster University |
| 15. | | South Eastern Trust | North Down Community Network |
| 16. | | The Resurgam Trust | Northern Ireland Public Health Research Network, Ulster University |
| 17. | | | Parenting Focus |
| 18. | | | PSNI |
| 19. | | | RCPsych NI |
| 20. | | | The Open University |

## Appendix H: Draft PHA Corporate Plan 2025-2030: Staff Engagement Evaluation Report

For AMT reference only

20241122
Staff-Engagement-E

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# Equality and Human Rights Screening Template

The PHA is required to address the 4 questions below in relation to all its policies. This template sets out a proforma to document consideration of each question.

What is the likely impact on equality of opportunity for those affected by this policy, for each of the Section 75 equality categories? (minor/major/none)

Are there opportunities to better promote equality of opportunity for people within the Section 75 equality categories?

To what extent is the policy likely to impact on good relations between people of a different religious belief, political opinion or racial group? (minor/major/none)

Are there opportunities to better promote good relations between people of a different religious belief, political opinion or racial group?



For advice & support on screening contact:

Anne Basten
Equality Unit
Business Services Organisation
2 Franklin Street
Belfast BT2 8DQ
028 90535564
email: Anne.Basten@hscni.net

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**SCREENING TEMPLATE**

See Guidance Notes for further information on the 'why' 'what' 'when', and 'who' in relation to screening, for background information on the relevant legislation and for help in answering the questions on this template .

## (1) INFORMATION ABOUT THE POLICY OR DECISION

### 1.1 Title of policy or decision

Public Health Agency (PHA) Corporate Plan 2025-2030

### 1.2 Description of policy or decision

- **what is it trying to achieve? (aims and objectives)**
- **how will this be achieved? (key elements)**
- **what are the key constraints? (for example, financial, legislative or other)**

The PHA Corporate Plan 2025-2030 sets out the strategic direction for the next five years. It details our vision, ambitions and evidence-based strategic priorities for the period 2025-2030.

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 vision and ambitions for health and wellbeing in Northern Ireland and reiterate our call for a continued focus on improving health and reducing health inequalities across HSC and wider society.

The plan is focussed around our strategic outcomes:

1. **Protecting health** – protect the population from serious health threats, such as infectious disease outbreaks or major incidents.
2. **Starting well** – laying the foundations for a healthy life from pre-birth, infancy, early years, childhood to adolescent years (0-18).
3. **Living well** – ensuring that people have the opportunity to live and work in a healthy way.
4. **Ageing well** – supporting people to age healthily throughout their lives.

The Corporate Plan also details the key indicators the PHA will use to monitor public health in relation to the detailed outcomes and focus of the period 2025-2030. It provides a basis for the Annual Business Plan and strategic direction and is a core accountability tool for the Department of Health, (DoH).

The Corporate Plan also incorporates how PHA will work going forward as an organisation 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), the Patient Client Council (PCC) and the Community and Voluntary (C&V) sector considering best practice to ensure we work effectively whilst being committed to people, partnerships, processes, digital capacity and be research and evidence driven.

**1.3 Main stakeholders affected (internal and external)**

**For example staff, actual or potential service users, other public sector organisations, voluntary and community groups, trade unions or professional organisations or private sector organisations or others**

**Internal**: Public Health Agency staff

**External**:
Service users and the public, DoH, Strategic Planning and Performance Group (SPPG), PHA/SPPG Joint Commissioning Groups, Integrated Care System (ICS) Area Integrated Partnership Board (AIPB), Local Commissioning Groups (LCGs), Patient and Client Council, Business Services Organisation, Health and Social Care Trusts, Voluntary & Community Sector, Professional organisations, Other Statutory Organisations such as education, housing, local government, justice, culture and Private Sector Organisations.

**1.4 Other policies or decisions with a bearing on this policy or decision**

- **what are they?**
- **who owns them?**

1. PHA Corporate Plan 2017-2021. Available via PHA website

2. PHA Board meetings

3. Community Planning led by each local Council

4. Guidance relating to governance, finance etc. Belfast: DoH

5. Guidance on quality and safety National Institute for Clinical Excellence

6. Policy guidance in relation to health improvement, health protection, service development, screening, quality & safety. Belfast: DoH

7. Health and Wellbeing 2026: Delivering Together. Belfast: DoH, 2016

8. Making Life Better: A Whole System Strategic Framework for Public Health 2013-2023. Belfast: Department of Health Social Services and Public Safety (DHSSPS), Jun 2014

9. Doing What Matters Most - Draft Programme for Government (PfG) Framework 2024-27. Belfast: NIE, 2024

10. Integrated Care System for Northern Ireland Framework (ICSNI), May 2024. Belfast: DoH

11. Mental Health Strategy 2021-2031. Belfast: DoH, 2021

12. Mental Health Strategy Early Intervention and Prevention Action Plan 2022-2025. Belfast: DoH, 2022

13. Live Better Initiatives. Belfast: DoH, 2024

14. Equality and Disability Action Plans 2023-2028. PHA, 2023

15. Protect Life 2 Strategy for Preventing Suicide and Self Harm, 2019. Belfast: DoH

16. Breastfeeding - A Great Start: A Strategy for Northern Ireland 2013-2023 [Internet], 2013. DHSSPS

17. A Fitter Future for All 2 [Internet], 2019. DHSSPS

18. Ten-Year Tobacco Control Strategy for Northern Ireland [Internet], 2012. DHSSPS

19. Preventing Harm, Empowering Recovery - A Strategic Framework to Tackle the Harm from Substance Use (2021-31) 2 Substance Use Strategy 2021-31 [Internet], 2021. DoH

20. A Cancer Strategy for Northern Ireland (2022-2032) [Internet], 2022. DoH

21. Health Inequalities - A Product of the NI Health and Social Care Inequalities Monitoring System. Department of Health

22. Health Survey (NI) First Results 2019/20. Department of Health

23. Systems, Not Structures: Changing Health and Social Care (Bengoa Report) Expert Panel Report, 2016. Belfast: DoH

**UK & International References**

24. Fair Society, Healthy Lives - The Marmot Review, 2010. Available via www.parliament.uk

25. Health Equity in England: The Marmot Review 10 Years On, 2020. Marmot M, Allen J, Boyce T, Goldblatt P, Morrison J. [Internet]. Available via The Institute of Health Equity

26. Compassionate Leadership. Available via The Kings Fund

27. Functions and Standards of a Public Health System [Internet], 2020. Faculty of Public Health

28. Creating Healthy Places: Perspectives from NHS England's Healthy New Towns Programme [Internet]. The Kings Fund

29. A Vision for Population Health Towards a Healthier Future [Internet], 2018. Buck D, Baylis A, Dougall D, Robertson R, available via The Kings Fund

30. What Are Health Inequalities? 2022. Williams E, Buck D, Babalola G, Maguire D. [Internet]. Available via The King Fund

31. Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health - Commission on Social Determinants of Health [Internet], 2008. Available via World Health Organisation (WHO)

32. World Health Organization. Closing the Gap in a Generation. Health Equity Through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health. Geneva: WHO, 2008

33. WHO - The Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP)

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## (2) CONSIDERATION OF EQUALITY AND GOOD RELATIONS ISSUES AND EVIDENCE USED

### 2.1 Data gathering

**What information did you use to inform this equality screening? For example previous consultations, statistics, research, Equality Impact Assessments (EQIAs), complaints. Provide details of how you**

1. Previous Corporate Strategy, Annual Business Plans and Directorate Plans, Health Survey NI Results, Health Inequalities Annual Report 2024 and equality screenings.
2. Meetings – through Directors & Assistant Directors to staff in their Directorates, Agency Management Team and PHA board.3. Northern Ireland Statistics and Research Agency (NISRA)
4. Personal and public involvement strategy and action plan
5. Statistics and information from Carers NI
6. Statistics and information from the BSO Human Resource Directorate
7. Workshops (and subsequent reports) with staff and key stakeholders including service users to discuss priorities
8. DoH Making Life Better consultation (previously Fit and Well)
9. Consultation responses to events and through questionnaires
10. A full list of research references is provided in the additional supporting paper provided.

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## 2.2 Quantitative Data

**Who is affected by the policy or decision? Please provide a statistical profile. Note if policy affects both staff and service users, please provide profile for both.**

<table>
<tr><th>Category</th><th>What is the makeup of the affected group? (%) Are there any issues or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group?</th></tr>
<tr><td>Gender</td><td>At 30 June 2023, Northern Ireland's population was estimated to be 1.92 million people. Between mid-2022 and mid-2023, the population of Northern Ireland increased by 9,800 people (0.5 per cent). Just over half of the population (50.8 per cent) were female, with 974,900 females compared to 945,500 males (49.2 per cent).<br>(NISRA Statistical Bulletin 2023)<br><br>The census day population comprised of 967,000 females and 936,100 males. This means that for every 100 females in Northern Ireland there were 96.8 males. (Census 2021)<br><br>PHA Workforce (as of Sept 2024)<br><table><tr><td>Male</td><td>23.75%</td></tr><tr><td>Female</td><td>76.25%</td></tr></table>Staff in post as of Sept 2024, 361 (permanent HC) 336.81 (permanent WTE) 43 (temporary HC) 36 (temporary WTE)<br><br>Transgender<br>The Gender Identity Research & Education Society (GIRES) highlights the following Office for National Statistics (ONS) 2021 UK Census question which asked people aged over 16: "Is the gender you identify with the same as your sex registered at birth?"<br><br>45.7 million (94.0% of the UK population aged 16 years and over) answered the question:<br>• 45.4 million (93.5%) answered "Yes" and<br>• 262,000 (0.5%) answered "No"<br>• 1.9 million (6.0%) did not answer the question.<br><br>Several factors may have reduced the number of "No" responses as the Census can be completed by a single family member for a whole household. Consequently, some trans and gender diverse people may not have been able to answer the question themselves. Others may not have felt it was safe to do so.</td></tr>
</table>

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Of the 262,000 people (0.5%) who answered “No”, indicating that their gender identity was different from their sex registered at birth:

• 118,000 (0.24%) answered “No” but did not provide any further information
• 48,000 (0.10%) identified as a trans man
• 48,000 (0.10%) identified as a trans woman
• 30,000 (0.06%) identified as non-binary
• 18,000 (0.04%) wrote in a different gender identity Data from other sources indicate that the Census figures may understate the size of the trans and gender diverse population.

The Gender Identity Research and Education Society (GIRES) estimate the number of gender nonconforming employees and service users, based on the information that GIRES assembled for the Home Office (2011) and subsequently updated (2014):

• gender variant to some degree 1%
• have sought some medical care 0.025%
• having already undergone transition 0.015%.

The numbers who have sought treatment seems likely to continue growing at 20% per annum or even faster. Few younger people present for treatment despite the fact that most gender variant adults report experiencing the condition from a very early age. Yet, presentation for treatment among young people is growing even more rapidly (50% p.a.). Organisations should assume that there may be nearly equal numbers of people transitioning from male to female (trans women) and from female to male (trans men).

Applying GIRES figures to NI population (using NISRA mid-year population estimates for June 2018) N=1,881,600:

• 18,816 people who do not identify with gender assigned to them at birth
• 470 likely to have sought medical care
• 282 likely to have undergone transition.

A 30-Country Ipsos Global Advisor Survey reflects 3.1% of people saying they were trans, non-binary, gender queer or gender fluid, Agender or another gender that was not male or female.

| | |
|---|---|
| Age | Census 2021 Population Statistics reflect there are 365,200 children in Northern Ireland aged 0 to 14, a 10,500 increase compared from the 354,700 children in 2011. In contrast the number of persons aged 65 and over has increased from 263,700 in 2011 to 326,500 in 2021. The ageing of the population can also be seen in the median age of the population (the age at which half the population are above or below), which over the last decade has increased by two years from 37 in 2011 to 39 in 2021.<br><br>Children (defined as those aged 0 to 14) make up 19.2% of the Northern Ireland population. This percentage varies across Local Government Districts and is highest in Mid Ulster where the proportion is 21.7%, and lowest in Ards and North Down where the proportion is 17.0%<br><br>One in eight children and young people in Northern Ireland experienced emotional difficulties, one in ten had conduct problems and one in seven problems with hyperactivity. (The Executive Summary of the Youth and Wellbeing Prevalence Survey 2020)<br><br>People over 60 make up 19% of the population, according to Census 2021. This represents a near 25% increase from 2011 and demonstrates the scale of population change due to ageing. People aged 65 and over account for 326,500 people or 17.2% of the Northern Ireland population. (Census 2021)<br><br>The number of people aged 85 and over in Northern Ireland was estimated to be 39,500 in mid-2020, an increase of 700 people (1.9 per cent) since mid-2019. Over the decade, the population aged 85 and over grew by 8,700 people (28.1 per cent) (Census Bulletin 2021)<br><br>By mid-2027, the number of people aged 65 and over is projected to overtake the number of children. By mid-2045, almost 1 in 4 people in Northern Ireland are projected to be aged 65 and over (NISRA Bulletin 2020)<br><br>The number of people aged 65 and older will grow from 17.8% in 2023 (342,482 total individuals) to 25.8% in 2050 (499,337 total individuals) The number of people aged 65 and over will, on average, grow annually by 7,409 individuals until 2040, and in the period 2024 to 2034, it will grow by 8,517 individuals on average every year. (NISRA 2020 and 2023 Statistics)<br><br>In 2022/23 the percentage of primary 1 pupils in the most deprived areas affected by obesity was more than double the proportion in the least deprived areas. The inequality gap in year 8 pupils affected by obesity was slightly lower, with the proportion in the most deprived areas 94% higher than in the least deprived areas.(Health Inequalities Annual Report 2024, DOH) |

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**NI Age Profile**

Band /Population/ Percentage

- 0-14 365,200 19.2%
- 15-64 1,211,500 63.7%
- 15-39 594,400 31.2%
- 40-64 617,100 32.4%
- 65+ 326,500 17.2%
- 65-84 287,100 15.1%
- 85+ 39,400 2.1%

(Census 2021)

PHA Workforce (as of Sept 2024)

| Age Group | % |
|---|---|
| 16-24 | 6.21% |
| 25-29 | 7.52% |
| 30-34 | 5.51% |
| 35-39 | 9.12% |
| 40-44 | 8.52% |
| 45-49 | 10.32% |
| 50-54 | 12.83% |
| 55-59 | 14.73% |
| 60-64 | 11.42% |
| >=65 | 13.83% |

Religion

In Northern Ireland, the main current religions are Catholic (42.3%), Presbyterian (16.6%), and Church of Ireland (11.5%). Other Christian denominations and other religions make up the remaining 24.7 (Census Bulletin; Religion 2021)

In addition, 17.4% of the population had 'No religion' – this is a marked increase on 2011 when 10.1% had 'No religion'. This points to the increased secularisation of our population.

**Religion or Religion brought up in**

The 2021 Census, regarding religious background, highlights four of the six NI counties had a Catholic majority and two had a Protestant majority. Just under one person in five (19.0%) either had 'no religion' (17.4%) or 'religion not stated' (1.6%). The equivalent percentages for the main religions were:

• Catholic (42.3%)
• Presbyterian Church in Ireland (16.6%)
• Church of Ireland (11.5%)

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• Methodist (2.4%)
• Other Christian denominations (6.9%)
• Other non-Christian Religions (1.3%)

Census Statistics 2021 bringing together information on current religion and religion of upbringing, 45.7% of the population were either Catholic or brought up as a Catholic, while 43.5% were recorded as 'Protestant and other Christian (including Christian related)'. Again, bringing together information on current religion and religion of upbringing, 1.5% of the population are classified as 'other religions' and 9.3% of the population identified that they neither belonged to nor were brought up in a religion ('None').

PHA Workforce (as of Sept 2024)

| | |
|---|---|
| Perceived Protestant | 1.35% |
| Protestant | 15% |
| Perceived Roman Catholic | 0.74% |
| Roman Catholic | 18.02% |
| Neither | 0.83% |
| Perceived Neither | |
| Not assigned | 64.06% |

**Political Opinion**

63% of the population voted in the 2022 NI Assembly election. Of these 29% voted Sinn Fein, 21% DUP, 14% Alliance, 11% UUP, and 9% SDLP (BBCNI).

The 2021 Census showed National identity (person based) number and percentage:

| National Identity | Population number | Population percentage |
|---|---|---|
| British only | 606,263 | 31.86% |
| Irish only | 554,415 | 29.13% |
| Northern Irish only | 376,444 | 19.78% |
| British and Irish only | 11,768 | 0.62% |
| British and Northern Irish only | 151,327 | 7.95% |
| Irish and Northern Irish only | 33,581 | 1.76% |
| British, Irish and Northern Irish only | 28,050 | 1.47% |
| Other | 141,327 | 7.43% |

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| | |
|---|---|
| | NI survey suggests 50% neither unionist nor nationalist - BBC News<br>**Half of the population of Northern Ireland describe themselves as "neither unionist nor nationalist", according to new research (2019).**<br><br>Just over a quarter (26%) replied that they considered themselves to be unionists, while just over a fifth (21%) described themselves as nationalists.<br><br>The responses were also broken down by gender, religious background and age. There was only a 2% difference between the proportion of men and women who identified as nationalist (22% and 20% respectively).<br><br>Among unionists, there was a gap of eight percentage points between men and women, with 31% of men describing themselves as unionist, compared with 23% of women. In terms of age, the group most likely to pick a side in the border debate was pensioners aged 65 and over, while people under the age of 45 were more likely to say there were neutral on the union.<br><br>The age group with the highest number of neutrals was the 35 to 44-year-olds' bracket, outstripping their younger 25 to 34-year-old peers by 10 percentage points.<br><br>The youngest age bracket (between 18 and 24 years old) also had a high number of neutrals, with 59% saying they were neither unionist nor nationalist. However, in that age group young unionists outnumbered young nationalists significantly, with a quarter of 18 to 24-year-old respondents describing themselves as unionist, and just 14% who said they were nationalists. At the other end of the scale, there was an even bigger political split between the over-65s. Just under a fifth (19%) of pensioners described themselves as nationalist while more than twice that number (41%) replied that they were unionist. Pensioners were also the least likely to say they were neutral on the union, with just 38% of over-65s falling into that category.<br>As regards religious background, exactly half of the Catholics surveyed identified as nationalist and more than half (55%) of Protestants identified as unionist. People who said they had no religion were most likely to say they had no political affiliation to unionism or nationalism.<br>Political Attitudes in NI update151.pdf<br><br>In the above NILT 2022 report, the breakdown of self-described community identities in Northern Ireland is unionist (31%), nationalist (26%) and ‘neither’ (38%) |

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<table>
<tr><td></td><td>PHA Workforce (as of Sept 2024)<table>
<tr><td>Broadly Nationalist</td><td>0.70%</td></tr>
<tr><td>Other</td><td>2.30%</td></tr>
<tr><td>Broadly Unionist</td><td>0.90%</td></tr>
<tr><td>Not assigned</td><td>94.49%</td></tr>
<tr><td>Do not wish to answer</td><td>1.60%</td></tr>
</table></td></tr>
<tr><td>Marital Status</td><td>46% (693,000 adults) were married or in a civil partnership in 2021. This made up 46% of our population aged 16 and over. In contrast 577,000 adults (38%) were single (never married/civil partnered).<br><br>Of the adult population living in households, just over half lived as part of a couple within the household (53% or 794,000 people in a married, civil partnership or co-habiting couple). The remaining 695,000 adults (47%), did not live as part of a couple within the household. (NISRA Bulletin)<br>Census 2021 findings highlight following population data:<br><br>• Single (never married/civil partnered) 576,700 (38.1%)<br>• Married 690,500 (45.6%)<br>• In a civil partnership 2,700 (0.2%)<br>• Separated [note 1] 57,300 (3.8%)<br>• Divorced [note 1] 91,100 (6.0%)<br>• Widowed [note 1] 96,400 (6.4%)<br><br>Note 1: These classifications include both the married and civil partnership equivalents. ‘Separated’ is ‘separated (still legally married or still legally in a civil partnership)’, ‘divorced’ is ‘divorced or formerly in a civil partnership now dissolved’ and ‘widowed’ is ‘widowed or surviving partner from a civil partnership’<br><br>The rise in the ‘single’ population and the fall in the ‘married’ population here is in line with results from recent censuses in England and Wales. These figures mirror changes in society and specifically in personal relationships that has been witnessed over the last 50 years.<br><br>Northern Ireland Life and Times Survey (2018):<br>• Single (never married) - 32%<br>• Married and living with husband/wife - 51%<br>• A civil partner in a legally-registered civil partnership - 0%<br>• Married and separated from husband/wife - 3%<br>• Divorced - 6% • Widowed - 7%</td></tr>
</table>

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PHA Workforce (as of Sept 2024)

| | |
|---|---|
| Divorced | 0.40% |
| Mar/CP | 16.93% |
| Other | 0.20% |
| Separated | 0.20% |
| Single | 4.41% |
| Unknown | 77.76% |
| Widowed | 0.10% |
| Not assigned | |

**Dependent Status**

There are over 220,000 people providing unpaid care for a sick or disabled family member or friend in Northern Ireland. Despite the multi-billion-pound savings they deliver here each year, too many local carers are being driven to breaking point by unrelenting caring duties, few opportunities for a break, poverty and patchy support from Health and Social Care services. ( A New Deal for unpaid carers in Northern Ireland | Carers UK 2023)

CarersNI State of Caring 2023 Annual survey (UK wide, including NI) This report examines the impact of unpaid caring on health and wellbeing in Northern Ireland, based on data from Carers NI's State of Caring 2023 survey.

It shows:

- 1 in 4 carers in Northern Ireland are suffering mental ill-health
- 50% feel lonely at least some of the time
- 43% identify more breaks as among their main needs as a carer
- More than 1 in 3 have put off health treatment for themselves because of the demands of caring. *(Available at State of Caring 2023: The impact of caring on health in Northern Ireland | Carers UK)*

**Carers NI (State of Caring 2022 report)**

There are over 290,000 people providing some form of unpaid care for a sick or disabled family member or friend in Northern Ireland – around 1 in 5 adults. (Carers UK, 2022).

Of those participating in the survey:

- 82% identified as female and 17% identified as male.
- 4% are aged 25-34, 17% are aged 35-44, 33% are aged 45-54, 31% are aged 55-64 and 14% are aged 65+.
- 24% have a disability.
- 98% described their ethnicity as white.

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- 28% have childcare responsibilities for a non-disabled child under the age of 18 alongside their caring role.
- 56% are in some form of employment and 18% are retired from work.
- 31% have been caring for 15 years or more, 16% for between 10-14 years, 25% for 5-9 years, 25% for 1-4 years, and 3% for less than a year.
- 46% provide 90 hours or more of care per week, 13% care for 50-89 hours, 23% care for 20-49 hours, and 19% care for 1-19 hours per week.
- 67% care for one person, 25% care for two people, 5% care for three people and 3% care for four or more people.

The economic value of unpaid care in Northern Ireland | Carers UK

- People providing unpaid care for sick or disabled family members and friends are saving Northern Ireland's health service £5.8 billion in care costs each year – representing £16 million per day, or £0.7 million per hour.
- The value of unpaid care in Northern Ireland has grown by over 40% during the last decade – significantly higher than the equivalent rise in England (30%) and Wales (17%) during the same period.
- In total, unpaid carers in Northern Ireland are saving the equivalent of 80% of the DoH's entire day-to-day spending budget for 2023-24.
- The annual amount of money saved by unpaid carers is greatest in the Northern Health and Social Care Trust (£1.3 billion), followed by the Belfast Trust (£1.1 billion), Southern Trust (£1 billion), South Eastern Trust (£985m) and Western Trust (£800m).

Census 2021 data highlights that one person in eight of the population aged 5 or more (or 222,200 people) provided unpaid care to a relative or friend who had a health condition or illness. The 2021 Census notes how many hours the carer provided each week. One person in twenty-five (68,700 people) provided 50 or more hours of unpaid care per week. • While people of all ages provided unpaid care, it was most common among those aged 40 to 64, at one person in five (or 124,600 people). • The census also found that 2,600 children aged 5 to 14 provided unpaid care. • The overall number of people providing unpaid care has not changed markedly from Census 2011 to Census 2021. However the number of people providing 50 or more hours unpaid care each week has increased (up from 56,300 people in 2011 to 68,700 people in 2021)

The 2021 census illustrated that in Northern Ireland (usual residents aged 5 and over 1,789,348) the percentage of usual residents aged 5 and over who provide:

- No unpaid care 87.58%
- 1-19 hours unpaid care per week 5.63%

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<table>
<tr><td></td><td>
<ul>
<li>20-34 hours unpaid care per week 1.38%</li>
<li>35-49 hours unpaid care per week 1.57%</li>
<li>50+ hours unpaid care per week 3.84%</li>
</ul>
PHA Workforce (as of Sept 2024)
<table>
<tr><td>Yes</td><td>4.01%</td></tr>
<tr><td>Not assigned</td><td>93.79%</td></tr>
<tr><td>No</td><td>2.20%</td></tr>
</table>
</td></tr>
<tr><td>Disability</td><td>According to NISRA statistics (Census 2021) nearly one person in every nine in Northern Ireland had a long-term health problem or disability which limited their day-to-day activities a lot (218,000 people). Over half of the population aged 65 or more (56.8% or 185,300 people) had a limiting long-term health problem or disability.<br><br>In contrast, this falls to just under 8% of those aged 0 to 14. The number of people that had a long-term health problem or disability which limited their day-to-day activities increased from 374,600 people in 2011 to 463,000 people in 2021 (or a nearly 25% increase in number over the decade). This level of increase mirrors the ageing of our population.<br><br>While the overall level of a limiting long-term health problem or disability increased from 20.7% to 24.3%, the largest change is in people whose day-to-day activities were limited ‘a little’ – up from 159,400 people in 2011 to 245,100 people in 2021.<br><br>The type of long-term health condition that was most frequently reported (whether solely or in combination with others) was ‘long-term pain or discomfort’ (11.6% of the population or 220,300 people). The least prevalent long-term health condition was ‘Intellectual or learning disability’ (0.9% or 16,900 people).<br>Out of all usual residents (n=1,903,179), the Percentage of usual residents whose day-to-day activities are:<br><br>• Limited a lot – 11.45%<br>• Limited a little – 12.88%<br>• Not limited – 75.67%</td></tr>
</table>

('day-to-day activities limited' covers any health problem or disability, including problems related to old age, which has lasted or is expected to last for at least 12 months.)

The 2021 census also set out the following types of long-term condition held by the population:

| **Type of long-term condition** | **Percentage of population with condition %** |
|---|---|
| Deafness or partial hearing loss | 5.75 |
| Blindness or partial sight loss | 1.78 |
| Mobility of Dexterity Difficulty that requires wheelchair use | 1.48 |
| Mobility of Dexterity Difficulty that limits basic physical activities | 10.91 |
| Intellectual or learning disability | 0.89 |
| Learning difficulty | 3.5 |
| Autism or Asperger syndrome | 1.86 |
| An emotional, psychological or mental health condition | 8.68 |
| Frequent periods of confusion or memory loss | 1.99 |
| Long – term pain or discomfort. | 11.58 |
| Shortness of breath or difficulty breathing | 10.29 |
| Other condition | 8.81 |

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Health Survey NI (2021-22) findings revealed two-fifths of respondents (41%) have a physical or mental health condition or illness expected to last 12 months or more (similar to 2019/20). This increased with age from 27% of those aged 16-24 to 69% of those aged 75 and over. Half (50%) of those living in the most deprived areas reported a long-term condition compared with less than two-fifths (37%) of those in the least deprived areas.

Less than a third (29%) of respondents have a long-standing illness that reduces their ability to carry out day-to-day activities (similar to 2019/20). Prevalence increased with age with 13% of those aged 16-24 reporting a limiting long-term condition compared with 56% of those aged 75 and over. Most of those (88%) with limiting long-term conditions reported their ability to carry out day-to-day activities had been reduced for 12 months or more.

A RNIB's Community Engagement project demonstrated 72 % of people with sight loss report they cannot read personal health information given to them by their GP. And 22 % say they have missed an appointment due to information being sent to them in an inaccessible format.

PHA Workforce as of Sept 2024

| | |
|---|---|
| No | 15.13% |
| Not assigned | 83.87% |
| Yes | 1.00% |

Ethnicity

Census 2021 data highlights that in 2021 the number of people with a white ethnic group was 1,837,600 (96.6% of the population). Conversely, the total number of people with a minority ethnic group stood at 65,600 people (3.4% of the population).

Within this latter classification, the largest groups were Mixed Ethnicities (14,400), Black (11,000), Indian (9,900), Chinese (9,500), and Filipino (4,500). Irish Traveller, Arab, Pakistani and Roma ethnicities also each constituted 1,500 people or more.

**2021 Census**

| Ethnic group | Population number | Population Percentage |
|---|---|---|
| White | 1,837,600 | 96.60% |
| Black | 11,000 | 0.60% |
| Indian | 9,900 | 0.50% |

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| | | | |
|---|---|---|---|
| | Chinese | 9,500 | 0.50% |
| | Filipino | 4,500 | 0.20% |
| | Irish Traveller | 2,600 | 0.10% |
| | Arab | 1,800 | 0.10% |
| | Pakistani | 1,600 | 0.10% |
| | Roma | 1,500 | 0.10% |
| | Mixed Ethnicities | 14,400 | 0.80% |
| | Other Asian | 5,200 | 0.30% |
| | Other Ethnicities | 3,600 | 0.20% |
| | All usual residents | 1,903,200 | 100.00% |

On census day 2021, 4.6 per cent (85,100 people) of NI population aged 3 and over had a main language other than English. In 2011, English was not the main language of 3.1 per cent (54,500 people). In 2021 the most prevalent main languages other than English were Polish (20,100 people), Lithuanian (9,000), Irish (6,000), Romanian (5,600) and Portuguese (5,000). The statistics released in the 2021 Census show an increasingly diverse population across ethnic group, main language, country of birth and passports held. This increasing diversity is evident to a greater or lesser degree across all 11 local councils

PHA Workforce (as of Sept 2024)

| | |
|---|---|
| Not assigned | 91.98% |
| White | 8.02% |
| Other | |
| Black African | |
| Indian | |
| Chinese | |

**Sexual Orientation**

The NI Census collected information on sexual orientation for the first time in 2021. NI population (Census 2021) highlighted:

- 31,600 people aged 16 and over (or 2.1%) identified as LGB+ ('lesbian, gay, bisexual or other sexual orientation'),
- 1.364 million people (90.0%) identified as 'straight or heterosexual' and
- 119,000 people (7.9%) either did not answer the question or ticked 'prefer not to say'.
- • 4.1% of adults (1 in 25) in Belfast identified as LGB+, while 1.1% of adults in Mid Ulster identified as LGB+.
- • 4.6% of people aged 16 to 24 identified as LGB+, this falls to 0.3% of people aged 65 and over.
- • Across England, Wales and Northern Ireland, Northern Ireland (2.1%) has the lowest percentage of people who identify as (LGB+),

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| | |
|---|---|
| | thereafter comes Wales with 3.0% of people who identify as LGB+ and then England with 3.2% (Census 2021)<br><br>PHA Workforce (Sept 2024)<br>Do not wish to answer: 0.50%<br>Not assigned: 94.19%<br>Opposite sex: 4.71%<br>Both Sexes:<br>Same sex: 0.60% |

*PHA workforce statistics provided by Human Resource equality monitoring information as of Sept 2024.*

### 2.3 Qualitative Data

**What are the different needs, experiences and priorities of each of the categories in relation to this policy or decision and what equality issues emerge from this? Note if policy affects both staff and service users, please discuss issues for both.**

*The PHA Corporate Plan 2025-2030 covers a wide range of issues across health improvement, health protection, safety and quality, research and development and screening and has the aim of improving the health and wellbeing of all people in NI (covering all section 75 groups) as well as reducing health inequalities. The document is high level and sets the strategic direction, and will be supported by the annual business plan and detailed plans and business cases as relevant over the five years. The Plan also recognises organisational reorganisation and the need to support staff, especially at a time of reform.*

*The health and well-being of individuals and groups spans a wide range of issues throughout their lives. The Agency recognises that the needs, experiences and priorities of individuals and groups within each Section 75 category may vary substantially. Some overarching work has been conducted over recent years to identify emerging themes regarding these, documented in publications such as;*

- *the PHA's "Health Briefings"*
  *www.publichealth.hscni.net/directorate-operations/communication-and-knowledge-management/health-intelligence*

- *the HSC document on "Section 75 Groups - Emerging Themes"*
  *ECNI - Equality Commission for Northern Ireland*

  *alongside the regular DoH, Social Services and Public Safety publication on inequalities monitoring*
  *Equality Screenings 2018 to 2024 - Business Services Organisation (BSO) Website*

*no one screening exercise or EQIA can do justice in giving consideration to all these aspects.*

*The direction set out in the plan is closely aligned with the core functions of the Agency, as defined by the legislation, and with other key strategies including the Making Life Better Public Health Framework and draft PFG.*
*PHA recognises that the needs, experiences and priorities of individuals and groups within each Section 75 category will vary and that some may require specific needs to experience the positive impact on health inequalities intended in this Corporate Plan. As PHA takes forward work to achieve each outcome, the actions, work and programmes will be screened individually. It is at this more detailed level that the needs, experiences and priorities of and potential impact on the Section 75 named groups will be considered and assessed specifically within each policy and strategy screening exercise.*

| ***Category*** | ***Needs and Experiences*** |
|---|---|
| Gender | |
| Age | |
| Religion | |
| Political Opinion | |
| Marital Status | |
| Dependent Status | |
| Disability | |
| Ethnicity | |
| Sexual Orientation | |

## 2.4 Multiple Identities

**Are there any potential impacts of the policy or decision on people with multiple identities? For example; disabled minority ethnic people; disabled women; young Protestant men; and young lesbians, gay and bisexual people.**

Please also see the comments at the start of 2.3

It is possible that some of the work taken forward under the outcomes set out in the Corporate Plan may impact on people with multiple identities. PHA recognises that the needs and experiences of people with multiple identities will vary across our work. In our commitment to ensuring that potential impacts are considered and mitigated, PHA will screen policies and strategies individually to ensure that the potential impacts of each policy or strategy are considered fully in that context.

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## 2.5 Making Changes

**Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to the policy or decision in order to promote equality of opportunity?**

| ***In developing the policy or decision what did you do or change to address the equality issues you identified?*** | ***What do you intend to do in future to address the equality issues you identified?*** |
|---|---|
| The Corporate Plan development included ensuring that it fully reflected the PHA role in reducing health inequalities. Some of these explicitly aim to address key equality issues.<br><br>Using our Communication department's expertise in public information the Corporate Plan was written in a style to make it accessible and understandable for a wide range of external stakeholders as well as PHA staff.<br><br>When preparing the Plan, we took the opportunity to review the purpose, vision and values to ensure its continued relevance to our work and our population. | The key actions and focus on reducing health inequalities contained within the plan will guide the work of the PHA throughout the five years and will be closely monitored through a variety of established performance monitoring systems.<br><br>Information will be gathered throughout the consultation period to further screen and consider the potential impact.<br><br>The Corporate Plan will be widely accessible and will be available in alternative formats.<br><br>As actions are taken forward in line with the outcomes of the Corporate Plan, equality issues will be reviewed and addressed as appropriate. Service leads have been reminded to keep under constant review the need for screening at an early stage when planning.<br><br>Service leads will be asked during development of each Annual Business Plan to review the need for screening at an early stage in planning and to consider and identify the actions, strategies and policies they will be progressing that will be screened and/or impact assessed.<br><br>We will also continue to implement the actions detailed in our action plan which accompanies our Equality Scheme.<br><br>Ultimately, however, we remain committed to equality screening, and if necessary equality impact assessing, the policies we develop and decisions we take. |

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## 2.6 Good Relations

**What changes to the policy or decision – if any – or what additional measures would you suggest to ensure that it promotes good relations? (refer to guidance notes for guidance on impact)**

| *Group* | *Impact* | *Suggestions* |
|---|---|---|
| Religion | Tackling the major inequalities in health and wellbeing and their causes will help promote equality of opportunity and good relations. | Continued focus on Partnership working and public participation at regional, local and community level |
| Political Opinion | Tackling the major inequalities in health and wellbeing and their causes will help promote equality of opportunity and good relations. | Continued focus on Partnership working and public participation at regional, local and community level |
| Ethnicity | Tackling the major inequalities in health and wellbeing and their causes will help promote equality of opportunity and good relations. | Continued focus on Partnership working and public participation at regional, local and community level |

## (3) SHOULD THE POLICY OR DECISION BE SUBJECT TO A FULL EQUALITY IMPACT ASSESSMENT?

A full equality impact assessment (EQIA) is usually confined to those policies or decisions considered to have major implications for equality of opportunity.

**How would you categorise the impacts of this decision or policy? (refer to guidance notes for guidance on impact)**

**Please tick:**

| | |
|---|---|
| Major impact | |
| Minor impact | |
| No further impact | √ |

**Do you consider that this policy or decision needs to be subjected to a full equality impact assessment?**
**Please tick:**

| | |
|---|---|
| Yes | |
| No | √ |

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Please give reasons for your decisions.

The PHA Corporate Plan sets out the focus and direction for the PHA from 2025-2030. Tackling health and wellbeing inequalities and improving health and wellbeing through early intervention and prevention is the essence of the Plan and complements the Section 75 Agenda, whilst promoting a shift across the health service, to the prevention of disease.

The Plan covers a wide range of issues across health improvement, health protection, safety and quality, research and development and screening and has the aim of improving the health and wellbeing of all people in NI (covering all section 75 groups) as well as reducing health inequalities.

The health and well-being of individuals and groups involves a huge range of aspects. With regards to each of these, the Agency recognises that the needs, experiences and priorities of groups within each Section 75 category may vary substantially and specific needs may need addressed to ensure that all people can experience the intended positive impact from this Corporate Plan. Individual strategies and policies will be equality screened as they are developed and taken forward.

## (4) CONSIDERATION OF DISABILITY DUTIES

### 4.1 In what ways does the policy or decision encourage disabled people to participate in public life and what else could you do to do so?

| ***How does the policy or decision currently encourage disabled people to participate in public life?*** | ***What else could you do to encourage disabled people to participate in public life?*** |
|---|---|
| The PHA actively promotes the inclusion of disabled people in service planning, monitoring and evaluation such as through Personal and Public Involvement initiatives and advisory groups. The PHA has additional regional leadership responsibilities for PPI.<br>This includes:<br>• The implementation of PPI across the HSC<br>• The chairing of the regional HSC PPI forum<br>• Report sharing best PPI practice across all HSC bodies | Encourage disabled people to get involved in user groups etc.<br><br>Always ensure that venues and events are completely accessible.<br><br>Seek to ensure that timings of meetings are such that people can use public transport and provide appropriate care parking facilities.<br><br>Provide support for carers costs if required. |

| | |
|---|---|
| • The establishment and pilot of robust PPI monitoring arrangements<br>• Raising awareness of and understanding PPI through training | |

**4.2 In what ways does the policy or decision promote positive attitudes towards disabled people and what else could you do to do so?**

| ***How does the policy or decision currently promote positive attitudes towards disabled people?*** | ***What else could you do to promote positive attitudes towards disabled people?*** |
|---|---|
| The PHA promotes positive attitudes towards disabled people and values their views.<br><br>The vision and outcomes stated in the Plan are for all people to be enabled and supported to achieve their full health and wellbeing potential. | Encourage positive attitudes to disabled people and challenge negative stereotyping through availability of corporate training programs such as e-learning Discovering Diversity programme. |

## (5) CONSIDERATION OF HUMAN RIGHTS

**5.1 Does the policy or decision affect anyone's Human Rights? Complete for each of the articles**

| **ARTICLE** | **Yes/No** |
|---|---|
| Article 2 – Right to life | No |
| Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment | No |
| Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour | No |
| Article 5 – Right to liberty & security of person | No |
| Article 6 – Right to a fair & public trial within a reasonable time | No |
| Article 7 – Right to freedom from retrospective criminal law & no punishment without law | No |
| Article 8 – Right to respect for private & family life, home and correspondence. | No |
| Article 9 – Right to freedom of thought, conscience & religion | No |

| | |
|---|---|
| Article 10 – Right to freedom of expression | No |
| Article 11 – Right to freedom of assembly & association | No |
| Article 12 – Right to marry & found a family | No |
| Article 14 – Prohibition of discrimination in the enjoyment of the convention rights | No |
| 1st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property | No |
| 1st protocol Article 2 – Right of access to education | No |

*If you have answered no to all of the above please move on to* ***Question 6*** *on monitoring*

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**5.2 If you have answered yes to any of the Articles in 5.1, does the policy or decision interfere with any of these rights? If so, what is the interference and who does it impact upon?**

| List the Article Number | Interfered with? Yes/No | What is the interference and who does it impact upon? | Does this raise legal issues?* Yes/No |
|---|---|---|---|
| | | | |

** It is important to speak to your line manager on this and if necessary seek legal opinion to clarify this*

**5.3 Outline any actions which could be taken to promote or raise awareness of human rights or to ensure compliance with the legislation in relation to the policy or decision.**

| |
|---|
| |

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## (6) MONITORING

### 6.1 What data will you collect in the future in order to monitor the effect of the policy or decision on any of the categories (for equality of opportunity and good relations, disability duties and human rights)?

| Equality & Good Relations | Disability Duties | Human Rights |
|---|---|---|
| A range of information and data will be collected, including through the consultation period, to help us fulfil our legal requirements as well as assist in the planning of services for the future | A range of information and data, including inclusion and participation of disabled people where possible, will be collected to help us fulfil our legal requirements as well as assist in the planning of services for the future | Data on promoting a culture of respect for human rights within the PHA. For example, work will continue on NI New Entrants Service and Inclusion Health |

Approved Lead Officer: Stephen Murray

Position: Assistant Director Planning and Business Services

Date: 07 March 2025

Policy/Decision Screened by: Julie Mawhinney

**Please note that having completed the screening you are required by statute to publish the completed screening template, as per your organisation's equality scheme. If a consultee, including the Equality Commission, raises a concern about a screening decision based on supporting evidence, you will need to review the screening decision.**
**Please forward completed template to: Equality.Unit@hscni.net**

**Template produced June 2011**

If you require this document in an alternative format (such as large print, Braille, disk, audio file, audio cassette, Easy Read or in minority languages to meet the needs of those not fluent in English) please contact the Business Services Organisation's Equality Unit:

2 Franklin Street; Belfast; BT2 8DQ; email: Equality.Unit@hscni.net; phone: 028 90535531 (for Text Relay prefix with 18002); fax: 028 9023 2304

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## Annex: PHA Corporate Plan Suggested Indicators

The following table outlines the current known availability of data on Section 75 groups for the proposed PHA Corporate Plan 2025-2030 indicators and has been compiled using data and information available on NISRA, PfG Measurement and the *Northern Ireland Health Survey First Results 2024* report. Work will continue to identify if this information is available and thus inform the ongoing screening of the draft Corporate Plan and as it is amended and finalised following consultation.

| | | Gender | Age | Religion | Political Opinion | Marital Status | Dependent Status | Disability | Ethnicity | Sexual Orientation |
|---|---|---|---|---|---|---|---|---|---|---|
| **Low birth weight (% of babies born weighing under 2500g)** | | Yes | Yes | No | No | No | No | No | No | No |
| **Vaccination uptake – MenC and MMR uptake** | **MMR** | Yes | Yes | No | No | No | No | No | No | No |
| | **MenC** | Yes | Yes | No | No | No | No | No | No | No |
| **Adults 65+yrs stating health is good or very good** | **65-74yrs** | Yes | Yes | No | No | No | No | No | No | No |
| | **75+yrs** | Yes | Yes | No | No | No | No | No | No | No |
| **Life expectancy at 65 years** | **Female** | Yes | Yes | No | No | No | No | No | No | No |
| | **Male** | Yes | Yes | No | No | No | No | No | No | No |
| **Life expectancy at birth** | **Female** | Yes | No | No | No | No | No | No | No | No |
| | **Male** | Yes | No | No | No | No | No | No | No | No |
| **Adult smoking prevalence** | | Yes | No | No | No | No | No | No | No | No |

| | | Gender | Age | Religion | Political Opinion | Marital Status | Dependent Status | Disability | Ethnicity | Sexual Orientation |
|---|---|---|---|---|---|---|---|---|---|---|
| **Deaths registered with suicide as case of death** | | Yes | No | No | No | No | No | No | No | No |
| **% adults drinking above weekly sensible limits** | **Female** | Yes | Yes | No | No | No | No | No | No | No |
| | **Male** | Yes | Yes | No | No | No | No | No | No | No |
| **Health life expectancy** | **Female** | Yes | No | No | No | No | No | No | No | No |
| | **Male** | Yes | No | No | No | No | No | No | No | No |
| **% Adult surveyed classified as obese** | | Yes | Yes | No | No | No | No | No | No | No |
| **Age standardised preventable mortality of the population (per 100,000)** | | Yes | Yes | No | No | No | No | No | No | No |

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**References**

NISRA – available at: https://data.nisra.gov.uk

**PfG Indicators Measurement Annex – available at:**

Programme for Government Population Indicators | Northern Ireland Statistics and Research Agency
(https://www.nisra.gov.uk/statistics/programme-government/programme-government-population-indicators)

Programme for Government (PfG) Wellbeing Dashboard | Northern Ireland Statistics and Research Agency
(https://www.nisra.gov.uk/statistics/programme-government)

PfG Wellbeing Framework
(https://datavis.nisra.gov.uk/executiveofficeni/pfg_wellbeing_dashboard.html)

**Northern Ireland Health Survey First Results 2022/2023 – available at:**

Health Survey (NI): First Results 2022/23 | Department of Health
(https://www.health-ni.gov.uk/news/health-survey-ni-first-results-202223)
*NB: 2023/24 release - December 2024*

# PHA Corporate Plan 2025-30 Equality Screening Additional Information: Supporting all people to experience the positive impacts of improved health and wellbeing

## Introduction and Purpose

The Corporate Plan sets out the direction for the next five years. This direction is aimed at having a positive impact on health and wellbeing and on health inequalities. The outworking's of the plan will have a real impact and will therefore be considered individually as they are taken forward to ensure any potential equality impacts are fully thought through and mitigated.

The Public Health Agency (PHA) recognises some additional support or measures may be required for everyone in our population to experience the positive impact intended from the plan. Using a number of sources of information, PHA has considered these as part of the Equality Screening and outlined some examples below. The following information will also be used to help in the development of the annual business plan and in the priorities of the corporate plan to support all people to experience the intended positive impacts on health and wellbeing.

As well as considering the health and wellbeing needs of people identifying within section 75 groups, (based on research and available information), consideration has also been given to themes of the plan and potential examples of where additional support or needs should be considered in the achieving our ambitions.

This paper makes use of a number of documents and briefings as referenced and intends to provide an overview of some of the needs and different supports required to ensure that all people can experience the benefits of improved health and wellbeing. This paper cannot give the full picture but aims to highlight where further consideration may be required in taking forward the outworking's of the corporate plan. Each policy, or programme progressed in line with the corporate plan will require its own screening and/or equality impact assessment and this document aims to provide a starting point.

## Themes

The Corporate Plan is based around four outward facing strategic themes encompassing core areas of focus for our organisation as we work towards our vision of a healthier Northern Ireland. This Plan is being developed during a period of reform both for the 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 vision and ambitions for health and wellbeing in Northern Ireland and reiterate our call for a continued focus on improving health and reducing health inequalities across HSC and wider society.

Strategic Themes:

1. *Protecting health* – protect the population from serious health threats; such as infectious disease outbreaks or major incidents.

2. *Starting well* – laying the foundations for a healthy life from pre-birth, infancy, early years, childhood to adolescent years (0-18).

3. *Living well* – ensuring that people have the opportunity to live and work in a healthy way.

4. *Ageing well* – supporting people to age healthily throughout their lives.

The Corporate Plan details the key indicators the PHA will use to monitor public health in relation to the themes and focus of work for the period 2025-2030. It will provide a basis for the Annual Business Plan, mapping the strategic direction the organisation will travel over the next five years ensuring accountability for the Department of Health, (DoH).

The Corporate Plan incorporates how the PHA will work going forward as an organisation, 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), the Patient Client Council (PCC) and the Community and Voluntary (C&V) sector; considering best practice to ensure we work effectively whilst being committed to people, partnerships, processes, digital capacity and be research and evidence driven.

The PHA recognises that the ambitions and priorities of the plan cannot be fully achieved in the lifetime of the plan but are important aspirations to be pursued and progressed towards meaningfully improving the health and wellbeing of all individuals and communities. The following examples outline where additional supports may be required for each theme to help all people experience the positive impact of the improved health and wellbeing intended in the plan. These are not exhaustive but intended to provide an overview of potential areas for support.

## *Protecting Health*

Protecting and improving health is about safeguarding the wellbeing of the entire population, rather than focusing on any one Section 75 group. The PHA are committed to embedding equality considerations into all aspects of our work, ensuring that decisions, policies, and implementations are screened to assess impact on different groups. Screening will help us identify and address potential inequalities, ensuring the corporate plan is inclusive and responsive to the diverse needs of our population.

While our overall aim is to improve health outcomes for everyone, we recognise some Section 75 groups may experience our work differently due to specific health inequalities,

social determinants, or access barriers. Therefore, we are committed to understanding and mitigating any unintended consequences while proactively addressing disparities.

For example;

- People living in the most deprived areas of Northern Ireland experience significantly poorer health outcomes. Life expectancy is lower, and rates of long-term health conditions, including respiratory diseases and mental health issues, are higher in these areas. [1]
- The gap in life expectancy between the most and least deprived areas is approximately 6.8 years for men and 4.5 years for women.[1]
- Older adults are more likely to suffer from chronic illnesses, such as cardiovascular disease, diabetes, and dementia. Social isolation and loneliness are growing concerns among older populations, impacting mental and physical health.[1]
- While the overall population of ethnic minorities in Northern Ireland is small, access to culturally competent healthcare remains a concern. Language barriers and different health beliefs can impact engagement with health services.[1]
- Studies indicate higher rates of mental health issues, including depression and anxiety, among LGBT+ individuals due to experiences of discrimination and stigma. Access to appropriate healthcare services, including mental health support, remains a priority.[1]
- Self-reported general health varies by religious background, with differences in the prevalence of long-term health conditions and disability levels. However, a significant portion of the population does not assign their health experiences to religious identity specifically. [2]
- According to the Northern Ireland Health Survey, older adults report higher incidences of long-term health conditions. Over 40% of people aged 65+ have at least one chronic condition, compared to around 20% in younger age group. The uptake of preventative health measures, such as screening and vaccinations, is generally higher in older populations but may be influenced by socioeconomic factors.[2]
- Research suggests that single individuals and LGBTQ+ populations may experience different health outcomes. LGBTQ+ individuals report higher levels of mental health challenges and may face barriers to accessing culturally competent healthcare. [3]
- Women generally have higher life expectancy than men, but they experience a higher prevalence of long-term health conditions and disabilities. Men are less likely to engage with primary healthcare services, leading to later diagnoses of certain conditions. [3]
- Census 2021 data shows that approximately 24% of the population in Northern Ireland has a long-term health problem or disability that limits daily activities. [7]
- Individuals with disabilities report lower health literacy, affecting their ability to access screening programs and vaccinations. [2]

- Carers experience significantly higher stress and poorer mental health than the general population. The provision of unpaid care has a direct impact on the health of carers, particularly those providing 50+ hours of care per week. [2]
- Individuals without dependents may experience different health service usage patterns, often accessing mental health and social care services at different rates than those with dependents.[3]
- The Equality Commission for Northern Ireland (ECNI) highlights that access to healthcare can be unequal due to barriers related to age, disability, gender, and other factors. For example, individuals with disabilities report dissatisfaction with health services, with 40% citing negative attitudes from medical professionals. Additionally, the Bamford Review found that mental ill-health affects one in four people in Northern Ireland, yet investment in mental health services has been historically lower compared to other UK regions. [4,5]
- Certain Section 75 groups face disparities in vaccination and screening. For instance, older adults and disabled individuals may encounter logistical barriers, while women may have more difficulty accessing reproductive health services compared to the rest of the UK. Ethnic minorities, such as the Traveller community, experience significantly poorer health outcomes, including much higher child mortality rates. [4]
- Research commissioned by the Equality Commission for NI notes men and women have different healthcare access patterns. Women are more likely to face challenges due to caring responsibilities, whereas men may avoid seeking healthcare due to stigma. Carers, who are predominantly women, also report higher levels of ill health, with 19% of those providing 50+ hours of care per week describing their health as poor .[5]
- The Department of Health (NI) emphasizes that emergency preparedness planning must consider vulnerable groups, such as older adults, disabled individuals, and those with pre-existing health conditions. Climate-related risks, such as heatwaves or flooding, disproportionately affect these populations due to mobility and access issues. [2]
- According to The Health Foundation [51] There has been a failure to act on education gaps due to lost learning time in the pandemic. These are between children from richer and poorer backgrounds and compared with previous cohorts. A cohort of ‘left-behind’ children face significant risks to their long-term health and living standards, as well as causing a long-term economic cost to the country. [51]
- People living in the most deprived areas, some ethnic minority groups and people without English as a first language are more likely to not be fully vaccinated.[52]
- People from minority groups may have problems accessing or understanding information about screening and in some cases methods of screening may create obstacles for some individuals. For example there is anecdotal evidence that uptake of cancer screening is lower amongst some section 75 groupings.[5]

*Starting Well*

What happens during pre-conception, pregnancy, the early years, the school years and adolescence is key to what happens in later life. This includes having an adequate standard of living, a secure family environment, good physical and mental health and wellbeing and being protected from harm.[6] The PHA will work in partnership with key organisations to support and empower families to create and provide a safe and nurturing home environment such as making better decisions about physical and mental health and wellbeing. We recognise that adolescence is a unique stage of development and an important time for laying the foundations of good health. Health inequalities can have a profound impact on a child's start in life. All children and young people, including those who have additional needs, should have the opportunity for better health and wellbeing.

The PHA recognises some children and young people throughout Northern Ireland will require additional support to experience the positive impacts on health and the best start in life as intended within the plan.

For example:

- A child who does not experience economic well-being and lives in poverty will be more likely to have poor health, will face barriers to play and can feel isolated. [6]
- Health outcomes can be affected at a very early age and even before children are born. Low birth weight can be a determinant of infant mortality or disability, and affect health outcomes into adulthood. [6]
- For disabled and chronically ill young people both the planning process and the actual move to adult services can be difficult frightening and stressful.[7]
- Anecdotal research suggests that there are between 40 and 50 young transgender people accessing support services in NI due to gender identity issues and referrals appear to be rapidly increasing. This figure however is likely to be a gross underestimate of the actual number of young people who experience gender distress in Northern Ireland. Extreme social pressures including the high levels of prejudice, discrimination and harassment trans people face combined with a general lack of awareness, understanding and knowledge of trans issues means many young people who experience gender distress do not or unable to seek the professional support they require.[8]
- In a project '*Achieving Equality for Transgender and Gender Diverse Youth in Schools*' transgender and gender diverse youth school experiences were characterised by rejection, harassment and bullying that prevented them from participating in learning [9]
- There are roughly 30,000 LGBT children in NI schools. Children and young people who are LGBT+ can experience bullying in schools and there is evidence of disproportionate levels of depression, anxiety, self-harm and suicide ideation among young LGB and transgender people. 'Outing' or fear of 'outing' has resulted in homelessness and social isolation. Concern about accessing public services and the need for inclusion and participation are often issues for young LGBT+ people [9]

- Research from the Dept of Education indicates 67% of LGBT young people find their schools unsupportive and unwelcoming. From the same research 48% of respondents had experienced bullying as a result of their sexual orientation or gender identity. The main forms of bullying experienced by LGB&T young people included name calling, lies or false rumours, being isolated by other pupils or hit/kicked/pushed/shoved around.[10]
- Census 2021 figures reflect there are 2,600 carers aged 15 or younger in Northern Ireland.[12]
- The Young Persons Behaviour & Attitudes Survey 2022: Substance Use (Smoking, Alcohol & Drugs) found that Boys (9%) were more likely to report ever having smoked than girls (6%) and young people living in the most deprived quintile were more likely to report ever having smoked (11%) than those in the least deprived quintile (5%). A proportion of boys and girls indicated they use e-cigarettes now (9%) and within this group 6% were classed as regular e-cigarette user. Around a third (31%) of young people reported ever having drank alcohol; Boys were more likely to report having taken an alcoholic drink (33%) than girls (29%). Boys (5%) were more likely to report having used drugs than girls (3%). [13]
- At 31 March 2024, there were 1,990 total waits for a Child and Adolescent Mental Health Service (CAMHS) assessment in Northern Ireland, of which 1,026 were waiting for more than nine weeks (52%). [14]
- A quarter (23%) of young people surveyed, and three quarters (75%) of young people interviewed with alcohol and/or drug problems, had experience of using A&E during a mental health crisis as specialist crisis services were not available or easily accessible to young people.[14]
- 390 children and young people in Northern Ireland were admitted to hospitals with a self-harm diagnosis, with four of the five Trust Areas registering an increase. Under 18's account for 10% of all self-harm presentation at emergency departments, with two thirds of these female. [6]
- Children known to social services represent 49.5% of all children in NI that experienced mental ill-health in 2015. Young adults known to social services in childhood represent 40.9% of those who presented to ED with self-harm or ideation, 38.0% of those who experienced a psychiatric admission, and 39.7% of suicide deaths in NI during follow-up.[15]
- Twice as many children are now growing up in poverty in a working family as a decade ago. Children of single parents, children with two or more siblings, and children who live in a family where someone experiences a disability, all face a much higher risk of poverty. [17]
- Associations between poor mental health outcomes and Adverse Childhood Experiences (ACE) highlight 47.5% of young people aged 11-19 years experienced at least one ACE. Young people in the least deprived areas more likely to have experienced no ACEs compared to those in the most deprived (59.9% vs 36.0%).[16]
- Neonatal mortality accounts for 70-80% of infant deaths in the UK, largely due to perinatal causes, such as maternal health, congenital malformations and preterm

birth. In 2018, the infant mortality rate was 4.2 per 1,000 live births in Northern Ireland, compared to 3.9 per 1,000 in England, 3.5 per 1,000 in Wales and 3.2 per 1,000 in Scotland. In 2018, the neonatal mortality rate was 3.2 per 1,000 live births in Northern Ireland, compared to 2.8 per 1,000 in England, 2.5 per 1,000 in Wales and 2 per 1,000 in Scotland. [16]

### *Living Well*

Adults now generally enjoy better health and wellbeing and can expect to live longer than previous generations. However, in recent years life expectancy rates have been stalling and there are still many challenges and significant health needs within our population that impact the ability of people to experience good physical and mental health and wellbeing. There are many factors that impact our health and wellbeing during our adult lives. These include where we live, our environment, access to education and employment, health services and the effects of poor diet, smoking, drug and alcohol misuse, low levels of physical activity, homelessness and food, fuel and financial poverty. Health inequalities continue to compound challenges to health and prevent many from experiencing good health and wellbeing. We must ensure that we provide targeted approaches where needed for those more vulnerable in our society. Equipping individuals and communities to live long healthy lives is a key outcome of the plan and addresses health and wellbeing throughout life but mainly in adulthood.

The PHA recognises that there are people throughout Northern Ireland who will require additional support to experience the positive impacts on health and well-being as intended within the plan and through the pursuit of this outcome.

For example:

- The long-term trend of improving life expectancy has stalled in all four UK nations, from a reduction of 0.05 in Northern Ireland. Northern Ireland has shown a decrease of 1.4 healthy life expectancy years from 2018–20 onwards.[18]
- Life expectancy for females living in the 20% most deprived areas in NI was 79.3 years. This was 5.0 years less than those in the 20% least deprived areas (84.3 years).[18]
- Women live longer than men but spend more years in poor health.[18]
- In a Lancet Public Health issue, a global review of three decades of health data has revealed huge health differences in men and women that begin in adolescence and grow throughout life. Globally, females have a higher burden of morbidity-driven conditions with the largest differences in disability adjusted life years (DALYs) for low back pain, depressive disorders and headache disorders, whereas males have higher DALY rates for mortality-driven conditions with the largest differences in DALYs for COVID-19, road injuries and ischaemic heart disease. [18]
- A review of the existing evidence shows that people of all ages from ethnic minority groups are more likely to have poor physical and mental health in later life.[19]

- Indicative evidence suggests that minoritised ethnic groups have higher risk of developing multiple long-term conditions (MLTCs)(e.g. chronic kidney disease, hypertension and depression) and do so earlier than the majority white population. [19]
- Prevalence of depression is significantly higher in older residents (unspecific ethnicity) living in care homes, compared with older people living in community settings [20]
- People in the most deprived areas of NI (30%) are more likely to have a probable mental illness compared to those in least deprived areas (20%); and poverty, particularly child poverty is key contributor, with one in 4 (24%) children in Northern Ireland living in poverty. Stable housing is also a key driver of wellbeing with almost 70% of people experiencing homelessness having a diagnosed mental health condition.[16]
- A considerable body of evidence points to a knock-on relationship between income or social inequalities with wider inequalities in areas such as health and social inclusion and the evidence in this report suggests that inequalities are increasing in some aspects among our ageing population.[24]
- Current statistics report that Lesbian, Gay, Bisexual and Transgender (LGB&T) people make up between 6 and 10% of the Northern Ireland population. For those over the age of 55, growing old is a real concern.[23]
- Northern Ireland has the fastest-growing older population in the United Kingdom and this number will continue to increase every year. Older people who identify as Lesbian, Gay, Bisexual and/or Transgender (LGB&/T) are generally likely to have a greater need for health and social care services compared with their heterosexual peers. Overall, they are two and half times more likely to live alone, twice as likely to be single and four and half times more likely to have no children to call on in times of need.[23]
- There are 80 to 100 transgender people known to, or who are accessing support services in Northern Ireland. However, it is widely acknowledged that transgender people remain invisible and the numbers are estimated to be much higher. There may be a prevalence of 600 per 100,000 people.[23]
- People living in poverty are more likely to have bad health in childhood and this is likely to persist right through the life cycle and to cause earlier death than for people who are ‘well-off’.[24]
- Studies suggest that the prevalence of smoking, alcohol and drug use is higher among LGB&T people. For example, a 2012 study of substance use among LGB&T people in Northern Ireland reported that 44% of respondents smoked, 91% of respondents reported that they drink alcohol and that 37% reported using an illegal drug in the last year. (p7-8)[25]
- Men have lower life expectancy 78.3 years for men, 82.3 years for women), and higher suicide rates (77% men, 23% women) and health risks in relation to alcohol, drug and substance abuse than women [2]

- The 2021 Census tells us 34.7% of people in Northern Ireland have one or more long-term health condition (659,800 people). The most prevalent conditions (whether

solely or in combination with others) were 'Long-term pain or discomfort' (11.6% of people), 'Mobility or dexterity difficulty that limits basic physical activities' (10.9% of people), and 'Shortness of breath or difficulty breathing' (10.3% of people).

- LGB&T people may experience barriers to accessing healthcare services. For example, a survey to explore the emotional health and wellbeing of LGB&T people in Northern Ireland (2013) found that around two fifths (42.6%) of LGB&T people reported being 'out' to their doctor, 35.8% reported that their doctor is not aware and 21.6% said they were unsure.[23]
- Women have also been reported to experience barriers to accessing health and social care services, including access to reproductive health services[28].
- There is a general lack of awareness amongst Black and Minority Ethnic people as to what health care services are available.[27]
- A research update in 2013 indicated that 10% of 16year olds felt that, at some point over the previous 12 months, they had needed professional medical support but had chosen not to access it. [7]
- People with Learning Difficulties have problems in accessing primary health care. Access is made more difficult because of communication difficulties and barriers in encounters between health professionals and PLD and practical issues such as long waiting times and lack of consultation time. [27]
- 1 in 4 carers in Northern Ireland are suffering mental ill-health [29]
- 50% of carers feel lonely at least some of the time [29]
- More than 1 in 3 have put off health treatment for themselves because of the demands of caring. [29]

### *Ageing Well*

As a population, we are living longer and many older adults enjoy good health and make significant contributions to their communities. For others, however, older age brings a risk of poor physical and mental health, social isolation and complex health problems. Poor health and frailty should not be inevitable outcomes as we age. As well as living longer, we also want to live healthier for longer so that we can continue to participate in activities we enjoy and live fulfilled, independent lives.

Older people make up an extremely heterogenous group, and their diversity is increasing. While the broad trend in longer lives can be celebrated, the way people experience older age varies hugely, influenced by a range of factors including income, geography, housing, gender, marital status, and health and disability. The PHA recognises some older people will require additional support to experience the positive impacts on health and living longer into old age as intended within the plan.

- More than one in six of the population of Northern Ireland is aged 65 or over.[30]
- The NI population aged 85 and over increased by 25.8% in the decade since mid-2013, a rate over five times higher than the population as a whole. An aging population presents a range of societal and economic challenges, as older people tend to require more health and social care.[30]

- The number of people aged 65 and older will grow from 17.8% in 2023 (342,482 total individuals) to 25.8% in 2050 (499,337 total individuals)[49]
- The number of people aged 65 and over will, on average, grow annually by 7,409 individuals until 2040, and in the period 2024 to 2034, it will grow by 8,517 individuals on average every year.[50] This will have a tremendous effect on the health and social care system, older people are more likely to experience health issues and disability.
- Findings from the NICOLA study (the largest public health study in Northern Ireland of older people) show a quarter of participants live alone and over half of those aged over 75 live alone, which could have serious health implications for this population. Living alone is twice as common in the most deprived areas compared to the least deprived areas and three times as common in larger urban areas than in most rural areas. Loneliness is a major public health (and welfare) issue and its effects on the health of older people are as large as the effects of many biological risk factors such as high blood pressure or cholesterol.[30]
- Women live longer than men but spend more years in poor health [18]
- Evidence shows that people of all ages from ethnic minority groups are more likely to have poor physical and mental health in later life.[20]
- Prevalence of depression is significantly higher in older residents (unspecific ethnicity) living in care homes, compared with older people living in community settings [20]
- Statistics report that Lesbian, Gay, Bisexual and Transgender (LGB&T) people make up between 6 and 10% of the Northern Ireland population. For those over the age of 55, growing old is a real concern.[23]
- Older LGB&/T people are likely to have a greater need for health and social care services. Research indicates that when compared to their heterosexual peers, they are 2.5 times more likely to live alone, twice as likely to be single and 4.5 times more likely to have no children to call on in time of need [23]
- Research in Northern Ireland in 2010 by Age NI found that 45% of people agreed they were aware of instances where older people had been treated with less dignity and respect when accessing services because of their age[31]
- The RNIB estimates that by 2030 there will be a 24 per cent increase in the number of people with sight loss in Northern Ireland and with sight loss comes increased risks for falls and accidents.

*Our organisation works effectively*

The capacity and efficacy of our organisation and our staff will underpin and enable progress towards the realisation of the first four themes. We must ensure our staff are supported, equipped and empowered to take forward this work over the next five years, in line with our values and cross-cutting principles.

The PHA recognises that some staff members may require additional measures to experience the positive impact intended by the plan and by this outcome of supporting, equipping and empowering staff.

For example, a recent breakdown of available information on known staff composition by Section 75 group shows that:

- Approximately 76% of PHA staff are female and approximately 23% are male
- Approximately 46% of staff are aged 30-54 years; over 39% of staff are over 55 years and around 13% are 16-29 years
- Approximately 35% of staff are or are perceived to be either Protestant or Roman Catholic

Other sources of information on HSC [32,33] workforce note that:

- At 31st March 2024, the HSC employed 74,039 (65,984.2 WTE) staff in post on either a full-time or part-time basis
- The HSC workforce grew by 22% (11,898.5 WTE) between 2015 and 2024
- Over three quarters (78%) of staff (57,780 headcount) were female and 22% were male (16,259 headcount)
- Over two fifths (42%) of HSC staff were under the age of 40; 38% were between 40 and 54, and 20% were aged 55 and over

## Section 75 Groups and Health and Wellbeing

The following examples outline where additional supports may be required for Section 75 groups to help all people experience the positive impact of the improved health and wellbeing intended in the plan. These are not exhaustive examples nor intended to be but are intended to provide an overview of potential areas for where additional measures may be required.

| ***Category*** | ***Potential areas for where additional measures may be required.*** |
|---|---|
| Gender | Men have lower life expectancy (78.3 years for men, 82.3 years for women), and higher suicide rates (77% men, 23% women) and health risks in relation to alcohol, drug and substance abuse than women. Women also experience barriers to accessing health and social care services, including access to reproductive health services.[1]<br><br>Transgender people experience disadvantage both in terms of access to specialist healthcare and the lack of transgender awareness in the general health care service. [23]<br><br>Additional health issues exist aligned to multiple identities. For example, there are high rates of suicide amongst young males, high levels of gay men bullied at school have considered suicide and the suicide rate amongst Travellers is higher than that of men in the general population. See Carafriend, Rainbow (2011) Left out of the Equation,UCD (2010) All Ireland Traveller Health Study and ECNI (2014) UNCRPD Parallel jurisdictional report.[37]<br><br>Reports indicate that there may be some challenges faced by LGBT+ people during the COVID-19 pandemic. The Stonewall LGBT in Britain - Health Report states that LGBT+ people are at greater risk of marginalisation during crises, and that those with multiple marginalised identities can struggle even more.<br><br>A report produced by the Lesbian Advocacy Services Initiative (LASI) found that lesbian and bisexual women experienced significant barriers to accessing health [38]<br><br>Women who had children before the age of 20 and who were unmarried when they had their first child are also at greater risk of being in poor health in later life[35]<br><br>Poor general health is closely associated with being financially poor in later life and is also associated with social isolation in later life, especially for men.[39] These include high levels of mental ill-health |

| Category | Potential areas for where additional measures may be required. |
|---|---|
| | among gay men, high suicide rates amongst Traveller men and barriers for disabled women in accessing sexual health and maternity services See Carafriend, Rainbow (2011) Left out of the Equation,UCD (2010) All Ireland Traveller Health Study and ECNI (2014) UNCRPD Parallel jurisdictional report. – [37]<br><br>There is evidence to suggest that low income women forgo hospital appointments because of the cost and inconvenience and highlight that this can have serious consequences for both women and their children.<br><br>Higher mortality from circulatory disease (1.4 years) and cancer (1.3 years) combined, contributed more than a third of the male life expectancy deprivation gap. Cancer was the largest contributor to the female life expectancy deprivation gap.<br><br>Women live longer than men but spend more years in poor health.[18]<br><br>In 2020-22, females in NI could expect to live 3.8 years longer than males. Males living in the 20% most deprived areas of NI could expect to live 74.0 years, 7.2 years less than those living in the 20% least deprived areas (81.2 years). Female life expectancy in the 20% most deprived areas was 79.3 years, 4.8 years fewer than females in the 20% least deprived areas (84.1 years). For both males and females, mortality across the majority of causes of death was higher in the most deprived areas than in the least deprived.[53] |
| Age | In 2021-23, life expectancy at age 65 in NI was 18.5 years for males and 20.7 years for females, with no significant change over the last five years. [53]<br><br>When asked which specific group was treated most unfairly, people aged over 70 were considered to be treated most unfairly in Northern Ireland (15% of respondents), [29]<br><br>There is a clear link between homophobia and poor mental health in Northern Ireland. For example, research into the mental and emotional health of 16year olds has confirmed that a group which is particularly vulnerable in terms of their mental health are same-sex attracted males and females.[29]<br><br>Evidence suggests that breastfeeding initiation rates and duration of breastfeeding remain low amongst teenage mothers [41] |

| Category | Potential areas for where additional measures may be required. |
|---|---|
| | A child who does not experience economic well-being and lives in poverty will be more likely to have poor health, will face barriers to play and can feel isolated.[16]<br><br>There has been an increase in the number of children referred to children's services, children in care and children on the child protection register in NI. DOH indicates that there were 4317 children in care as of September 2024 which represented a 27.6% increase from March 2020. Poor people are more likely to have bad health in childhood and this is likely to persist right through the life cycle and to cause earlier death than for people who are well-off.[17]<br><br>Health outcomes can be affected at a very early age and even before children are born. Low birth weight can be a determinant of infant mortality or disability, and affect health outcomes into adulthood<br><br>In 2014, a total of 390 children and young people in Northern Ireland were admitted to hospitals with a self-harm diagnosis, with four of the five Trust Areas registering an increase. Under 18's account for 10% of all self-harm presentation at emergency departments, with two thirds of these female.[6]<br><br>A considerable body of evidence points to a knock on relationship between income or social inequalities with wider inequalities in areas such as health and social inclusion and the evidence in this report suggests that inequalities are increasing in some aspects among our ageing population.[9]<br><br>A research update in 2013 indicated that 10% of 16 year olds felt that, at some point over the previous 12 months, they had needed professional medical support but had chosen not to access it. [15]<br><br>Research in Northern Ireland in 2010 by Age NI found that 45% of people agreed they were aware of instances where older people had been treated with less dignity and respect when accessing services because of their age [30]<br><br>People over 60 make up 19% of the population, according to Census 2021. This represents a near 25% increase from 2011 and demonstrates the scale of population change due to ageing. People aged 65 and over account for 326,500 people or 17.2% of the Northern Ireland population. [02] |

| Category | Potential areas for where additional measures may be required. |
|---|---|
| | The Young Persons' Behaviour Attitude Survey (YPBAS) 2013 found that 13% of 11-16 yrs had smoked tobacco and 38% had drunk alcohol. Alcohol and drug related admissions to hospital and alcohol and drug related deaths are 3-4 times higher in areas of deprivation.[13]<br><br>In 2022/23 the percentage of primary 1 pupils in the most deprived areas affected by obesity was more than double the proportion in the least deprived areas. The inequality gap in year 8 pupils affected by obesity was slightly lower, with the proportion in the most deprived areas 94% higher than in the least deprived areas.(Health Inequalities Annual Report 2024, DOH) |
| Religion | Jamison et al (2004:34) concluded that when both need and supply factors are considered, there appears to be no significant effect of religion on inpatient hospital use in Northern Ireland. [41] |
| Political Opinion | McEvoy et al (1999), in a study of Loyalist and Republican prisoners and their families, highlight that political ideology can often act as a barrier to accessing and using services provided by statutory and voluntary agencies. They also note that politically motivated ex-prisoners and their families have a tendency not to use professional and voluntary organisations who do not take into account their status and political ideology. Evidence continues to suggest that many ex-prisoners and their families are suspicious of institutions which are supported or influenced by Government agencies (Shirlow, 2001). 42<br><br>Within a NI context, the 2022 NI Life and Times survey welcomed 1,405 respondents and included people who were generally uninterested in politics or feel unrepresented by mainstream political party positions. Six out of ten respondents did not think of themselves as supporters of any particular party, although one in two said they felt a little closer to one party than others. The breakdown of self-described community identities is unionist (31%), nationalist (26%) and 'neither' (38%) 55<br><br>In a previous study, by NILT in 2019, the same survey revealed over a quarter (26%) replied that they considered themselves to be unionists, while just over a fifth (21%) described themselves as nationalists. The results suggest women were more likely than men to describe themselves as neutral re political opinion - 55% of women said they were neither unionist nor nationalist, compared with 45% of men. A quarter of 18 to 24-year-old respondents describing themselves as unionist, and just 14% who said they were nationalists. Just under a fifth |

| *Category* | *Potential areas for where additional measures may be required.* |
|---|---|
| | (19%) of pensioners described themselves as nationalist while more than twice that number (41%) replied that they were unionist. |
| Marital Status | Women who had children before the age of 20 and who were unmarried when they had their first child are also at greater risk of being in poor health in later life [43]<br><br>What evidence that is available (mainly GB studies) suggest that poverty and associated factors such as lone mother's lack access to affordable transport and child care can be barriers to accessing health and social care.[43]<br><br>Evidence suggests that women living on low incomes, especially lone mothers, struggle to provide a balanced healthy diet for both themselves and their children. Research carried out by the Food Commission on behalf of the NCH highlights that lack of money often made it impossible for parents to buy nutritional foods for their children and that in Northern Ireland healthier versions of food cost on average 14% more than unhealthier versions (NCH, 2004:5). [43]<br><br>Burchett & Seelie (2003:5) in an examination of the diet of pregnant teenagers found that the risk of a seriously inadequate diet during pregnancy was higher for pregnant teenage women who lived alone and had no support from parents, partners or friends. [28]<br><br>Men who become lone fathers through the death of their partner and men who become lone fathers through, for example, the inadequate parenting of the mother may have different needs and experiences in accessing health and social care. Similarly lone fathers with younger children may have different needs and experience different access barriers in comparison to lone fathers with older children. Non-custodial fathers may have different needs and experience different access barriers than custodial fathers. Older lone fathers, younger lone fathers and lone fathers with children with disabilities may also have different experiences. There is clearly a need for a greater research focus exploring the variations in experiences between lone fathers. [43]<br><br>Married people have better mental and physical health compared with unmarried people. Those who have been married longer also tend to live longer. [7] |

| Category | Potential areas for where additional measures may be required. |
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| Dependent Status | Women who had children before the age of 20 and who were unmarried when they had their first child are also at greater risk of being in poor health in later life[25]<br><br>The State of Caring 2024 survey found that unpaid carers are finding it increasingly difficult to afford day-to-day living costs, with the worry and anxiety of this affecting their mental health and wellbeing.<br><br>The pressures of caring can take a significant toll on carers' physical and mental health. In the 2021 State of Caring Survey, 25% of carers say their physical health is bad or very bad and 30% of carers say their mental health is either bad or very bad. The 2011 Census found that carers providing round the clock care are more than twice as likely to be in bad health than non-carers.1 6 out of 10 carers (61%) said their physical health has worsened as a result of caring, while 7 out of 10 (72%) said they have experienced mental ill health.2 These findings are reinforced in the 2021 GP Patient Survey, which found that carers are more likely to be in poor health than the general population, with 6 in 10 (60%) of carers having a long-term condition, disability or illness compared to 50% of those who weren't caring.<br><br>Many carers continue to feel marginalised and often believe that their own particular health and social care needs are overlooked (Arksey et al, 2003:1). [34] *These include:*<br>1. Professional Characteristics Barriers<br>2. Barriers relating to service issues<br>3. Barriers relating to language or cultural issues<br>4. Barriers relating to carer or care recipient characteristics<br>5. Barriers relating to information and knowledge issues:<br><br>Research[12] suggests that the caring role has both negative and positive affects on young people. It is notable that the vast majority of young people actually want to provide care. Other positive impacts of caring include, maturing earlier, developing life skills and learning to take responsibility (Thomas et al, 2003:37). However, as Thomas et al (2003:36-37) suggests, caring can also have a range of negative impacts including:<br>• Physical Impact<br>• Social Impact<br>• Educational Impact<br>• Emotional Impact |

| Category | Potential areas for where additional measures may be required. |
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| | There are over 220,000 people providing unpaid care for a sick or disabled family member or friend in Northern Ireland. Despite the multi-billion-pound savings they deliver here each year, too many local carers are being driven to breaking point by unrelenting caring duties, few opportunities for a break, poverty and patchy support from Health and Social Care services. ( A New Deal for unpaid carers in Northern Ireland \| Carers UK 2023)<br><br>CarersNI State of Caring 2023 Annual survey (UK wide, including NI) This report examines the impact of unpaid caring on health and wellbeing in Northern Ireland, based on data from Carers NI's State of Caring 2023 survey.<br><br>It shows:<br>• 1 in 4 carers in Northern Ireland are suffering mental ill-health<br>• 50% feel lonely at least some of the time<br>• 43% identify more breaks as among their main needs as a carer<br>• More than 1 in 3 have put off health treatment for themselves because of the demands of caring. *(Available at State of Caring 2023: The impact of caring on health in Northern Ireland \| Carers UK)*<br><br>People with learning disabilities now have a greater life expectancy than ever before and as a result there is an expanding population of older parents who are continuing to care for a son or daughter well into old age.[34]<br>There are also specific barrier to service access for BME Carers: (Barriers to Service Access :Welsh Assembly Government Report, 2003)[35]<br>• Self-identification: often BME carers do not define themselves as such.<br>• Lack of culturally sensitive services: BME carers are unlikely to access health and social services which are not culturally sensitive<br>• Language barriers: insufficient language specific information and lack of translation and interpretation services are perceived to be major barriers to accessing services.<br>• Stereotyping: some health and social care professionals continue to stereotype BME carers often having perceptions that they “look |

| Category | Potential areas for where additional measures may be required. |
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| | after their own" and assume that BME carers do not wish to access carers' support services.<br>• Lack of knowledge: the health and social care system is<br>• Complex and often many BME carers are confused about where to go to for assistance.<br><br>Prevalence of depression is significantly higher in older residents (unspecific ethnicity) living in care homes, compared with older people living in community settings. [8] |
| Disability | Findings suggest that most women with learning disabilities did not make their own decisions and some of those who did, found their choices constrained by various factors, such as their young age, fears of losing their service, and previous traumatic experiences. [45]<br><br>People with Learning Difficulties47 have problems in accessing primary health care. Access is made more difficult because of communication difficulties and barriers in encounters between health professionals and PLD and practical issues such as long waiting times and lack of consultation time. This can result in a failure to access primary health services such as men's and women's health screening, cervical screening, genetic screening, dental checks and treatment and health promotion. Basic health problems may be unidentified or regarded merely as part of the learning disability rather than a medical problem.<br><br>There can be issues around a lack of understandable information and addressing carers instead of users. [47]<br><br>For disabled and chronically ill young people both the planning process and the actual move to adult services can be difficult, frightening and stressful. During adolescence, they will experience change in a number of areas: from paediatric to adult health services, school to higher education or work and childhood dependence to adult autonomy. Associated problems can occur such as social isolation, a lack of daily-living skills, difficulties in finding work and additional problems in family relationships such as over-protectiveness by parents and low parental expectations. Transition can also cause considerable stress for families and carers.[7]<br><br>Public health emergencies will always disproportionately affect disabled citizens, it is vital that they are included in all stages of planning, to mitigate the effects of emergencies. By 2030 there will be a 24 per cent increase in the number of people with sight loss in Northern Ireland – |

| Category | Potential areas for where additional measures may be required. |
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| | predicting an increased risk of number of falls and accidents. Sight loss also has profound emotional and practical impacts: there is a significant association between depression and sight loss [i], which can be compounded by a lack of awareness of available support. (RNIB 2025)<br><br>Persons with disabilities must be considered when preventing and responding to health emergencies because they are more likely to be affected, both directly and indirectly. For example, during the COVID-19 pandemic, persons with disabilities living in institutions have been "cut off from the rest of society" with reports of residents being overmedicated, sedated, or locked up, and examples of self-harm also occurring (Brennan, C.S 2020)<br><br>In the COVID-19 pandemic, there are higher mortality rates among persons with intellectual disabilities *(*Williamson, E.J., et al*)*, who are also less likely to receive intensive care services (Baksh, R.A., et al 2021)<br><br>An estimated 1.3 billion people – or 16% of the global population – experience a significant disability today. This number is growing because of an increase in noncommunicable diseases and people living longer. (WHO 2023)<br><br>Persons with disabilities find inaccessible and unaffordable transportation 15 times more difficult than for those without disabilities.<br><br>Health inequities arise from unfair conditions faced by persons with disabilities, including stigma, discrimination, poverty, exclusion from education and employment, and barriers faced in the health system itself. Persons with disabilities die earlier, have poorer health, and experience more limitations in everyday functioning than others. |
| Ethnicity | Poor life expectancy and high levels of suicide persist for the Irish Traveller community.<br>Maternal and infant mortality is also an issue for some BME groups. There are also concerns about poor health outcomes for the Roma community. 38<br><br>Most people felt their opportunities to access services were about the same as everyone else. For instance 72.3% in ROI and 73.5% in NI thought their access to the Accident and Emergency Department (A & E) was the same, with 14.9% in ROI and 17.9% in NI rating their access as worse, and 12.8% in ROI and 8.6% in NI as better, than everyone else. |

| Category | Potential areas for where additional measures may be required. |
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| | Respondents were asked to rate various difficulties in accessing health services. The barriers identified included the waiting list (cited by 62.7% of respondents in ROI and 46.8% in NI), embarrassment (47.8% in ROI and 50.0% in NI) and lack of information (37.3% in ROI and 28.6% in NI).39<br><br>Connolly (2002:7)48 identifies a number of difficulties experienced by Black and Minority Ethnic people which he suggests are consistent across a wide range of public services (including health and social services). These include:<br>• Difficulties accessing existing services by those who speak little or no English (that is, language barriers).<br>• A general lack of awareness amongst Black and Minority Ethnic people as to what services are available.<br>• Low take-up of GP registration amongst some Black and Minority Ethnic groups (for example, Irish Travellers find it difficult registering with a GP because of no permanent address).<br>• the need for more staff training and cultural awareness in issues relevant to Black and Minority Ethnic people.<br>• a failure to meet even the most basic cultural needs of Black and Minority Ethnic people (such as dietary requirements or religious observance).48<br>For disabled and chronically ill young people both the planning process and the actual move to adult services can be difficult frightening and stressful.7<br><br>A review of the existing evidence shows that people of all ages from ethnic minority groups are more likely to have poor physical and mental health in later life.7<br><br>People of all ages from ethnic minority groups are more likely to have poor physical and mental health.7<br><br>For migrants, having little or no English is considered to be one of the most significant barriers to accessing health and social care and other key services. 1<br><br>There is a general lack of awareness amongst Black and Minority Ethnic people as to what services are available. 48<br><br>It is recognised that some Black and Minority Ethnic persons can face barriers to accessing support services, and that there may be cultural differences in knowledge and understanding of self harm and suicidal |

| *Category* | *Potential areas for where additional measures may be required.* |
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| | ideation and that at times additional support is needed. For example, individuals for which English is not their main language.<br><br>The Department of Health (England) assessment of impacts on equalities for the Preventing suicide in England noted that, 'Black and minority ethnic groups have high rates of severe mental illness, which may put them at high risk of suicide. The rates of mental health problems in particular migrant groups, and subsequent generations, are also sometimes higher. More recent arrivals, such as some asylum seekers and refugees, may also require mental health support following their experiences in their home countries. *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/267020/Preventing_suicide_equalities_impact-1.pdf* |
| Sexual Orientation | LGB&T people may experience barriers to accessing healthcare services. For example, a survey to explore the emotional health and wellbeing of LGB&T people in Northern Ireland (2013) found that around two fifths (42.6%) of LGB&T people reported being 'out' to their doctor, 35.8% reported that their doctor is not aware and 21.6% said they were unsure.[13]<br><br>A report produced by the Lesbian Advocacy Services Initiative (LASI) found that lesbian and bisexual women experienced significant barriers to accessing health[48]<br><br>There is, for example, a clear link between homophobia and poor mental health in Northern Ireland. For example, research into the mental and emotional health of 16 year olds has confirmed that a group which is particularly vulnerable in terms of their mental health are same-sex attracted males and females.[10]<br><br>Research has indicated that people from the LGB&/T community generally have poorer health. This is manifested, for example, in higher rates of cervical, breast and anal cancer. [10]<br><br>Anecdotal evidence suggests there are between 40-50 young trans people accessing support services due to gender identity issues and referrals are increasing[4]<br><br>Trans young people face lengthy waiting lists when seeking specialist gender services and problems with the referral process. In order to cope and thrive, online resources and spaces have become increasingly |

| Category | Potential areas for where additional measures may be required. |
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| | important for trans young people. Finding good-quality resources and information can be difficult for young people and families.<br><br>Current statistics report that t 2.1% (31,600) of our population aged 16 and over identified as 'lesbian, gay, bisexual or other (LGB+)' and 90.0% (1,363,900) identified as 'straight or heterosexual' Older LGB&/T people are likely to have a greater need for health and social care services. Research indicates that when compared to their heterosexual peers, they are:<br>○ 2.5 times more likely to live alone<br>○ Twice as likely to be single<br>○ 4.5 times more likely to have no children to call on in time of need[11]<br><br>There are 80 to 100 transgender people known to, or who are accessing support services in Northern Ireland. However, it is widely acknowledged that transgender people remain invisible and the numbers are estimated to be much higher. There may be a prevalence of 600 per 100,000 people.[12]<br><br>Studies suggest that the prevalence of smoking, alcohol and drug use is higher among LGB&T people. For example, a 2012 study of substance use among LGB&T people in Northern Ireland reported that 44% of respondents smoked, 91% of respondents reported that they drink alcohol and that 37% reported using an illegal drug in the last year. (p7-8)[13] |

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# Appendix B - Rural Needs Impact Assessment (RNIA) Template

## SECTION 1 - Defining the activity subject to Section 1(1) of the Rural Needs Act (NI) 2016

**1A. Name of Public Authority.**

**Public Health Agency**

**1B. Please provide a short title which describes the activity being undertaken by the PHA that is subject to Section 1(1) of the Rural Needs Act (NI) 2016.**

**Development of the Public Health Agency's Corporate Plan 2025-2030**

**1C. Please indicate which category the activity specified in Section 1B above relates to.**

| | | | | | | |
|---|---|---|---|---|---|---|
| Developing a | Policy | | Strategy | | Plan | x |
| Adopting a | Policy | | Strategy | | Plan | |
| Implementing a | Policy | | Strategy | | Plan | |
| Revising a | Policy | | Strategy | | Plan | |
| Designing a Public Service | | | | | | |
| Delivering a Public Service | | | | | | |

**1D. Please provide the official title (if any) of the Policy, Strategy, Plan or Public Service document or initiative relating to the category indicated in Section 1C above.**

**Public Health Agency Corporate Plan 2025-2030**

**1E. Please provide details of the aims and/or objectives of the Policy, Strategy, Plan or Public Service.**

The Public Health Agency (PHA) Corporate Plan 2025-2030 sets out the strategic direction for the next five years. It details our vision, ambitions and evidence-based strategic priorities for the period 2025-2030.

The 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 vision and ambitions for health and wellbeing in Northern Ireland and reiterate our call for a continued focus on improving health and reducing health inequalities across HSC and wider society.

The key foundations for our work are reflected across a wide range of departmental policies and strategies that influence and determine the work of PHA, most notable are *Making Life Better*, the Northern Ireland Public Health Framework and *Delivering Together* 2026

The PHA empowers citizens of Northern Ireland to improve their health. In partnership with others, we actively focus on preventing disease and injuries, promoting good physical and mental health, and providing information to support informed decision making. The approach is integral to the Department of Health's broader role of improving the health of citizens of N. Ireland. This is a solid foundation on which to embed a population health approach over the next 5 years during which we will continue our focus on:

i. **Reducing health inequalities** and its impact on personal and community wellbeing.
ii. Delivering programmes for **screening, vaccinations and immunisation** against preventable disease.
iii. Using the most **up to date knowledge and evidence** and participate in research and development activities to increase our understanding of 'what works'.
iv. Providing **advice and expertise to partners** across the health and social care system, as well as to other sectors.
v. Fulfilling all our **statutory responsibilities** as set down in legislation and policy, and advocate for systemic change to address intractable "wicked" problems that impact on the quality of life of our population.
vi. **Communicating and sharing information** to get the message across to everyone about how to stay healthy and well.
vii. **Looking outwards internationally** to bring fresh thinking and innovation of new methods through digitalisation and effective approaches to Northern Ireland public health initiatives.
viii. **Advocating for an inequality strategy** that must involve government who hold the "levers of change", e.g., legislation, tax, reform, particularly in core, chronic, intractable areas such as early years, obesity, healthy behaviour change (smoking/vaping).
ix. **Anticipating population health challenges** e.g. anti-microbial resistance, climate change impacts which will get out of control if action is not taken in the 2020s.

**Our Focus**

The strategic themes detailed below encompass core areas of focus for our organisation as we work towards our vision of a healthier Northern Ireland.

Over the next five years, as we work to fulfil our purpose and advance towards our vision we will focus on delivering a number of key public health priorities for Northern Ireland around our 4 strategic themes:

1. Protecting health – protecting the population from serious health threats, such as infectious disease outbreaks or major incidents.
2. Starting well – laying the foundations for a healthy life from pre-birth, infancy, early years, childhood to adolescent years.
3. Living well – ensuring that people have the opportunity to live and work in a healthy way.
4. Ageing well – supporting people to age healthily throughout their lives.

In working to achieve the priorities set out in this plan, we commit to:

- tackling and reducing health inequalities being at the heart of everything we do;
- championing a whole system, cross-government approach to tackle the challenges and barriers to improving health and reducing health inequalities;
- providing professional public health advice to the planning and commissioning of safe, effective, equitable, high quality health care;
- listening to, involving, and working together with individuals, families, local communities, HSC and other key partners in all our work;
- ensuring planning, guidance and decisions are based on best available evidence and driven by data, research and experience;
- improving equity of access to prevention and early intervention information, services and interventions etc for those who need them;

## 1F. What definition of 'rural' is the PHA using in respect of the Policy, Strategy, Plan or Public Service?

The Public Health Agency's Corporate Plan 2025-2030 will impact on all citizens of NI in both urban and rural areas. Public Health is a shared agenda which requires everyone to take ownership of the factors within their personal control to improve and protect their health and wellbeing. It is the responsibility of government and the health and social care system to put in place the measures and programmes that protect and improve health and wellbeing at a societal level.

| | |
|---|---|
| Population Settlements of less than 5,000 (Default definition). | X |
| Other Definition (Provide details and the rationale below). | |
| A definition of 'rural' is not applicable. | |

*Details of alternative definition of 'rural' used.*

N/A

*Rationale for using alternative definition of 'rural'.*

N/A

*Reasons why a definition of 'rural' is not applicable.*

N/A

## SECTION 2 - Understanding the impact of the Policy, Strategy, Plan or Public Service

**2A. Is the Policy, Strategy, Plan or Public Service likely to impact on people in rural areas?**

Yes [x] No [ ] If the response is **NO** GO TO Section **2E**.

**2B. Please explain how the Policy, Strategy, Plan or Public Service is likely to impact on people in rural areas.**

The PHA Corporate Plan 2025-2030 is high level document which sets out the strategic direction for the organisation and recognises the PHA's commitment to supporting and developing its staff. As the PHA takes forward the Corporate Plan and works to achieve outcomes, the actions, work and programmes will be screened individually through a Rural Needs Impact Assessment (RNIA). It is at this more detailed level that the PHA will understand, identify and consider how the development of a policy, strategy, plan or public service will impact on people in rural areas.

As part of the planning, commissioning, delivery and evaluation of HSC Services, service users, carers and the public (including people from rural areas) had the opportunity to have their voices heard in a meaningful way, ensuring that their knowledge, expertise and views were listened to through the public consultation.

This helped inform the RNIA and important factors were highlighted with examples including; farm families who experience barriers to accessing healthcare services and exhibit low help-seeking behaviour or do not prioritise their health and wellbeing. These rural groups are also referenced as a priority when considering reducing the levels of loneliness and social isolation as well as consideration for older people and those facing digital poverty when considering development within digital capacity.

These are just a few of the examples from the responses received which will be shared with the relevant teams and staff within the PHA to consider these factors when individually screening actions, work and programmes.

**2C. If the Policy, Strategy, Plan or Public Service is likely to impact on people in rural areas *differently* from people in urban areas, please explain how it is likely to impact on people in rural areas differently.**

Around 670,000 people, i.e. over a third (36%) of the population live in rural areas in Northern Ireland (NI)' – total population as per NISRA census 2021 is 1.92million.

As the PHA takes forward the Corporate Plan and works to achieve each outcome, the actions, work and programmes will be screened individually through a Rural Needs Impact Assessment (RNIA). It is at this more detailed level that the PHA will understand, identify and consider how the development of a policy, strategy, plan or public service will impact on people in rural areas.

**2D. Please indicate which of the following rural policy areas the Policy, Strategy, Plan or Public Service is likely to primarily impact on.**

| | |
|---|---|
| Rural Business | |
| Rural Tourism | |
| Rural Housing | |
| Jobs or Employment in Rural Areas | |
| Education or Training in Rural Areas | |
| Broadband or Mobile Communications in Rural Areas | |
| Transport Services of Infrastructure in Rural Areas | |
| Health of Social Care Services in Rural Areas | X |
| Poverty in Rural Areas | |
| Deprivation in Rural Areas | X |
| Rural Crime or Community Safety | |
| Rural Development | |
| Agri-Environment | X |
| Other (Please state) | |

**If the response to Section 2A was YES GO TO Section 3A.**

**2E. Please explain why the Policy, Strategy, Plan or Public Service is NOT likely to impact on people in rural areas.**

N/A

## SECTION 3 - Identifying the Social and Economic Needs of Persons in Rural Areas

**3A. Has the PHA taken steps to identify the social and economic needs of people in rural areas that are relevant to the Policy, Strategy, Plan or Public Service?**

Yes [ ] No [X] If the response is **NO** GO TO Section **3E**.

**3B. Please indicate which of the following methods or information sources were used by the PHA to identify the social and economic needs of people in rural areas.**

| | | | |
|---|---|---|---|
| Consultation with Rural Stakeholders | [ ] | Published Statistics | [ ] |
| Consultation with Other Organisations | [ ] | Research Papers | [ ] |
| Surveys or Questionnaires | [ ] | Other Publications | [ ] |
| Other Methods or Information Sources (include details in Question 3C below). | | | [ ] |

**3C. Please provide details of the methods and information sources used to identify the social and economic needs of people in rural areas including relevant dates, names of organisations, titles of publications, website references, details of surveys or consultations undertaken etc.**

N/A

**3D. Please provide details of the social and economic needs of people in rural areas which have been identified by the PHA?**

N/A

**If the response to Section 3A was YES GO TO Section 4A.**

**3E. Please explain why no steps were taken by the PHA to identify the social and economic needs of people in rural areas?**

As the PHA takes forward the Corporate Plan and works to achieve each outcome, the actions, work and programmes will be screened individually through a Rural Needs Impact Assessment (RNIA). It is at this more detailed level that the PHA will understand, identify and consider how the development of a policy, strategy, plan or public service will impact on people in rural areas.

## SECTION 4 - Considering the Social and Economic Needs of Persons in Rural Areas

**4A. Please provide details of the issues considered in relation to the social and economic needs of people in rural areas.**

As the PHA takes forward the Corporate Plan and works to achieve each outcome, the actions, work and programmes will be screened individually through a Rural Needs Impact Assessment (RNIA). It is at this more detailed level that the PHA will understand, identify and consider how the development of a policy, strategy, plan or public service will impact on people in rural areas.

## SECTION 5 - Influencing the Policy, Strategy, Plan or Public Service

**5A. Has the development, adoption, implementation or revising of the Policy, Strategy or Plan, or the design or delivery of the Public Service, been influenced by the rural needs identified?**

Yes [ ] No [X] If the response is **NO** GO TO Section **5C**.

**5B. Please explain how the development, adoption, implementation or revising of the Policy, Strategy or Plan, or the design or delivery of the Public Service, has been influenced by the rural needs identified.**

N/A

**If the response to Section 5A was YES GO TO Section 6A.**

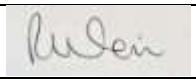
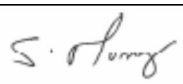
**5C. Please explain why the development, adoption, implementation or revising of the Policy, Strategy or Plan, or the design or the delivery of the Public Service, has NOT been influenced by the rural needs identified.**

As the PHA takes forward the Corporate Plan and works to achieve each outcome, the actions, work and programmes will be screened individually through a Rural Needs Impact Assessment (RNIA). It is at this more detailed level that the PHA will understand, identify and consider how the development of a policy, strategy, plan or public service will impact on people in rural areas.

## SECTION 6 - Documenting and Recording

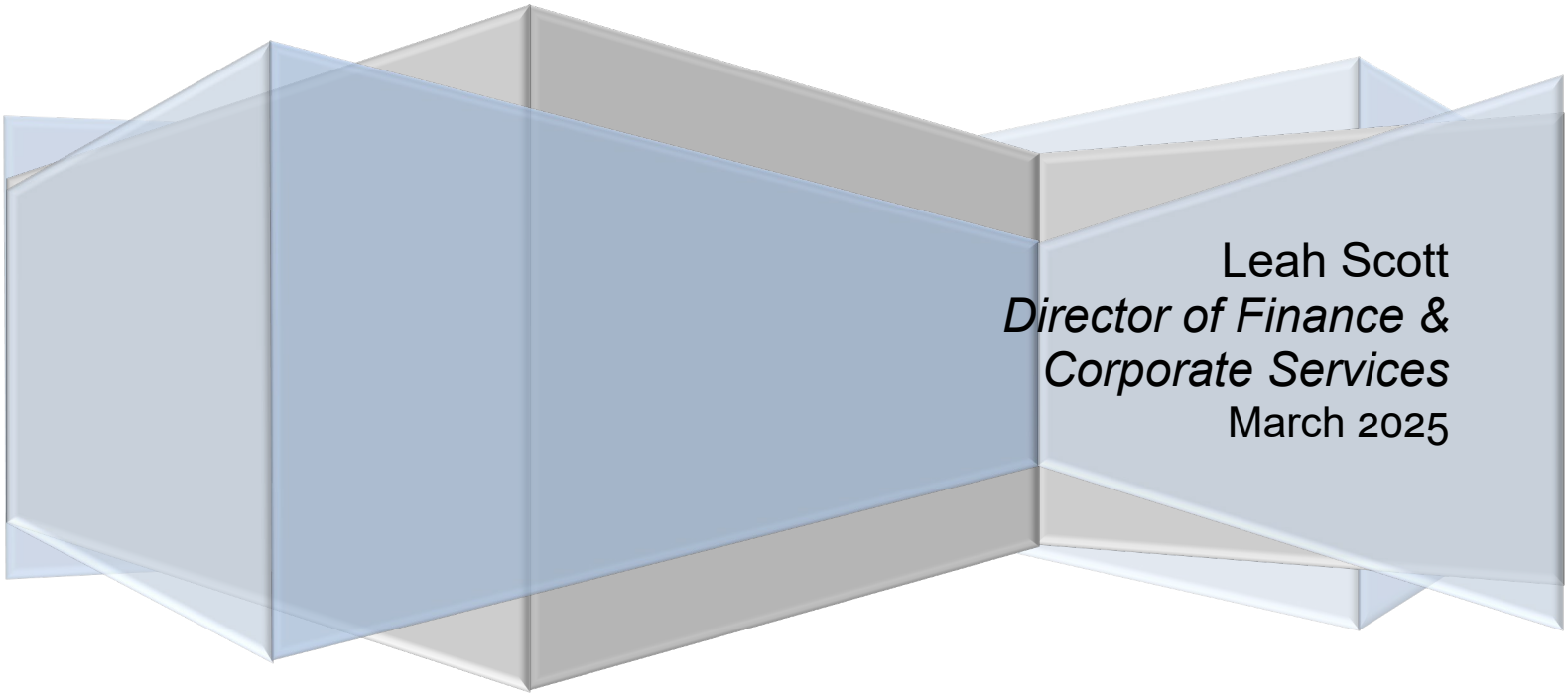
**6A. Please tick below to confirm that the RNIA Template will be retained by the PHA and relevant information on the Section 1 activity compiled in accordance with paragraph 6.7 of the guidance.**

I confirm that the RNIA Template will be retained and relevant information compiled. X

| | |
|---|---|
| **Rural Needs Impact Assessment undertaken by:** | Rosslyn Weir |
| **Grade:** | Project Support Manager |
| **Directorate:** | PHA Finance and Corporate Services |
| **Signature:** |  |
| **Date:** | 07 March 2025 |
| **Rural Needs Impact Assessment approved by:** | Stephen Murray |
| **Grade:** | Assistant Director Planning and Business Services |
| **Directorate:** | PHA Finance and Corporate Services |
| **Signature:** |  |
| **Date:** | 07 March 2025 |

HSC Public Health Agency

# Finance Report
## Month 10 - January 2025



Leah Scott
*Director of Finance & Corporate Services*
March 2025

## Section A: Introduction/Background

1. This summary report reflects the draft year-end position as at the end of January 2025 (month 10) and includes a range of risks associated with the delivery of the full year budget. Supplementary detail is provided in **Annex A**. A breakeven position is currently projected for the year.

### Table 1: PHA Summary Revenue position – January 2025

| | Annual Budget | | | | | Year to Date | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Programme | | Ringfenced | Mgt & | Total | Programme | | Ringfenced | Mgt & | Total |
| | Trust | PHA Direct | Trust & | Admin | | Trust | PHA Direct | Trust & | Admin | |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Available Resources** | | | | | | | | | | |
| Departmental Revenue Allocation | 48,619 | 56,178 | 3,033 | 31,073 | **138,903** | 40,516 | 46,258 | 2,124 | 25,659 | **114,558** |
| Assumed Retraction | - | - | - | - | **-** | - | - | - | - | **-** |
| Revenue Income from Other Sources | - | 52 | - | 597 | **649** | - | 52 | - | 516 | **568** |
| **Total Available Resources** | 48,619 | 56,230 | 3,033 | 31,670 | **139,552** | 40,516 | 46,310 | 2,124 | 26,175 | **115,124** |
| **Expenditure** | | | | | | | | | | |
| Trusts | 48,619 | - | 1,753 | - | **50,371** | 40,516 | - | 1,460 | - | **41,976** |
| PHA Direct Programme * | - | 57,523 | 1,281 | - | **58,804** | - | 46,585 | 623 | - | **47,208** |
| PHA Administration | - | - | - | 30,377 | **30,377** | - | - | - | 25,272 | **25,272** |
| **Total Proposed Budgets** | 48,619 | 57,523 | 3,033 | 30,377 | **139,553** | 40,516 | 46,585 | 2,083 | 25,272 | **114,456** |
| **Surplus/(Deficit) - Revenue** | - | (1,293) | - | 1,293 | (0) | - | (275) | 41 | 903 | **668** |
| ***Cumulative variance (%)*** | | | | | | ***0.00%*** | ***-0.59%*** | ***1.91%*** | ***3.45%*** | ***0.58%*** |

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

### Update on the PHA budget allocation for 2024/25

2. During the year, the PHA baseline budget has been amended for the following changes:
   - £3.2m R&D Funding for the National Institute for Health and Care Research Payment;
   - £3.0m for Shingles vaccines;
   - £1.5m for RSV and mPox vaccinations;
   - £2.3m for Covid & Flu vaccinations (ringfenced Covid funding);
   - £0.6m for various Nursing programmes (Text-a-Nurse etc.);
   - £0.5m Fresh Start funding (ringfenced);
   - £0.3m for various Admin costs related to posts;
   - £0.7m retraction resulting from the slippage exercise in month 7 and month 10; and
   - £0.65m pertaining to R&D VPAG Programmed Activities and Trusts.

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

4. The PHA has a year to date surplus at January 2025 of £0.7m (month 9 £1.1m) against the year to date budget for 2024/25 & is summarised in **Table 2** below:

**Table 2: PHA Summary financial position - January 2025**

| | Annual Budget | YTD Budget | YTD Expenditure | YTD Variance | Projected year end surplus / (deficit) |
|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 |
| Health Improvement | 13,989 | 11,657 | 11,657 | 0 | |
| Health Protection | 10,929 | 9,108 | 9,108 | 0 | |
| Service Development & Screening | 15,750 | 13,125 | 13,125 | 0 | |
| Nursing & AHP | 7,925 | 6,604 | 6,604 | 0 | |
| Centre for Connected Health | 0 | 0 | 0 | 0 | |
| Quality Improvement | 25 | 21 | 21 | 0 | |
| Other | 0 | 0 | 0 | 0 | |
| **Programme expenditure - Trusts** | **48,619** | **40,516** | **40,516** | **0** | **0** |
| Health Improvement | 31,253 | 24,750 | 24,298 | 452 | |
| Health Protection | 18,807 | 17,069 | 16,967 | 102 | |
| Service Development & Screening | 3,348 | 2,169 | 2,122 | 47 | |
| Research & Development | 3,252 | 3,200 | 3,200 | 0 | |
| Operations, incl. Campaigns | 408 | 279 | 402 | (122) | |
| Nursing & AHP | 1,052 | 393 | 404 | (11) | |
| Quality Improvement | 18 | 18 | 44 | (26) | |
| Other | (908) | (735) | (847) | 112 | |
| Savings target | (1,000) | (833) | 0 | (833) | |
| **Programme expenditure - PHA** | **56,230** | **46,311** | **46,585** | **(276)** | **(1,293)** |
| **Subtotal Programme expenditure** | **104,849** | **86,826** | **87,101** | **(276)** | **(1,293)** |
| Public Health | 17,608 | 14,593 | 14,365 | 228 | |
| Nursing & AHP | 6,368 | 5,292 | 4,549 | 743 | |
| Operations | 5,441 | 4,484 | 3,655 | 829 | |
| Quality Improvement | 425 | 425 | 421 | 4 | |
| PHA Board | 470 | 308 | 1,331 | (1,023) | |
| Centre for Connected Health | 458 | 374 | 328 | 45 | |
| SBNI | 900 | 700 | 623 | 77 | |
| **Subtotal Management & Admin** | **31,670** | **26,175** | **25,272** | **903** | **1,293** |
| Trusts | 1,753 | 1,460 | 1,460 | 0 | |
| PHA Direct | 1,281 | 663 | 623 | 41 | |
| **Ringfenced** | **3,033** | **2,124** | **2,083** | **41** | **0** |
| **TOTAL** | **139,553** | **115,125** | **114,456** | **668** | **0** |

*Note: Table may be subject to minor roundings.*

## Section B: Update – Revenue position

5. In respect of the year to date position:

- The annual non-Trust programme budget is £56.2m, and expenditure of £46.6m has been recorded for the first ten months of the financial year with **an overspend of £0.3m reported** (month 9, £0.4m underspend). This budget is currently projected to achieve planned overspend of £1.3m by the end of the financial year

which will be used to absorb the anticipated underspend in Administration budgets outlined below.

- In Management & Administration, a year-to-date **underspend of £0.9m** (month 9, £0.7m underspend) resulting from high levels of vacancies, offset by the application of the balance of the 23-24 savings target held in the PHA Board (£1.2m). The year-end underspend is expected to be approximately £1.3m (month 9, £1.3m).
- Ringfenced funding comprises NI Protocol funding (£0.156m), Tackling Paramilitarism / Fresh Start (£0.528m) and COVID (£2.349m). A small variance is reported on this budget to date, however a breakeven position is forecast for the full year.

**Section C: Risks**

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

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

8. **2024/25 Financial Plan and Recurrent savings to be identified recurrently:** The 2023/24 opening allocation letter applied a £5.3m recurrent savings target to the PHA budget. While PHA has identified a recurrent source for £4.1m of the £5.3m savings target, the balance of £1.2m will be achieved non-recurrently from slippage on Administration budgets in 2024/25. An additional £1m recurrent savings has been applied in 2024/25, and it is expected this will be achieved non-recurrently from slippage on Administration budgets in 2024/25. Savings targets will continue to be monitored throughout the year with the identification of further recurrent savings plans finalised for 2024/25, however there are significant challenges in delivering the full requirement recurrently.

**Section D: Update - Capital position**

9. The PHA has a capital allocation (CRL) of £5.75m. This mainly relates to projects managed through the Research & Development (R&D) team. The overall summary position, as at January 2025, is reflected in **Table 3** below.

**Table 3: PHA Summary capital position – January 2025**

| Capital Summary | Total CRL £'000 | Year to date spend £'000 | Full year forecast £'000 | Forecast Surplus/ (Deficit) £'000 |
|---|---|---|---|---|
| **HSC R&D:** | | | | |
| R&D - Health ALBs | 0 | 0 | 0 | 0 |
| R&D - Trusts | 0 | 0 | 0 | 0 |
| R&D - Other Bodies | 3,310 | 3,170 | 3,310 | 0 |
| R&D - Capital Receipts | (738) | (452) | (738) | 0 |
| **Subtotal HSC R&D** | **2,573** | **2,718** | **2,573** | **0** |
| **Other:** | | | | |
| Congenital Heart Disease Network | 764 | 251 | 764 | 0 |
| iReach Project | 614 | 430 | 614 | 0 |
| R&D - NICOLA | 778 | 147 | 778 | 0 |
| VMS Enhancement (Exc. Child flu) | 196 | 171 | 196 | 0 |
| VMS Pertussis Vaccination | 45 | 42 | 45 | 0 |
| VMS RSV Vaccination | 45 | 32 | 45 | 0 |
| MAC Books | 2 | 2 | 2 | 0 |
| R&D VPAG | 70 | 16 | 70 | 0 |
| R&D VPAG Trusts | 581 | 0 | 581 | 0 |
| Path Safe Wastewater Surveillance | 417 | 313 | 417 | 0 |
| Other - Capital receipts | (332) | (249) | (332) | 0 |
| **Subtotal Other** | **3,181** | **1,156** | **3,181** | **0** |
| **Total PHA Capital position** | **5,753** | **3,874** | **5,753** | **0** |

**Recommendation**

10. The PHA Board are asked to note the PHA financial update as at January 2025.

# Public Health Agency

## Annex A - Finance Report

## 2024/25

**Month 10 - January 2025**

# Public Health Agency
## 2024/25 Summary Position - January 2025

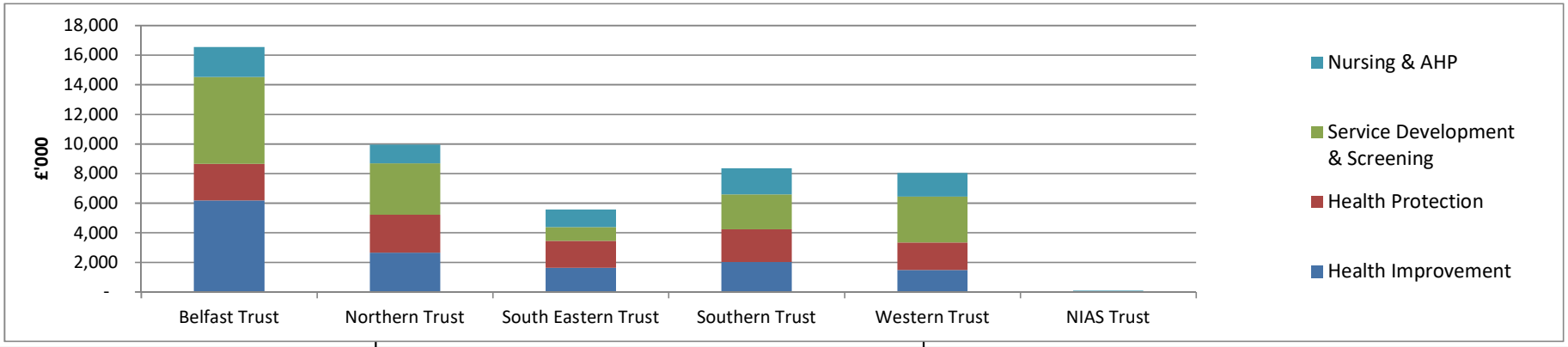
| | Annual Budget | | | | | Year to Date | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Programme | | Ringfenced | Mgt & | Total | Programme | | Ringfenced | Mgt & | Total |
| | Trust | PHA Direct | Trust & Direct | Admin | | Trust | PHA Direct | Trust & Direct | Admin | |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Available Resources** | | | | | | | | | | |
| Departmental Revenue Allocation | 48,619 | 56,178 | 3,033 | 31,073 | **138,903** | 40,516 | 46,258 | 2,124 | 25,659 | **114,558** |
| Assumed Retraction | - | - | - | - | **-** | - | - | - | - | **-** |
| Revenue Income from Other Sources | - | 52 | - | 597 | **649** | - | 52 | - | 516 | **568** |
| **Total Available Resources** | 48,619 | 56,230 | 3,033 | 31,670 | **139,553** | 40,516 | 46,310 | 2,124 | 26,175 | **115,124** |
| **Expenditure** | | | | | | | | | | |
| Trusts | 48,619 | - | 1,753 | - | **50,371** | 40,516 | - | 1,460 | - | **41,976** |
| PHA Direct Programme * | - | 57,523 | 1,281 | - | **58,804** | - | 46,585 | 623 | - | **47,208** |
| PHA Administration | - | - | - | 30,377 | **30,377** | - | - | - | 25,272 | **25,272** |
| **Total Proposed Budgets** | 48,619 | 57,523 | 3,033 | 30,377 | **139,553** | 40,516 | 46,585 | 2,083 | 25,272 | **114,456** |
| | | | | | | | | | | |
| **Surplus/(Deficit) - Revenue** | - | (1,293) | - | 1,293 | 0 | - | (275) | 41 | 903 | **668** |
| ***Cumulative variance (%)*** | | | | | | ***0.00%*** | ***-0.59%*** | ***1.91%*** | ***3.45%*** | ***0.58%*** |

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

The year to date financial position for the PHA shows a surplus of £668k, with an underspend on Management and Admin budgets due to vacancies and an overspend in Programme budgets.

The PHA is forecasting a breakeven position at year end, with a surplus on Administration budgets being offset by a closely managed overspend on Programme budgets.

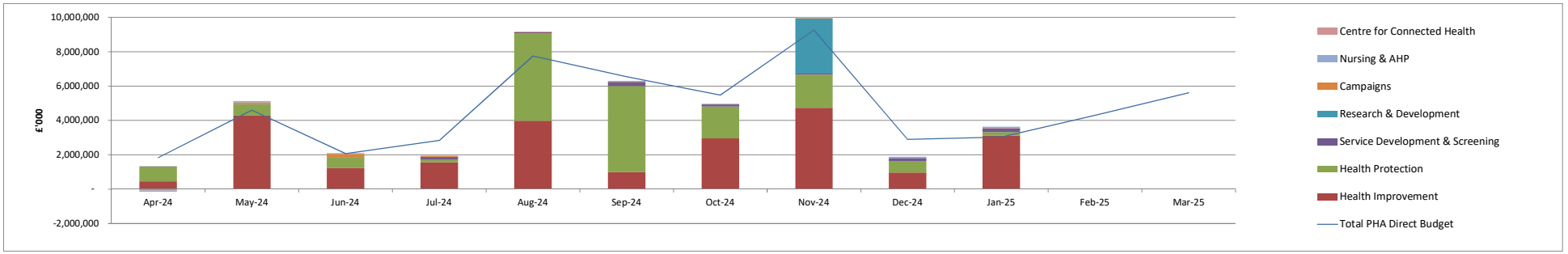
# Programme Expenditure with Trusts




| Current Trust RRLs | Belfast Trust | Northern Trust | South Eastern Trust | Southern Trust | Western Trust | NIAS Trust | Total Planned Expenditure | YTD Budget | YTD Expenditure | YTD Surplus / (Deficit) |
|---|---|---|---|---|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Health Improvement | 6,178 | 2,661 | 1,638 | 2,035 | 1,476 | - | **13,989** | 11,657 | 11,657 | - |
| Health Protection | 2,473 | 2,561 | 1,827 | 2,201 | 1,868 | - | **10,929** | 9,108 | 9,108 | - |
| Service Development & Screening | 5,871 | 3,487 | 924 | 2,367 | 3,102 | - | **15,750** | 13,125 | 13,125 | - |
| Nursing & AHP | 2,023 | 1,257 | 1,180 | 1,755 | 1,609 | 100 | **7,925** | 6,604 | 6,604 | - |
| Quality Improvement | 25 | - | - | - | - | - | **25** | 21 | 21 | - |
| **Total current RRLs** | **16,570** | **9,966** | **5,569** | **8,358** | **8,055** | **100** | **48,619** | **40,516** | **40,516** | - |
| ***Cumulative variance (%)*** | | | | | | | | | | ***0.00%*** |

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

## PHA Direct Programme Expenditure




| | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Total | YTD Budget | YTD Spend | Variance | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | |
| **Profiled Budget** | | | | | | | | | | | | | | | | | |
| Health Improvement | 1,593 | 3,013 | 1,269 | 1,819 | 3,196 | 1,356 | 3,478 | 4,159 | 1,986 | 2,881 | 3,305 | 3,198 | **31,253** | 24,750 | 24,298 | 452 | *1.8%* |
| Health Protection | 182 | 1,429 | 441 | 438 | 4,991 | 4,835 | 1,712 | 1,962 | 798 | 281 | 645 | 1,094 | **18,807** | 17,069 | 16,967 | 102 | *0.6%* |
| Service Development & Screening | 0 | 150 | 143 | 452 | 77 | 327 | 335 | 172 | 212 | 301 | 197 | 982 | **3,348** | 2,169 | 2,122 | 47 | *2.2%* |
| Research & Development | - | - | - | - | - | - | - | 3,200 | - | - | 52 | - | **3,252** | 3,200 | 3,200 | - | *0.0%* |
| Operations, incl. Campaigns | - | 3 | 155 | 122 | - 40 | 40 | 28 | - 20 | - 30 | 22 | 61 | 67 | **408** | 279 | 402 | (122) | *-43.7%* |
| Nursing & AHP | 59 | 11 | 55 | 0 | - 59 | 64 | 7 | 28 | 154 | 72 | 300 | 359 | **1,052** | 393 | 404 | (11) | *-2.7%* |
| Quality Improvement | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 13 | - 6 | - | - | **18** | 18 | 44 | (26) | *-142.0%* |
| Other | - | - | - | - | - | - | - | (150) | (150) | (435) | (172) | (1) | **(908)** | (735) | 0 | (735) | *100.0%* |
| Savings target | (83) | (83) | (83) | (83) | (83) | (83) | (83) | (83) | (83) | (83) | (83) | (83) | **(1,000)** | (833) | (847) | 14 | *100.0%* |
| **Total PHA Direct Budget** | **1,753** | **4,525** | **1,980** | **2,749** | **8,083** | **6,541** | **5,478** | **9,268** | **2,900** | **3,032** | **4,305** | **5,615** | **56,230** | **46,310** | **46,585** | **(275)** | |
| ***Cumulative variance (%)*** | | | | | | | | | | | | | | | | ***-0.59%*** | |
| **Actual Expenditure** | **1,143** | **5,313** | **2,220** | **2,037** | **8,562** | **6,419** | **5,059** | **10,113** | **1,997** | **3,722** | | | **46,585** | | | | |
| **Variance** | **609** | **(788)** | **(240)** | **712** | **(479)** | **123** | **419** | **(845)** | **903** | **(690)** | | | **(275)** | | | | |

The year-to-date position shows an overspend of £0.3m against profile. An overall year-end Programme overspend of c£1.3m is anticipated, and this is being managed closely in order to offset a forecast underspend in Administration budgets.

Whilst £4.1m of £5.3m savings target applied to PHA in 2023/24 has been achieved, the remaining £1.2m has been identified non-recurrently from Management & Administration budgets while a recurrent solution is identified. A further £1m of recurrent savings has been applied to the PHA in 2024/25 and has been met non-recurrently in-year from an unrequired prior year accrual while a recurrent solution is identified.

January 2025

# Public Health Agency
## 2024/25 Ringfenced Position

| | Annual Budget | | | Year to Date | | |
|---|---|---|---|---|---|---|
| | Covid | Other ringfenced | Total | Covid | Other ringfenced | Total |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Available Resources** | | | | | | |
| DoH Allocation | 2,349 | 684 | **3,033** | 1,671 | 453 | **2,124** |
| Assumed Allocation/(Retraction) | - | - | - | - | - | **-** |
| Total | 2,349 | 684 | **3,033** | 1,671 | 453 | **2,124** |
| **Expenditure** | | | | | | |
| Trusts | 1,753 | - | **1,753** | 1,460 | - | **1,460** |
| PHA Direct | 597 | 684 | **1,281** | 205 | 417 | **623** |
| Total | 2,349 | 684 | **3,033** | 1,666 | 417 | **2,083** |
| | | | | | | |
| **Surplus/(Deficit)** | **-** | **-** | **-** | **5** | **35** | **41** |

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

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

# PHA Administration

## 2024/25 Directorate Budgets

| | Nursing & AHP £'000 | Quality Improvement £'000 | Finance & Corporate Services £'000 | Public Health £'000 | PHA Board £'000 | Centre for Connected Health £'000 | SBNI £'000 | Total £'000 |
|---|---|---|---|---|---|---|---|---|
| **Annual Budget** | | | | | | | | |
| Salaries | 6,123 | 418 | 3,983 | 17,362 | 1,530 | 408 | 616 | **30,440** |
| Goods & Services | 245 | 7 | 1,457 | 246 | (1,060) | 50 | 284 | **1,230** |
| **Total Budget** | **6,368** | **425** | **5,441** | **17,608** | **470** | **458** | **900** | **31,670** |
| **Budget profiled to date** | | | | | | | | |
| Salaries | 5,091 | 418 | 3,318 | 14,406 | 1,225 | 340 | 513 | **25,311** |
| Goods & Services | 201 | 7 | 1,166 | 187 | (917) | 34 | 187 | **864** |
| **Total** | **5,292** | **425** | **4,484** | **14,593** | **308** | **374** | **700** | **26,175** |
| **Actual expenditure to date** | | | | | | | | |
| Salaries | 4,354 | 416 | 2,388 | 13,586 | 1,310 | 307 | 477 | **22,838** |
| Goods & Services | 195 | 5 | 1,267 | 779 | 21 | 21 | 146 | **2,434** |
| **Total** | **4,549** | **421** | **3,655** | **14,365** | **1,331** | **328** | **623** | **25,272** |
| **Surplus/(Deficit) to date** | | | | | | | | |
| Salaries | 737 | 1 | 930 | 820 | (84) | 33 | 36 | **2,473** |
| Goods & Services | 6 | 2 | (101) | (593) | (939) | 13 | 42 | **(1,570)** |
| **Surplus/(Deficit)** | **743** | **4** | **829** | **228** | **(1,023)** | **45** | **77** | **903** |
| ***Cumulative variance (%)*** | *14.04%* | *0.90%* | *18.49%* | *1.56%* | *-332.35%* | *12.08%* | *11.04%* | ***3.45%*** |

PHA's administration budget is showing a year-to-date surplus of £0.9m, which is being generated by a number of vacancies, particularly within the Finance & Corporate Services and Nursing & AHP Directorates, offset by the application of the balance of the 23-24 savings target held in the PHA Board (£1.2m). Senior management continue to monitor the position closely in the context of the PHA's obligation to achieve a breakeven position for the financial year.

The full year surplus is currently forecast to be c£1.3m, and this is being managed by PHA through a managed deficit in Programme expenditure in the financial year. Whilst £4.1m of £5.3m savings target applied to PHA in 2023/24 has been achieved, the remaining £1.2m has been identified non-recurrently from Management & Administration budgets while a recurrent solution is identified.

# PHA Prompt Payment

## Prompt Payment Statistics

| | January 2025<br>Value | January 2025<br>Volume | Cumulative position as at January 2025<br>Value | Cumulative position as at January 2025<br>Volume |
|---|---|---|---|---|
| Total bills paid (relating to Prompt Payment target) | £3,895,205 | 411 | £71,537,212 | 4,738 |
| Total bills paid on time (within 30 days or under other agreed terms) | £3,727,205 | 384 | £69,680,141 | 4,546 |
| **Percentage of bills paid on time** | **95.7%** | **93.4%** | **97.4%** | **95.9%** |

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

The 10 day prompt payment performance remains above the current DoH target for 2024/25 of 70%, at 81% on volume for the year to date.