HSC Public Health Agency

agenda

Title of Meeting	164th Meeting of the Public Health Agency Board
Date	16 May 2024 at 1.30pm
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

1 1.30	Welcome and Apologies	Chair
2 1.30	Declaration of Interests	Chair
3 1.30	Minutes of Previous Meeting held on 18 April 2024	Chair
4 1.35	Actions from Previous Meeting / Matters Arising	Chair
5 1.40	Reshape and Refresh Programme	Chair
6 1.50	Reports of New or Emerging Risks	Chief Executive
7 1.55	Raising Concerns	Chief Executive
8 2.00	Updates from Committees: • Governance and Audit Committee • Remuneration Committee • Planning, Performance and Resources Committee **[PHA/01/05/24]** • Screening Programme Board • Procurement Board • Information Governance Steering Group • Public Inquiries Programme Board	Committee Chairs
9 2.20	Operational Updates: • Chief Executive's and Executive Directors' Report	Chief Executive/ Executive Directors
	• Finance Report **[PHA/02/05/24]**	Ms Scott
10 2.40	Complaints Report **[PHA/03/05/24] (For approval)**	Chief Executive
11 2.45	Performance Management Report **[PHA/04/05/24] (For discussion)**	Ms Scott

12 ALB Self-Assessment **[PHA/05/05/24] (For approval)** Chair
3.05

13 Items for Noting:
3.15

- Overview of Budget Planning for 2024/25 **[PHA/06/05/24]**

- Our People Plan **[PHA/07/05/24]**

14 Chair's Remarks Chair
3.25

15 Any Other Business Chair
3.30

16 Details of next meeting:

Thursday 20 June 2024 at 1.30pm

Meeting Room, County Hall, Ballymena

HSC Public Health Agency

minutes

Title of Meeting	163rd Meeting of the Public Health Agency Board
Date	18 April 2024 at 1.30pm
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

Present

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

In Attendance

Dr Aideen Keaney	-	Director of Quality Improvement
Mr Robert Graham	-	Secretariat

Apologies

Mr Brendan Whittle	-	Director of Community Care, SPPG

40/24	**Item 1 – Welcome and Apologies**
40/24.1	The Chair welcomed everyone to the meeting. Apologies were noted from Mr Brendan Whittle.
41/24	**Item 2 – Declaration of Interests**
41/24.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda.
41/24.2	Mr Clayton declared an interest in relation to Public Inquiries as Unison is engaging with the Inquiries.

42/24	**Item 3 – Minutes of previous meeting held on 20 March 2024**
42/24.1	The minutes of the Board meeting held on 16 February 2024 were **APPROVED** as an accurate record of that meeting.
43/24	**Item 4 – Actions from Previous Meeting / Matters Arising**
43/24.1	An action log from the previous meeting was distributed in advance of the meeting.
43/24.2	The Chief Executive advised that for the action relating to Serious Adverse Incidents (SAIs) from the February meeting, he will complete this action as a follow up to the discussion on SAIs in the private session.
43/24.3	Ms Henderson asked if a Procurement Plan would be brought to the Board, but the Chair said that he was expecting this Plan to be brought through the Planning, Performance and Resources (PPR) Committee. The Chair added that the PPR Committee needs to be looking at these types of issues and be clear regarding timescales **(Action 1 – Chair)**.
43/24.4	Mr Clayton noted that there was a discussion at the February meeting around the support to affected families following an SAI and he had e-mailed Ms Reid seeking clarity on this. Ms Reid advised that she would respond to Mr Clayton directly regarding this **(Action 2 – Ms Reid)**.
44/24	**Item 5 – Reshape and Refresh Programme**
44/24.1	The Chair said that an update report on the Reshape and Refresh programme had been issued to members and that there will be a Programme Board meeting on Monday.
44/24.2	The Chair asked Ms Scott about the transfer of finance staff and Ms Scott replied that some staff have transferred across while others are being recruited.
44/24.3	The Chair advised that he has set up a meeting with Ms Scott to understand the budget principles and that he was extending an invitation to any other members who wished to attend.
45/24	**Item 6 – Reports of New or Emerging Risks**
45/24.1	The Chief Executive advised that there were no new risks to report on.
46/24	**Item 7 – Raising Concerns**
46/24.2	The Chief Executive reported that there were no new concerns to be brought to the attention of the Board.

47/24 **Item 8 – Updates from Board Committees**

Governance and Audit Committee ***[PHA/01/04/24]***

47/24.1 Mr Stewart reported that the Governance and Audit Committee had met on Monday and that the approved minutes of the February meeting had been issued to members. He said that the paper requested on screening will be brought to the Board meeting in May.

47/24.2 Mr Stewart expressed his concern as what overall level of assurance the Head of Internal Audit will give PHA given that following the 5 audits carried out this year, 2 received a satisfactory level of assurance and 3 received a limited level of assurance. He added that a report on outstanding audit recommendations showed that only 80% had been fully implemented and while he acknowledged that audit clinics had taken place to review these, he noted that in previous years the figure was over 90%. The Chair asked how long these recommendations have been outstanding and Mr Stewart advised that there is a range of dates with some going back to 2015 and 2018. The Chair said that the Board needs to understand what is preventing these recommendations from being implemented. Mr Stewart advised that there are two recommendations which are linked to the lack of a strategic plan and there is a recommendation following an audit on recruitment where a suggestion was made that there should be a tracker for different stages of the process and he did not find it acceptable that management had deemed this it was not possible to implement this.

47/24.3 Mr Stewart said that there had been no risks added to, or removed from, the Corporate Risk Register. He added that there was a discussion about the risk on migration to SPPG and that this risk is now out of date and needs revised. He said that the information governance action plan had been considered and there were some targets rated “red” relating to training for new staff which he acknowledged is an issue the Chief Executive is keen to address. He advised that there was a discussion around the level of support given to ex-employees for Public Inquiries. He said that the Committee had considered the Nursing and AHP Directorate Risk Register. The Chief Executive advised that AMT had recently approved a proposal regarding a new induction programme where there will be a mix of in-person and virtual meetings with Directors.

Remuneration Committee

47/24.4 The Chair advised that the Remuneration Committee has not met since the last Board meeting.

Planning, Performance and Resources Committee

47/24.5 The Chair advised that the Planning, Performance and Resources Committee has not met since the last Board meeting.

Screening Programme Board

47/24.6 The Chair noted that the Screening Programme Board has not met since the last Board meeting.

Procurement Board

47/24.7 The Chair noted that the Procurement Board has not met since the last Board meeting.

Information Governance Steering Group

47/24.8 The Chair noted that the that the Information Governance Steering Group has not met since the last Board meeting.

At this point Mr Clayton left the meeting.

Public Inquiries Programme Board

47/24.9 Professor Rooney advised that the Public Inquiries Programme Board had met on one occasion and the main item for discussion was the continuing preparations for Dr McClean's appearance at the COVID Inquiry on 2 May. She said that she would be happy to assist in any way she can. She added that she spoken to Mr Alastair Ross about resources.

47/24.10 The Chief Executive said that it is anticipated that the Muckamore Inquiry will come to an end this year. He advised that two former Directors have been called to the Inquiry and PHA has offered support to them, but adding that the Inquiry dictates the level of support that can be given.

At this point Mr Clayton re-joined the meeting.

48/24 Item 9 – Operational Updates

Chief Executive's and Executive Directors' Report

48/24.1 The Chief Executive advised that he wishes to do some team building with the Executive Team.

48/24.2 Professor Rooney asked if there was any update in relation to the work on commissioning. The Chief Executive replied that he and the Chair are part of a group looking at this. The Chair said that PHA will have a different role to play in future. The Chief Executive commented that within the health system, PHA is seen as a trusted organisation and he expressed concern that in the vacuum created by the establishment of SPPG, there is more expectation on PHA. He advised that PHA has a role in commissioning which is outlined in legislation.

48/24.3 Mr Stewart said that PHA's role in commissioning is to provide professional advice and this should be only at the highest level. He noted that in the past the PHA Board would have received a Commissioning Plan that was essentially approved before it was brought to the Board.

48/24.4 Mr Clayton asked about the reconfiguration of labs and cervical screening and whether this process will work. Dr McClean explained that there are currently 4 laboratories in Northern Ireland and only 1 is required. She said that any staff impacted will be redeployed. Mr Clayton asked if this is the most feasible option. Dr McClean outlined that in the quality standards for cervical screening there should be 1 laboratory for every 35,000 tests, but in Northern Ireland there would only be a total of 18,000 tests. She added that it would be better to have one site from a perspective of sustainability, and that Trusts have been asked to look at their current staffing. Mr Clayton suggested in a few months' time there may need to be another review, but Dr McClean said that Trusts have been asked to come back if they feel they can deliver the service. She added that there was a workshop to look at options, which was dominated by staff and service users who felt that 2 laboratories would be the best option, but this is unsustainable.

48/24.5 The Chair asked Dr McClean how she anticipated that this would be resolved and Dr McClean confirmed that she expected that more than one laboratory will come forward for assessment and that others will not.

48/24.6 Professor Rooney asked about advance care planning. She suggested that where PHA is being asked to take on a piece of work, but cannot run a campaign, it could link with Marie Curie. The Chief Executive said that he had not given consideration to a campaign. Ms Reid commented that doing this work is appropriate, but there are many different elements. She added that PHA has made it clear that it does not have the budget so it will either have to be funded by the Department or be funded through PHA slippage. She advised that a paper is going to the Department along with correspondence from the Chief Executive outlining the parameters for PHA carrying out this work.

48/24.7 Ms Henderson asked why PHA is doing this work when it has no budget to do so and cannot run a campaign. She asked if PHA has the capacity to facilitate this work. Ms Reid advised that a lot of the work is already happening with no impact on core work and this is about supporting healthcare professionals having conversations with families and about doing the right thing for people. She acknowledged that there is no capacity to have a campaign but PHA will try to integrate this with work that is happening in other areas.

48/24.8 The Chief Executive said that PHA would not run a campaign without a budget. Mr Stewart commented that he was not convinced and asked why PHA is doing this work without additional resources. Ms Reid said that PHA has not previously taken on this work without those caveats in

place. She advised that there are patients whose wishes have not been recorded and this gives clinicians a safety net. Mr Stewart said that this is about methodology and communication and there is a gap here that PHA cannot fill. The Chief Executive advised that PHA will be integrating this work through groups that are already in place. He added that PHA is not organising a campaign or recruiting any staff, but doing what it can do within existing resources.

48/24.9 Ms Henderson asked if there is a perception of PHA having a role in being at the interface between patients and carers and their wishes. Ms Reid advised that PHA has a role within organ donation of increasing awareness, but not about the decisions people make. She added that PHA can have a wide influence within the healthcare sector.

48/24.10 Professor Rooney asked if PHA is recording the conversations and how will PHA know if it has been effective. Ms Reid said that the information will be on Encompass. The Chief Executive advised that this work will sit within SPPG. The Chair sought assurance that this work will not take away from the core activities of PHA but Ms Reid replied that this is an enhancement of an existing service and is in line with what PHA would want to do. Ms Henderson said that it is helpful that the Board is aware of it.

48/24.11 The Chair said that at some point PHA needs to be able to determine if this work has or has not had an impact. Professor Rooney asked if there is an end point. The Chief Executive advised that there are discussions at AMT about initiatives that PHA would like to do, but PHA cannot do them if it is not resourced to do so.

*Finance Report **[PHA/02/04/24]***

48/24.12 Ms Scott advised that the Finance Report reflects the current position and that PHA, despite having a saving target of £5.3m is on target to achieve a break-even position.

48/24.13 The Chair commended the work to achieve this outcome but noted that PHA is required to achieve the same savings in 2024/25. He asked if there is a financial plan to achieve savings. Ms Scott advised that a Plan is being developed and will be brought to the Board in June. She said that she is expecting that PHA will receive a flat cash budget with funding for pay.

48/24.14 The Board noted the Finance Report.

49/24 Item 10 – Complaints Report [PHA/03/04/24]

49/24.1 The Chief Executive presented the Complaints Report and said that there were no matters that he was concerned about. He noted that one complaint had a long timeline for completion, but this was due to the complexity of the complaint.

49/24.2 The Chair said that the Board needs to be aware of complaints and seek assurance that they are being progressed in a timely way.

49/24.3 Mr Blaney asked if there are any implications for PHA when a complaint goes to the Ombudsman. The Chief Executive explained that when a complaint is made a member of the public has the right to go to the Ombudsman if they are dissatisfied with PHA's response. He advised that the complaint currently sitting with the Ombudsman has been there for some time and a determination has yet to be made if it will be taken forward.

49/24.4 Mr Clayton suggested that if a complaint is not going to be resolved within timescales there should be a rationale outlined. He advised that the Governance and Audit Committee had seen an example of a complaint which he said was useful.

49/24.5 The Chief Executive pointed out that the report is about complaints and compliments, but no compliments have been received. The Chair advised that over the last few weeks he has met a lot of people and has not received any negative comments about PHA.

49/24.6 The Board noted the Complaints Report.

50/24 Item 11 – Substance Use Strategic Commissioning and Implementation Plan – Consultation Response [PHA/04/04/24]

Mr Kevin Bailey joined the meeting for this item

50/24.1 Mr Bailey thanked members for the opportunity to present this report today. He explained that since he last presented to the Board on the Substance Use plan, there has been a public consultation, during which 34 responses were received which were mainly positive. He said that PHA staff have been working on the responses and have engaged with over 150 individuals to develop a strategic plan.

50/24.2 Mr Bailey advised that in terms of the responses, the main feedback was that people wanted to see more clarity in terms of how priorities will be implemented and timescales for this. He said that minor changes will be made to the Plan and there will be a workshop in May/June to look at pathways for early intervention and prevention. He added that PHA needs to also look at its workforce and ensure that the right processes are in place as PHA will be held accountable for its work. He said that PHA is in a good place as it has the budget and there is a procurement process. He noted that there may be some challenges as some of the services need to be commissioned by SPPG.

50/24.3 Mr Bailey explained that previously PHA would have been responsible for Tier 1 and Tier 2 services while HSCB was responsible for Tier 3 and Tier 4, but there is now better engagement. He said that the focus is now on pathways rather than on a tiered structure. He added that

people are keen for that change and there is a need to have a Regional Mental Health Service, and that he had an early discussion with Mr Paul Quinn in SPPG regarding this.

50/24.4 Mr Stewart noted a link between substance misuse and the benefits system and Mr Bailey said that the Department for Communities has been involved in this process.

50/24.5 The Chair asked about the ownership of this work and whether it is PHA or SPPG or both. Mr Bailey replied that it is a joint programme, but there are specific actions for each organisation. The Chair asked if there will be ongoing workshops and Mr Bailey confirmed that there is a small core team that will continue to meet on a monthly basis.

50/24.6 Professor Rooney noted that there are different tiers within the service. Mr Bailey explained that there is little difference between Tier 2 and Tier 3, with one being in the community and one being in the statutory sector. He acknowledged that it is complex. Professor Rooney asked if there is a clear delineation. The Chief Executive said that within the SPT there will be service development leads and representatives who make those linkages. He added that the SPTs will bring people together to ensure that there is a consistent approach across the PHA.

50/24.7 Professor Rooney asked about PHA's role in commissioning Tier 1 and Tier 2 services. The Chief Executive said that PHA will ensure that these services are commissioned appropriately, and it will also aim to influence what SPPG and Trusts spend. Mr Bailey added that PHA has an aspiration to remove the tiers. The Chief Executive advised that having a regional mental health service will allow for better alignment with Trusts and make it easier for service users and practitioners to navigate the system.

50/24.8 Ms Henderson sought clarity that the next stage is for the Plan to be updated with any changes and then procurement to proceed. Mr Bailey advised that the summary document of the consultation responses will be placed online within the next week and a statement put on the PHA website. He added that procurement will commence but there is a lot of other work going on and staff are being lost so a paper will be brought to the Procurement Board in May.

50/24.9 Mr Clayton said that this document is useful as it shows how this work has developed and that it is good that consultees will see what changes have been made. In terms of the Plan itself, he asked whether the outcomes and actions will help reduce health inequalities. Mr Bailey explained that PHA's approach has changed where it will now target those most disadvantaged and there will be KPIs. The Chief Executive added that this work is focused on the 20% most deprived and PHA may wish to make this clear and upfront.

50/24.10 Professor Rooney asked if Mr Bailey is happy that this work is

	manageable and can be done within existing resources. Mr Bailey replied that there is a good list of initiatives to be done, but some of the work will depend on services being able to change. However, he added that for some elements, additional funding will be needed and he will be preparing a paper on that. He said that funding of around £1.5m will be needed over the next 3 years. The Chair advised that PHA needs to think further than the Department in terms of funding sources and link up with the community and voluntary sector or PEACEPLUS. Mr Bailey said that PHA already has a link with PEACEPLUS.
50/24.11	The Chair asked if Mr Bailey was content with the outcome of this work and Mr Bailey replied that he was. The Chair said that he wished to place on record his thanks to Mr Bailey and his team for their work. He also expressed an interest in attending the workshop that Mr Bailey is organising.
50/24.12	The Board **APPROVED** the Substance Use Strategic Commissioning and Implementation Plan consultation response.
51/24	**Item 12 – Chair's Remarks**
51/24.1	The Chair reported that he had attended the recent PHA mental health conference which he said was excellent. He advised that he, along with other Chairs of HSC bodies, had met with the Health Minister. He said that he had met with staff in County Hall and they are keen to see change in PHA. He advised that he had presented certificates at a mental health first aid event.
51/24.2	The Chair said that he had met with the Chief Executive of North Down and Ards Council, the Chair of RQIA, representatives from Queen's University and the Chief Executive of Fermanagh and Omagh Council.
51/24.3	The Chair advised that he had met with representatives from PHA's Sponsor Branch in the Department and that these will be more regular going forward. He said that he had met with the Chair of the Northern Ireland Fire and Rescue Service and it is keen to work with PHA.
51/24.4	The Chair said that he and the Chief Executive had met with Ms Marie Mallon to look at Board development for 2024/25.
51/24.5	The Chair noted that following his meetings with Local Councils, a theme coming through is that PHA has good engagement at a local level. He said that PHA needs to have better stakeholder engagement and he intends to meet as many people as he can. He added that PHA needs to look at partnership working in order to get more funding.
52/24	**Item 13 – Any Other Business**
52/24.1	There was no other business.

53/24 **Item 14 – Details of Next Meeting**

Thursday 16 May 2024 at 1.30pm

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

Signed by Chair:

Date:

Phase 3 Progress Report May 2024

	Progress	Key areas to note
Structure	Tier 3 (Assistant Director) job descriptions are under development. Process of evaluation is planned for June for tier 3 with an expectation to commence the management of change for this level to commence immediately after the post evaluations are available.	Timescale associated with Structure has been scoped, with a view to progressing Tier 3 only in first instance. This will allow successful tier 3 applicants to input into tier 4. Key milestones include: • Tier 3 complete by Sept 24 • Tier 4 complete by Aug 25 • Tier 5 complete by Dec 25.
Functions	**HSCQI -** Oversight Board being established to oversee transfer of HSCQI to RQIA – first meeting was scheduled for 29th April but had to be postponed due to illness. Terms of Reference have been developed and core responsibilities of the group are to: o Establish a measurement framework to support the benefits of transfer to be realised. o Explore the Governance model required to support integration of HSCQI into RQIA and take necessary steps in order to implement this in preparation for transfer. o Ensure the relevant engagement with the BSO HR Team on the transfer of staff from the Public Health Agency to the RQIA in line with statutory process. o Explore the corporate requirements such as technology & accommodation to ensure smooth transition. o Develop an internal & external communications plan to support communication of the revised arrangements.	Oversight Board meeting to be rescheduled as soon as possible with view to completing transfer by Autumn 2024.
	Finance – Finance team from SPPG has TUPED to PHA. M.O.U has been established to oversee the transition period. Director of Finance and Corporate Services has taken up post	A finance subgroup will oversee short term and longer-term financial planning relating to reshape / refresh.
	Connected Health – Discussions are in progress between BSO and DHCNI relating to the transfer.	

	SBNI - M.O.U between DoH, SBNI / PHA is under revision. PHA have provided comments to the DoH to support the revision and strengthen the M.O.U going forward.	Revisions to M.O.U include a number of areas for clarification including: • Corporate hosting responsibilities specifically for PHA. • PHA accountability responsibilities as a member of the Partnership.
Governance	Workshop scheduled for 9th May to explore introduction of planning teams and take forward plans for implementing shared leadership approach to planning and implementation including implementation of Health Inequalities framework. Workshop 1 objective: Collective understanding of what Planning Teams are, how they should operate and what benefits they will bring to the organisation.	Group established to develop Health Inequalities framework for PHA. Outworking of Planning Team workshop will be a key driver of success for the new operating model. Governance and Performance framework will be key to addressing silo working in the future.
Culture	Work continues through ODEF which is co-chaired by Programme Manager Reshape Refresh & HR Business Partner. Contains over 50 staff from across organisation. ODEF presented to AMT on 17th April with update on - People Plan & plan for launch, - Skills Framework and plans for launch, - Health & Wellbeing Audit baseline finding report - Plans for recognition & celebration and improving organisational culture. - Corporate induction update & links with areas for improvement.	ODEF - Option papers will be developed to support the next steps in relation to these areas which will help continue to build and develop our culture which is essential during organisational change. AMT Team Leadership Programme being developed – areas which will be explored include promoting positive behaviours and HSC Values translation.
Data, Digital and Innovation	Working group established to oversee the development of strategy for PHA, co-chaired by Prof Ian Young. Progress underway to develop job description for Director of Population, Data and Intelligence with hope that this will be in position to recruit in Autumn 2024.	Digital strategy has been drafted and shared with group for consideration. Plans to recruit Director of Population, Data and Intelligence by Autumn 2024.

Communication	Monthly virtual executive teams check ins scheduled beginning 7th May. F.A.Q following engagement sessions developed and issued to staff. Mural has been updated with proposed new structures and staff are encouraged to engage with this. External stakeholder mapping exercise is underway.	Plan to engage with DoH Senior Leadership forum to update on progress as part of external communications plan.

HSC Public Health Agency

minutes

Title of Meeting	Meeting of the Planning, Performance and Resources Committee
Date	8 February 2024 at 2.00pm
Venue	Meeting Rooms, Linum Chambers, Bedford Street, Belfast

Present

Mr Colin Coffey	-	Chair
Professor Nichola Rooney	-	Non-Executive Director
Ms Anne Henderson	-	Non-Executive Director

In Attendance

Mr Stephen Murray	-	Interim Assistant Director of Planning and Business Services
Mr Stephen Wilson	-	Interim Director of Operations
Ms Karyn Patterson	-	HR Business Partner, BSO
Mr Lindsay Stead	-	Assistant Director of Finance, SPPG
Mr Robert Graham	-	Secretariat

Apologies

Mr Craig Blaney	-	Non-Executive Director
Ms Tracey McCaig	-	Director of Finance, SPPG

1/24	**Item 1 – Welcome and Apologies**
1/24.1	The Chair welcomed everyone to the meeting. Apologies were noted from Mr Craig Blaney and Ms Tracey McCaig.
1/24.2	The Chair said that he wished to ensure that the meetings of this Committee were useful for members and that the information being brought is not being discussed in other forums. He added that he would be keen to review the terms of reference.
1/24.3	Ms Henderson said that she felt that the three areas of planning, performance and resources were covered. She said that there needs to be further work on performance management, as well as a look at business planning processes, as well as the finance and people side. Professor Rooney echoed this saying there needs to be more work on performance management.

1/24.4 The Chair said that he is keen to see outcomes, rather than outputs, and that the Committee should be satisfied that PHA is getting a good return on its investment.

1/24.5 Mr Wilson advised that the terms of reference are due for review and this will be added to the agenda of the next meeting. The Chair proposed that he and Mr Wilson meet to discuss them after this meeting **(Action 1 – Mr Wilson)**.

2/24 Item 2 – Declaration of Interests

2/24.1 The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.

3/24 Item 3 – Minutes of Previous Meeting held on 16 October 2023

3/24.1 Members **APPROVED** the minutes of the meeting held on 16 October 2023.

4/24 Item 4 – Matters Arising

4/24.1 Mr Wilson advised that for the two outstanding actions on performance management, a paper is being prepared and this will be brought to the next meeting.

4/24.2 Mr Wilson said that the information on Trust spend, which was shown to members at the last meeting, would be shared with members via e-mail.

4/24.3 Mr Wilson reported that it has not been possible for Ms Mawhinney to prepare the paper on Strategic Planning Teams (SPTs) as she has been temporarily been moved into the public health directorate, but that the paper will come to the next meeting.

5/24 Item 5 – Planning

Draft PHA Business Plan 2024/25

5/24.1 Mr Wilson advised that the PHA Business Plan is due to be presented to the March Board meeting and that this version represents a work in progress. He said that there was due to be a discussion on this at the Agency Management Team (AMT) meeting last week, but that was cancelled. He advised that there was an initial discussion at yesterday's meeting, and it was agreed that substantial changes need to be made. He explained that senior managers had identified key priorities from across the directorates and the aim of this Plan is to consolidate the main priorities, but in the context of not having a commissioning directive. He acknowledged that some of the areas listed were not necessarily the main priorities and therefore this represented a work in progress. Mr Murray echoed this and reiterated that there has not yet been an opportunity to properly engage with Directors.

5/24.2 The Chair commented that he expected there to be a Programme for Government (PfG) shortly and therefore PHA will be updating its Corporate Plan during the next 12 months. He said that he would share with members the draft AFBI Business Plan which shows how KPIs relate to the objectives in the Corporate Plan **(Action 2 – Chair)**. Mr Wilson said that he would content to look at the AFBI Plan but pointed out that PHA's corporate priorities are included in this Business Plan. he added that directorate business plans should feed into the Business Plan and individual staff objectives should be tailored around these as well. The Chair said that once he shared the AFBI Business Plan, he would meet with Mr Wilson to look at how the PHA Business Plan can be pulled together. He said that the Plan should be outcome focused, rather than output focused **(Action 3 – Chair)**.

5/24.3 Ms Henderson agreed that linking the Corporate Plan and the Business Plan makes sense. She said that she wanted to hear the view of AMT on the draft Plan. She commented that in areas such as vaccination and screening, PHA's role is to increase uptakes, rather than have an output. She noted that the Performance Management Report has 96 actions and said that this was too many and needed to be reduced. She asked if all of the actions in the Business Plan were Ministerial priorities, and noted that some of them related to "establishing" initiatives, rather than having outcomes. She said that there is a sense of frustration because the health of the nation is decreasing and there needs to be a vision from the Minister and the Agency to improve it.

5/24.4 Professor Rooney said that when it comes to health inequalities, PHA cannot do it all, but it should target the most vulnerable. She asked where the action around CBT training originated from. The Chair said that there needs to be a separate discussion with Executive Directors on how this Plan can be pulled together. He added that there is a lot of KPIs and there is a need to get a balance between KPIs and activity.

5/24.5 Mr Wilson explained that within the Performance Management Report, there is a Part A and a Part B, and that Part A was limited to 9 key actions as the ask last year was to identify 9 key priorities. He said there seemed to be a lot of duplication between the Part B plan and directorate business plans so this year, the intention is to do away with the Part B plan. He added that PHA is on a journey and that Directors have not had the time to look at this. He agreed that there is a need to have outcomes, but there are challenges in this, for example the length of time it can take for an action to bring an outcome, or the fact that PHA works with other partners to achieve outcomes. He hoped that having a new Assembly in place will help because there will be a new PfG and an updated Making Life Better.

5/24.6 The Chair repeated that he would share the AFBI Business Plan and then there could be further discussion by correspondence. Ms Henderson said that she felt reassured knowing that the Plan has been considered by AMT and that discussions are beginning on revising it.

She acknowledged that it is not an easy task to navigate, but indicated that she was pleased that the Part B plan is being dropped.

5/24.7 Professor Rooney asked if PHA would review the previous year's Plan to see if any action need to stop, or be continued on. Mr Wilson replied that there would be some actions which PHA may determine will not be the focus for this year, but there is still work to do. He added that the SPTs will be key and will be embedded in the planning framework. He said that PHA needs to look at its priorities and how it uses its resources to best effect.

5/24.8 The Chair said that the Plan will change. He commented that if a KPI is not progressing then the Board can intervene. He said the Plan will act as a prompt.

5/24.9 Mr Murray noted that this is a complex area because PHA is both a facilitator and a contributor and works to drive areas of work forward. He said that this Committee will get its information from the reports on the SPTs and that they should have 1/3/5-year vision.

5/24.10 The Chair said that there is a lot of work to be done, but it can be progressed through correspondence.

6/24 Item 6 – Performance

Performance Management Report

6/24.1 Mr Wilson advised that the Performance Management Report contained both the Part A and Part B reports and that it had only been presented at AMT yesterday. He said that today's meeting would give members an opportunity to queries the RAG ratings in the update. He acknowledged that there needs to be a tightening of the timescales for preparing this report.

6/24.2 Professor Rooney said that timing is key and it is important that all elements of PHA's work fit together. She commented that childhood vaccination should be in PHA's Business Plan. Mr Wilson advised that there are discussions ongoing about how to make performance management reporting work in real time. He said that PHA has access to vaccination information and has the potential to bring this into a dashboard. He noted that this report is for the period up to 31 December, so PHA would like to have more of a sense of real time reporting. He acknowledged that vaccinations is a big issue and it is unlikely that this rating will change from "red" before the year end. He explained that PHA has stepped up its emergency plans and has launched an MMR catch-up campaign, but with no media messaging. He added that a risk around the absence of campaigns will appear on PHA's Corporate Risk Register.

6/24.3 Ms Henderson queried the "green" rating for action 3c in Part A which

related to mental health. She advised that at the Procurement Board, it was noted that there were not sufficient resources to take this work forward. She added that given this is a Ministerial priority and represents £11m of spend, it requires more attention and more resources.

6/24.4 Mr Murray noted that there are two different issues and that this action relates to the development of a framework, however that should not prevent the procurement exercises from taking place. He said that it is unlikely that the framework will be completed by the end of March. Ms Henderson said that her sense is that there are insufficient resources for this work at present. Mr Wilson agreed that the report will be revised and this rating changed.

6/24.5 Ms Henderson asked if it would be possible to receive an update on Protect Life 2 and the commissioning framework at the March Board meeting as this is an area that is lagging behind. Mr Murray replied that it is not that far behind target as some procurements within Phase 1 are progressing, but added that he would be content to bring an update **(Action 4 – Mr Wilson/Mr Murray)**. Ms Henderson reiterated her sense that there are insufficient resources and added that there is a sense of frustration are being redirected into other work. Mr Wilson noted that there are pressures in other parts of the system with regard to procurement.

6/24.6 Ms Henderson said that action 9f, relating to performance management returns from external providers, should not be rated "green", as the process for tracking these is not yet in place. Mr Murray advised that the process is now in place, but at the end of December it would have been more appropriate to rate the target as "amber".

Update on Screening Programmes

6/24.7 This item was not covered.

7/24 Item 7 – Resources

7/24.1 The Chair asked Mr Stead to give an update on PHA's financial position.

7/24.2 Mr Stead reported that the month 9 report, which will be brought to the PHA Board next week, still indicates that PHA will achieve a year-end break-even position with a manageable surplus. He advised that he meets with Mr Murray on a weekly basis to track slippage and look at opportunities for reinvestment. He added that the slippage in relation to the vaccination budget is still around £100k.

7/24.3 With regard to the 2024/25, Mr Stead advised that there has been no further update and PHA has not received any feedback on its savings proposals. Mr Wilson echoed this, saying that there is still no clarity for 2024/25 and there is a meeting scheduled for next week to discuss

savings.

Our People Report

7/24.4 Ms Patterson delivered a short presentation on the "Our People" report which she outlined was broken down into 3 areas – workforce profile, workforce development and workforce planning.

7/24.5 Ms Patterson reported that over the last 12 months, the number of permanent staff in PHA has increased with turnover sitting at 9.3%. She advised that resignation is the main reason for staff leaving, with 44% of these being staff at Bands 6-8a, and 33% at Bands 3-5. She added that an exit survey was introduced last summer but there has not been good traction on it. With regard to recruitment, she reported that there has been some improvement in management activities, helped by having a series of workshops last summer to guide staff through the recruitment process. She advised that cumulative sickness absence is sitting at 4.74% which represents a slight decrease. She added that work is ongoing to support managers and staff.

7/24.6 Under workforce development, Ms Patterson reported that the Organisation Development Engagement Forum (ODEF), jointly chaired by her and Ms Gráinne Cushley has around 50 staff involved in the 3 different workstreams. She outlined some of the work which has been delivered, including a change in PHA communicates with its staff through a weekly newsletter, and the staff engagement event held last year. She added that work has commenced on developing a skills framework. She reported that appraisal compliance is just below the 95% target.

7/24.7 Ms Patterson said that PHA will need to think about workforce planning in the context of the Reshape and Refresh programme as 40% of staff are over the age of 50, and many of them have more than 15 years' service in the PHA. She noted that their retirement represents a significant risk to the organisation in terms of a loss of corporate memory. Mr Stead asked how close this is to becoming an issue in terms of service impact, but Ms Patterson replied that this is difficult to determine. She noted that one of the pension schemes is going through a consultation process which could see more flexibility for its members who may then choose to retire early.

7/24.8 Professor Rooney thanked Ms Patterson for the update and said that she was pleased to see the increased compliance levels with appraisals. She asked Ms Patterson what her assessment would be on staff morale given there is a lot "firefighting". Ms Patterson replied that PHA needs to capitalise on the staff engagement event which was very successful, and that to date there has been good engagement with staff with over 100 signed up to participate in different as well as staff being engaged in the Reshape and Refresh work. She said that PHA is an organisation going through a change process, but morale appears to be good. Ms

Henderson commented that morale will impact on performance. The Chair noted that the Chief Executive is due to carry out a round of visits to all PHA offices to talk to staff. He added that he had visited Gransha Park and his feeling was that staff are looking forward to the change.

7/24.9 The Chair asked if PHA participates in any Civil Service surveys. Ms Patterson replied that PHA would participate in the NHS staff survey and that the next survey is due to take place this year.

7/24.10 Professor Rooney asked if HR is involved in workforce policy, for example training non-medical staff in public health. Ms Patterson said that she would not be, but she acknowledged that it is an area that needs to be looked at, once the Reshape and Refresh work is completed. Professor Rooney said that she hopes that PHA can move away from having professional silos.

8/24 Item 8 – Any Other Business

8/24.1 The Chair said that he would like to review the agenda for these meetings and to look at its effectiveness as well as who should be in attendance. He added that the agenda should be broken down into 4 key areas, the first of which would be "corporate" where there would be updates on different strategic areas with the relevant officers in attendance. He said that the second area would be "financial" which would look at the effectiveness of how PHA spends its resources. He added that there would be a section on "people" which would look at training and areas like co-employment of consultants with Queen's University. He said that the final area would be systems. He asked members to take time to reflect on this after the meeting, noting that not all of the areas will be covered at all of the meetings.

8/24.2 Ms Henderson agreed that it would be useful for the operational staff to attend the meeting. She said that the Chairs of the SPTs should attend to present their reports. For the performance management report, she said that the Board needs to receive exception reports for targets rated "red". For screening, she commented that the Board needs to know how backlogs are being dealt with. She noted that for the report considered today, it would not be possible for the Committee to give the Board the assurance it requires. Mr Wilson advised that with regard to vaccinations, there is a multi-disciplinary team looking at this area. Ms Henderson suggested that the chair of that team should come to this Committee.

8/24.3 Mr Wilson said that he had no issue with the proposed outline of future meetings and he noted that it is the Chair's intention to delegate more to Committees so that they provide a recommendation for the Board to accept reports. He added that in the performance management report, if an action is rated "red" the relevant officer should either be in attendance or provide an exemption report.

8/24.4 Professor Rooney commented that she would be content with the proposed change to the agenda to ensure meetings are as productive as possible. She said that she wished to be assured that PHA is spending its funds on important areas that are within its remit, and that PHA should take ownership of its work instead of being reactive. The Chair said that the starting point is having a Corporate Plan. He agreed that the relevant operational staff need to attend meetings. He suggested that he would meet with Mr Wilson to discuss the format of the agenda and that can be evaluated in the future **(Action 5 – Chair)**, but he urged all members to consider how the meetings can be more effective.

8/24.5 "Mr Stead said that he would be content for the agenda to be restructured but that the scale of what PHA is required to do is vast relative to the resources available to it. He also agreed that not all actions / KPIs can be measured in outcomes but rather outputs in a number of instances. With regard to reporting on the financial effectiveness of what is spent, Mr Stead advised there is abundant financial information available (i.e. budget papers, MYR, monthly finance report, final accounts, savings plans, annual financial plan etc) but said these reported expenditure on a functional basis and to review effectiveness would need a fresh look at aligning what is spent with SPT programmes, corporate objectives and key actions / themes in the PMRs. He said this would be a key challenge for the new Director of Finance and the new Finance Directorate and may not be doable in the level of detail needed within current organisational resources but it should be given consideration.

8/24.6 Professor Rooney said that she wishes to see a move away from working down professional lines. Mr Murray said that the aim is that the SPTs will provide corporate oversight and produce a report which shows how their work links to PfG outcomes and this would be the "golden thread" that shows how PHA's work is connected and how it makes a difference. He added that PHA needs a strong planning infrastructure around this.

8/24.7 The Chair said that there is a need to develop an action plan based on today's discussion and that he would provide an update at the Board meeting next week.

8/24.8 Mr Murray advised that the public consultation on the Substance Use commissioning framework closed in November and PHA has pulled together the responses into a summary report. He said that the intention was that this Committee would see that report before it went to the PHA Board and so it will be circulated to members via e-mail. He added that the final draft Strategy would then be presented to the PHA Board in April. He said that when the document is circulated, he would be happy to receive comments or discuss any concerns that members had.

8/24.9 The Chair noted that this Committee meets 4 times a year and said that

there is a need to look at the cycle of meetings as well as the format of the agenda **(Action 6 – Chair)**.

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

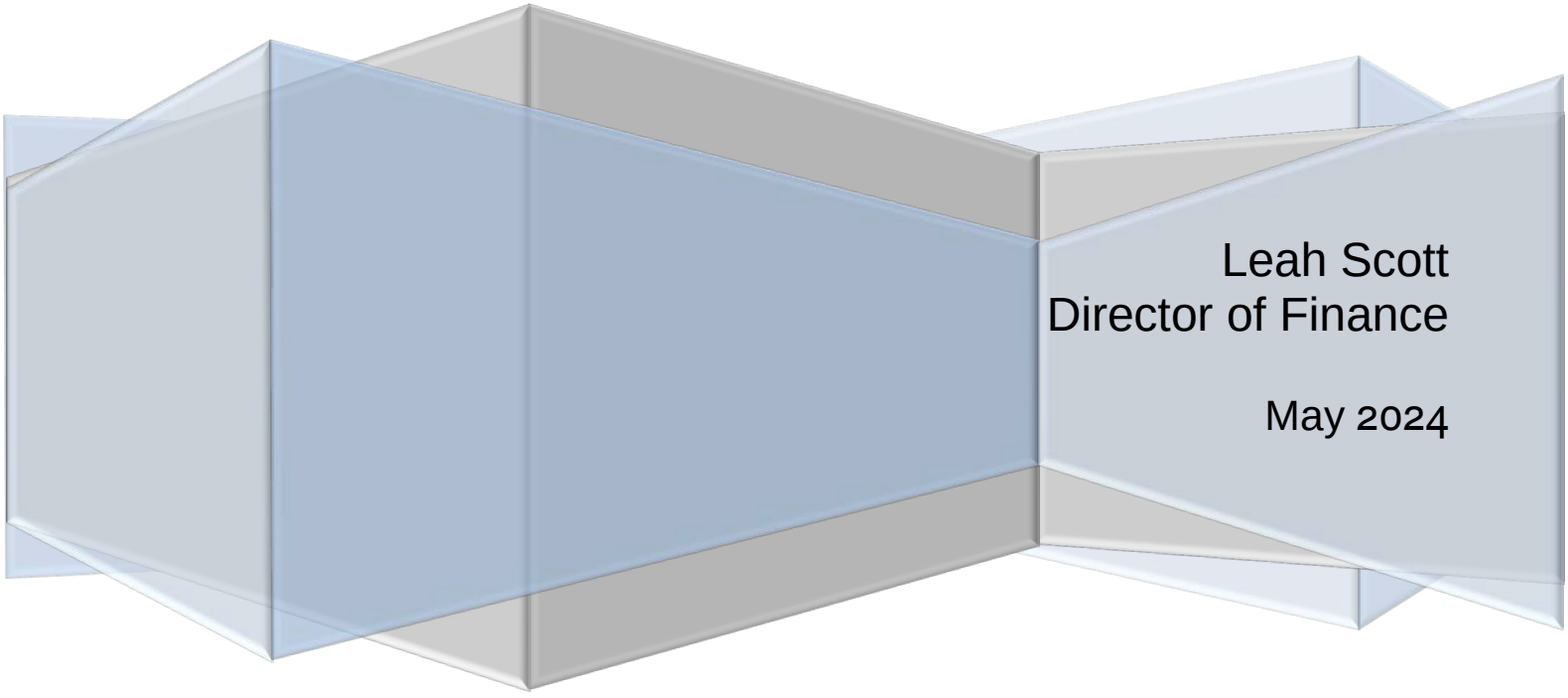
Thursday 2 May 2024 at 10.00am

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

Signed by Chair:

Date: 2 May 2024

Finance Report
March 2024



Leah Scott
Director of Finance

May 2024

Section A: Introduction/Background

1. The PHA Financial Plan for 2023/24 has set out the funds notified as available, risks and uncertainties for the financial year and summarised the opening budgets against the high-level reporting areas. It also outlined how the PHA would manage the overall funding available, in the context of cash releasing savings targets applied to the organisation. It received formal approval by the PHA Board in the June 2023 meeting.

2. The Financial Plan detailed the quantum of cash releasing savings targets (£5.3m, plus an additional £3.2m in respect of the area of Research and Development), the plans in place in year to address the target applied and the resultant opening forecast deficit of £0.65m. A focus on reducing and closing this gap is continuing as plans are required to meet the target both in-year and recurrently.

3. This executive summary report reflects the year-end position as at the end of March 2024 (month 12). Supplementary detail is provided in Annex A.

Section B: Update – Revenue position

4. The Financial Plan indicated an opening position for the Agency of a £650k deficit for the year. This is summarised in Table 1.

Table 1: Opening financial position 2023/24

	R&D £m	Other £m	Total £m
Savings targets applied	3.20[1]	5.30	8.50
Actions (2023/24):			
R&D budget reduced pending DoH decision on expenditure (UK wider NIHR)[1]	3.20[1]		3.20
Programme: budget / expenditure reductions		3.60	3.60
Management & Administration: anticipated net slippage		1.10	1.10
Subtotal deficit	**-**	**0.60**	**0.60**
HSCQI budget provision (unfunded pressure)		0.05	0.05
Opening deficit position	**-**	**0.65**	**0.65**

[1] Assumes funding in respect of R&D will be provided in line with DoH decision.

5. The PHA has reported a surplus position of £0.1m at March 2024 (February 2024, forecast surplus of £0.3m).

6. The month 12 position is summarised in Table 2 below.

Table 2: PHA Summary financial position - March 2024

	Annual Budget	YTD Budget	YTD Expenditure	YTD Variance
	£'000	£'000	£'000	£'000
Health Improvement	13,464	13,464	13,464	0
Health Protection	9,832	9,832	9,832	0
Service Development & Screening	15,738	15,738	15,738	0
Nursing & AHP	8,001	8,001	8,001	0
Centre for Connected Health	0	0	0	0
Quality Improvement	24	24	24	0
Other	2,081	2,081	2,081	0
Programme expenditure - Trusts	**49,141**	**49,141**	**49,141**	**0**
Health Improvement	29,915	29,915	30,209	(294)
Health Protection	17,303	17,303	17,473	(170)
Service Development & Screening	2,951	2,951	2,968	(17)
Research & Development	3,241	3,241	3,240	1
Campaigns	491	491	613	(121)
Nursing & AHP	753	753	718	35
Quality Improvement	123	123	92	31
Other	(1,685)	(1,685)	(281)	(1,404)
Programme expenditure - PHA	**53,093**	**53,093**	**55,057**	**(1,964)**
Subtotal Programme expenditure	**102,234**	**102,234**	**104,197**	**(1,964)**
Public Health	18,318	18,318	17,190	1,128
Nursing & AHP	5,564	5,564	5,235	329
Operations	5,708	5,708	5,441	268
Quality Improvement	782	782	710	71
PHA Board	535	535	300	235
Centre for Connected Health	490	490	464	26
SBNI	880	880	886	(6)
Subtotal Management & Admin	**32,277**	**32,277**	**30,227**	**2,050**
Trusts	218	218	218	0
PHA Direct	54	54	54	0
Subtotal Transformation	**272**	**272**	**272**	**0**
Trusts	167	167	167	0
PHA Direct	5,314	5,314	5,320	(6)
Other ringfenced	**5,481**	**5,481**	**5,487**	**(6)**
TOTAL	**140,264**	**140,264**	**140,184**	**80**

Note: Table may be subject to minor roundings

7. In respect of the reported position:

- **Programme – Trusts**: A total of £49.1m has been allocated to Trusts at this point, with full spend against budget shown.

- **Programme – PHA**: The remaining annual programme budget is £53.1m.
    - A cumulative overspend of £2.0m is shown for the year (month 11, £1.7m) against the Programme budgets listed. This reflects a managed overspend to absorb anticipated underspends on Admin budgets.
    - A mid-year review of the financial plan reported that £4.1m of recurrent budget reductions were identified in year. Work is ongoing to fully identify the remaining savings measures to meet the full financial target applied to PHA in 2023/24 recurrently, pending the out-workings of refreshed Directorate structures and any resultant impacts on baselines.
    - Savings plans will continue to be closely monitored and are regularly reported to the AMT and PPR Committee.

- **Management & Administration**: Annual budget of £32.3m.
    - An underspend of £2.0m is reported for the year (month 11, £1.7m), reflecting underspends in Public Health, Nursing & AHPs and Operations. The primary surplus to date relates to the area of Public Health where staff costs have reduced due to role vacancies. Expenditure against funded budgets are reviewed with Directorate budget holders to understand any ongoing trends and incorporate these into the year-end forecast position.
    - The level of underspend continues be subject to close scrutiny based with a view to developing a Financial Plan for 2024/25.

- **Ringfenced**: There is annual budget of c£5.5m in ringfenced budgets, the largest element of which relates to a Covid funding allocation for the Vaccine Management System (£2.7m) and Autumn Booster campaign (£1.6m), along with other funding allocations such as Safe Staffing (£0.3m) and Suicide Prevention (£0.3m) and smaller allocations for NI Protocol and for SBNI. A breakeven position has been achieved on these budgets in 2023/24.

Section C: Risks

8. The following significant assumptions, risks or uncertainties facing the organisation were managed throughout the year to arrive at the draft breakeven position noted.

9. **Recurrent impact of savings made non-recurrently in-year**: The opening allocation letter indicated that, whilst 2023/24 savings measures may be non-recurrent in nature, the funding reductions are recurrent and therefore PHA is expected to work to ensure savings are made recurrently going forward into 2024/25 where necessary. While PHA has identified a significant element of the £5.3m savings target applied, there remain challenges in delivering the full requirement recurrently. PHA has identified savings / budget reductions for £4.1m recurrently in-year following a mid-year review and are continuing to work on developing savings proposals to address the remaining gap pending costing of refreshed Directorate structures and any resulting impacts on baseline.

10. **EY Reshape & Refresh review and Management and Administration budgets**: The PHA is currently undergoing a significant review of its structures and processes, and the final report from EY 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. In addition, there have been a number of material vacancies which are generating slippage and for which Directors are reviewing options for the remainder of the year.

11. **SEUPB / CHITIN income**: PHA receives income from EU partner organisations for the CHITIN R&D project. Claims are made on a quarterly basis, however PHA have not been receiving payments on a regular basis. At 31 March 2023, the value of funding due was c£4.3m however, PHA had an equal and opposite creditor listed for monies due to other organisations. Since year end a total of now c£2.6m has been received. R&D staff are continuing to work closely with colleagues in partner organisations and the relevant funding body to ensure the expected full reimbursement of all claims.

12. **Demand led services:** There are a number of demand led budgetary areas which are more difficult to predict funding requirements for, presenting challenges for the financial management of the Agency's budget. For example, smoking cessation / Nicotine Replacement Therapy (NRT) and Vaccines. The financial position of these budgets is being carefully tracked.

13. **Funding allocated during the year**: At the start of the financial year there are a number of areas where funding is anticipated but has not yet been released to the PHA. These included Pay awards for the 2023/24 financial year which have been received in month 12.

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

Section D: Update - Capital position

15. The PHA has a capital allocation (CRL) of £5.6m. This all relates to projects managed through the Research & Development (R&D) team. The overall summary position, as at March 2024, is reflected in Table 3, with a breakeven position achieved on capital funding.

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

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

Special EU Programmes Body (SEUPB) matches expenditure claims, ensuring a breakeven position. Further information on delays experienced in the reimbursement of costs is provided in Section C, above.

Table 3: PHA Summary capital position – March 2024

Capital Summary	Total CRL £'000	Year to date spend £'000	Full year forecast £'000	Forecast Surplus / (Deficit) £'000
HSC R&D:				
R&D - Other Bodies	4,004	4,004	4,004	0
R&D - Trusts	0	0	0	0
R&D - Capital Receipts	(369)	(369)	(369)	0
R&D - Other	452	452	452	0
Subtotal HSC R&D	**4,087**	**4,087**	**4,087**	**0**
CHITIN Project:				
CHITIN - Other Bodies	180	180	180	0
CHITIN - Trusts	0	0	0	0
CHITIN - Capital Receipts	(180)	(180)	(180)	0
Subtotal CHITIN	**0**	**0**	**0**	**0**
Other:				
Congenital Heart Disease Network	363	363	363	0
iReach Project	405	405	405	0
R&D - NICOLA	731	731	731	0
ICT - VMS	39	39	39	0
Subtotal Other	**1,538**	**1,538**	**1,538**	**0**
Total PHA Capital position	**5,625**	**5,625**	**5,625**	**0**

18. PHA has also received four other smaller capital allocations for the Congenital Heart Disease (CHD) Network (£0.4m), iReach Project (£0.4m), NICOLA (£0.7m) and ICT VMS (£0.1m). With the exception of the ICT VMS these allocation are managed through the PHA R&D team.

Recommendation

19. The PHA Board are asked to note the PHA financial update as at March 2024.

Public Health Agency

Annex 1 - Finance Report

2023/24

Month 12 - March 2024

PHA Financial Report - Executive Summary

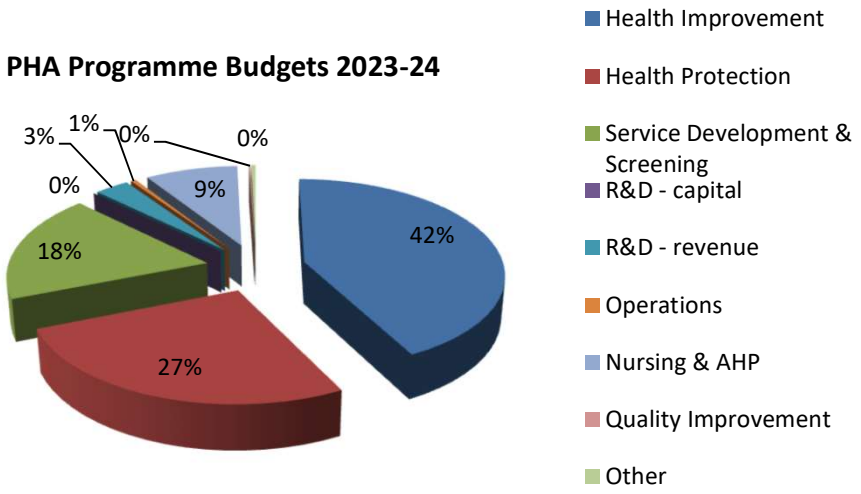
Year End Financial Position (page 2)

At the end of month 12, PHA is reporting an underspend of £0.1m against its profiled budget. This position is a result of PHA Direct programme budgets projected overspend for the financial year offset by underspends within Adminstration budgets (page 6).

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

Programme Budgets (pages 3&4)

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

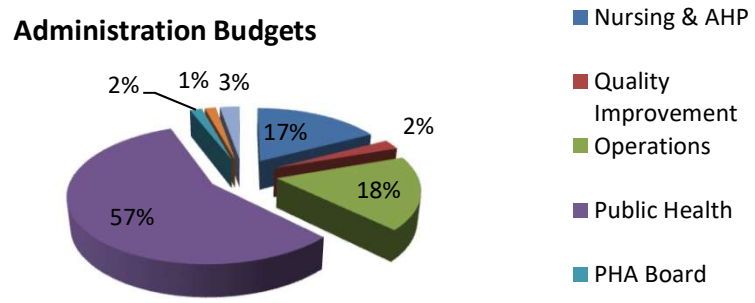


Administration Budgets (page 5)

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

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

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



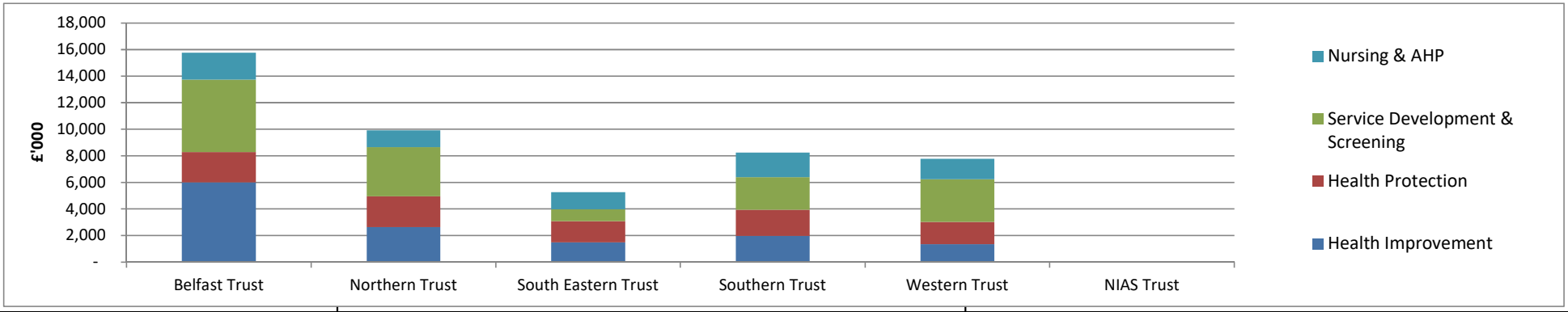
Public Health Agency
2023/24 Summary Position - March 2024

	Year to Date				
	Programme		Ringfenced	Mgt & Admin	Total
	Trust	PHA Direct	Trust & Direct		
	£'000	£'000	£'000	£'000	£'000
Available Resources					
Departmental Revenue Allocation	49,141	53,028	5,753	31,553	**139,476**
Assumed Retraction	-	-	-	-	**-**
Revenue Income from Other Sources	-	65	-	724	**789**
Total Available Resources	49,141	53,093	5,753	32,278	**140,264**
Expenditure					
Trusts	49,141	-	385	-	**49,526**
PHA Direct Programme	-	55,057	5,374	-	**60,431**
PHA Administration	-	-		30,227	**30,227**
Total Proposed Budgets	49,141	55,057	5,759	30,227	**140,184**
Surplus/(Deficit) - Revenue	-	(1,964)	(6)	2,050	80
Cumulative variance (%)	***0.00%***	***-3.70%***	***-0.10%***	***6.35%***	***0.06%***

Please note that a number of minor roundings may appear throughout this report.

The year end financial position for the PHA shows an underspend £0.1m, which is a result of PHA Direct Programme expenditure being in an overspend position and being offset by an underspend within the area of Management & Admin.

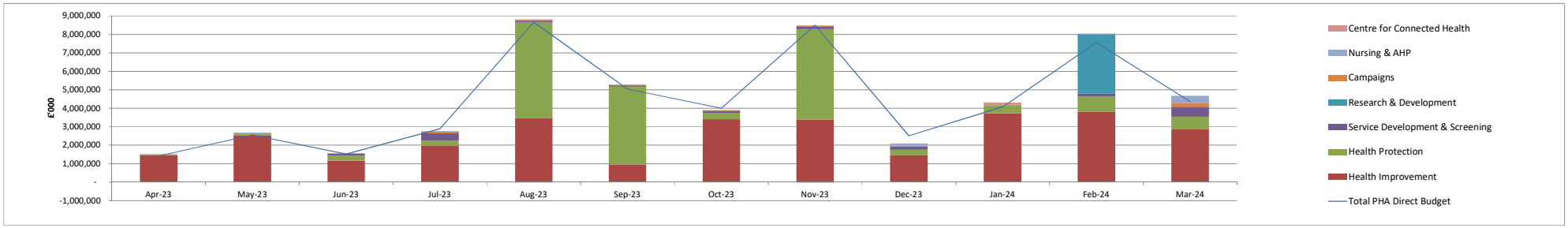
Programme Expenditure with Trusts



Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	NIAS Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	5,998	2,631	1,477	1,976	1,358	24	**13,464**	13,464	13,464	-
Health Protection	2,285	2,318	1,602	1,958	1,669	-	**9,832**	9,832	9,832	-
Service Development & Screening	5,466	3,706	897	2,461	3,208	-	**15,738**	15,738	15,738	-
Nursing & AHP	2,019	1,260	1,281	1,855	1,557	29	**8,001**	8,001	8,001	-
Quality Improvement	24	-	-	-	-	-	**24**	24	24	-
Other	626	364	333	376	329	53	**2,081**	2,081	2,081	-
Total current RRLs	**16,418**	**10,280**	**5,590**	**8,626**	**8,120**	**106**	**49,141**	**49,141**	**49,141**	-
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-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	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	1,318	2,228	1,356	1,920	3,482	975	2,912	4,172	1,493	3,472	3,531	3,056	**29,915**	29,915	30,209	(294)	*-1.0%*
Health Protection	42	204	184	122	5,143	4,030	1,192	4,131	525	632	134	964	**17,303**	17,303	17,473	(170)	*-1.0%*
Service Development & Screen	29	73	219	493	93	105	412	371	380	- 83	410	448	**2,951**	2,951	2,968	(17)	*-0.6%*
Research & Development	-	-	-	-	-	-	-	-	-	-	3,210	31	**3,241**	3,241	3,240	1	*0.0%*
Campaigns	1	1	9	90	18	28	10	122	60	26	27	102	**491**	491	613	(121)	*-24.7%*
Nursing & AHP	32	53	- 33	21	26	26	55	37	30	- 26	321	212	**753**	753	718	35	*4.6%*
Centre for Connected Health	-	-	-	-	-	-	-	-	0	-	-	-	**-**	-	24	(24)	*#DIV/0!*
Quality Improvement	-	-	-	-	18	-	-	16	23	-	25	41	**123**	123	92	31	*25.3%*
Other	-	-	(212)	245	- 122	- 123	- 581	- 351	0	54	(100)	(494)	**(1,685)**	(1,685)	(281)	(1,404)	*100.0%*
Total PHA Direct Budget	**1,421**	**2,558**	**1,522**	**2,890**	**8,658**	**5,041**	**4,000**	**8,498**	**2,511**	**4,075**	**7,558**	**4,360**	**53,093**	**53,093**	**55,057**	**(1,964)**	
Cumulative variance (%)																***-3.70%***	
Actual Expenditure	**1,608**	**2,765**	**1,643**	**2,898**	**8,801**	**5,414**	**3,867**	**8,533**	**2,177**	**4,335**	**8,165**	**4,851**	**55,057**				
Variance	**(187)**	**(207)**	**(121)**	**(7)**	**(143)**	**(373)**	**133**	**(35)**	**334**	**(259)**	**(607)**	**(491)**	**(1,964)**				

The year-to-date position shows an overspend of approximately £2.0m against profile, reflecting a closely managed plan to offset an underspend in Administration budgets.

Public Health Agency
2023/24 Ringfenced Position

	Annual Budget				Year to Date			
	Covid	NDNA	Other ringfenced	Total	Covid	NDNA	Other ringfenced	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources								
DoH Allocation	4,674	272	807	**5,753**	4,674	272	807	**5,753**
Assumed Allocation/(Retraction)	-	-	-	-	-	-	-	**-**
Total	4,674	272	807	**5,753**	4,674	272	807	**5,753**
Expenditure								
Trusts	-	218	167	**385**	-	218	167	**385**
PHA Direct	4,682	54	638	**5,374**	4,682	54	638	**5,374**
Total	4,682	272	805	**5,759**	4,682	272	805	**5,759**
Surplus/(Deficit)	**(8)**	**-**	**2**	**(6)**	**(8)**	**-**	**2**	**(6)**

PHA has now received COVID allocation of £3.0m (£2.7m for Vaccine Management System & £0.3m for Vaccinators and Covid Vaccine Storage) for financial year 2023/24.

Transformation funding has been received for a Suicide Prevention project totalling £0.3m. This project is being monitored and reported on separately to DoH, and a breakeven position is anticipated for the year.

Other ringfenced areas include Farm Families (£0.2m), Safe Staffing (£0.3m), NI Protocol (£0.1m) and funding for SBNI relating to EITP (£0.1m). A breakeven position for each of these areas is shown for the year.

PHA Administration

2023/24 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	5,378	770	4,565	18,075	405	440	629	**30,261**
Goods & Services	186	12	1,144	242	131	50	251	**2,016**
Total Budget	**5,564**	**782**	**5,708**	**18,318**	**535**	**490**	**880**	**32,277**
Budget profiled to date								
Salaries	5,378	770	4,565	18,075	405	440	629	**30,261**
Goods & Services	186	12	1,144	242	131	50	251	**2,016**
Total	**5,564**	**782**	**5,708**	**18,318**	**535**	**490**	**880**	**32,277**
Actual expenditure to date								
Salaries	4,956	706	3,660	16,270	320	382	623	**26,917**
Goods & Services	279	4	1,781	920	- 20	82	263	**3,309**
Total	**5,235**	**710**	**5,441**	**17,190**	**300**	**464**	**886**	**30,227**
Surplus/(Deficit) to date								
Salaries	421	64	905	1,805	84	57	6	**3,344**
Goods & Services	(92)	7	(638)	(678)	150	(32)	(12)	**(1,294)**
Surplus/(Deficit)	**329**	**71**	**268**	**1,128**	**235**	**26**	**- 6**	**2,050**
Cumulative variance (%)	*5.92%*	*9.13%*	*4.69%*	*6.16%*	*43.86%*	*5.24%*	*-0.70%*	***6.35%***

A surplus of £2.0m is shown on the Administration budget for 23/24, which is being generated by a number of vacancies, particularly within Public Health Directorate. Senior management continue to monitor the position closely, and as part of the Mid Year Review £1.2m was offered up from the Administration budgets to meet the £5.3m 23/24 savings target.

PHA Prompt Payment

Prompt Payment Statistics

	March 24 Value	March 24 Volume	Cumulative position as at March 24 Value	Cumulative position as at March 24 Volume
Total bills paid (relating to Prompt Payment target)	£4,277,462	381	£77,770,216	5,184
Total bills paid on time (within 30 days or under other agreed terms)	£3,613,529	368	£67,436,258	4,986
Percentage of bills paid on time	**84.5%**	**96.6%**	**86.7%**	**96.2%**

Prompt Payment performance for March shows that PHA met its prompt payment target on volume, but missed it on value. The year to date position shows that on volume, PHA is achieving its 30 day target of 95.0% but failing to achieve the 95% target on value, due to two large vaccines invoices (approx. £8m) which missed the payment deadline earlier in the year. Prompt payment targets will continue to be monitored closely over the 2023/24 financial year.

The 10 day prompt payment performance remains very strong at 82.2% on volume for the year to date, which significantly exceeds the 10 day DoH target for 2023/24 of 70%.

HSC Public Health Agency

item 10

Title of Meeting	PHA Board Meeting
Date	16 May 2024
Title of paper	PHA Annual Complaints Report 2023/24
Reference	PHA/03/05/24
Prepared by	Alastair Ross / Catherine Collins
Lead Director	Aidan Dawson
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to present the annual Complaints Report for 2023/24 to the Board for noting.

2 Background Information

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

Recommendation 2.2 of the Audit recommended that,

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

As part of the PHA management response, an Annual PHA Complaints Report has been drafted and is now tabled for consideration. In line with the DoH guidance, the report sets out detail in respect of the number of complaints, response times and the learning achieved by the organisation.

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

The report will be produced on an annual basis with 2023/24 to be used as a comparator year against which future activity can be monitored.

3 Key Issues

Between 1st March 2023 and 31st March 2024, PHA received eight complaints. Seven of these complaints have been closed while one remains open. Further information is contained within the Report.

4 Next Steps

The next quarterly Complaints Report will be prepared and brought to the Governance and Audit Committee and PHA Board.

PHA ANNUAL COMPLAINTS REPORT

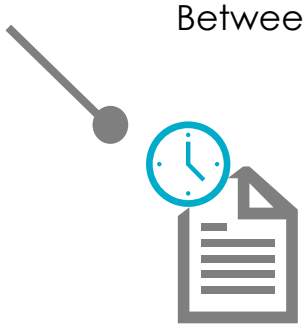
2023/2024

HSC Public Health Agency

HSC Public Health Agency

8 Complaints made to the PHA

Between 1 April 2023 and 31 March 2024



On average it took us 28 working days to issue a complaint response

Key Performance Indicators

7 Complaints acknowledged in writing within 2 working days of being received

4 Complaint response letters issued within 20 working days of the complaint being received

Themes

Communicating with the PHA

Vaccinations and Screening

Complaints

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

Number of Complaints

During the period 1 April 2023 to 31 March 2024, the PHA received eight complaints across three of our four Directorates.

A breakdown of the number of complaints received by Directorate is set out below.

Types of Complaints

Given the breadth of work undertaken by the PHA we receive complaints across a wide range of topics. The graphic below details some of the complaints we received during 2023/24.

Responding to Complaints

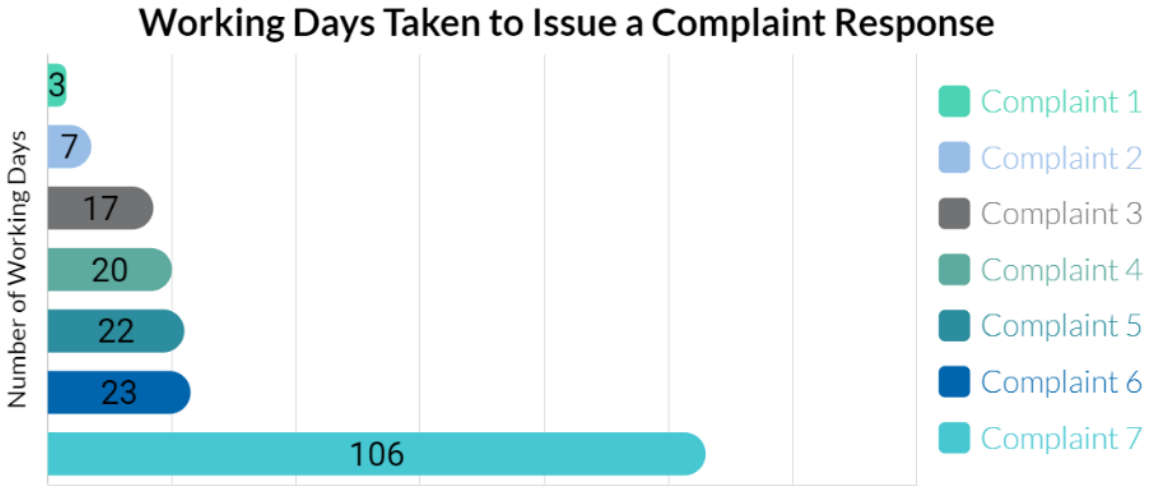
We aim to send an acknowledgement within two working days of a complaint being received.

During 2023/24, we were able to acknowledge seven of our eight complaints within two working days - that equated to 86%.

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

During 2023/24, we were able to issue a response within twenty working days for four of the seven complaints we concluded - that equated to 57%.

The bar chart below shows how long it took us to issue a response in respect of the seven complaints we concluded - one of our complaints has remained open into 2024/25 so is not included here.



Learning from Complaints

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

During the year, we made the following changes as a result of learning derived from our complaints process:

We worked to ensure that we always include a named point of contact when we are communicating with people affected by our services

We revised the content of our cervical screening correspondence to provide more accurate information relating to the issue of test results

We updated our website with a new 'Compliments and Complaints' section to make it easier for individuals to contact the PHA or learn about our complaints process

The role of the Ombudsman

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

The PHA is aware of one complainant having approached the Ombudsman in 2023/24 in relation to a complaint made in 2022/23. This complaint was not accepted for further investigation by the Ombudsman.

ANNUAL COMPLAINTS REPORT

2023/2024

PHA Complaints Office

complaints.pha@hscni.net

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

Public Health Agency

HSC Public Health Agency

item 11

Title of Meeting	PHA Board Meeting
Date	16 May 2024
Title of paper	Performance Management Report
Reference	PHA/04/05/24
Prepared by	Stephen Murray / Rossa Keegan
Lead Director	Leah Scott
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to provide the PHA Board with a report on progress against the objectives set out in the PHA Annual Business Plan 2023/24.

2 Background Information

PHA's Annual Business Plan was approved by the PHA Board in March 2023. Against this plan 37 actions were developed against 10 priorities for 2023/24.

3 Key Issues

The attached paper provides the progress report, including RAG status, on the actions set out in the PHA Annual Business Plan 2023/24 Part A as at 31 March 2024.

Of the 37 actions across 10 Key Priorities

- 7 actions have been categorised as red (significantly behind target/will not be completed)
- 7 actions have been categorised as amber (will be completed, but with slight delay)
- 23 actions have been categorised as green (on target to be achieved/already completed).5

For the Business Plan Part B, it was agreed that any actions rated Amber or Red would be reported on by exception to the Board. As at 31 March 2024, 13 actions

have been categorised as amber and 5 actions have been categorised as red – an exception report is included.

4 Next Steps

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

PERFORMANCE MANAGEMENT REPORT

Monitoring of Targets Identified in

The Annual Business Plan 2023 – 2024 Part A

As at 31 March 2024

This report provides an update on achievement of the actions identified in the PHA Annual Business Plan 2023-24 Part A.

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

There are a total of 37actions across 10 Key Priorities in the Annual Business Plan. Each action has been given a RAG status as follows:

	On target to be achieved or already completed		Will be completed, but with slight delay
	Significantly behind target/will not be completed		

Of the 37 actions, 23 are currently rated Green 9 are current rated with an Amber RAG status and 5 with a Red RAG status.

The progress summary for each of the actions is provided in the following pages.

	Key Priorities				
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun Sep Dec Mar	**Mitigating actions where performance is Amber / Red**
1a	All children and young people have the best start in life	Vaccination By December 2023, increase by 1% the uptake rates for pre-school immunisation (based on December 2022 position).			Director of Public Health Joanne McClean Downward trend in vaccine uptake over the last few years has continued and is also seen in the other UK nations. A low work uptake group ongong, linking in with the 4 nations working group. MMR catch-up campaign has also been running from Jan 24- Mar 24.

COVER statistics	Q3 Oct-Dec 22 (%)	Q4 Jan-Mar 23 (%)	Q1 Apr-Jun 23 (%)	Q2 Jul-Sep 23 (%)	Q3 Oct-Dec 23 (%)	Diff %
12 months						
DTaP/IPV/Hib/HepB	92.5	92.4	91.6	92.5	92.0	-0.5
PCV	94.6	94.6	94	94.6	94.6	0
Rotavirus	88.8	89.7	89.4	89.1	89.4	0.6
MenB	92.8	92.6	91.7	92.4	91.9	-0.9
24 months						
DTaP/IPV/Hib/HepB	94.4	94.0	93.8	93.1	93.7	-0.7
MMR1	89.5	89.4	89.3	88.8	89.5	0
PCV booster	90.2	91.8	89.8	89.1	89.7	-0.5
Hib/Men C	89.8	89.8	89.8	89	89.7	-0.1
Men B	89.0	89.2	88.6	88.1	88.7	-0.3
5 years						
DTaP/IPV/Hib/HepB	94.0	93.6	94.4	94.4	94.7	0.7
DTaP/IPV/Hib/HepB (booster)	87.9	86.9	86.1	85.9	86.7	-1.2
MMR1	93.9	93.5	93.5	93.6	93.6	-0.3
MMR2	87.5	86.4	85.6	85.4	86.4	-1.1
Hib/Men C booster	93.3	92.9	93	93.1	93.0	-0.3

Source: PHA Health Protection Vaccine Surveillance Team

		Key Priorities			
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun Sep Dec Mar	**Mitigating actions where performance is Amber / Red**
1b		Family Support Complete the re-tender of the regional Early Intervention Support Service for families by June 2023 and expand service to increase number of families supported from 630 to 800 by March 2024 (subject to additional funding from DoH being allocated, as planned)	Re-tender process complete; new contracted services scheduled to commence from 1st October 2023 Additional funding from DoH allocated and approved by AMT in August 2023; co-design process complete with providers re service enhancement/expansion and scheduled to commence from 1st October 2023. Dec 23 Update: Re-procured and enhanced service provision commenced from 1st October 2023; work also underway re short-term substance use pilot. March 24 update: Work completed.		Director of Public Health Joanne McClean

		Key Priorities			
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun Sep Dec Mar	**Mitigating actions where performance is Amber / Red**
2a	All older Adults are entitled to live healthier and more fulfilling lives	Vaccination Implement the 'Shingrix for All' vaccine programme with phased introduction from September 2023	This programme was successfully implemented on 1st September 2023. Shingrix vaccine has been implemented for all the eligible groups.		Director of Public Health Joanne McClean
2b		Falls prevention Implement the Regional Falls Pathway and Bundle for Care Homes in 10 % of care homes in each Trust area by March 2024	On track ECCF launched on 7 August 2023. Falls steering group meeting to plan implementation strategy including CEC training on products. Falls work continues to be implemented at a local level, however process delayed due to Falls resources launch being delayed from April 2023 to August 2023. Enhancing Clinical Care Framework (ECCF) launched on 7 August 2023. Falls steering group reconvened to plan implementation strategy. Sustainability, Spread and Scale Workplan shared.		Director of NMAHP Heather Reid Work to progress the implementation of resources continues with independent sector and Trust Care Home in reach teams. PHA Nursing/ AHP coordinating a regional approach to the implementation

	Key Priorities				
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun Sep Dec Mar	**Mitigating actions where performance is Amber / Red**
			PHA is progressing Care Home training module with CEC and has facilitated information sessions across the region. Post falls guidance tool has been updated to reflect updated NICE Guidance. Information session with care homes held on 21st December via MS Teams. Trust care home support teams continue to work on implementation with locality care homes. CEC module being piloted with a group of care homes, plan to launch in Spring 2024. Providers of IT systems to care homes have copies of the pathway and bundle to upload to their IT platforms. Encompass also building forms onto their platform. Trust falls coordinators in agreement to endorse the Regional falls Pathway within their Care Home request for assistance letters		

	Key Priorities								
	Action from Business Plan:		**Progress**	**Achievability (RAG)**				**Mitigating actions where performance is Amber / Red**
				Jun	Sep	Dec	Mar	
3a	All Individuals and communities are equipped and enabled to live long and healthy lives	Screening Implement primary HPV testing into the cervical screening programme by March 2024	Implementation of primary HPV – An implementation project structure has been established with the key organisations represented. A project team and board have been established and work is progressing across a number of workstreams. The PHA is leading the project with significant input from SPPG and the Pathology Network. While planning has progressed during 2022/23, it is anticipated that primary HPV testing will be introduced during 2023/24. pHPV testing introduced for all new samples received at laboratories from 11 December 2023. March 24 update: primary HPV screening was formally implemented in the NI Cervical Screening Programme on 11th December 2023					Director of Public Health Joanne McClean

3b		Alcohol and Drugs Joint Draft Commissioning Framework for Alcohol and Drug services to be approved by PHA Board by May 2023 and procurement of phase 1 services completed by March 2024	Substance Use Strategic Commissioning and Implementation Plan (The Plan) drafted. The Plan has been agreed by the SUS HSC Advisory Board, the SUS Programme Board and CMO. The Plan has been approved at PHA AMT and SPPG SMT in June The Plan was presented to PHA PPR Committee in early June and a number of issues were highlighted that required further clarification prior to the document being considered by PHA board. Due to the delay in approving the document there will potentially be a short delay in completion of phase 1 of the procurement process. . Dec 23 update: The public consultation closed on 24 November, receiving 40 responses, 14 of which were directly from the general public. The team are reviewing, analysing and editing the Plan as appropriate. Once updated the Plan will be presented for scrutiny and approval via the SUS Programme Board, PHA AMT, SPPG SMT and PHA Board across February-March 2024. Phase 1 of the regiaonl D&A procurement process is underway, with the pre-procurement work being finalised by March 2024.					Director of Public Health Joanne McClean

	Key Priorities							
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun	Sep	Dec	Mar	**Mitigating actions where performance is Amber / Red**
			March 24 update: A summary response to the consultation process has been completed. This has been approved by AMT (10 April 24) and will be presented to PHA Board (18 April 24) for final approval. Once Board approval is obtained the finalised Plan will be printed and distributed regionally.					

3c		Mental Health / Suicide prevention Draft PHA Mental Health, Emotional Wellbeing and Suicide Prevention commissioning framework developed by March 2024.	Dec 23 Update: Focus in 23/24 has shifted onto re-procuring the contracts that are currently covered by DAC's. Project initiation Document for Protect Life 2 Comissioning was presented to, and endorsed by the Procurment Board on 30 November 2023. Initial work has been undertaken in developing the Commissioning framework but this will not be concluded in year as a result of staff absences (2 key staff have been off on long term illness but are now back to work) and will need to be carried forward into 24/25. March 24 Update: PID setting out staged plan for PL2 procurement for next 3-5years presented at, and endorsed by, procurement Board on 30th November 2024. Implementation of workstream plans has commenced however there have been delays.					Director of Public Health Minimal impact on DAC's anticipated. Joanne McClean Limited staffing capacity has created delays for a number of actions. The additional complexity of DoH Reviewing the Protect Life 2 Action plan has added to complexities. Timelines for actions have been amended, and revised timelines agreed with Procurement Board. Continued staffing challenges may lead to further delays. Additional staffing has been requested as part of the Health Improvement Review MOC process. This has also been highlighted to DoH

	Key Priorities				
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun Sep Dec Mar	**Mitigating actions where performance is Amber / Red**
					Colleagues. MHSPT have agreed to consider wider workforce requirements to support delivery of these actions.

3d		Cardiovascular Disease prevention Cardiovascular population health profile to be produced by March 2024	Phase 1: The development of the NI population simulation module is advancing on schedule and progress aligns with projected milestones. The expectation is that by the Q2/ 2023, it will transition into the crucial validation, testing, and refinement stages to further enhance its efficacy and reliability. Phase 2: The research component commences Q2/2023, a pivotal step that aims to furnish the model parameters necessary for seamless integration into the Population Simulation Model. This phase is expected to compete by the Q4/ 2024. Upon completion, the primary deliverable will be a sophisticated Cardiovascular Population predictive model. This advanced tool is designed to aid in intricate, multifaceted scenario planning and provide valuable metrics for measuring the success of interventions. Model development phase was completed and the model populated with estimates from the literature and local surveys. Requests are underway to access local data to parameterise the model with observed risk factor and health status data. There has been a changeover in analyst, which is being used as an opportunity to consolidate documentation and plan next steps for application of the work.					Director of Public Health Joanne McClean

		Key Priorities						
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun	Sep	Dec	Mar	**Mitigating actions where performance is Amber / Red**
3e		Cancer Prevention Mutli- disciplinary working group to be established by May 2023 to develop an action plan for addressing primary and secondary cancer prevention in line with the 2022 cancer strategy by March 2024	Work is on-going across a number of Strategies but due to staffing pressures and re-deployment of staff, the team to co-ordinate the response is not yet in place.					Director of Public Health Joanne McClean Due to staffing pressures and re-deployment of staff, the team to implement this is not yet in place. Co-chairs have now been identified

		Key Priorities						
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun	Sep	Dec	Mar	**Mitigating actions where performance is Amber / Red**
3f		Smoking Regional tobacco commissioning team to be established by June 2023	Further to an internal process a regional tobacco commissioning team has been established. 1x B8a post & 2xBand 7 posts re-prioritised to focus on this Teams development in June 2023. Team to be further expanded Sept - Dec 23 (+1 B7 &+ 1B6) delayed in line with HI Review Process March 24 update (GREEN): Health Improvement MOC Review is ongoing at present. The additional Band 7 and Band 6 posts have been confirmed within the Tobacco Control Team.					Director of Public Health Joanne McClean
4a	All health and wellbeing services should be safe and high quality	Quality Improvement HSCQI workplan agreed by the HSCQI Alliance by June 2023	June 2023 - HSCQI workplan for 2023/24 is in draft. The workplan cannot currently be agreed as HSCQI have not been allocated a programme budget for 2023/24, as at end June 2023. **Sept 2023 onwards** - HSCQI non recurrent programme funding for 2023/24 allocated by DoH in August 2023. HSCQI workplan has been agreed.					Director of HSCQI Aideen Keaney

		Key Priorities			
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun Sep Dec Mar	**Mitigating actions where performance is Amber / Red**
4b		Infection/ prevention Control Re-establish the HSCA/AMR improvement Board by May 2023 and agree an action plan by March 2024, for reducing anti-microbial use in line with regional targets set.	HCAI-AMR Improvement Board re-establishing Q3 2023 supported by Antimicrobial Resistance Programme Manager (started in post end of June 2023). PHA HCAI-AMR team highly engaged with DoH and UKHSA in the development of the UK National Action Plan for AMR and on track to deliver by March 2024. IPC Manual launch - All sections are signed off and the content for the site has gone to the web developer to build the site. I anticipate the launch will happen in this financial year i.e. before the end of March 2024. HCAI-AMR Improvement Board re-established Q3 2023-24 and Terms of Reference signed off by PHA and SPPG. Quarterly meeting schedule in place. Trust performance monitoring in place in line with regional targets and DoH Service Delivery Plan. New UK National Action Plan due for publication in May 2024. IPC Manual completed and published: NI Infection Control Manual		Director of Public Health Joanne McClean

<table>
<tr><td></td><td colspan="5">Key Priorities</td></tr>
<tr><td></td><td colspan="2">Action from Business Plan:</td><td>Progress</td><td>Achievability (RAG)
Jun Sep Dec Mar</td><td>Mitigating actions where performance is Amber / Red</td></tr>
<tr><td>4c</td><td></td><td>Health Protection Response

All standard operating procedures for acute response to be reviewed and updated by March 2024.</td><td>Review of standard operating procedures has commenced. Progress delayed due to reduced Consultant capacity relating to long term sickness absence and resignations.

As of 7/12/2023, 23% of SOPS were retired as no longer relevant or duplicates. 82% have been completed or are in progress. 18% need further review.

Permanent HP consultant posts have been advertised along with locum HP consultant posts.

For HP Team - update 13/02/2024:
<table><tr><th>SOP</th><th>Total</th></tr><tr><td>SOPs needing revised on commencing project*</td><td>87</td></tr><tr><td>Current SOPs on SharePoint after review.*</td><td>65</td></tr><tr><td>Retired SOPs*</td><td>20</td></tr></table>*Figures will not add up as some SOP were amalgamated</td><td></td><td>Director of Public Health

Joanne McClean

Acute response group established and has reviewed SOP’s on the 13/02/24.

Progress stalled due to the acute response to measles and pertussis cases in the duty room.</td></tr>
<tr><td>5a</td><td>Our organisation works effectively</td><td>Quarterly update reports on PHA Business Plan to be provided to PHA Board</td><td>First report brought to PHA Board Aug 23.
Second report brought to PHA Board Nov 23.
Third report brought to PHA Board Feb 24.
Fourth report due to be brought to PHA Board May 2024.</td><td></td><td>Director of Operations

Stephen Wilson</td></tr>
</table>

		Key Priorities			
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun Sep Dec Mar	**Mitigating actions where performance is Amber / Red**
5b	Implement the agreed action plan for 2023/24 that sets out the key programmes of work that will be progressed by PHA officers in meeting Ministerial, DOH and PHA Corporate priorities.	90% of actions in the 23/24 Action Plan to be RAG rated as Green and exception reports to be provided to PHA board to address those rated Red/Amber.	As at March 31st 2024, 69% (41) of the actions on the Action Plan are rated as Green. 23% (13) Amber and 8% (4) rated as red.		Director of Operations Stephen Wilson Lead Directors will review those actions where performance has not been fully achieved and agree timescales for completion.

	Key Priorities								
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun	Sep	Dec	Mar	**Mitigating actions where performance is Amber / Red**
6a	Continue to shape and influence the design and implementation of the proposed new Integrated Care system and ensure the role of the Public Health Agency is embedded appropriately into the new planning and commissioning model being established.	PHA to be appropriately represented on the 5 pilot Area Integrated Partnership Boards to be established in each Trust area	PHA has senior public health representation on the Southern Pilot AIPB. Timing of roll out of AIPBs in the remaining areas awaits the DoH evaluation of the pilot and decisions on their remit and membership. The test AIPB did not meet between December 2023 and March 2024, though a meeting is planned for May 2024					Director of Operations Stephen Wilson Director of Public Health Joanne McClean
6b		Population health profile information to be produced by June 2023 to help inform the test model for the Southern AIPB.	An initial population health profile was presented to the AIPB in June 2023 setting out key issues impacting on the health and wellbeing of the local population. A dashboard was developed and presented in July 2023 to the AIPB and to the ICS Regional Working Group (RWG) on 6th September. PHA staff from the public health, nursing, AHP, health intelligence and health improvement teams have provided presentations and professional advice to the AIPB between July and December which supported the AIPB's decisions on its action plan priorities.					Director of Operations Stephen Wilson Director of Public Health Joanne McClean

		Key Priorities						
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun	Sep	Dec	Mar	**Mitigating actions where performance is Amber / Red**
6c		Ensure PHA priorities relating to health protection, prevention and early intervention are reflected in draft AIPB plans	The test AIPB action plan focussed on secondary prevention in Frailty and was by senior PHA staff with expertise in this area. Primary prevention is led by CPPs. AIPBs in other Trust areas have yet to formally commence					Director of Operations Stephen Wilson Director of Public Health Joanne McClean PHA reps will continue to work with incoming shadow AIPB members and highlight key public health issues to be considered in setting the planning priorities.
7a	Our Organisation Works Effectively Work with DoH to implement	Phase 2A of the Reshape and Refresh programme (Detailed implementation plan) completed by end of May 2023	Phase 2a of the Reshape & Refresh programme was completed at end May 2023. Key deliverables such as V1 Operating Model, Change & Transition status report and Functions Placement Roundtable outputs were signed off at Programme Board in July 23.					Chief Executive Aidan Dawson

	Key Priorities				
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun Sep Dec Mar	**Mitigating actions where performance is Amber / Red**
7b	phase 2 of the Reshape and Refresh of the PHA and agree a new operating model that will deliver a re-focused professional, high quality public health service for the population of NI	Implementation of phase 2B (Continue to Transform) to commence by end of May 23 and conclude by November 23.	Phase 2B of the Programme has completed, facilitated by EY, resulting in the development of a Target Operating Model. The Target Operating Model contains a number of core componenets, which through implementation, would provide the Agency with a framework to operate more effectively.These include: • Governance and accountability • People & development • Data & Intelligencce • Functions & Structures • Culture & engagement The Programme Board approved the Target Operating Model in December 2023 subject to further refinement relating to the organisational structure which was finalised in Jan 2024.		Chief Executive Aidan Dawson

		Key Priorities			
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun Sep Dec Mar	**Mitigating actions where performance is Amber / Red**
7c		Monthly newsletters published to provide staff with regular updates of progress and key milestones.	An update on Reshape & Refresh has been featured in a variety of settings including CX virtual engagement session, weekly news bulletin. A weekly change and comms group continue to meet and identify ways and methods to best communicate key messages. A variety of methods have been used during phase 2a & 2b including: - large staff engagement sessions - team sessions, - weekly newsletter, - video series, - updates on intranet site, - integration with Organisation Development & Engagement Forum (ODEF). A new virtual engagement tool Mural was launched in December 2023 which includes an overview of proposed new structures.		Chief Executive Aidan Dawson.

	Key Priorities				
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun Sep Dec Mar	**Mitigating actions where performance is Amber / Red**
8a	Our Organisation Works Effectively PHA will place additional focus on staff welfare and wellbeing and agree and implement a range of appropriate actions	95% of Individual appraisals and personal development plans agreed by end of July 2023 which clearly demonstrate the staff member's role in helping to contribute to the Agency's ABP key priorities. (subject to sickness absence, maternity and those seconded out of the PHA)	At 30th June 2023 compliance stood at 63.24%. At 31st July 2023 compliance stands at 82.84% At 30th September 2023 compliance stands at 87.88%. At 31st December 2023 compliance stands at 89.23% At 31st March 2024 compliance stands at 95%.		Director of Operations Stephen Wilson Director of HR Robin Arbuthnot

	Key Priorities								
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun	Sep	Dec	Mar	**Mitigating actions where performance is Amber / Red**
8b		A recruitment strategy to be agreed by 30th June 2023 which will include the defined reasons for use of temporary contracts and exit strategy arrangements.	This is delayed although building blocks are all in place including key work on: • a new internal Talent Mobility process implemented as a 'proof of concept' model to replace former EOI process. • Full review of all temporary positions is completed (see 8c) which will be in keeping with any future parameters determined. • An exit strategy is in place for all temporary posts which are being executed. • A new process for onward management of temporary positions aligned to scrutiny process is in place. • The 'recruitment strategy' has now been determined to be incorporated into the People Plan which is out for consultation until 17th January 2024 consultation. It is expected the People Plan will be approved in Q4 . • The People Plan will be presented at AMT in April 2024 for approval with an expectation of launch in June 2024					Director of HR Robin Arbuthnot From the time of writing the business plan, it was decided the recruitment strategy should form part of the overall People Plan which is scheduled for implementation in June 2024.

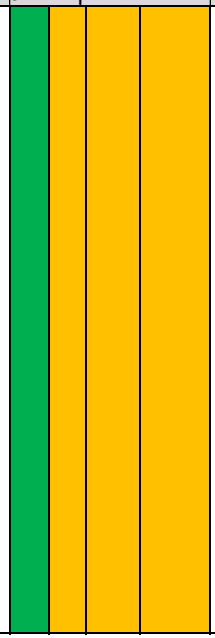
		Key Priorities						
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun	Sep	Dec	Mar	**Mitigating actions where performance is Amber / Red**
8c		All temporary contracts to be reviewed and aligned to the parameters within the agreed recruitment strategy by 30th September 2023.	An Exit strategy is in place for all temporary positions which will align with the parameters expected to be included in the recruitment element of the People Plan. Exit strategies are being actively managed with a new process in place to ensure robust governance arrangements are in place and aligned to the scrutiny process. A 28% reduction in temporary staffing has been realised since March 2023.					All Directors

8d		Staff absence will be effectively managed to ensure appropriate and timely support for staff and with the aim of working towards the agreed target	Staff absence is reported to AMT on a monthly basis. Although overall sickness absence rates have increased (4.83% at end of Q1 23/24), all long term absence is actively managed with support from Occupational Health. There are a range of HWB resources to support staff and the Staff Experience workstream of the Organisation Development Engagement Forum (ODEF) have staff health & well being as a key area in their action plan for the current year. Regular reports are provided to Directors on sickness absence in their Directorate to ensuring ongoing management of such. As part of the work of ODEF a new H&WB survey has been approved for launch in November as part of the live well work well programme of work. This will see local champions identified alongside a programme of work to ensure further development of the ongoing work to support staff H&WB. Results of the HWB Survey are planned for presentation to AMT in April 2024 including an action plan for implementation.					All Directors

		Key Priorities			
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun Sep Dec Mar	**Mitigating actions where performance is Amber / Red**
8e		Hybrid working pilot scheme to be fully implemented with evaluation undertaken which will feed into any future arrangements by March 2024	The Pilot scheme moved to full implementation from 1st April 2023. The evaluation is in progress with an online questionnaire open until mid April 2024 with Focus groups for further staff engagement planned for April 2024. It is expected the feedback to AMT will be presented by June 2024 to inform the future approach.		Director of HR Robin Arbuthnot Hybrid working pilot arrangement extended to faciliate the evaluation and outworkings.

<table>
<tr><td></td><td colspan="5">Key Priorities</td></tr>
<tr><td></td><td colspan="2">Action from Business Plan:</td><td>Progress</td><td>Achievability (RAG)
Jun Sep Dec Mar</td><td>Mitigating actions where performance is Amber / Red</td></tr>
<tr><td>8f</td><td></td><td>Staff will have completed all mandatory training as required by the organisation. 90% compliance by end of December 2023</td><td>
<table>
<tr><th>Date</th><th>June 23</th><th>Sept 23</th><th>Dec 23</th><th>Mar 24</th></tr>
<tr><td>Cyber Sec</td><td>86.95 %</td><td>92.08 %</td><td>90.59 %</td><td>92.65 %</td></tr>
<tr><td>DSE</td><td>62.56 %</td><td>81.19 %</td><td>85.19 %</td><td>91.18 %</td></tr>
<tr><td>Equality</td><td>65.02 %</td><td>84.16 %</td><td>84.44 %</td><td>89.71 %</td></tr>
<tr><td>Equality- Line Mgr</td><td>44.35 %</td><td>92.08 %</td><td>86.67 %</td><td>84.55 %</td></tr>
<tr><td>Fire Safety</td><td>68.47 %</td><td>81.68 %</td><td>85.68 %</td><td>83.09 %</td></tr>
<tr><td>Fraud</td><td>62.56 %</td><td>80.45 %</td><td>79.75 %</td><td>88.24 %</td></tr>
<tr><td>Health & Safety</td><td>70.20 %</td><td>83.66 %</td><td>83.46 %</td><td>89.95 %</td></tr>
<tr><td>IG Awareness</td><td>49.51 %</td><td>65.35 %</td><td>71.29 %</td><td>79.90 %</td></tr>
<tr><td>Manual Handling</td><td>43.35 %</td><td>67.82 %</td><td>69.38 %</td><td>80.39 %</td></tr>
<tr><td>Risk Mgmt</td><td>79.06 %</td><td>87.38 %</td><td>84.20 %</td><td>89.22 %</td></tr>
</table>
</td><td></td><td>All Directors

Line managers are able to use the ‘MyTeam’ function on LearnHSCNI to identify staff who are not compliant so appropriate action can be taken. Directors are also provided with updated compliance reports on a monthly basis. DSE and Manual Handling are new modules.
IG Awareness has changed from last 3 years to 1 year with some back end issues affecting recording of training.</td></tr>
</table>

		Key Priorities			
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun Sep Dec Mar	**Mitigating actions where performance is Amber / Red**
8g		To develop a People Plan by the 30th September 2023 to support the delivery of the PHA's strategic objectives and take forward implementation in line with agreed milestones.	This is under development. Closely aligned to the ODEF action plan, the latter is now agreed and in progress allowing for this plan to be developed over the summer months. A draft People Plan was shared with ODEF members early September as the first stage of consultation before being released for wider staff consultation in early December 2023 with a closing date of 17th January 2024. Using the feedback to inform the final draft The People Plan will be presented at AMT in April 2024 for approval with an expectation of launch in June 2024.		Director of Operations Stephen Wilson Director of HR Robin Arbuthnot Draft People Plan further consulted on in Q3/Q4 2024 with a view to having an approved document in Q1 2025..

9a	Our Organisation Works Effectively Ensure good financial governance and stewardship of PHA budgets and expenditure decisions and implement a new performance management framework for the organisation to establish clear processes of accountability and performance reporting across all	90% of Internal Audit recommendations from 2022/23 addressed and progress reported to GAC by October 2023	5 recommendations remained outstanding from 22/23 (33% of total recommendations issued during 22/23).					Director of Operations Stephen Wilson Director of Finance Leah Scott Audit clinics were held in January 24 to agree actions required to achieve full implementation. 2 of the outstanding recommendations for population screening are to be reviewed by GAC with the intention to have these removed as they are not within PHA control to achieve. Remaning 3 recommendations are partially implemented and work is progressing to complete.

		Key Priorities						
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun	Sep	Dec	Mar	**Mitigating actions where performance is Amber / Red**
9b	levels of the organisation.	100% of Internal Audit recommendations from 2022/23 addressed and progress reported to GAC by March 2024	End of Year audit follow up complete with 80% (78 out of 97) of outstanding recommendations fully implemented. 19% (18 out of 97) are partially implemented and 1% (1 out of 97) has not been implemented. The Report was presented at GAC in April 2024.					Director of Operations Stephen Wilson Director of Finance Leah Scott An audit clinic was held in January 24 to agree what action is required to achieve completion of remaining outstanding recommendations and work is progressing to achieve these as soon as possible.
9c		All Directorate Business Plans approved by 30 May 2023	Operations Directorate Plan complete NMAHP Directorate Plan complete PHD Directorate Plan complete HSCQI Directorate Plan complete					All Directors

		Key Priorities			
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun Sep Dec Mar	**Mitigating actions where performance is Amber / Red**
9d		Delivery of a balanced Financial Plan by end of May 2023, taking into account budgetary uncertainties and agreed investment plan – approval by Board in June 2023	Financial Plan approved by the PHA Board in June 2023, with a forecast financial deficit forecast (£0.65m). A mid-year review of financial performance against the Board approved Financial plan was completed during October which was formally approved by AMT and presented to PPRC. PHA has achieved a breakeven position for 2023/24		Director of Operations Stephen Wilson Director of Finance Leah Scott

		Key Priorities			
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun Sep Dec Mar	**Mitigating actions where performance is Amber / Red**
9e		Budget holders to manage their agreed budgets to support the statutory breakeven target of +0.25% or circa 0.3m within 2023/24	Financial Plan approved by the PHA Board in June 2023, with a forecast financial deficit forecast (£0.65m). A mid-year review of financial performance against the Board approved Financial plan was completed during October and indicated a breakeven forecast, due primarily to lower than anticipated management & administration costs. This position closely monitored by finance alongside budget holders throughout the year. Accountability meetings have been held by the Chief Executive and Deputy Secretary with each Directorate during December/January. PHA has achieved a break even position for 2023/24		All Directors Director of Finance Tracey McCaig .

	Key Priorities							
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun	Sep	Dec	Mar	**Mitigating actions where performance is Amber / Red**
9f		90% of quarterly PMRs for PHA contracts with external providers are submitted on time, KPIs are being achieved and next quarterly payments approved.	System for tracking PMR returns and KPI achievement is operational as at the end of December 2024. First data returns currently being collated and being analysed. For quarter ending December 2023, 49% of returns were provided within the agreed contractual time period and 78% of returns within 7 days of this date. Of the 320 PMRs processed, 67% (215) of PMRs were approved for payment within 7 days of receipt. 87% (277) were approved within 14 days. The remaining 13% were approved once any outstanding quieries were addressed with the Provider					All Directors Contract managers will continue to work with providers to reinforce the requirements to have returns back within the agreed period.

	Key Priorities							
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun	Sep	Dec	Mar	**Mitigating actions where performance is Amber / Red**
10 a	Our Organisation Works Effectively Ensure that the level of public and professional awareness, recognition and confidence in the PHA as the leading Public Health organisation in Northern Ireland is maintained in order to encourage	2% year on year increase in unprompted and prompted public awareness levels of PHA (including role and functions) established through quantitative/qualitative research programme as at March 2024.	Qualitative research deferred due to budget pressures. Follow up Omnibus survey (May 2023) confirmed no significant change in recognition of PHA Brand and how the PHA is perceived. Findings include: - Minor change (2%) decrease in PHA brand recognition (prompted) - Respondents own opinion of PHA remains a tie between neutral and positive. Negative opinions of PHA remains very low <2%. - Respondents trust in the PHA and its values remains around 50% however significant level of uncertainy remains.					Director of Operations Stephen Wilson DoH pause in campaign advertising activity undoubtedly impacted on the feasibility of meeting the year on year target. Tactical led communications around programmes of work will help inform public audiences eg.planned MMR vaccination catch up.

		Key Priorities			
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun Sep Dec Mar	**Mitigating actions where performance is Amber / Red**
10 b	wider engagement with and support for public health priorities.	PHA Public Inquiry team established by end of June 23.	A formal structure is now in place to govern public inquiry (PI) work within the Agency. The PHA PI response is now co-ordinated through a PI Programme Management Board, chaired by the Chief Executive. The PI Programme Management Board meet on a fortnightly basis to oversee the Agency's response to historic, active and impending statutory public inquiries. The day to day inquiry response is co-ordinated through a dedicated inquiries team led by staff working at AfC Ba 8A level with access to a formal Steering Group chaired by the Director of Operations when required.		Director of Operations Stephen Wilson

		Key Priorities			
	Action from Business Plan:		**Progress**	**Achievability (RAG)** Jun Sep Dec Mar	**Mitigating actions where performance is Amber / Red**
10 c		100% of Inquiry Rule 9 statements are provided in a timely manner in accordance with agreed deadlines.	The receipt and onward progression of PI Rule 9 requests are now actively monitored within the formalised PI governance structure to ensure that the Agency can respond to any requests in a timely manner. During 23/24, the Agency has successfully submitted a number of Rule 9 requests in relation to the following public inquiries: - Infected Blood Inquiry - Muckamore Abbey Hospital Inquiry - UK Covid-19 Inquiry - Urology Services Inquiry		Director of Operations Stephen Wilson

HSC Public Health Agency

PERFORMANCE MANAGEMENT REPORT

Monitoring of Targets Identified in

The Annual Business Plan 2023 – 2024 Part B

As at 31 March 2024

This report provides an update on achievement of the actions identified in the PHA Annual Business Plan 2023-24 Part B.

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

There are a total of 59 actions in the Annual Business Plan. Each action has been given a RAG status as follows:

	On target to be achieved or already completed		Will be completed, but with slight delay
	Significantly behind target/will not be completed		

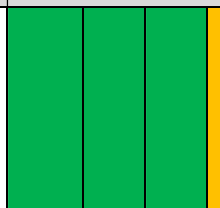
Of these 59 actions 41 have been rated green, 13 as amber and 5 as red.

Outcome	Red	Amber	Green	Total
1) All children and young people have the best start in life			5	**5**
2) All older adults are enabled to live healthier and more fulfilling lives		2	2	**4**
3) All individuals and communities are equipped and enabled to live long and healthy lives	2	4	9	**15**
4) All health and wellbeing services should be safe and high quality		1	10	**11**
5) Our organisation works effectively	3	6	15	**24**
Total	**5**	**13**	**41**	**59**

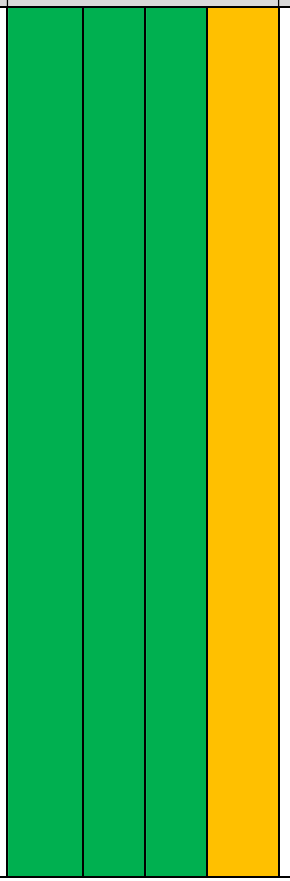
The following report contains details of those actions which have been rated **Amber** or **Red** as at 31st March 2024

		Outcome 3: All individuals and communities are equipped and enabled to live long and healthy lives			
	Priority	**Action**	**Progress** *(Performance measures from ABP in blue for reference)*	**Achievability (RAG)** **Jun/Sep/Dec/Mar**	**Mitigating actions where performance is Amber / Red**
10	1	Undertake review of current PHA arrangements for implementation of vaccine programmes and implement a PHA wide co-ordinated approach in partnership with SPPG and other stakeholders with appropriate oversight arrangements. By April Implement recommendations to establish the new PHA model of vaccination arrangements Review all immunisation programme uptake, looking at comparators with other UK administrations whether we are achieving WHO / JCVI / DoH recommended uptake for all vaccines in adult and children	*Completion of review of arrangements by April 2023* *Establish project team to implement the recommendations by end of May 2023* *Implement improved communications system to support workflow by end of June 2023* *Implementation of recommendations from review of current arrangements for vaccination by March 2024* *Increase in uptake rates across all programmes (based on 22/23 baseline) by March 2024.*		Director of Public Health Joanne McClean Downward trend in vaccine uptake over the last few years has continued and is also seen in the other UK nations.

		Outcome 3: All individuals and communities are equipped and enabled to live long and healthy lives			
	Priority	**Action**	**Progress** *(Performance measures from ABP in blue for reference)*	**Achievability (RAG)** **Jun/Sep/Dec/Mar**	**Mitigating actions where performance is Amber / Red**
			PHA immunisation team have implemented JIRA communication system and are actively using it to plan new programmes of work. The team are working to establish the immunisation oversight/programme board. Invitation letters will be sent to participating organisations in due course. SPPG finance colleagues have been supporting the immunisation team in recent months to ensure good programme governance.		Shingrix uptake in NI has improved compared to 2022/23. A working group has been established for childhood immunisations.
17	2	Scope the development of a trauma-informed and responsive approach within the PHA	• *Analysis/audit of existing trauma informed and responsive practice across the PHA* • *Development of trauma informed and responsive scoping paper* • *Integration of trauma informed and responsive approaches across the ODEF structures and PHA People Strategy*		Director of Public Health Dr Joanne McClean Health improvement colleagues have been working with

		Outcome 3: All individuals and communities are equipped and enabled to live long and healthy lives			
	Priority	**Action**	**Progress** *(Performance measures from ABP in blue for reference)*	**Achievability (RAG)** **Jun/Sep/Dec/Mar**	**Mitigating actions where performance is Amber / Red**
			• *No. of awareness raising and/or training sessions delivered and no. of attendees* • *Feedback from attendees to garner success* • *Case study/example re change in practice/adopting new ways of working* Trauma informed and responsive lunchtime webinar facilitated for PHA staff on 2 May 2023, with over 40 staff in attendance. Trauma informed and responsive scoping paper developed. Currently with Heads/DPH for consideration. Initial meeting with ODEF leads and Refresh-Reshape lead to consider options to take forward work across PHA on a trauma informed and responsive approach. Consideration currently being given to the embedding of a trauma informed and responsive approach within the development of the PHA People Strategy. A further review is planned for September 2023.		SBNI, and Trauma Informed Oregon to shape the whole staff survey for PHA and supporting communications across the agency. It is envisaged that the survey will be issued in May 2024. Following the survey and interviews/focus groups with key staff Trauma Informed Oregon will produce a baseline report for PHA,

		Outcome 3: All individuals and communities are equipped and enabled to live long and healthy lives			
	Priority	**Action**	**Progress** *(Performance measures from ABP in blue for reference)*	**Achievability (RAG)** **Jun/Sep/Dec/Mar**	**Mitigating actions where performance is Amber / Red**
			Analysis/audit of existing trauma informed and responsive practice across the PHA will take place in quarter 3 of this year. Senior PHA staff actively engaging in regional trauma informed and response working groups in partnership with SBNI. Sept update: Trauma informed and responsive scoping paper developed and still currently with Heads/DPH for consideration. Given capacity issues within the ODEF structure and support staff integration of trauma informed and responsive approaches across ODEF and the PHA people strategy will now take place across quarter 3 and 4. Analysis/audit of existing trauma informed and responsive practice across the PHA will take place in quarter 4 of this year.		highlighting existing areas of good practice and making recommendations for further embedding of a trauma informed and responsive approach across PHA.

		Outcome 3: All individuals and communities are equipped and enabled to live long and healthy lives			
	Priority	**Action**	**Progress** *(Performance measures from ABP in blue for reference)*	**Achievability (RAG)** **Jun/Sep/Dec/Mar**	**Mitigating actions where performance is Amber / Red**
			Senior PHA staff actively engaging in regional trauma informed and response working groups in partnership with SBNI. Dec 23 update: PHA People Strategy has been developed via the OFED members – this is currently out for internal consultation and will be reviewed in the context of embedding a trauma informed and responsive approach within the development of the. Linkages have been created between SBNI and Trauma Informed Oregon to support the Analysis/audit of existing trauma informed and responsive practice across the PHA. An update paper is being drafted to go to AMT (by end of Jan 2024) in support of the PHA completing a pilot assessment with Trauma Informed Oregon. The Pilot will take place across February-March 2024 providing a comprehensive baseline assessment and further recommendations for consideration.		

		Outcome 3: All individuals and communities are equipped and enabled to live long and healthy lives			
	Priority	**Action**	**Progress** *(Performance measures from ABP in blue for reference)*	**Achievability (RAG)** **Jun/Sep/Dec/Mar**	**Mitigating actions where performance is Amber / Red**
			March 24 update: A comprehensive written response was submitted to HR colleagues on the draft PHA People Strategy in the context of embedding a trauma informed and responsive approach within the people strategy. However the current iteration of the people plan does not make any reference to a trauma informed and responsive PHA. AMT approved (Jan 24) the SBNI and Trauma Informed Oregon Pilot to support the analysis/audit of existing trauma informed and responsive practice across the PHA.		
18	2	Implement the PHA agreed actions in relation to commissioning of Protect Life 2 (PL2) Strategy	*Completed consultation report for postvention services by September 2023.* Consultation reports published *at* Public consultation on services for those bereaved by suicide | HSC Public Health Agency (hscni.net) *Service specification for postvention services agreed by March 2024*		Director of Public Health Dr Joanne McClean Limited staffing capacity has create delays for a number of actions. The

		Outcome 3: All individuals and communities are equipped and enabled to live long and healthy lives			
	Priority	**Action**	**Progress** *(Performance measures from ABP in blue for reference)*	**Achievability (RAG)** **Jun/Sep/Dec/Mar**	**Mitigating actions where performance is Amber / Red**
			PID for PL2 agreed with Procurement Board, revised action Business Case developed by end March 24 *Service Specification(s) for training agreed by March 2024.* PID for PL2 agreed with Procurement Board, revised action Business Case developed by end March 24 CBT Awareness course development – Specification in draft - aim to award by 1st April. Commissioning priorities for community based suicide prevention services agreed by December 2023. PID setting out staged plan for PL2 procurement for next 3-5years presented at, and endorsed by, procurement Board on 30th November 2024.		additional complexity of DoH Reviewing the Protect Life 2 Action plan has added to complexities. Ti melines for actions have been amended, and revised timelines agreed with Procurement Board. Continued staffing challenges may lead to further delays. Additional staffing has been requested as part of the Health

		Outcome 3: All individuals and communities are equipped and enabled to live long and healthy lives			
	Priority	**Action**	**Progress** *(Performance measures from ABP in blue for reference)*	**Achievability (RAG)** **Jun/Sep/Dec/Mar**	**Mitigating actions where performance is Amber / Red**
					Improvement Review MOC process. This has also been highlighted to DoH Colleagues. M HSPT have agreed to consider wider workforce requirements to support deliver of these actions.
19	2	**Cardio Vascular Disease** Establish baseline population profile and risk factors for Cardio Vascular Disease. Establish baseline incidence of emergency admissions with	*Establish baseline population risk factors - relying on baseline GP QOF data or GPIP subject to access, regional health and wellbeing surveys conducted by NISRA and any other relevant information sources identified.*		Director of Public Health/Operations Dr Joanne McClean

		Outcome 3: All individuals and communities are equipped and enabled to live long and healthy lives						
	Priority	**Action**	**Progress** *(Performance measures from ABP in blue for reference)*	**Achievability (RAG)** **Jun/Sep/Dec/Mar**				**Mitigating actions where performance is Amber / Red**
		cardiovascular disease, and the distribution of severe cardiovascular disease in the population, using secondary care data. Work to increase awareness of signs and symptoms of heart attacks and strokes so that people receive early treatment.	Mass media campaigns paused. Communications reach will be significantly reduced without mass media advertising. Campaign evaluation survey will not be commissioned if there isn't mass media campaign advertising.FAST campaign evaluation report produced in 23/24 FAST campaign evaluation report Model development phase was completed and the model populated with estimates from the literature and local surveys. Requests are underway to access local data to parameterise the model with observed risk factor and health status data. There has been a changeover in analyst, which is being used as an opportunity to consolidate documentation and plan next steps for application of the work.					Stephen Wilson Mass media campaigns are still paused, therefore work to increase awareness can't be achieved.
20	2	**Cancer prevention** Develop an approach to primary and secondary prevention of cancer in line with 2022 cancer strategy.	*Improved performance against the suite of metrics as set out in the Baseline Health Survey 2021/22* Work is on-going across a number of Strategies but due to staffing pressures and re-deployment of staff,					Director of Public Health Dr Joanne McClean Limited staffing capacity has created delays

		Outcome 3: All individuals and communities are equipped and enabled to live long and healthy lives						
	Priority	Action	Progress *(Performance measures from ABP in blue for reference)*	Achievability (RAG) Jun/Sep/Dec/Mar				Mitigating actions where performance is Amber / Red
			the team to co-ordinate the response is not yet in place.					for a number of actions. Co-chairs have now been identified and plan to meet to identify staff members to start a steering group to implement these actions.
23	3	Lead on the coordination and Delivery of the Strengthening Communities for Health partnership by the delivery of PHASE 2 of the Community Development Action Plan that will increase communities capacity and will see the development of a commissioning framework for supporting Community-led approaches to addressing health inequalities,	*Delivery of the ELEVATE programme to see minimum of 8 training sessions delivered* *Continue to promote the online portal and review usage rates* *5 engagement events with C&V and statutory sector to refine training needs* *Provide support to development of guidance on Community level of the ICS through Strengthening Communities for Health Steering Group*					Director of Public Health Dr Joanne McClean Diane McIntyre Engagement with stakeholders regarding the Investment

		Outcome 3: All individuals and communities are equipped and enabled to live long and healthy lives						
	Priority	Action	Progress *(Performance measures from ABP in blue for reference)*	Achievability (RAG) Jun/Sep/Dec/Mar				Mitigating actions where performance is Amber / Red
			6 Community Development Practitioners' Forum sessions delivered in partnership with Project Echo *Comprehensive map of investment produced in partnership with other funders.* 15 sessions of the Elevate training programme were delivered, including both online and face to face sessions. The promotion of the online Portal and associated tools continued with more than 30 new documents added to the site. There are now more than 4,000 users registered to the site, with over 12,000 views in the 2023/24. Work on the retendering of this capacity building programme is underway. Engagement has taken place with ICS colleagues on how the new service can align and support the induction process for AIPB members, to assist with shared knowledge and understanding around health inequalities and community development principles and practice. Agreement has been secured from the ICS NI Programme Steering Board to integrate this					Decision Support Tool (DST) (map of investment) has continued with presentations made to AMT, ADOG, SPPG, DoJ, TEO and Lisburn Council. Interest remains high in the development of the DST and information on investments continue to be added to the platform. A timeline for the retendering of the Elevate programme has been agreed and external support secured. Discussions have

		Outcome 3: All individuals and communities are equipped and enabled to live long and healthy lives						
	Priority	**Action**	**Progress** *(Performance measures from ABP in blue for reference)*	**Achievability (RAG)** **Jun/Sep/Dec/Mar**				**Mitigating actions where performance is Amber / Red**
			programme within the developing AIPB member induction process. Agreement from the ICS NI Programme Steering Board has also been secured to support the community engagement element of the AIPB's through the development of best practice guidance on community engagement. 5 events / meetings with VCS colleagues have taken place with focus on the future development of our capacity building programme and linkages with the Community Development Practitioners Forum. The Forum only met twice in year, due to a mixture of staff pressure on both statutory and VCS sectors. Agreement has been reached to align this work more closely with the next phase of our capacity building programme. The Decision Support Tool has been presented to 4 government departments and 2 HSC Trust CMT's. Feedback for the Tool has been positive. Additional levels of geographical breakdown have been added to the platform, with an additional £13 million of investment mapped and added. The platform has					taken place with ICS NI colleagues on potential support / alignment of this resource with the emerging AIPB's, including how the C&V sectors could be further supported to engage with the AIPB structures. The current Elevate programme is on target to deliver all training sessions in year, however, the application process for Year 2 of the Practitioners Forum has been delayed due to staffing

		Outcome 3: All individuals and communities are equipped and enabled to live long and healthy lives						
	Priority	Action	Progress *(Performance measures from ABP in blue for reference)*	Achievability (RAG) Jun/Sep/Dec/Mar				Mitigating actions where performance is Amber / Red
			been ustilised to support the response to AQ's received.					resources and will now be completed in Qtr 4.

		Outcome 4: All health and wellbeing services should be safe and high quality						
	Priority	**Action**	**Progress** *(Performance measures from ABP in blue for reference)*	**Achievability (RAG)** **Jun/Sep/Dec/Mar**				**Mitigating actions where performance is Amber / Red**
27	2	Introduce Breast Screening Select software in Northern Ireland	*New system implemented and operational by Dec 23* Likely to be by Sept 24. This is a complex project involving multiple partner organisations including: NHS England, (NHSE); Public Health Wales (PHW) and private sector companies. Mitigation is in accordance with the project risk and issues register.					Director of Public Health Dr Joanne McClean Progress was delayed while waiting for input from Department of Legal Services to finalise the information governance requirements and contracts, and NHSE to modify the software for

		Outcome 4: All health and wellbeing services should be safe and high quality			
	Priority	**Action**	**Progress** *(Performance measures from ABP in blue for reference)*	**Achievability (RAG)** **Jun/Sep/Dec/Mar**	**Mitigating actions where performance is Amber / Red**
					data migration.

		Outcome 5: Our organisation works effectively			
	Priority	**Action**	**Progress** *(Performance measures from ABP in blue for reference)*	**Achievability (RAG)** **Jun/Sep/Dec/Mar**	**Mitigating actions where performance is Amber / Red**
37	1	Complete the transition of the acute health protection service, using learning from the COVID response, from interim arrangements put in place during the COVID pandemic to a business as usual arrangement which is consultant led, delivered by PHA staff with robust arrangements in place to respond appropriately to incidents and calls on a 24/7 basis.	Agency use at Consultant level (working at 40% of overall capacity). Roster of SpR's with delegated responsibility in place to release consultant capacity. *All SOPs used for acute response are reviewed and updated during 23/24* - Ongoing with MDT of specialty doctors, SpR's and HP nurses. 23% of SOP's retired. 82% of SOP's completed or are in progress, 18% outstanding for review. *100% of outbreaks and incidents where an outbreak control or incident management team is convened have a named consultant lead* - Significant reduction in Consultant capacity necessitating more frequent change in personel within the acute response service. Named Consultant for each outbreak is not currently deliverable at this time. An operational plan is in progress that reflects collective leadership and ownership, details roles and responsibilities for any emerging incidents and outbreaks. *An outbreak / or incident report is completed for every outbreak or incident where an IMT or OCT are convened.* The aforementioned operational plan will detail roles and responsibilities for delivering outbreak and incident reports.		Director of Public Health Dr Joanne McClean An operational plan is in progress that reflects collective leadership and ownership, detailing roles and responsibilities for any emerging incidents and outbreaks. Actions are ongoing to secure recruitment of

		Outcome 5: Our organisation works effectively			
	Priority	**Action**	**Progress** *(Performance measures from ABP in blue for reference)*	**Achievability (RAG)** **Jun/Sep/Dec/Mar**	**Mitigating actions where performance is Amber / Red**
			100% of calls to the duty room are responded to on the same day. User feedback system implemented in acute response service. Work with colleagues across PHA to implement a service user feedback system by September 2023. Bank staff are supporting the duty room resilience in the short-term.		qualified PH Consultants. Business as usual service operating 24/7. Consultant vacancies have increased across the year and presenting challenges in securing cover. Locum shifts are being used to ensure there is 24/7 cover. Recruitment for permanent consultant was unsuccessful. Continual advertising for locum consultants and planned

		Outcome 5: Our organisation works effectively			
	Priority	**Action**	**Progress** *(Performance measures from ABP in blue for reference)*	**Achievability (RAG)** **Jun/Sep/Dec/Mar**	**Mitigating actions where performance is Amber / Red**
					recruitment for permanent consultants continues.
38	1	Review current policy requirements in relation to climate change and develop a PHA Plan setting out our organizational responsibilities and key actions that need to be progressed.	*Draft Plan developed by March 2024* There has not been sufficient senior staff capacity to take this forward in 2023/24.		Director of Public Health Dr Joanne McClean Further Discussion is needed about how we take this forward.
43	4	Develop a new PHA Corporate Website providing greater	*Corporate website redevelopment project team in place by end of August 2023. Project plan agreed by end of Nov 2023.*		Director of Operations Stephen Wilson

		Outcome 5: Our organisation works effectively			
	Priority	**Action**	**Progress** *(Performance measures from ABP in blue for reference)*	**Achievability (RAG)** **Jun/Sep/Dec/Mar**	**Mitigating actions where performance is Amber / Red**
		functionality for engagement with target audiences.	Original plan for development by BSO ITS has had to be stood down due to elongated time frame (2 years). Discussions with BSO ITS have confirmed an alternative delivery option via external support is required. Delay in staff appointment has impacted the project – planning is now underway and will extend into 2024/25		Additional staff member recruited. Revised PID under development.
45	4	Develop a knowledge management plan which ensures the effective dissemination of Health Intelligence resources.	Knowledge management plan developed. The Head of Health Intelligence and PHA Chief Data Advisor have identified the need to develop Knowledge Hubs to fulfil the 3 knowledge management processes: 1. knowledge creation 2. knowledge storage 3. knowledge sharing 4. The next step is to test the proof of concept by piloting a Knowledge Hub for one Strategic Planning Team. This will require additional non-recurrent resources which have yet to be identified.		Director of Operations Stephen Wilson To be considered as part of development of new data and Digital capacity

		Outcome 5: Our organisation works effectively			
	Priority	**Action**	**Progress** *(Performance measures from ABP in blue for reference)*	**Achievability (RAG)** **Jun/Sep/Dec/Mar**	**Mitigating actions where performance is Amber / Red**
48	4	Support the further development of multi-disciplinary Strategic Planning Teams (SPT) that will agree future priorities for the agency on specific priority / thematic areas, building on the work and experience of existing Mental Health, Emotional Wellbeing and Suicide Prevention SPT including formally establishing Alcohol and Drugs SPT, Older People SPT and agreeing further priority areas	*Proposal and next steps for Older People SPT to be submitted to AMT for approval by May 2023* Paper submitted and agreed *Propose a model for cross-directorate MDT working to deliver PHA core agenda* Paper on development of SPTs submitted to AMT for consideration *Develop a operational manual for SPTs to ensure consistency of approach.* Draft Operational manual / SOP document is in development and will be refined once future Operational model for PHA has been agreed		Director of Operations Stephen Wilson Role and function of Planning teams to be considered at a workshop in early May 2024. Pilot SPTs remain operational until the new structures agreed.
49	4	Implement the PHA board Performance Framework and implement an operational reporting system that will ensure there is clear accountability at all levels of the PHA.	*Quarterly performance management reports provided to PHA board* Reports provided on a quarterly basis. *Directorate Business Plans approved by May 2023*		Director of Operations Stephen Wilson Lead Directors will review those actions

		Outcome 5: Our organisation works effectively			
	Priority	**Action**	**Progress** *(Performance measures from ABP in blue for reference)*	**Achievability (RAG)** **Jun/Sep/Dec/Mar**	**Mitigating actions where performance is Amber / Red**
			Directorate Plans approved. *Quarterly performance monitoring meetings held between CE and Directors* Meeting have been scheduled with Directors *90% of ABP targets fully achieved by March 2024.* *69% of Actions were fully achieved.*		where performance has not been fully achieved and agree timescales for completion.
50	4	Review and update the PHA corporate plan in line with DoH guidance and timescales (when notified).	*PHA Draft Corporate Plan to be developed by March 2024.* Timescales and context for developing new Corporate plan still to be advised by DoH		Director of Operations Stephen Wilson A draft Organisational plan was developed in year and development of new PHA corporate plan deferred to 24/25. This has migrated onto

		Outcome 5: Our organisation works effectively			
	Priority	**Action**	**Progress** *(Performance measures from ABP in blue for reference)*	**Achievability (RAG)** **Jun/Sep/Dec/Mar**	**Mitigating actions where performance is Amber / Red**
					the agreed 24/25 ABP Draft process and timelines to be discussed with PPR Committee on 3rd May 2024.
51	4	Review the PHA Business Continuity Plan and conduct an Annual Test of the plan	*Undertake a review to ensure all details within the plan are up-to-date.* Review undertaken, after an annual test carried out 13 March 2023. *Undertaken an annual test of the business continuity plan to ensure it is fit for purpose (by 31 March 2024)* BCP Audit undertaken in November/December 2023 with recommendations being taken forward as appropriate.		Director of Operations S Wilson BIA (Business Impact Assessment) undertaken across all directorates to re-shape PHA BCP and establish Directorate BCPs. Will be completed and

		Outcome 5: Our organisation works effectively			
	Priority	**Action**	**Progress** *(Performance measures from ABP in blue for reference)*	**Achievability (RAG)** **Jun/Sep/Dec/Mar**	**Mitigating actions where performance is Amber / Red**
			A robust review of the BCP, to include individual Divisional plans, is underway, starting with a Business Impact Analysis (BIA) as described above.		BCP tested by 31 March 2025.
54	4	Establish an Accommodation Review Project Board to oversee the development of an Accommodation Strategy that will set out options for securing suitable accommodation for the PHA.	*PHA Accommodation Review Project Board established by July 2023* *By January 2024, Initial scoping of PHA accommodation needs completed and initial options for future accommodation models developed.* *PHA accommodation needs are included in regional plans* Terms of Reference for the Accommodation Review Project Board have been drafted but nominations to the Group have yet to be made. However, the work that has been completed in regard to the introduction of the Pilot Hybrid Working Scheme and the Desk Booking System will assist with much of the initial scoping work in regard to Directorate and organisational needs.		Director of Operations S Wilson The broad requirements of the PHA in regard to accommodation are also detailed in the Property Asset Management Plan that was submitted to

		Outcome 5: Our organisation works effectively			
	Priority	**Action**	**Progress** *(Performance measures from ABP in blue for reference)*	**Achievability (RAG)** **Jun/Sep/Dec/Mar**	**Mitigating actions where performance is Amber / Red**
			The Annual Property Asset Management Plan that was sumitted also outlines some of the furture requirements in regard to accommodation.		the Department in September

HSC Public Health Agency

item 12

Title of Meeting	PHA Board Meeting
Date	16 May 2024
Title of paper	ALB Self-Assessment
Reference	PHA/05/05/24
Prepared by	Robert Graham
Lead	Colin Coffey
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

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

2 Background Information

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

3 Key Issues

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

4 Next Steps

The Self-Assessment for 2023/24 will be completed and brought to the PHA Board in August 2024.

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

BOARD GOVERNANCE SELF ASSESSMENT TOOL

For use by Department of Health Sponsored Arms Length Bodies

Updated 16th June 2016

Contents

Introduction

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

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

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

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

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

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

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

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

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

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

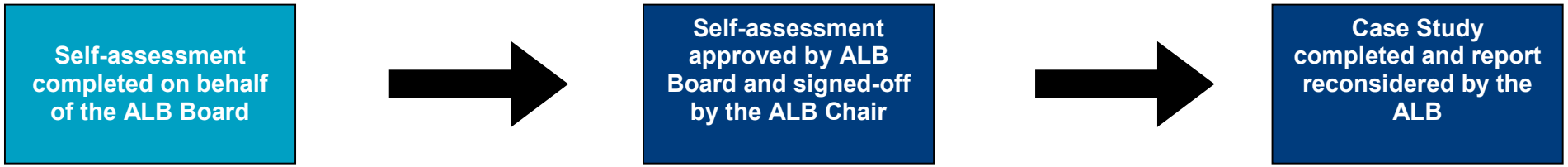
Complete the self-assessment: It is recommended that responsibility for completing the self-assessment sits with the Board and is completed section by section with identification of any key risks and good practice that the Board can evidence. The Board must collectively consider the evidence and reach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

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

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

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

Overview



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

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

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

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

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

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

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

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

Step 1

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

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

Step 2

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

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

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

Step 3

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

Scoring Criteria

The scoring criteria for each section is as follows:

Green if the following applies:

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

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

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

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

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

Red if the following applies:

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

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

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

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

1. Board composition and commitment

1. Board composition and commitment overview

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

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

1. Board composition and commitment

1.1 Board positions and size

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

1. Board composition and commitment

1.2 Balance and calibre of Board members

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

1. Board composition and commitment

1.3 Role of the Board

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

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

1. Board composition and commitment

1.4 Committees of the Board

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

1. Board composition and commitment

1.5 Board member commitment

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

2. Board evaluation, development and learning

2. Board evaluation, development and learning overview

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

1. Effective Board-level evaluation;

2. Whole Board Development Programme;

3. Board induction, succession and contingency planning;

4. Board member appraisal and personal development.

2. Board evaluation, development and learning

2.1 Effective Board level evaluation

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

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

2. Board evaluation, development and learning

2.2 Whole Board development programme

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

2. Board evaluation, development and learning

2.3 Board induction, succession and contingency planning

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

2. Board evaluation, development and learning

2.4 Board member appraisal and personal development

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

3. Board insight and foresight

3. Board insight and foresight overview

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

1.Board Performance Reporting

2.Efficiency and productivity

3.Environmental and strategic focus

4.Quality of Board papers and timeliness of information

3. Board insight and foresight

3.1 Board performance reporting

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

3. Board insight and foresight

3.2 Efficiency and Productivity

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

3. Board insight and foresight

3.3 Environmental and strategic focus

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

3. Board insight and foresight

3.4 Quality of Board papers and timeliness of information

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

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

3. Board insight and foresight

3.5 Assurance and risk management

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

4. Board engagement and involvement

4. Board engagement and involvement overview

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

1.External Stakeholders

2.Internal Stakeholders

3.Board profile and visibility

4. Board engagement and involvement

4.1 External stakeholders

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

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

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

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

4. Board engagement and involvement

4.2 Internal stakeholders

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

4. Board engagement and involvement

4.3 Board profile and visibility

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

5. Board Governance Self- Assessment Submission

Name of ALB – Public Health Agency

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

Approved by TBC (ALB Chair)

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2023

1.1 Board positions and size

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Amber	As at 31 March 2023, the Board had a full complement of members, but the Chair's term ended on 31 May 2023 and as at 31 March 2023 a recruitment exercise has not commenced.	The Board will continue to raise with the Department the need for the vacant Chair position to be resolved as quickly as possible.		
GP2 Green	The Board receives full information from senior officers in order to inform it in its deliberations, decisions and evaluatons			
GP3 Green	The process for voting, and who the voting members are is as outlined in Standing Order 5.2.17. Members are aware of their responsibilities in this area from induction and through guidance from the chair.			
GP4 Green	There are now three Committees of the Board and their terms of reference are outlined in standing orders. They are: • The Governance and Audit Committee			

	• The Remuneration and Terms and Conditions of Service Committee • The Planning, Performance and Resources Committee			
GP5 Green	The appointment time of NEDs is appropriately managed to ensure continuity of corporate memory is retained across the Board.			

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

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2023

1.2 Balance and calibre of Board members

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The appointment of NED's is the responsibility of the Department of Health and the Public Appointments Unit over which the PHA has no control. As highlighted above there will be a change in Chair during 2023/24 and the second term of one other Non-Executive Director will also end during 2023/24. Two of the four Executive Directors are in interim positions.			
GP2 Green	The Board has an appropriate representation of experienced members across all 3 sectors.			
GP3 Green	The Board is extremely conscientious in its concern to ensure equality of opportunity in accordance with Section 75 of the Northern Ireland Act 1998 and oversees the submission of the annual Equality report to the Equality			

	Commission			
GP4 Green	There are three Non-Executive Directors with a background spedific to the business of the PHA.			
GP5 Green	As per legislation, the Board is constituted from local government and lay members. The Board includes people with relevant technical and professional expertise.			
GP6 Green	As at 31 March 2023 the composition of the Board reflects the need for a balance between those that are new and those that have served for longer than 3 years.			
GP7 Green	All Board members are experienced board members.			
GP8 Green	The Chair of the Board (as at 31 March 2023) has 32 years experience of leading a large and complex organisation up to 2015. This organisation would have been regulated by the Northern Ireland Charity Commission.			
GP9 Green	The Chair of the Board (as at 31 March 2023) has served on boards in the private, voluntary and public sector since 1985.			

GP10 Green	The Chair of the Governance and Audit Committee has highly competent financial skills.			

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

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2023

1.3 Role of the Board

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

	with vigour. In year a new performance monitoring system was introduced by the Board to address previous shortcomings in process. The Board is satisfied that it takes responsibility for the performance of the ALB.			
GP4 Green	Non-Executive Directors regularly make a point of emphasising the role of challenge and support for the Board.			
GP5 Green	The Chair has a positive relationship with sponsor branch of the Department and is in regular contact. The Chair and Chief Executive are members of the Programme Board overseeing the reform and refreshing of the PHA and liaise directly with the CMO in this regard through a Review Programme Board. The Chair is also a member of the Health ALB's Chairs' Forum which provides a good opportunity to discuss issues directly with the Minister and Senior DoH colleagues.			
GP6 Green	All NEDs hold the CEO and Executive Directors to account at regular Board meetings and			

	Committee meetings.			
GP7 Green	The Board effectiveness is considered to be of a high standard. This has improved following the implementation of recommendations made by Internal Audit following an audit of Board effectiveness carried out during 2021/22.			
GP8 Green	The Board makes decisions based on data and evidence presented. The board as a whole shares corporate responsibility for all decisions.			
GP9 Green	Board members do respect confidentiality and sensitive information. During 2022/23 all Board members ensured that their HSC issued laptops were operational and these are used for communicating confidential information.			
GP10 Green	The Board is clear on the relative responsiblilities to be discharged by Board and at Executive level. The Board governs and Executives manage.			

GP11 Green	Board members contribute fully to Board decisions and deliberations and exercise a challenge function which is both healthy and supportive.			
GP12 Green	The Chair is always available for guidance and advice for board members.			
GP13 Green	The Chair maintains a clear focus on the important issues facing the Board and facilitates the Board discussions so that all members are heard, engaged and actively involved in debate and constructive challenge prior to making a Board decision.			
GP14 Green	The Board is provided with the appropriate information and considers the concerns and needs of identified stakeholders. As the Regional lead for PPI across the HSC the Board takes seriously its responsibility to drive forward its role in regard to Patient and Public Involvement across its programmes of work.			
GP15 Green	Currently the Board does not approve annually the scheme of delegation to its committees. While Committees do not have delegated powers of decision			

	making, their terms of reference are included within Standing Orders which are approved by the Board.			
GP16 Green	The Board receives evaluation reviews on some programmes and projects. However, the Board has agreed that more work is required to ensure consistent and in depth evaluation is provided in a timely fashion on a Outcomes based plaform.			

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

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2023

1.4 Committees of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	Clear terms of reference have been given for the three Board Committees.			
GP2 Green	The Board is aware that it has full responsibility for all decisions taken by Committees of the board.			
GP3 Green	The scheme of delegation is outlined in Standing Orders.			
GP4 Green	There are clear lines of responsibility in terms of reporting and accountability regarding each committee back to the Board.			
GP5 Green	There is an Assurance Framework in place that covers the Board, and its Committees, and this is reviewed and approved by the Governance and Audit Committee and also the Board. It outlines the frequency of when certain reports and papers should come to the Board and the			

	assurance provided.			
GP6 Green	The Board receives regular reports from its committees. These summarise the key issues as well as any decisions or recommendations made.			
GP7 Amber	The GAC undertakes a formal evaluation each year of the performance of its committee. (Self assessment). However, a formal evaluation of the Remuneration Committee has not been undertaken. The Chairs of committees report back to the chair of the Board regarding the annual appraisal of each member of such committees.	There is a need to carry out an audit of the effectiveness of the Remuneration Committee.		
GP8 Green	The Chair of the Committee is responsible for reporting back to the Board on all issues dealt with by that Committee. This is understood by all Board members.			

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

RF5		

1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2023

1.5 Board member commitment

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

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

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

2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2023

2.1 Effective Board level evaluation

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The PHA Board completed its annual self-assessment in 2021/22.			
GP2 Green	The PHA Board continues to review itself to ensure improvement and development.			
GP3 Green	A review of Board effectiveness was carried out by Internal Audit in 2021/22 and many of the recommendations have been fully implemented.			
GP4 Red	The Board has not obtained the perspective of staff or external stakeholders in the completion of this questionnaire.	The Board will also stipulate how it intends to engage with staff and stakeholders as part of the process for completing the questionnaire.		
GP5 Green	The current self-assessment has covered those questions/areas included in the DHSSPS checklist, both 'hard' and 'soft' dimensions of effectiveness.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3	The Board will undertake a survey of those outside the Board as part of its self-assessment in 2023/24	
RF4		

2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2023

2.2 Whole Board development programme

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	Following the Internal Audit of Board effectiveness, a programme of work was put in place, e.g. the Board Buddy initiative. During 2022/23 there were also Board workshops on strategy and governance (specficially the Assurance Framework and this Self-Assessment). It is anticipated that following the appointment of a new Chair during 2023/24 a new Board Development Programme will be put in place.			
GP2 Green	The relationship between the Minister, Department and ALB board members is included in the Management Statement. It should be noted that Management Statements are due to be replaced by Partnership Agreements but the work on this has not yet finished. This matter was			

	raised at the most recent Accountability Review meeting.			
GP3 Green	The Governance and Audit Committee has oversight on all matters of the control and challenge function of the PHA Board. Its meetings are reported directly to the Board both for noting and action. The GAC Chair also provides an update alongside the minutes whist compiling an Annual Report.			
GP4 Green	This will be covered as part of the Board Development Programme referenced at GP1 above.			
GP5 Green	This will be covered as part of the Board Development Programme referenced at GP1 above.			
GP6 Green	This will be covered as part of the Board Development Programme referenced at GP1 above.			

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

2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2023

2.3 Board induction, succession and contingency planning

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	All Board members have had induction which includes attendance at the On Board training course. Specific induction is also provided for new members of the Governance and Audit Committee. New Board members will meet with in the first instance the Chair followed by a meeting with the Chief Executive, the Director of Finance, Director of Public Health, the Director of Nursing and AHP and the Director of HSCQI.			
GP2 Green	Induction is undertaken as soon as possible after appointment.			
GP3 Green	At the induction, new members will receive a pack of relevant corporate and strategic documentation.			

	As part of the Board effectiveness review, the induction process was reviewed.			
GP4 Amber	Deputising arrangements are specified within Standing Orders. An Interim Deputy Chief Executive was appointed, but retired in 2020/21. The role of Deputy Chair is currently vacant as the previous Deputy has resigned from the Board.	The appointment of a Deputy Chair will be reviewed by May 2023.		
GP5 Green	Appropriate action has been taken by the PHA. The Chair will liaise with PAU to ensure that any future vacancies do not impact on the governance of the PHA.			

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

2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2023

2.4 Board member appraisal and personal development

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	Annual appraisals are carried out by the Chair in line with the requirements of the PAU. The Chair has initiated a series of more regular 1:1 meetings with members.			
GP2 Green	The Chief Executive carries out appraisals with Executive Directors. The performance of the Chief Executive and Executive Directors is discussed at the Remuneration Committee.			
GP3 Green	The Chair receives an appraisal from the Chief Medical Officer.			
GP4 Green	As part of the appraisal system, this is clearly discussed and specified to ensure continuous development. Not all will have been given specific responsibilities, this will be reviewed by the Chair.			

GP5 Green	Board members appraisals allow members to highlight development needs. At each appraisal the chair explicitly asks each Non-Executive Director what additional training they feel would be useful.			
GP6 Green	This is covered through the appraisal system and PDPs, as well as through Director/Chief Executive away days. Relevant training/awareness is also built in where particular needs arise during the year.			
GP7 Green	It is assumed that where appropriate, this is the case.			

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

3. Board insight and foresight

ALB Name - Public Health Agency Date – 31 March 2023

3.1 Board performance reporting

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	PHA prepared an Annual Business Plan for 2022/23. The Board approved this Plan and also approved a Financial Plan. The PHA Corporate Strategy and Annual Business Plan (including commissioning direction targets) set the parameters for performance reporting. Work will commence on the development of a new PHA Corporate Strategy.			
GP2 Green	During the course of the year, quarterly progress reports were brought by AMT to the Board to update on progress against the actions in the Plan. The Board also received a monthly Finance Report.			

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

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

3. Board insight and foresight ALB Name - Public Health Agency Date – 31 March 2023

3.2 Efficiency and Productivity

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

	Key performance is reported via the PHA Performance Management Report.			

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

3. Board insight and foresight ALB Name - Public Health Agency Date – 31 March 2023

3.3 Environmental and strategic focus

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The Chief Executive provides a verbal report at every Board meeting. This, if required, will cover areas such as the external environment, policy changes and any other areas as required. The Chair also provides a written report for each meeting of the Board.			
GP2 Amber	BSO Internal Audit carried out an audit of Serious Adverse Incidents (SAIs) within PHA and HSCB during 2021/22, the report of which was discussed at the Governance and Audit Committee in April 2022. The audit considered the robustness of the arrangements in place within both HSCB and PHA for the governance, oversight and performance management/accountability	The implementation of the recommendations made by BSO Internal Audit by AMT will be monitored by the Governance and Audit Committee and reported to the whole Board. An action plan was shared with Governance and Audit Committee in April 2022 outlining the steps being taken to address the recommendations made by Internal Audit.		

	arrangements in place in respect of SAIs. A limited assurance was provided, on the basis that HSCB and PHA does not have a joint accountability mechanism in place to ensure each partner delivers their respective responsibilities. Management indicated that HSCB (SPPG) and PHA, as part of their improvement plan, are developing a partnership agreement which will set out the escalation arrangement between SPPG and PHA. It was recommended that Performance information to the Agency Board needs to be significantly developed. This recommendation was accepted by management. The Board considers findings and recommendations from reports that relate directly or indirectly to the PHA, and consider the impact of such reports on the PHA. The Board develops actions in conjunction with the Agency Management Team to respond to any such findings and recommendations, as well as considering the learning outcomes in an effort to sustain continuous			

	organisational improvement.			
GP3 Green	PHA prepared an Annual Business Plan for 2022/23 which was brought to the Board for approval. The Business Plan highlighted the need to continue to focus a significant element of resource on dealing with the Covid-19 pandemic, whilst also attempting to return to 'business as usual'. The plan reflected the key actions from all functions and directorates across the five strategic outcomes and three delivery areas.			
GP4 Green	As GP3 above, and reports are brought to the board on a quarterly basis as outlined in section 3.1 (GP2). There is also an Assurance Framework which outlines what reports are required to be brought to the board and a corporate calendar outlining when these will be brought to the board. Work is ongoing to develop a new PHA Corporate Strategy. In light of pressures on HSC organisations in 2021/22, DoH agreed that existing Corporate Strategies for all ALBs could be extended to cover 2022/23.			

GP5 Green	The Board's annual programme of work allows for time for the board to consider environmental and strategic risks (including confidential board meetings, board workshops and board away day). Where relevant the Assurance Framework will be amended to include additional reporting, and/or amendments brought back through Executive Directors for the Risk Register. As per section 3.1 (GP4) the Corporate Risk Register is openly discussed and challenges on same are made at the Governance and Audit Committee. The Corporate Risk Register is brought to the Board annually, or more frequently at the request of the Governance and Audit Committee. The Chair and Chief Executive of the Agency sit on the Departmental Programme Board undertaking a programme to reshape and refresh the Agency.			

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

3. Board insight and foresight ALB Name - Public Health Agency Date – 31 March 2023

3.4 Quality of Board papers and timeliness of information

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

	of GAC has raised the issue of the need for clarity in terms of the rationale behind whether it should be noting, approving, decision-making or discussion.			
GP4 Amber	Many programmes which are delivered by Health and Social Trusts or by voluntary organisations are not subject to performance against key objectives as far as the Board is concerned. There is a need for Board to stipulate which programmes should be presented to the board in order to satisfy Board members that the outcomes of these programmes are as agreed and to a sufficiently high level. During 2022/23, the Planning, Performance and Resources Committee was established and it will look at this area. If an urgent issue arises in between board meetings the chair of the Chief Executive will write by email to Board members alerting them to any urgent developments. If necessary the Chair or Chief Executive may discuss issues by telephone with Board members particularly in the case of a highly sensitive	The Planning, Performance and Resources Committee should look at Trust programme expenditure as part of its remit.		

	issue.			
GP5 Amber	Board papers include the relevant information in respect of proposals or decisions that have been proposed or made. They also state if they have been considered by the Executive Team, or other board committee before they are brought to the board.	Reports should follow the guidance in the ICSA publication,"Effective Board Reporting"(2018) (for implementation by March 2023).		
GP6 Green	The Board is presented with quality updates. The PHA has a robust mechanism for ensuring the collection and analysing of data. Board members regularly question and challenge data to ensure quality and understanding of same when both verbal and formal papers are brought to Board meetings. Also, the Governance and Audit Committee has the opportunity to challenge and question data provided. Internal and External Audit consider data quality in relevant audits.			
GP7 Green	The Board cannot recollect a discussion about the underlying data quality of			

	performance measures. A review of PHA by Dr Ruth Hussey made recommendations with regard to the PHA developing its science and intelligence capability. PHA is hoping to secure funding to implement fully the recommendations of that Review.			
GP8 Green	The Assurance Framework outlines clearly the information being brought to the Board for approval/noting etc. Board members discuss the information status at various workshops.			
GP9 Amber	Board members will not always be able to demonstrate that they understand fully the information presented to them particularly how that information was collected and quality assured. Board members will be encouraged by the Chief Executive to contact him in an instance where they do not understand information or complex data. The Chair himself will attempt to answer this. if not this is not possible he will refer the matter to a			

	senior member of staff with the appropriate expertise. That member of staff will report back either to the chair or to the Board member concerned.			
GP10 Amber	The PHA takes all steps to ensure that documentation presented to the Board complies with DoH guidance where appropriate. However, the design of reports needs to be reviewed.	When reports are being designed and written, authors and editors must keep in mind and be explicit about the purpose of presenting each report to the Board.		

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

3. Board insight and foresight ALB Name - Public Health Agency Date – 31 March 2023

3.5 Assurance and risk management

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The PHA has a clear strategy and policy and procedures in relation to risk management and emerging risks which have been approved by the GAC. These are regularly reviewed and are also supported by operational procedures. This clearly includes the level of risk, risk appetite and how risks escalate from directorate risk register to Corporate Risk Register, as well as reporting arrangements to GAC and PHA Board. During 2022/23, the Governance and Audit Committee continued to review directorate risk registers from across the organisation.			
GP2 Green	There is an Assurance Framework in place which outlines the key sources of assurances and how these will be reported to the board.			

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

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

4. Board engagement and involvement ALB Name - Public Health Agency Date – 31 March 2023

4.1 External stakeholders

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

GP3 Amber	When the PHA developed its Corporate Plan for the period 2017/21, this involved a public consultation exercise, part of which saw two stakeholder events which offered an opportunity for stakeholders to attend and give their views on PHA's future strategic direction. When PHA is developing its new Corporate Plan, it is anticipated that that there will be a similar approach.			
GP4 Green	The PHA Business Plan is available in a number of formats to ensure access to a wide range of stakeholders. The Business Plan is in a format that has been tried and tested to ensure a wide range of stakeholders understand the work of the PHA.			
GP5 Green	The PHA ensures that the learning from SAIs is disseminated and where appropriate influences the commissioning of services			
GP6 Green	PHA Board / Agency has very constructive and effective relationships with a range of key stakeholders.			

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

4. Board engagement and involvement ALB Name - Public Health Agency Date – 31 March 2023

4.2 Internal stakeholders

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Green	The Chair and Chief Executive have undertaken staff engagement sessions with staff in order to discuss issues of concern throughout the organisation. As part of the Reshape and Refresh review programme, the Chief Executive met with staff in all PHA offices.			
GP2 Green	Staff are involved in the development of corporate and directorate business plans at directorate/function level. This information is then fed through to the corporate business plan.			
GP3 Green	This is communicated through Directors to their teams, and is the basis for appraisals.			
GP4 Green	The Board regularly thanks individuals and departments at Board meetings or other group functions, it acknowledges contributions and achievements			

	as and when appropriate.			
GP5 Green	The PHA Board and Agency have clear values and behaviours that have been communicated to staff not only in internal meetings by management, but clearly in policies and procedures.			
GP6 Green	Staff are informed about major risks etc through a range of channels, including emails from the Chief Executive, and through Chief Executive and Directorate briefings.			

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

4. Board engagement and involvement ALB Name - Public Health Agency Date – 31 March 2023

4.3 Board profile and visibility

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1 Amber	Board members are given the opportunity to attend PHA events. During 2022/23 opportunities included the Balmoral Show, seminars on tobacco and drugs, a celebratory event relating to the Farm Families Healthcheck programme and the Contact Tracing Recognition Event. These events give the opportunity for Board members to meet stakeholders as well as PHA staff.	Board members should continue to be kept informed of opportunities to attend high profile events.		
GP2 Amber	The Chair is a very active member of the Health Chairs' Forum. There is much cross fertilisation in the discussions with Chairs of other health bodies. He is also an active member of the Public Sector Chairs Forum for Northern Ireland where there is an opportunity to meet and discuss issues with tears of ALBs across government departments.	Board members should continue to be kept informed of opportunities to attend high profile events.		

	The Chair is an active member of the Institute of Directors and uses that as an opportunity to promulgate the work of the PHA In an informal manner.			
GP3 Amber	As GP1 above.			
GP4 Amber	As GP1 above.			
GP5 Green	The Board holds its meetings in public, and only has a small number of confidential sessions, with very specific, sensitive and/or urgent agendas. Board agendas and minutes are published on the PHA website. The schedule of meetings in 2022/23 included meetings in other PHA offices, e.g. Tower Hill and Gransha Park.			
GP6 Green	As part of the Board member appraisal process, the Chair gives feedback to NEDs on their contributions at meetings and values informed and challenging contributions at Board meetings.			

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

Summary Results **ALB Name - Public Health Agency** **Date – 31 March 2023**

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

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

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

3.5 Assurance and risk management	Green	

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

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

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

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

6. Board impact case studies

6. Board impact case studies

Overview

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

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

2. Organisational culture change; and

3. Organisational strategy.

6. Board impact case studies

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

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

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

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

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

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

6. Board impact case studies ALB Name - Public Health Agency Date – 31 March 2023

6.1 Case Study 1

Performance issues in the area of quality, resources (finance, HR, Estates) or Service Delivery	
Brief description of issue	In April 2021 a paper was brought to the PHA Board proposing the establishment of a Resources and General Purposes Committee, along with a proposed remit.
Outline Board's understanding of the issue and how it arrived at this	The Board felt it needed to drill down on certain issues which did not come under the remit of the other two statutory Committtees of the Board.
Outline the challenge/scrutiny process involved	The Board considered the remit proposed by the Chair but expressed concerns about it cutting across the role of other Committees and it also being too broad.
Outline how the issue was resolved	A new terms of reference was drafted and brought back to the Board in October 2022. This led to the formal establishment of the Committee and it held its first meeting in December 2022. The name of the Committtee was changed to the Planning, Performance and Resources (PPR) Committee.
Summarise the key learning points	The Board needed to ensure that the remit of the new Committee was not operational and needed to be distinguished from the role of the other Committees and that there was no duplication of work for PHA officers.
Summarise the key improvements made to the governance arrangements directly as a result of above	The establishment of the Committee has allowed more in-depth discussion in areas, particularly finance. The Committee considered the first draft of the Agency's response to the savings proposals requested by the Department of Health for 2023/24. It also receives updates on the development of the PHA's Business Plan for 2023/24 and the establishment of Strategic Planning Teams (SPTs). Going forward, it is intended that the Committee will have early sight of the quarterly Performance Management Reports before they are submitted to the full PHA Board.

6. Board impact case studies ALB Name - Date –

6.2 Case Study 2

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

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

6.3 Case Study 3

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

HSC Public Health Agency

item 13

Title of Meeting	PHA Board Meeting
Date	16 May 2024
Title of paper	Overview of Budget Planning for 2024/25
Reference	PHA/06/05/24
Prepared by	Leah Scott
Lead Director	Leah Scott
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to bring an update to the PHA Board on the work to develop a budget for 2024/25. This paper was shared with members of the Planning, Performance and Resources Committee at its meeting on 2 May.

2 Background Information

This paper sets out an overview of the financial planning process to establish a balanced budget for the Public Health Agency in 2024/25.

There are several elements of the overall Agency budget which at this stage of the financial year are at a planning stage. A detailed financial plan will be available for Board approval in June 2024.

A high-level breakdown of how the PHA currently invests its baseline budget is set out in the table below:

Table 2 : Breakdown of PHA Budget Area	£m
Screening Programmes	17.8
Immunisation and vaccination programmes	18.3
Other health protection	0.6
Mental health / Suicide prevention	12.0
Drug and Alcohol	8.4
Obesity / Physical Activity	4.8

Smoking cessation	3.7
Other Health and Wellbeing programmes	14.7
Nursing and AHP initiatives	7.7
M&A	27.0
Total	**115.0**

3 Timetable

The following table is an overview of the key milestones required to deliver the budget plan by 30 June 2024:

Consideration of Draft Budget – AMT	12th June 2024
Consideration of Draft Budget – PPR Committee	14th June 2024 (Date TBC)
Approval of Budget – Board	20th June 2024

4 Assumptions

Following initial conversations with Department of Health officials, an assumption is made that for 2024/25, no increase will be applied to allocations from 2023/24.

It is assumed that separate financial provision for 2024/25 pay increases will be calculated and allocated separately when agreed.

A separate allocation to fund the VMS of £1.5m will also be assumed along with assumed income to fund the cost of the new HPV service.

PHA will review pressures to identify savings to cover inescapable programme pressures as identified in the savings plan submitted to DoH in January 2024.

No allocation has been assumed in relation to price increases (inflation) at this stage.

It is assumed that capital allocation will be made on the basis of 2023/24 with no provision for pay or price increases.

A further meeting has been arranged with SPPG to discuss allocation to Trusts in 2024/25 to ensure consistency.

5. Work Programme

Work is underway to review the following areas:

- Workforce Plan (high level costing of the new Directorate structure)
- Review of the Management & Administration Budget
  (In the context of the Reshape and Refresh project)

- Review of services pressures carried forward from 2023/24
- Review of new emerging pressures for 24/25
- Review of existing commitments against baseline Programme Budgets
- Research & Development Budget (including Capital)

HSC Public Health Agency

item 13

Title of Meeting	PHA Board Meeting
Date	16 May 2024
Title of paper	Our People Plan
Reference	PHA/07/05/24
Prepared by	Karyn Patterson
Lead Director	Leah Scott
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

The purpose of this paper is to bring the draft People Plan to the PHA Board for noting.

2 Background Information

As part of the Reshape and Refresh Programme, the PHA has established an Organisational Development Engagement Forum (ODEF) had set out an action plan for the 23/24 year, which included a number of strategic developments including:

- Development of a People Plan;
- Development of a Skills Framework;
- Baseline Health & Wellbeing Survey to inform onward actions;
- Development of an approach to consider Culture including recognition;
- Development of Tools to support Communication.

A People Plan has been developed and this draft was brought to the Agency Management Team on 17 April and the Planning, Performance and Resources Committee on 2 May.

3 Key Issues

The People Plan aims to build the necessary infrastructure to complement the new operating model and provide support to the staff over the next two years by ensuring that they:

- Are inspired with a shared sense of purpose to improve and protect Public Health;
- Feel valued, supported and engaged in all that they do;
- Are knowledgeable, skilled and competent.

HSC Public Health Agency

Our People Plan 2024 - 2025

DRAFT DOCUMENT

Working together · Excellence · Openness & Honesty · Compassion

Artwork by a staff member
Take 5 staff Event - November 2023

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A Word from our Chief Executive

Welcome to the Agency's first ever People Plan - a plan which is for everyone who works here. It sets out our commitment as an organisation to working together to improve the working lives for all our staff and in doing so to ensure we deliver the best possible services to our population.

I recognise there is a significant amount of change ongoing currently under our Reshape Refresh programme, and it is with this backdrop that Our People Plan aims to support the development of our infrastructure to support our new operating model whilst also supporting staff in our journey over the next 2 years, by ensuring our staff:

- are inspired with a shared sense of purpose - to improve and protect Public the Health of our population;
- feel valued, supported and engaged in all they do;
- are knowledgeable, skilled and competent.

Our approach has been shaped and influenced by a number of drivers at regional level, as well as locally through engagement with you, our people. Achieved through a range of staff surveys as well as your involvement in our Organisational Development Engagement Forum (ODEF) and the workstreams derived therefrom, your voice has been heard.

Our People Plan sets out our ambition, and our commitment to you from the Leadership Team, and is very much the start of our journey to make the Agency 'Team PHA' - the 'employer of choice'. We have 3 key priorities;

- staff experience
- workforce development
- culture

Each of these priorities has a number of key targets to be achieved over the next 2 years which seek to achieve our overall goals. We all have a role in bringing the people plan to life, achieving these goals and together we will make the Agency a great place to work now and into the future.

Aidan Dawson,
Chief Executive

Contents

Introduction

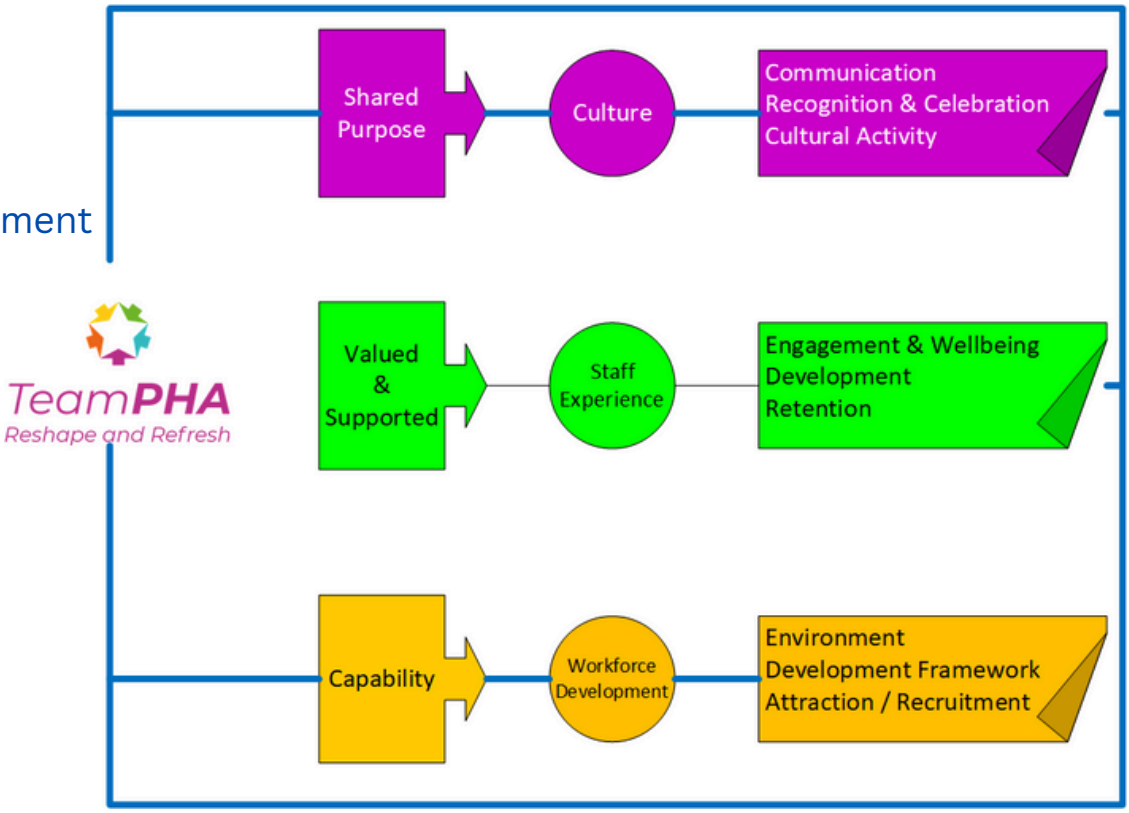
Within the Public Health Agency (*hereafter referred to as 'the Agency'*), we greatly value our staff and the contribution they make to the Health & Social Care (*HSC*) service every day. We operate within the context of the HSC Workforce Strategy - 'Delivering for our People' with the Agency aiming to do just that through continued transformational change at every level in the organisation. In line with the HSC Collective Leadership Strategy we will use a collective leadership approach, harnessing diversity, working collaboratively and effectively with the goal of becoming 'Team PHA - the Employer of Choice'.

To achieve this high level goal we will work towards 3 underpinning targets, to ensure our staff:

- are inspired with a shared sense of purpose - to improve and protect Public the Health of our population;
- feel valued, supported and engaged in all they do;
- are knowledgeable, skilled and competent.

The Agency will strive to achieve these targets through collaborative working, underpinned by the work of the Organisation Development Engagement Forum (ODEF) workstreams :

- Culture
- Staff Experience
- Workforce Development



Through all we do, the HSC Values of; **Compassion**, **Working Together**, **Excellence and Openness & Honesty** provide a guide to all of us and define the way we work. The Agency remains committed to placing them at the forefront of how we do things. Here is a summary reminder of the core components;

Working Together

We work together for the best outcome for the people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.

Excellence

We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high quality, compassionate care and support.

Openness & Honesty

We are open and honest with each other and act with integrity and candor.

Compassion

We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.

Together our values set out how we work together, respecting each other for who we are and the role we have in our organisation, towards achieving our Corporate goals and our People goals.

Through the remainder of this document, the key target milestones towards achieving each goal are summarised with further details on the timelines and progress available from the ODEF workplans available at this link.

Culture

Our People have a shared sense of purpose

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Our People have a shared sense of purpose

The Agency aims to:

- improve and protect health and wellbeing;
- reduce health inequalities;
- promote healthy habits and reduce barriers to good health;
- improve the quality and safety of care services; and
- support related research and innovation.

We want to ensure that all our staff have a shared sense of purpose and understand how their individual roles fits into the wider strategic context.

Organisation culture and behaviour is a key element which impacts on how, as an organisation we are connected and adapt to the changing world around us. Culture will also underpin the other two workstreams, so all are inextricably linked. Organisational culture is impacted by a number of key areas which include:

- Communications - building trust, clarity and engagement.
- Growth & Learning - Recognition and celebration of the work our staff do;
- Positive Environment - Creation of a culture which accepts and understands diversity, exhibits the HSC Values, feels inclusive, rewarding and progressive.

Communications

Communication enables employees to stay connected to their workplace, understand the organisation's purpose and strategy, identify with its values, and develop a sense of belonging by understanding how they contribute to it.

Successful communication will include feedback loops to ensure that communication is truly 2 way. It will ensure feedback is used to strengthen continued improvement and support the Agency in building trust, clarity and engagement. It will ensure staff both feel informed and listened to, supporting the flow of communications at all levels.

Our People have a shared sense of purpose

Growth & Learning

Growth & Learning is fundamental to ensuring our staff are equipped for the future. Linked to the HSC Collective leadership strategy, giving staff both the opportunity to be recognised for their hard work as well as learning from each other is valuable in both personal and organisational growth. It recognises the value of diversity and builds accountability for long term improvement and maturity of culture.

Employee recognition mechanisms provide the opportunity for staff to share their achievements, link their work to the organisations goals, and experience a sense of belonging and recognition in the workplace. Acknowledging and celebrating accomplishments not only boosts morale and motivation but also contributes to a positive work culture, fostering productivity and continued commitment.

As staff share their respective achievements, this will in turn create learning opportunities for others and support the wider organisation to see how their work blends together and complements the overall organisational goals.

Implementing a corporate approach to staff recognition will allow the Agency to harness the power of recognition and cultivate a thriving and engaged workforce.

Positive Environment

Creating a positive working environment is in keeping with the HSC workforce strategy and promotes both psychological safety as well as general Health & Well being. Linked also to growth and learning, sharing the learning from positive change across the Agency and indeed the wider HSC should be actively encouraged.

The HSC is a complex system to work within and fully understand. Opportunities to grow our staff will support the development of an inclusive, rewarding and progressive working environment where all can feel empowered to do their best and deliver high quality services. Everything we do should be underpinned by the HSC Values of; Working Together; Excellence; Openness & Honesty and Compassion.

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Our People have a shared sense of purpose

Organisational Objective	ODEF Workstream	Related Key Focus Areas	Targets (2023-2025)
Our Staff have a shared sense of purpose	Culture	Communication	**Communications** will be **Streamlined** and continually evaluated for effectiveness .
			Communication will be 2 way so we can listen and **act upon staff feedback** with feedback loops to ensure a shared understanding of the actions arising from feedback.
		Growth & Learning	Activities to **recognise and celebrate** our staff and their success will be developed.
		Positive Environment	Develop and implement proposals on **PHA wide activities** which might support internal cultural development. This might range from internal activities to those engaging with / through external organisations.
			To promote the HSC Values in all we do ensuring the promotion of diversity and the psychological safety of all.

Staff Experience

Our People feel supported, valued and engaged

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Our People feel supported, valued and engaged

Staff Experience is reliant on a number of core elements including:

- Engagement & Wellbeing;
- Development;
- Retention.

The Agency will seek to develop a positive staff experience through these key strands. The following sets out the key aspects of each element and how this will translate into action within the Agency.

Engagement & Wellbeing

Staff engagement is a concept that describes the level of enthusiasm and dedication an individual feels toward their job. It is about how motivated, involved and willing to recommend the organisation as a place to work. Staff engagement is important because it is linked to better quality care, lower mortality rates, better patient experience and lower staff turnover. Research also shows staff who feel engaged will be passionate about their work and believe that their efforts make a difference. It is about a shared sense of purpose, clarity of goal, clarity of role and being motivated, however it is also a barometer of well being and having a predisposition to being able to optimise personal performance.

The Agency is committed to engaging with staff at all levels to create the culture for our shared sense of purpose and ensure staff feel valued and supported.

The following are 7 key principles the Agency will seek to use in developing and maintaining staff engagement ;

1. Keep going - we will never give up in our journey of improvement.
2. Keep building - we will ensure solid foundations and continue to develop.
3. Listen and act - we will find ways to embrace and take action on staff feedback.
4. Involve staff - we will continue to encourage staff involvement.
5. Ensure everyone has a voice - we will seek to ensure involvement at all levels.
6. Appreciate and Value - we will celebrate and recognise staff contribution.
7. Innovate and Adapt - we will modernise and respond to changing dynamics.

Overall, the Agency is committed to improving staff engagement, 2 way communication and promoting the HSC Values and principles of equality which underpin all we do.

Development

Development - is the learning experiences which help staff to develop and improve their professional practice. It is often referred to as Continuous Professional Development (CPD) and is anything that helps to develop knowledge, training or experience which can be translated into improving day to day working practice.

The Agency is committed to the development and modernisation of its workforce to ensure staff are knowledgeable, skilled and competent to meet business needs.

This will be achieved through a range of approaches and with the development of a culture of continuous improvement and psychological safety which ensures readiness for the future service delivery.

Development is learning - and learning comes from anything that helps staff to develop and improve their practice. It could be learning from:

- a conversation with a colleague,
- doing a new piece of work,
- working in a new team,
- reading a relevant journal or news article,
- listening to a relevant podcast,
- reflecting on the last few months of your work.

The Agency will ensure there are both formal and informal mechanisms for staff to;

- Reflect on performance,
- Review proudest moments and areas for development,
- Recognise contribution and achievements,
- Realise potential,
- Consider development needs.

Ultimately staff need to understand their 'shared sense of purpose'. Shared purpose is what happens when a group of individuals align with a common challenge, vision or goal. Purpose is the ‘why’ not the ‘what’ or the ‘how’ of change, and should act as a guide and driver of our decisions and actions. It taps into people’s need for meaningful work; to be part of something bigger than ourselves and our Outcomes Based Accountability framework (OBA).

Retention

Retention is the term given to the strategies deployed which encourage staff to remain with the Agency, whilst recognising that a level of staff turnover is both inevitable and healthy.

Retention is very much influenced by the staff experience which begins even before employment. Staff experience will be influenced by a wide variety of factors often referred to as the 'value proposition'. In simple terms this means taking care of what staff need to keep them interested and committed. Whilst pay, terms and conditions will always be a factor in this arena, the following are equally important:

- Training & Development opportunities;
- The nature of the work itself;
- Progression opportunities;
- Relationships;
- Shared purpose.

All of these areas are directly aligned to the HSC Values, Working together; Excellence; Openness & honesty; and Compassion as well as equality principles. All can be underpinned by the need to consider Staff Health & Wellbeing as a priority to ensure staff are supported to give of their best.

Organisational Objective	ODEF Workstream	Related Key Focus Areas	Targets (2023-2025)
Our Staff feel supported valued and engaged	Staff Experience	Engagement & Wellbeing	**Baselining** staff Health & Wellbeing.
			Engaging PHA delivery partners to support the **Work Well Live Well model** for our staff.
			Promote Health & Wellbeing through regular communication of available resources.
			Commence development of a **climate change and sustainability workplace** wellbeing plan.
		Development	**Appraisals** will be available for all staff.
			Staff Development Opportunities will be available with a clear framework for career progression.
		Retention	**Corporate & Local Induction** Process will be reviewed and updated to ensure engaging and informative.
			Promotion of **new Appraisal tools** for all staff and to review feedback for further improvements.
			To **update policies** in the area of staff development and promote opportunities available.
			Exit Survey will be used as a means of feedback.

Workforce Development

Our People are knowledgeable, skilled and competent

Our People are knowledgeable, skilled and competent

Workforce Development is a key element of an effective workforce and provides the frameworks of an organisations people practices. It has many aspects, however within this People Plan we will focus on the following 3 areas:

- Recruitment
- Environment, skills and competencies
- Workforce Planning

The following sets out the key aspects of each element and how this will translate into action within the Agency.

Recruitment

People are at the heart of the Agency's success and in this regard it is vital that the Agency attracts, recruits and retains the highest calibre of staff.

Recruitment across the HSC is managed in line with a regionally agreed Recruitment & Selection Framework which ensures a consistent, fair and objective approach to Recruitment. This framework sets out the key principles and process.

All recruitment activity is managed through our partners in the HSC Recruitment Shared Service Centre (RSSC), with the exception of Medical Recruitment which is managed through the BSO HR Team and very short term opportunities which are managed locally through the Agency's Internal Talent Mobility Process. In exceptional circumstances it may be necessary to seek short term cover through a contracted Recruitment Agency.

Fundamental to any recruitment process, irrespective of the route is candidate attraction, and that is reliant on two key factors;

- Candidate information and
- Advertising channels.

The Agency will focus attention on improving attraction as a means of securing high calibre applicants.

Alongside candidate attraction, candidate experience is vital to retain the interest of applicants throughout the process. The Agency is committed to working with the Recruitment partners to influence and improve candidate experience.

Environment, Skills & Competencies

The work environment is the setting, social features and physical conditions in which staff work. These elements can impact feelings of well-being, workplace relationships, collaboration, efficiency and employee health.

The Agency recognises this is a significant aspect and is committed to developing an appropriate strategy to ensure the needs of staff are met.

The skills and competencies required of staff must be clearly established in a framework to ensure that staff have clarity about what is expected from them (mandatory training) and what they can expect from the organisation in the area of personal / career development opportunities.

There are 'essential skills' which are those widely transferable such as communication, team working, problem solving that all staff require and more specialist skills such as those gained through formal education or development programmes. Specifically, there are Public Health Standards to ensure staff are professionally competent and are optimising their capacity to effectively deliver the Public Health agenda, working in the areas identified by the Faculty of Public Health (FPH) and through the functions described in the Public Health Skills and Knowledge Framework (PHSKF).

The Agency desires to ensure that staff have a clear career pathway which also ensures the organisation has knowledgeable, skilled and competent staff to meet both current and future business needs.

Workforce Planning

Workforce Planning is a term used to describe the actions required to ensure the Agency has a workforce available to meet the future service needs. It uses a range of available data to ensure that a workforce supports business needs, goals and strategic plans. There are many factors to take account of in this arena which is ultimately about a balance of supply and demand. This is an area which will require investment to scope the requirements and identify solutions.

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Our People are knowledgeable, skilled and competent

Organisational Objective	ODEF Workstream	Related Key Focus Areas	Targets (2023-2025)
Our Staff are knowledgeable, skilled and competent	**Workforce Development**	Recruitment	**Attraction** - To consider new and innovative ways to raise the profile of the Agency across HSC; Education and beyond to support attraction at a range of levels.
			Candidate Information - develop standard documentation which might improve attraction.
			Candidate Experience - To work with the Recruitment partners to influence and improve candidate experience throughout the recruitment journey.
			Keeping Activity moving - To regularly host sessions for Managers on proactively managing their recruitment exercise, sharing available tools to build knowledge of support arrangements to navigate the process.
			Job Descriptions - Review the Regional Job Description Template to consider wording to reflect PHA specific requirements particularly in the area of Emergency Response and transport requirements. Influence change to the presentation of Job Descriptions to support attraction.
			Job Description Library - commence planning as to how this might be achieved and to link to developing of 'Template' Job Descriptions for the same role but in various programmes of work not only to ensure consistency but flexibility to meet organisaional needs.

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Our People are knowledgeable, skilled and competent

Organisational Objective	ODEF Workstream	Related Key Focus Areas	Targets (2023-2025)
Our Staff are knowledgeable, skilled and competent	**Workforce Development**	Environment, skills & competencies	**Hybrid Working as a model** will be operational as a trial with an evaluation process agreed to facilitate decisions on the future model and fit for organisational purposes.
			A skills & competencies framework will be developed and implemented with an audit tool used to support the identification of current levels for every staff member. This will also require to be linked to Job Descriptions to both support attraction and approaches to recruitment.
			Learning Management system will be in place and actively used across the Agency.
			Mandatory Training will be available and completed.
			New Ways of Working will be considered and an action plan developed which will ensure the Agency modernises approaches in line with the technology and resources available.
			Emergency Planning will be in place to ensure readiness to respond to any future incidents. This will include linkages to Job Descriptions and the skills / competencies framework.
		Workforce Planning	Undertake a **scoping exercise** of the risks and challenges in the area of workforce planning which might inform strategies for succession planning. This should be linked to and inform the skills / competencies framework.

HSC Public Health Agency

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