HSC Public Health Agency

agenda

PHA Board Meeting

Date and Time 21 November 2024 at 1.30pm

Venue Fifth Floor Meeting Room, 12/22 Linenhall Street

1 1.30	Welcome and Apologies	Chair
2 1.30	Declaration of Interests	Chair
3 1.30	Minutes of Previous Meeting held on 18 October 2024	Chair
4 1.35	Actions from Previous Meeting / Matters Arising	Chair
5 1.40	Presentation from Department of Health Serious Adverse Incident Redesign Programme Team	Chair
6 2.10	Reshape and Refresh Programme	Chair
7 2.20	Reports of New or Emerging Risks	Chief Executive
8 2.25	Raising Concerns	Chief Executive
9 2.30	Draft PHA Corporate Plan 2025/30 **[PHA/01/11/24] (For approval)**	Ms Scott
10 3.00	Performance Management Report **[PHA/02/11/24] (For noting)**	Ms Scott
11 3.20	Updates from Committees: • Governance and Audit Committee • Remuneration Committee • Planning, Performance and Resources Committee **[PHA/03/11/24]** • Screening Programme Board • Procurement Board • Information Governance Steering Group • Public Inquiries Programme Board	Committee Chairs
12 3.30	Operational Updates: • Chief Executive's and Executive Directors' Report	Chief Executive/ Executive Directors
	• Finance Report **[PHA/04/11/24]**	Ms Scott

13 3.50	Sealing of MOU between Western Trust and PHA **[PHA/05/11/24] (For approval)**	Chief Executive
14 3.55	Chair's Remarks	Chair
15 4.00	Any Other Business	Chair

16 Details of next meeting:

Friday 30 January 2025 at 1.30pm

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

HSC Public Health Agency

minutes

PHA Board Meeting

Date and Time 18 October 2024 at 10.00am

Venue Conference Rooms 1/3, 12/22 Linenhall Street, Belfast

Present

Mr Colin Coffey	-	Chair
Mr Aidan Dawson	-	Chief Executive
Dr Joanne McClean	-	Director of Public Health
Ms Leah Scott	-	Director of Finance and Corporate Services
Mr Craig Blaney	-	Non-Executive Director
Mr John Patrick Clayton	-	Non-Executive Director
Ms Anne Henderson	-	Non-Executive Director
Mr Robert Irvine	-	Non-Executive Director
Professor Nichola Rooney	-	Non-Executive Director
Mr Joseph Stewart	-	Non-Executive Director

In Attendance

Mr Stephen Wilson	-	Head of Chief Executive's Office
Mr Robert Graham	-	Secretariat

Apologies

Ms Heather Reid	-	Interim Director of Nursing, Midwifery and Allied Health Professionals
Ms Meadhbha Monaghan	-	Chief Executive, Patient Client Council

107/24 **Item 1 – Welcome and Apologies**

107/24.1 The Chair welcomed everyone to the meeting. Apologies were noted from Ms Heather Reid and Ms Meadbhba Monaghan.

107/24.2 The Chair said that he had attended the NICON conference over the previous two days and was pleased that prevention was the main theme. He commended the presentation delivered by Dr McClean and Ms Reid and said that Ms Jayne Brady has asked for a copy. He advised that the First Minister and Deputy First Minister were in attendance and they had agreed that there needs to be a cross-departmental approach to health.

108/24 **Item 2 – Declaration of Interests**

108/24.1 The Chair asked if anyone had interests to declare relevant to any items on the agenda.

108/24.2 Mr Clayton declared an interest in relation to Public Inquiries as Unison is engaging with the Inquiries.

109/24 Item 3 – Minutes of previous meeting held on 28 August 2024

109/24.1 The minutes of the Board meeting held on 28 August 2024 were **APPROVED** as an accurate record of that meeting.

109/24.2 The Chair said that going forward he would like the minutes to be more concise and to detail the outcomes that have been agreed and the decisions made.

110/24 Item 4 – Actions from Previous Meeting / Matters Arising

110/24.1 Mr Stewart noted that as per the action log, the correspondence relating to campaigns had been sent to Mr Peter Toogood and not to the Minister as was requested by the Board. He outlined that if PHA cannot inform people about vaccinations through a campaign programme, then uptake rates will decrease and there will be vaccine wastage. Dr McClean advised that PHA does raise this issue with the Department and agreed that a letter from the Chair to the Minister may be helpful. Mr Wilson added that PHA made specific reference to campaigns when it submitted its savings proposals for the year and informed the Board that in the area of organ donation, PHA has been asked not to proceed with a campaign where previously there was ring-fenced funding.

110/24.2 Ms Henderson asked if PHA is ordering less vaccine stock this year and Dr McClean replied that approximately £1m less of flu vaccine has been ordered. Mr Clayton noted that there is a challenge for PHA in terms of the misinformation on vaccines if it cannot undertake a mass media campaign.

110/24.3 Mr Clayton asked about the “Live Better” initiative and a separate briefing for the Board on this. Dr McClean advised that two areas have been identified for the pilot, one in Belfast and one in the north west. Mr Wilson added that there is an oversight board meeting on Monday where the outcomes of the pilot will be agreed as well as an action plan.

111/24 Item 5 – Reshape and Refresh Programme

111/24.1 The Chair reported that progress is ongoing and that interviews have taken place for some of the Deputy Director posts, but others will have to be advertised externally. He expressed concern around the time taken for this process to complete and if it could be speeded up.

111/24.2 The Chair advised that he had received correspondence from the Royal College of Nursing, and that he spoke to both the Deputy Permanent Secretary and the Chief Nursing Officer about it. He said that he had responded to the letter and had heard nothing further. Dr McClean explained that historically PHA would have been an organisation of specific different staff groups, but now it needs to become an organisation of staff with all sorts of qualifications who are focused on

public health. She noted the Chair's concern about the length of time the process is taking, but said that there are affected staff and this needs to be borne in mind.

111/24.3 Mr Blaney asked whether there should be a member of the Board that staff can reach out to. Dr McClean advised that there are a number of different routes staff can utilise. She outlined that there have been staff engagement sessions, engagement with HR and Trade Unions and Ms Gráinne Cushley has been offering to meet with staff. Mr Clayton said that meetings with Trade Unions should continue and agreed that there needs to be a balance struck. Mr Stewart said that the Board should not be involved given the mechanisms that are already in place.

112/24 Item 8 – Updates from Board Committees

Governance and Audit Committee ***[PHA/04/10/24]***

112/24.1 Mr Stewart reported that the Governance and Audit Committee (GAC) had considered a range of papers beginning with the Corporate Risk Register. He noted that while no new risks have been added to the Register, and no risks removed, the rating of the risk relating to Public Inquiries has been reduced from "high" to "medium" with the rationale being that this is due to the completion of a lot of work relating to Inquiries. However, he felt that there is an element of the risk relating to reputational damage, and this has not diminished, therefore the GAC would recommend the rating remains as "high". Mr Wilson explained that the Agency Management Team (AMT) had discussed this and had reviewed all aspects of the risk, including the reputational damage element, and it was felt that as the findings for Module 1 of the COVID Inquiry are for the system as a whole, rather than individual organisations, the risk of reputational damage has reduced. He acknowledged that there is potential for criticism from the Muckamore Inquiry but following the evidence given by the two former PHA Directors of Nursing, the Inquiry felt assured about PHA's role and while the potential for criticism has not been removed, the view is that the Inquiry is looking at systems rather than individual parties. He added that the risk will be kept under review.

112/24.2 Ms Scott commented that taking action to cover a reputational risk is a risk in itself. The Chair said that with the outworking of the Reshape and Refresh programme and the development of a new Corporate Plan, PHA has an opportunity to reposition itself in the health system and should be wary of anything that could impact on that. Mr Stewart said that the Board needs to be sighted on areas of reputational risk.

112/24.3 Ms Henderson said that PHA should be following Public Inquiries closely and taking action while they are being heard. She asked if PHA is changing any of its processes while Public Inquiries are ongoing rather than waiting 2/3 years down the line. Mr Wilson replied that PHA is looking at the recommendations from all Public Inquiries and acting on any implications. The Chair said that a paper should come to the Board on this.

112/24.4	Mr Irvine commented that when reputational damage is lost, it is hard to regain so PHA needs to heighten its awareness and mitigate any potential damage. *At this point the Chief Executive joined the meeting.*
112/24.5	The Chief Executive said that he was content to keep the risk rated "high" if that is the advice of the Board.
112/24.6	Mr Stewart advised that the Committee had considered the Finance and Corporate Services Directorate Risk Register which contained a risk around the antiquity of the finance system.
112/24.7	Mr Stewart reported that a review has been undertaken of PHA's Standing Orders and Standing Financial Instructions and while most of the amendments were around the updating of references to reflect the appointment of PHA's Director of Finance and Corporate Services, there were two areas of concern, one relating to PHA's role as "providing professional leadership" to the HSC and the other relating to a need for clarity around what is meant by "joint commissioning".
112/24.8	Mr Wilson advised that the reference to "professional leadership" comes from the 2011 Framework Document which remains the extant Framework. The Chief Executive noted that in the past two of PHA's Directors would have also sat on the Board of HSCB. He said that PHA would have provided advice into commissioning through professional lines, but he noted that there has not been a Commissioning Plan for a number of years.
112/24.9	Mr Clayton noted that there has not been a Commissioning Plan since 2019/20 and this is linked to the new Integrated Care System (ICS). He added that within the Corporate Risk Register, there is reference to PHA operating *ultra vires*. He said that as ICS is not yet set up statutorily. PHA needs to be clear about its legal powers and responsibilities, and if it will be providing professional advice and information.
112/24.10	Ms Henderson said that even from reading the Corporate Plan, she does not understand what PHA's role is vis-à-vis commissioning. The Chief Executive asked her to outline what she feels the risk is and Ms Henderson replied that the whole system is in doubt as to where responsibilities lie and this makes it inefficient and ineffective, and therefore a risk to PHA and for the system. The Chief Executive said that it is a shared risk and the argument could be made that all ALBs face the same risk so ultimately the risk could belong to the Permanent Secretary or the Minister.
112/24.11	The Chair said that there is a recognition that there needs to be a change to the commissioning approach. Ms Henderson asked if staff can continue to operate in a context where there is no clarity. Dr McClean said that PHA would keep notes of meetings where it has given professional advice, and that she is hopeful that there will be clarity in future.

112/24.12	Mr Clayton asked for clarity around what the risk is because by stating that PHA could act *ultra vires* would suggest that PHA is outside its legal powers and using its funding inappropriately. The Chief Executive said that in the future, commissioning might disappear. He explained that commissioning is a contract and the funding goes to the Trusts and the contract is with SPPG, not PHA. He added that at a regional level, there is a high level set of outcomes and the accountability and risk is with the Trusts, whereas PHA's role is about advice and joint planning. He noted that PHA can provide advice and that advice can either be accepted or ignored.
112/24.13	Mr Stewart said that there have been a lot of meetings to discuss the future of commissioning, but no progress and at present Ms Scott is the Director responsible for the Commissioning Plan and the PHA Board has responsibility for approving a joint Commissioning Plan that in his view, is not joint. He added that the Board needs to note the concerns from GAC that the reference to the Commissioning Plan in Standing Orders is misleading.
112/24.14	The Chair agreed that PHA needs to raise this issue as it has been ongoing for over 2 years. It was agreed that there should be a meeting to discuss this involving the Chair, the Chief Executive, Mr Wilson, Mr Stewart and Mr Clayton **(Action 1 – Secretariat)**. The Chair undertook to raise this at his next meeting with Mr Peter Toogood **(Action 2 – Chair)**.
112/24.15	Mr Stewart reported that Internal Audit had awarded a satisfactory level of assurance following a recent audit of Board Effectiveness. He noted that one issue that remained from the previous audit was around the development of a Corporate Plan. He advised that 78% of outstanding Internal Audit recommendations have been completed, but added that he had received correspondence from the Chair of the Department's Audit and Risk Committee about the level of outstanding audit recommendations across health as a whole.
112/24.16	Mr Stewart advised that there was an update on the Information Governance Action Plan which highlighted issue around training and induction. He reported that there were no cases of fraud and that the Committee had approved the Anti-Fraud Plan subject to an amendment around the role of Director of Finance and Corporate Services in reporting fraud to the PSNI.
112/24.17	The Chair thanked the Committee for its work in going through all of these papers in detail.
112/24.18	As he had to leave the meeting, Mr Irvine raised some queries on the Joint Emergency Preparedness report which had been considered by the Committee. He said that the Report details a lot of activity and he had a query who was in overall charge and it seemed to be the PHA by default. He highlighted a concern around the adequacy of the training budget. He said that the Report should contain an Executive Summary

highlighting the key issues and how these will be addressed so that these can be reviewed in the next year's Report.

113/24 **Item 6 – Reports of New or Emerging Risks**

Corporate Risk Register as at 30 September 2024 ***[PHA/01/10/24]***

113/24.1 Ms Henderson outlined that there needs to be a risk on the Corporate Risk Register around the limited findings in relation to community and voluntary sector contracts. She said that PHA is rolling forward £20m of contracts and Internal Audit has raised questions about value for money. While she accepted that most of the funding is being appropriately spent, she said that some of the funding could be redirected or re-prioritised into other areas. She added that there also needs to be reference to the £10m being managed through the Procurement Board.

113/24.2 Ms Henderson said that this risk needs to be clearly articulated in PHA's Governance Statement and Mid-year Assurance Statement. She acknowledged that Ms Scott is taking forward work in this area.

113/24.3 The Chair noted that procurement has been an issue since he joined the organisation and that the AMT is taking this forward as a corporate issue, but said that there needs to be a plan.

At this point Professor Rooney joined the meeting

113/24.4 The Chief Executive said that PHA's Corporate Plan should govern how it spends its funding and that will help PHA realign its priorities. Ms Henderson said she welcomed the fact that PHA now has more resources in the area of Finance.

113/24.5 Members **AGREED** that the new risk should be included and **APPROVED** the Corporate Risk Register.

At this point Mr Irvine left the meeting.

114/24 **Item 10 – Joint PHA/SPPG/BSO Annual Report on Emergency Preparedness 2023/2024 [PHA/06/10/24]**

Ms Mary Carey joined the meeting for this item

114/24.1 Dr McClean advised that PHA compiles this Report in conjunction with SPPG and BSO and then send it up to the Department. She said that Ms Carey and her team do the bulk of the work in terms of writing the Report.

114/24.2 Ms Carey said that the Report follows a set template which she hoped will change and that this has been highlighted to the Department. In terms of the Report itself, she advised that there are variances in terms of the level of information provided by Trusts. She explained that the core standards are a national assurance framework so Northern Ireland can be aligned with the rest of the UK.

114/24.3	Ms Carey noted the points made by the GAC in terms of the Report having an Executive Summary outlining any risks for PHA and how these will be mitigated and said that this will be fed back to the team at the Department, but added that there is a new team at the Department in Emergency Planning. With regard to the training budget, she explained that this has been raised and PHA is preparing a business case as part of a wider application for all HSC bodies.
114/24.4	Mr Clayton commented that the GAC was struck by how low the budget was given the nature of the work and felt that this is a concern that needed to be raised with the Board. He noted that PHA's level of compliance with the standards was rated as "partial" for the second successive year, and this is the first time this has happened. He suggested that this is partly due to the shortage of public health consultants and this should also be flagged with the Department. Mr Stewart added that the risk to PHA has been exacerbated by the fact that neither SPPG nor BSO have any dedicated resource in this area, and that should also be flagged up. Dr McClean agreed that a £30k training budget is light and that this has been flagged up with the Department. She welcomed the Board's support in terms of raising this again but said that as the team at the Department is relatively new, she suggested that she and Ms Carey should meet with them in the first instance **(Action 3 – Dr McClean)**.
114/24.5	The Chair sought clarity as to whether the Preparedness Group had met in 2024 and Ms Carey replied that they had, but adding that some of the monitoring meetings had been stood down. The Chair noted that within the Report there are paragraphs on the emergency preparedness arrangements within SPPG and BSO, but nothing about PHA. Dr McClean advised that the overall Report describes the work of PHA. Responding to a query the Chair raised about the learning from exercises, Ms Carey explained that there are debriefs to look at any actions that need to be taken forward.
114/24.6	The Chair asked about pandemic preparedness work which was to have been completed by January 2024. Ms Carey explained that all Trusts were due to have submitted their preparedness plans by that date and that there is a workshop taking place this afternoon. The Chair asked again about whether PHA is confident that it is taking forward any learning, particularly given the funding constraints. Dr McClean advised that this is a complex area and said that all the learning will not have been taken forward, but added that there are plans, but some of these require funding. She outlined how, at the start of the pandemic, PHA was not able to stand up a Contact Tracing Services at scale and these types of issues need to be thrashed out with the Department. She added that PHA has asked for £250k to have a resilience team.
114/24.7	The Chair said that looking at it from a purist perspective, if PHA has been told by experts that it needs to be able to deliver a particular service, but PHA cannot because it needs resources, then PHA should ask for those resources. He added that for pandemics, PHA should

develop a pandemic plan. Ms Carey explained that pandemics are one element of emergency planning. She highlighted that for CBRN (chemical, biological, radiological, and nuclear), the Department of Justice is leading on a gap analysis which will be included in a paper about training. She added that there is also mass casualty training as well as other areas so all of this needs reviewed in terms of what training can be delivered, and then there will be the need to take forward the recommendations from Module 1 of the COVID Inquiry.

114/24.8 Ms Henderson asked at what level these issues have been raised with the Department. Ms Carey replied that it is at the Emergency Planning Forum. Mr Stewart said that if PHA knows that it needs more resources, this should be raised with the Department because it goes to the heart of the Hussey Review. Ms Henderson asked if the Board could see the paper that is prepared. Dr McClean advised that a draft has been shared with the Department and that further engagement is needed with Trusts, but she would share it **(Action 4 – Dr McClean)**. Ms Carey added that after this afternoon's meeting, PHA would like to meet with the Department to agree the next steps as there needs to be a consolidated policy document and a plan developed.

114/24.9 The Board **APPROVED** the joint PHA/SPPG/BSO Annual Report on Emergency Preparedness 2023/2024.

115/24 **Item 7 – Raising Concerns**

Raising A Concern in the Public Interest (Whistleblowing) Policy 2024 ***[PHA/02/10/24]***

115/24.1 The Chair advised that this updated Policy was approved by the Governance and Audit Committee and added that Mr Blaney has agreed to become the designated Non-Executive Director with responsibility for oversight of the Policy. Mr Blaney asked about training and if this will be provided.

115/24.2 Mr Clayton commented that this is a complex area and suggested that the appendix which details the process should be put more upfront in the Policy. Professor Rooney noted that at NICON there was a lot of emphasis on candour, and the issue around people knowing what to do and others acting appropriately. The Chair said that PHA has a duty of care to both staff who raise concerns and those whom the concerns are raised about.

115/24.3 Members **APPROVED** the Raising A Concern in the Public Interest (Whistleblowing) Policy 2024.

112/24 **Item 8 – Updates from Board Committees (ctd.)**

Update from Committees ***[PHA/03/10/24]***

112/24.19	The Chair advised that he had gone through all of the terms of reference for the various Boards/Committees that members participate in and asked if members were comfortable with their roles in terms of whether they are decision makers or observers.
112/24.20	Mr Clayton explained that the main function of the Information Governance Steering Group is to set the work plan for the year which goes to the Governance and Audit Committee for sign off, adding that he would wish to avail of Information Asset Owner training.
112/24.21	Mr Wilson said that it is useful to have members on groups as “critical friends” who can provide assurances back to the Board. Ms Henderson agreed that Non-Executive Directors are there as observers and not decision makers, adding that being on these groups gives Non-Executives visibility. She noted that the Procurement Board is not a decision making Board as its recommendations go to AMT.
112/24.22	Professor Rooney commented that she was concerned when the Public Inquiries Programme Board was set up about questions around what the Board knew, or did not know, and therefore felt it was useful to have that oversight, but agreed that she does not get involved in decision making. The Chief Executive advised that there are good processes in place for handling Inquiries and said that it is useful to have a Non-Executive Director in attendance. Ms Scott added that she also welcomed Non-Executive Director presence.
112/24.23	The Chair summarised the discussion saying that Non-Executive Directors were content to be involved and he would review the paper. He added that when terms of reference are reviewed they should clearly indicate that Non-Executive Directors are observers.
	Remuneration Committee
112/24.24	The Chair noted that the Remuneration Committee has not met since the last Board meeting.
	Planning, Performance and Resources Committee
112/24.25	The Chair noted that the Planning, Performance and Resources Committee has not met since the last Board meeting.
	Screening Programme Board
112/24.26	The Chair noted that the Screening Programme Board has not met since the last Board meeting.
	Procurement Board
112/24.27	

Ms Henderson advised that the Procurement Board has met since the last Board meeting and that the issues discussed have already been covered earlier in the meeting.

112/24.28 *Information Governance Steering Group*

112/24.29 Mr Clayton reported that the Information Governance Steering Group met in September and that there were two issues he wished to raise.

112/24.30 Mr Clayton noted that there remain issues with regard to completion of online training for new starts in relevant policies and although there is a new start induction day, the situation has not improved. He advised that an Annual Report on Information Asset Registers was not completed in 2023/24 because some of the Registers were not reviewed with Information Asset Owners indicating that they were not clear about how to complete these. He added that there was an action to initiate some training.

112/24.31 Ms Scott reported that following last week's GAC meeting, action was taken to prepare a 2023/24 report which would note exceptions for those Registers not completed.

The Chief Executive said that there has been an improvement in the uptake of mandatory training among new starts, but there needs to be some follow up with existing staff.

112/24.32 *Public Inquiries Programme Board*

Professor Rooney advised that since the last Board meeting, three former Directors of Nursing have provided information to the Muckamore Inquiry. She noted that the questioning from the Inquiry focused on where PHA's role starts and ends with regard to the commissioning process. She said she hoped that the recommendations from the Inquiry will help clarify that. She asked how the new structures in PHA will deal with this. The Chair advised that he has discussed this with the Chief Executive and that in 2025, the Directors will present a report to the Board answering these questions.

116/24 Item 9 – Operational Updates

Chief Executive's and Executive Directors' Report

116/24.1 The Chief Executive advised that he had spent Sunday and Monday in Humberside as part of a delegation looking at their ICS planning and performance arrangements. He said that 20 years after its introduction, it is still working to resolve some areas, but he added that it was interesting to note that there is an unrelenting focus on equity and creating equity in the health system.

116/24.2 Mr Clayton expressed concern at the data around maternal mortality and asked what is being done in Northern Ireland to improve this. The Chief Executive advised that a report on midwifery services, prepared by

Professor Mary Renfrew, is about to be published and that Ms Reid has been part of a group providing advice on how its recommendations will be taken forward.

116/24.3 Mr Clayton asked if there is a terms of reference for the review of PHA's quality assurance processes in relation to cervical screening being undertaken by NHS England and if the Board can see these. Dr McClean replied that a meeting with NHS England took place on Monday and a draft terms of reference are being drafted, and she would be content to share these **(Action 5 – Dr McClean)**. Ms Henderson asked if the review will look at PHA's new model, but Dr McClean advised that the focus will be on the old system. In response to a query from Professor Rooney as whether this review will impact on other quality assurance processes, Dr McClean explained that review is solely looking at cervical screening.

116/24.4 Professor Rooney asked if PHA would get extra resources to carry out work on Traveller health. The Chief Executive said that this has to be explored but he explained that this was identified as an area of co-operation at a meeting with Chief Executives from both sides of the border as this group faces high levels of health inequalities.

116/24.5 Professor Rooney said that if PHA is being asked to undertake the management of vaccination programmes, and there is an element of that around raising awareness, it should have the freedom to undertake a campaign. The Chief Executive explained that there is a blanket ban on TV and radio advertising. Ms Scott advised that there is a targeted approach being undertaken by GPs, but Professor Rooney reiterated that PHA should have the freedom to act.

116/24.6 Mr Clayton welcomed the update on the Pandemic Preparedness Group and said that it would that it would be helpful for the Board to be briefed about it **(Action 6 – Dr McClean)**.

116/24.7 Ms Henderson asked when the Board would receive an update on Protect Life 2 and the Chief Executive said that this will be brought to the next meeting **(Action 7 – Chief Executive)**.

*Finance Report **[PHA/04/08/24]***

116/24.8 Ms Scott reported that PHA is projected to achieve a break-even position at the end of the year. She said that the next few months will be critical as underspends are likely to be identified. The Chair asked if PHA has options in the event of an underspend and Ms Scott replied that a paper on this will be brought to the next AMT meeting.

116/24.9 The Board noted the Finance Report.

117/24 Item 11 – Review of Assurance Framework [PHA/07/10/24]

117/24.1	The Chair noted that the Assurance Framework was approved by the Governance and Audit Committee.
117/24.2	Mr Stewart said that the Committee had raised the concern around joint commissioning which was raised earlier in the meeting. Mr Clayton commented that the Framework needs to be reviewed on a biannual basis.
117/24.3	Members **APPROVED** the Assurance Framework.
118/24	**Item 12 – Mid-Year Assurance Statement [PHA/08/10/24]**
118/24.1	The Chair said that, following the discussion earlier in the meeting, the Mid-Year Assurance Statement will need to be updated. Ms Scott agreed to share the updated version with members **(Action 8 – Ms Scott)**.
118/24.2	Mr Clayton noted that while the section on cervical screening was revised, the section on RQIA reports remains unclear in terms of what it is referring to. Ms Scott noted that this is a mid-year position and it will be updated further for the Annual Report.
118/24.3	Subject to amendments, members **APPROVED** the Mid-Year Assurance Statement
119/24	**Item 13 – Complaints, Compliments and Claims Quarterly Report [PHA/09/10/24]**
119/24.1	Mr Wilson advised that a process has now been put in place to capture compliments in this Report. With regard to complaints, he said that there was nothing significant to report.
119/24.2	Mr Wilson noted that there remains one legal issue, relating to SBNI. The Chair asked how this now sits with the new MOU in place and Ms Scott explained that an MOU is not a legal document so would not impact on any legal process.
119/24.3	Members noted the Complaints, Compliments and Claims Quarterly Report.
120/24	**Item 15 – Policies for Approval** *Data Protection Confidentiality Policy* ***[PHA/10/10/24]*** *Access to Information Policy* ***[PHA/11/10/24]***
120/24.1	Ms Scott advised that these policies have been updated based on best practice.
120/24.2	The Board **APPROVED** the Data Protection Confidentiality Policy and the Access to Information Policy. *Anti-Fraud and Anti-Bribery Policy Statement & Response Plan* ***[PHA/12/10/24]***

120/24.3	Ms Scott advised that this Policy has been amended following an issue that was raised at the Governance and Audit Committee.
120/24.4	The Board **APPROVED** the Anti-Fraud and Anti-Bribery Policy Statement & Response Plan
121/24	**Item 14 – Update on Avian Flu**
121/24.1	Dr McClean advised that there is no new updates in relation to avian flu and work in this area is continuing alongside other pandemic planning work.
122/24	**Item 16 – HSCQI Annual Report 2023-2024 [PHA/13/10/24]**
122/24.1	The Chief Executive advised that this will be last HSCQI Annual Report as the function is due to move over to RQIA on 1 November. He said that he would like to take the opportunity to acknowledge the contribution of HSCQI to the work of PHA under the leadership of Dr Aideen Keaney.
122/24.2	The Board **APPROVED** the HSCQI Annual Report 2023/2024.
123/24	**Item 17 – Chair's Remarks**
123/24.1	The Chair gave an overview of recent meetings he had attended. He said that he had attended the Needle and Syringe Exchange event, and commended the work that PHA is undertaking in this area.
123/24.2	The Chair said that, along with the Chief Executive, he had facilitated a meeting with HSC Trust Chairs to give them an overview of ICS.
123/24.3	The Chair reported that he had attended the NICON dinner, and he gave members an update on the recruitment of new Non-Executive members for the Board.
124/24	**Item 18 – Any Other Business**
124/24.1	There was no other business.
125/24	**Item 19 – Details of Next Meeting**
	Thursday 21 November 2024 at 1.30pm
	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast
	Signed by Chair:
	Date:

Serious Adverse Incident Review -Patient and Client Council Engagement Platform

We were invited by the Patient and Client Council (PCC) to join an engagement platform to provide a lived experience perspective on the Department of Health's SAI Redesign Project. We have been working with the PCC and the Department of Health, providing the Department with feedback on papers they have shared with us to date. We have also had two meetings with Departmental officials leading on the review project.

Based on our collective experience of the current SAI process, and our conversations with the Department we wanted to share with you key reflections that we feel are fundamental to the success of patient safety review processes and important considerations given the critical role and responsibility that Trust Boards play.

We have shared with the Department, and are happy to share with you, a series of personal vignettes, which reflect some of our experiences of the current SAI process and which should illustrate some of its current failings.

Ann Heslip

Charles Little

Fergal Bradley

Fiona Humphries

Maureen O'Reilly

(Engagement Platform Members)

The Fundamentals

The fundamental starting point for any new policy must be the objective of delivering a robust investigation, to a consistent standard, which factually establishes what happened. There can be no genuine learning, meaningful accountability or referral, if the policy, procedure and practices do not robustly and consistently establish what happened in a given safety incident.

Independent investigations and reviews

Based on our lived experiences of the current SAI review process, we consider it of paramount importance that those carrying out Patient Safety Incident investigations and reviews are independent of the Trusts involved. The importance of independent investigations is a long-established principle and practice in other equivalent spheres, and is of principal importance to ensure public trust in the process. Investigations need to be independent, and be seen to be independent, to maintain public trust in the HSC system. Independence also provides assurance to Trust Boards

Participation of those affected

Prior to Harm being Caused:

If anyone raises safety concerns, including risk of harm to a patient or others, prior to harm occurring then an immediate review must be carried out by all those involved. This must include everyone concerned who may be affected or involved whether Health Care Professional or not. For example, patients, family members, PSNI, Social Workers, Carers, Probation Service, and Lay Staff may all legitimately raise concerns. All opinions must be treated equally and if unanimous agreement cannot be reached to the contrary then it must be assumed safety is in jeopardy and a Patient Safety Incident called.

After Harm has been Caused:

It must be clearly understood that **all** those affected have a right to know how and why they or their family member was harmed, whether directly or indirectly by a Patient Safety Incident. It must therefore be clearly understood that a PSI Review is not solely about learning, it is also about providing the truth to all those affected and ensuring that they get all the support they need. Those affected have the right to be involved in deciding whether a PSI Review takes place, the level of independence, and the Terms of Reference, they also have the right to be fully engaged throughout the Review if they so wish, and have the right to comment on the draft Report and have their views either incorporated or recorded in the final Report.

Quality of initial investigations and reviews

Ensuring investigations are carried out independently and to a regionalised standard also requires dedicated resources and trained staff to be allocated to Patient Safety Incident Reviews. This position is supported by the RQIA Review of the systems and processes for learning from Serious Adverse Incidents in Northern Ireland, as amended May 2023[1]. Careful consideration should be given to the dedicated and regionalised resources required to fulfil any new policy and practice introduced for patient safety reviews. The starting point of this approach needs to be a baseline review of existing resources expended on SAIs within each Trust and by the SPPG.

Independent Assurance

Based on our lived experience, and such recent cases as that related to the Southern Trust[2], we have limited confidence in the existing mechanisms designed to provide assurance that SAI reviews are being carried out appropriately and to the appropriate standard. Trusts should not be responsible for providing such assurance. The potential pitfalls of self-assurance, self-assessment and self-declaration are well established, and evidenced by our own lived experiences. Trust Boards should receive assurances that regional patient safety incident review Standards and Principles are being met, through a meaningful evaluation/assurance mechanism, independent of them.

Governance and Accountability

If we are serious about delivering genuine learning and improvements, Trusts should consider it to be in their own interests to have independent investigations/reviews and be the recipients of regional, independent, standardised and transparent assurance reports of patient safety reviews. Such an approach should give Boards confidence that patient safety reviews are being carried out appropriately in their Trust and are capable of providing those affected with a factual understanding of what happened and meaningful implementable learnings for the Trust. Boards should consider what they are and should be accountable for. Boards should be accountable to the Department and the Minister for ensuring staff report and are candid about patient safety incidents and are supported to do so; that staff co-operate fully with any investigation and review and are supported to do so; and for evidencing that the Trust has appropriately considered any patient safety reports and evidenced the implementation of the learnings emanating from independently produced reports, the quality of which has been assured by a third party. In cases of unexpected death, of either a patient or others, where an Inquest may be possible, the Trust Board should have confidence that all reports comply with the evidential requirements of the Coroners Act (Northern Ireland) 1959.

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[1] RQIA Review of the Systems and Processes for Learning from SAIs in NI

[2] https://www.bbc.co.uk/news/articles/c93y0d0wlrdo - Southern Trust: 'We had to fight for answers around dad's death' - BBC News

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Strategic Planning and Performance Group (SPPG) Paper: Serious Adverse Incidents – Regional Position[1]

Table 1 - Number of SAIs reported by year

Organisation	Year SAI Reported to SPPG						Total
	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	
NHSCT	88	86	88	70	87	53	**472**
SHSCT	76	76	95	104	78	50	**479**
BHSCT	118	178	183	180	170	123	**952**
SEHSCT	56	69	90	64	99	66	**444**
WHSCT	85	82	75	67	65	58	**432**
NIAS	36	21	25	39	45	14	**180**
Total for all 6 Trusts	459	512	556	524	544	364	**2959**

Overdue Reports – Current overall position for all HSC Trusts as at 27/10/24

Overdue refers to reports that have not been submitted within the timescales as set out in the extant procedure i.e.

- Level 1 – 8 weeks
- Level 2 – 12 weeks
- Level 3 – timescale will have been agreed by DRO

[1] *Data Source – RL Datix*

Table 2 – Current number of SAI reports overdue by each HSC Trust broken down by year reported to SPPG

Organisation	Year SAI reported to SPPG and remaining overdue								Total Overdue
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	
BHSCT	**4**	**2**	**2**	**12**	**15**	**30**	**82**	**53**	**200**
NHSCT					1	16	56	29	**102**
NIAS							1	5	**6**
SEHSCT					2	3	28	32	**65**
SHSCT						7	27	28	**62**
WHSCT						3	18	28	**49**
Total Overdue for all 6 Trusts	**4**	**2**	**2**	**12**	**18**	**59**	**212**	**175**	**484**

Overdue Reports - Overall position for all HSC Trusts as at 27/10/23

Table 3 – Total number of SAI reports overdue by each HSC Trust broken down by year reported to SPPG

Organisation	Year SAI reported to SPPG remaining overdue							Total
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	
BHSCT	5	5	7	30	48	111	72	**278**
NHSCT					12	43	32	**87**
NIAS						1	8	**9**
SEHSCT					5	24	33	**62**
SHSCT			1		9	36	28	**74**
WHSCT			1	2	6	23	18	**50**
Total Overdue for all 6 Trusts	**5**	**5**	**9**	**32**	**80**	**238**	**191**	**560**

Reshape & Refresh Update November 2024

Programme Implementation Governance Structures - Regular meetings are ongoing in relation to the Implementation Team, Programme Board and Staff side forum to support the Implementation phase of the Programme.

Structures – Tier 3 Management of Change process to support the implementation of the new structure is ongoing. First round of recruitment is complete with update issued to staff. 2 posts have been accepted at this stage and 2 additional posts under offer. Remaining posts have moved into a second round has been released via an internal trawl. This is now at interview stage with anticipated completion by early December.

Functions –

1) **Finance –** Finance function has successfully transferred across into the Agency from SPPG and is now operational.
2) **HSCQI –** The HSCQI function successfully transferred from PHA to RQIA on 1st November. A Programme Oversight Group was established to manage the transfer which included HR, Communication, Governance and Finance work areas. It was agreed that a final Board will formally sign of the transfer and all associated actions in early December.
3) **SBNI -** SBNI / PHA MOU is currently under revision. A recent meeting between DoH, SBNI and PHA was held to further discuss a number of areas. It is anticipated a revised version will be complete within coming weeks.
4) **Connected Health –** Confirmation that this function is within scope for TUPE transfer. Transfer process will commence following agreement on location of transfer in which discussions are ongoing.
5) **R&D –** work is underway to develop a bid to support the development of an R&D office within the Agency. A working group has been established to take forward the business case development and ethics considerations.

Governance –

Corporate Governance: Linking closely with the Planning & performance team within the Agency (who currently oversee implementation of SPTs), a number of planning team workshops were held to discuss the roll out of 'Public Health Planning Teams' and the governance associated with these. This work has linked closely to corporate plan development and will include the development of a health inequalities framework. Plan for the operationalisation of planning teams in Jan / Feb to support priority identification for 25/26 planning year.

Professional Governance: Draft framework under development which will support registrant staff working within the Agency to maintain registration and provide clear accountability in terms of the provision of Professional Public Health Advice and escalation.

Culture – Work continues through Organisational Development and Engagement Forum (ODEF) to oversee areas relating improving staff experience, developing the workforce and culture. This includes:

- Planning staff event 4th December

- Roll out of the People Plan and associated actions
- Identification of culture champions & roll out of workplan including staff recognition & celebration
- Training health & wellbeing champions & establishment of action plans
- Further development of skills development framework including work related to 'public health' profile.

Data, Digital & Intelligence – Director job description has been finalised. Plan for submission to DoH for job evaluation within the coming weeks and move to recruitment as soon as possible.

Communication – A number of activities are ongoing which support communication particularly during the Implementation phase of the Programme. These include:

- First Tues sessions ongoing, with attendance figures encouraging. Feedback indicates it is a useful, informative session for staff.
- Weekly staff news continues which consolidates all information and shares updates of key activities of reshape & refresh amongst other PHA news.
- Drop in sessions held each location during October – F.A.Q will be updated in relation to queries received.
- Quarterly Chief Executive site visits planned for November.
- Mural has been updated with Tier 3 JD information etc and staff are encouraged to engage with this.

HSC Public Health Agency

item 9

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	21 November 2024
Title of paper	Draft PHA Corporate Plan 2025/30
Reference	PHA/01/11/24
Prepared by	Julie Mawhinney
Lead Director	Leah Scott

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

1 Purpose

The purpose of this paper is for the PHA Board to approve the draft PHA Corporate Plan 2025/30 prior to it going out for public consultation.

2 Key Issues

This document presents the first draft of the PHA Corporate Plan 2025-2030, outlining strategic priorities and key outcomes for the period 2025-2030. This Plan sets out the strategic direction for the PHA for the next five years, taking account of engagement and discussion with a range of stakeholders, Department of Health (DoH) priorities, and the Draft Programme for Government Framework.

In developing this Corporate Plan, time has been taken to review previous Corporate Strategies, considering progress to date as well as continuing challenges. A programme of engagement with external stakeholders, DoH sponsor branch, and PHA staff and PHA board members has also taken place. The information gathered through each part of the engagement process is reflected throughout this plan.

3 Next Steps

Subject to Board approval, it is hoped to release the draft Plan for public consultation for 12 weeks via Citizen Space at the end of November / early December. Consultation will include sending a questionnaire to stakeholders as well as making use of the PHA corporate website and social media channels. Staff will be asked to feedback their views

and share the consultation with stakeholders through existing networks and partnerships. Work is underway with the CP Project Team to facilitate further ‘in person’ engagement with service users and stakeholders as part of this consultation process. The draft plan will be amended to take account of responses and presented to the PHA board for final approval and submission to the DoH in March 2025 with the aim to publish.

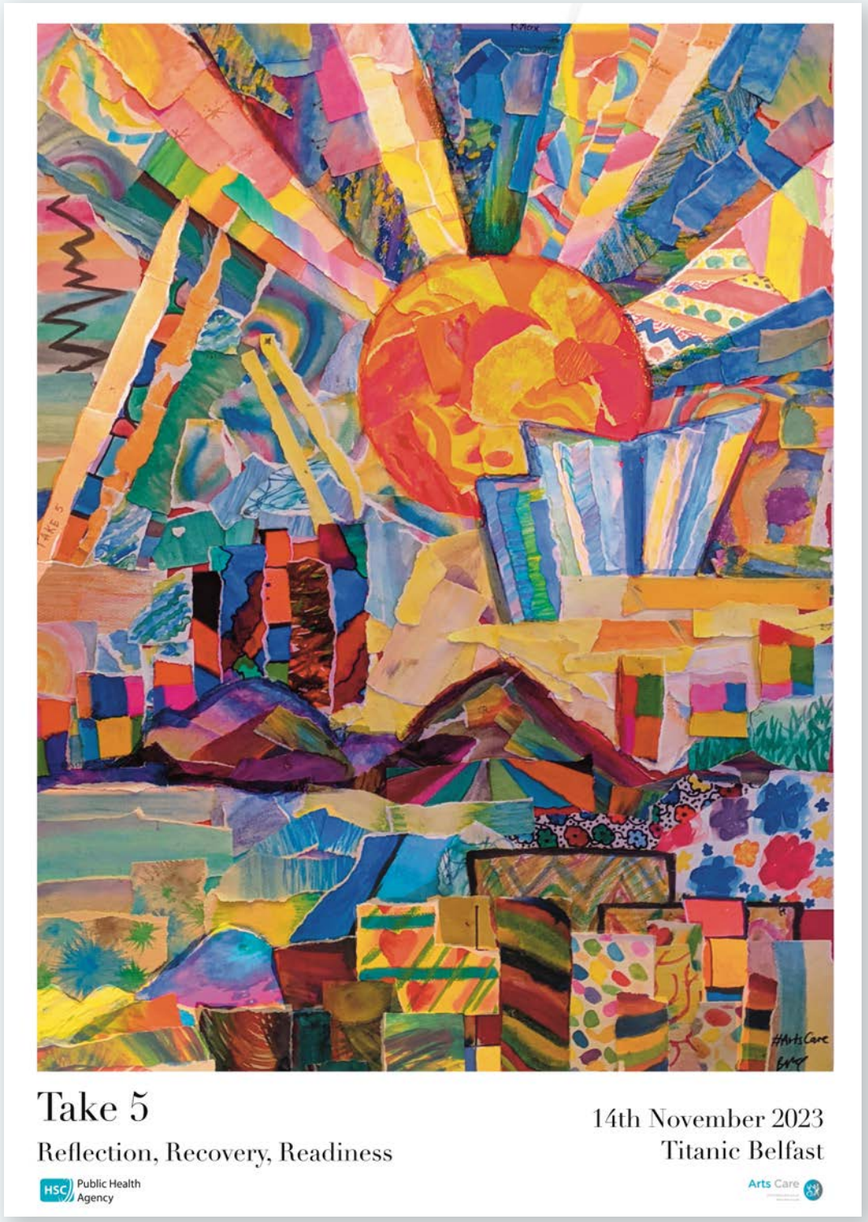
Public Health Agency

Corporate Plan 2025–2030

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

HSC Public Health Agency

Contents



Collage of artwork from PHA all staff event 2023.

Foreword

Foreword

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

This plan is being developed during a period of reform both for our organisation and for Health and Social Care (HSC) and in a time of significant financial constraint. However, we have embraced the opportunity provided by this time of change and constraint to set out our vision and ambitions for health and wellbeing in Northern Ireland and reiterate our call for a continued focus on improving health and reducing health inequalities across HSC and wider society.

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

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

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

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

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

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

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

Aidan Dawson
Chief Executive

Colin Coffey
Chair

Purpose, vision and values

Purpose:

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

Vision:

A healthier Northern Ireland.

Values:

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

Our context and the health profile of Northern Ireland

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

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

Determinants of health

Health is determined by many factors, social, political, environment, economic ~~and changes~~ in these can have significant impacts on the health and wellbeing of the population and in recent years, society has experienced many significant events of this nature: the COVID-19 pandemic, cost of living crisis, climate change, the outworking of EU exit and other political change.[5] The pandemic also highlighted both the stubborn and systemic inequalities in health that Northern Ireland continues to experience. Health inequalities remain and continue to divide our society. While this situation is not unique to Northern Ireland, it remains a major issue with significant differences in health outcomes between the most and least disadvantaged.

A time of change

The challenges facing our health and social care system, and indeed health systems worldwide, are also well documented, and Northern Ireland's health and social care system remains under immense and growing pressure.[11] Further change is also underway both in the development and implementation of the Integrated Care System for Northern Ireland (ICSNI). The current economic climate and constrained financial environment for HSC continues to impact on population health and requires creative, innovative and collaborative ways of working, and make best use of available resources to deliver better health outcomes and help people to stay well.

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

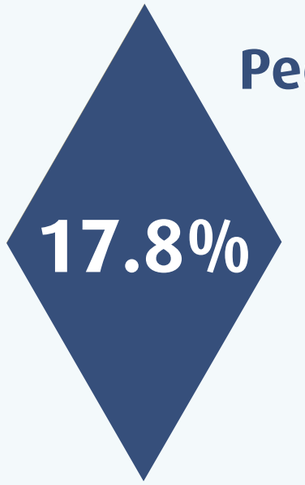
Regional strategic frameworks

These key foundations for our work are reflected across the draft Programme for Government Framework 2024-2027 and the wide range of departmental policies and strategies that influence and determine the work of PHA, including Making Life Better public health framework, and Health and Wellbeing 2026: Delivering Together.[10-12] The PHA also has lead responsibility for implementing a number of strategies across key areas of work, including maternity and early years; mental health, emotional wellbeing and suicide prevention, obesity, tobacco use; alcohol and drugs; and long-term conditions, including cancer.[13-19]

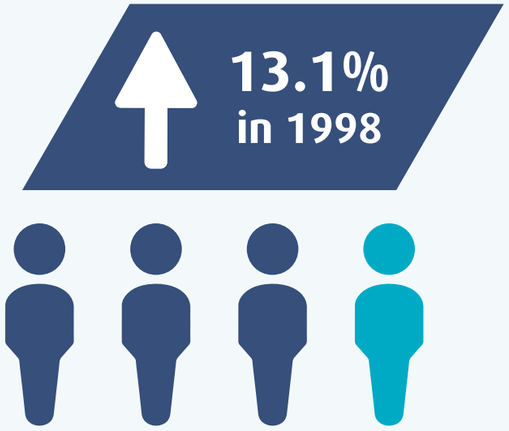
There are many DoH and indeed other departmental strategies and policies that are relevant to the setting of priorities for the PHA. The outcomes and priorities for the PHA for the next five years reflect and align with these key strategic documents, and our contribution to progressing this agenda and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

Population of Northern Ireland

1.9m

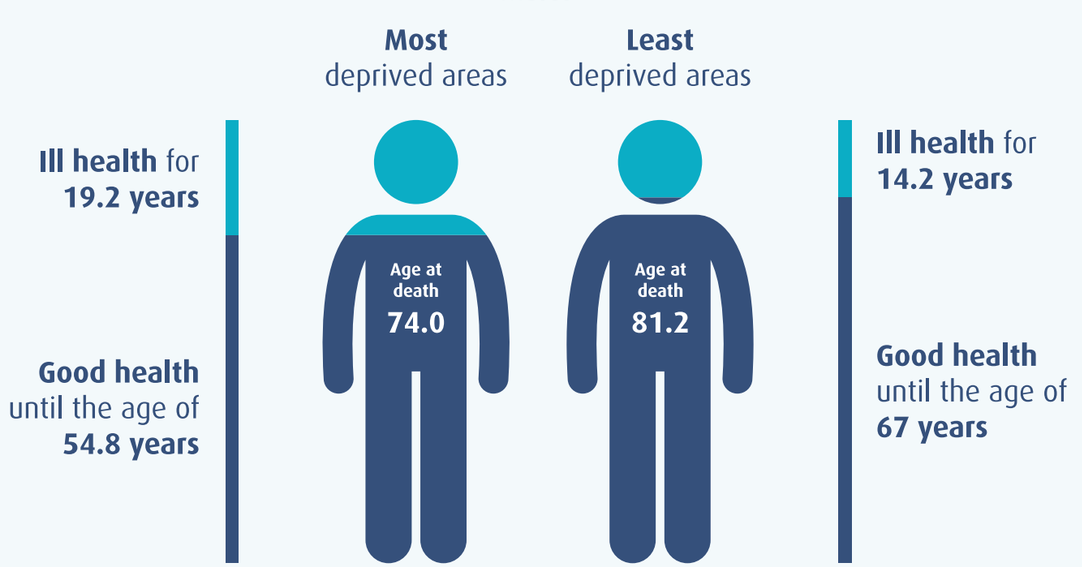


People aged 65+

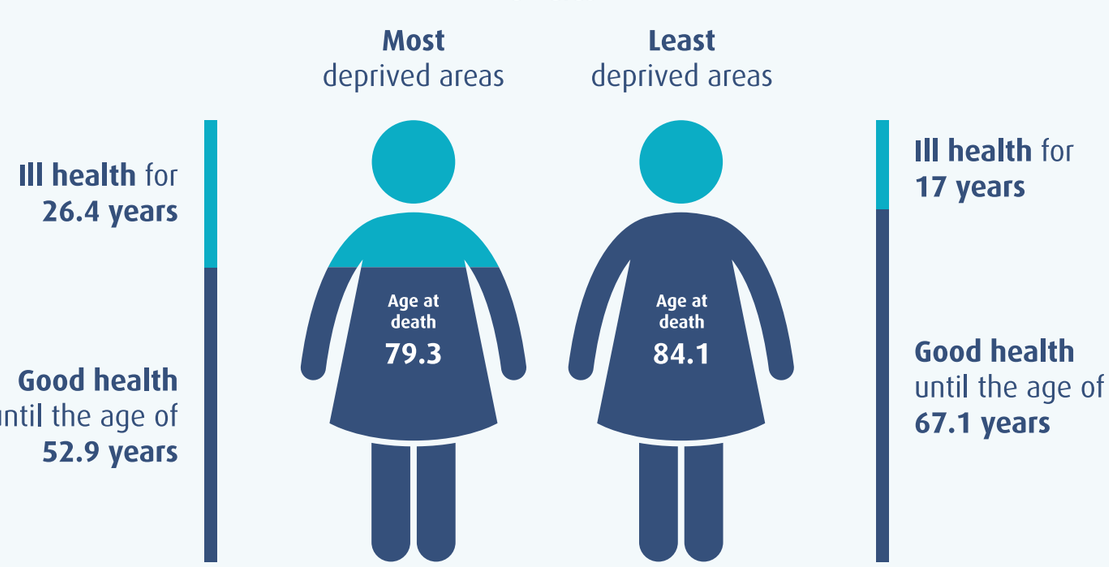


Life expectancy and Healthy life expectancy

Males



Females



Adults who
smoke

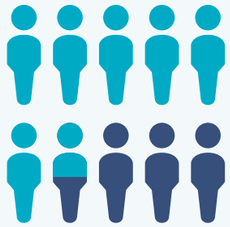
14%

MMR
uptake at
5 years old

85.4%

Adults living
with overweight
or obesity

65%



179

alcohol
related deaths

Babies
breastfed
(at discharge)

51%

1 in 5
people may have a
mental health difficulty

179 preventable deaths

per 100,000
of the population

1 in 5

P1 children living with
overweight or obesity

203

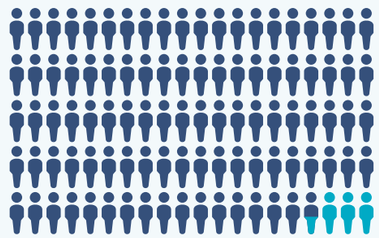
Deaths

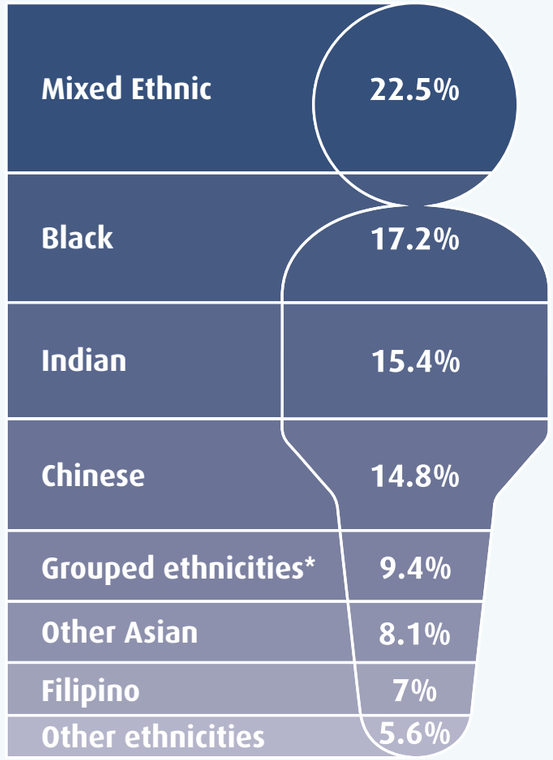
by suicide

96.6%
White

3.4%
Ethnic minority

Northern Ireland population





*Includes Irish Traveller, Arab, Pakistani and Roma

65,600

Ethnic minority
population

What is public health?

What is public health?

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

There are three key domains of public health practice:[1]

1. Health protection

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

2. Health improvement

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

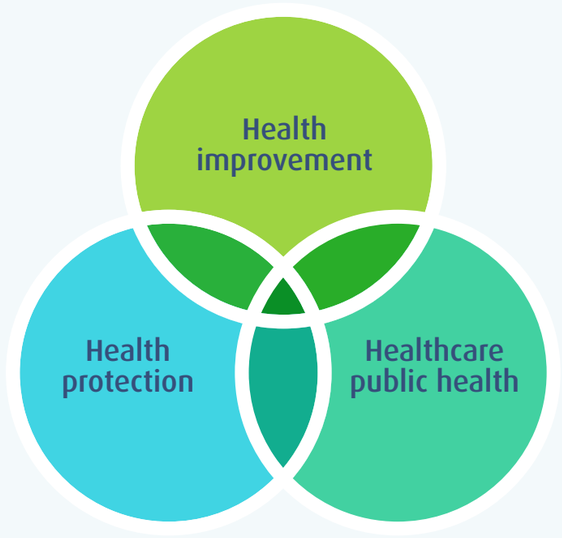
3. Healthcare public health

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

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

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

Three key domains of public health practice



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

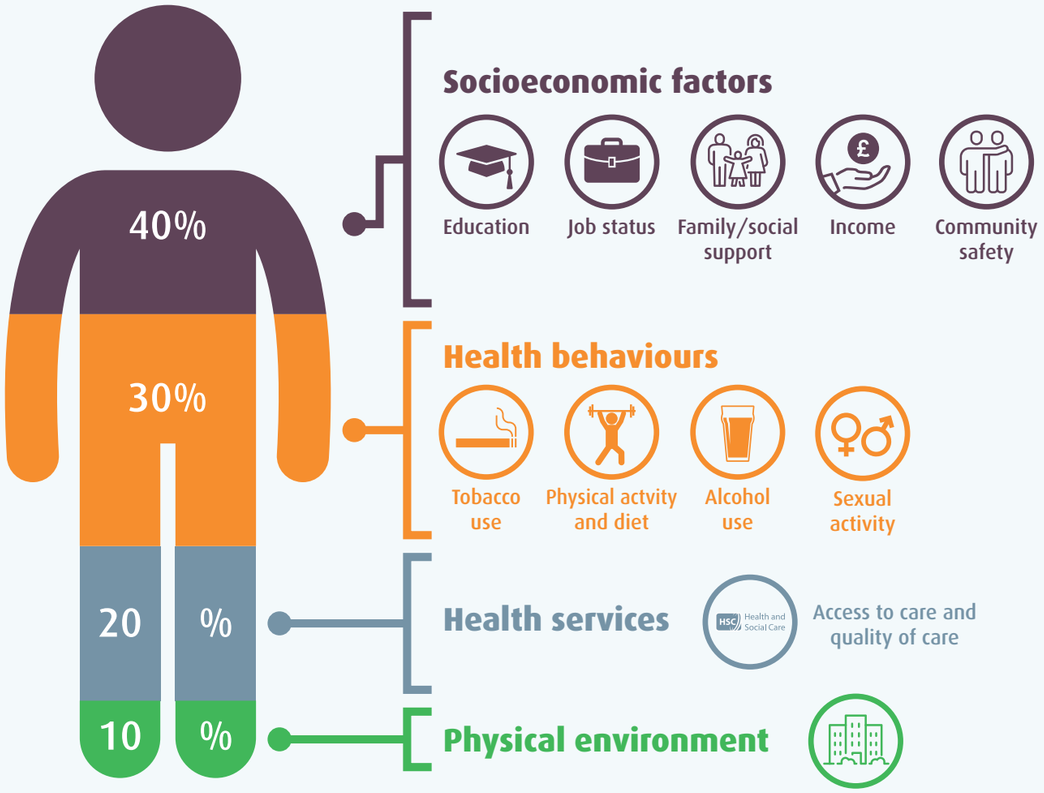
> *"Public health is the science and art of preventing disease, prolonging life and promoting health and wellbeing, through the organised efforts of society.[2]"*

What factors impact on our health and wellbeing?

Many factors, known as the 'wider determinants of health' affect our health and wellbeing. These include social, economic and environmental conditions such as income, education, access to green space, healthy food, work and living conditions.[3] It is widely recognised that, taken together, these factors are the principal drivers of how healthy people are.[4]

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

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



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

What are health inequalities?

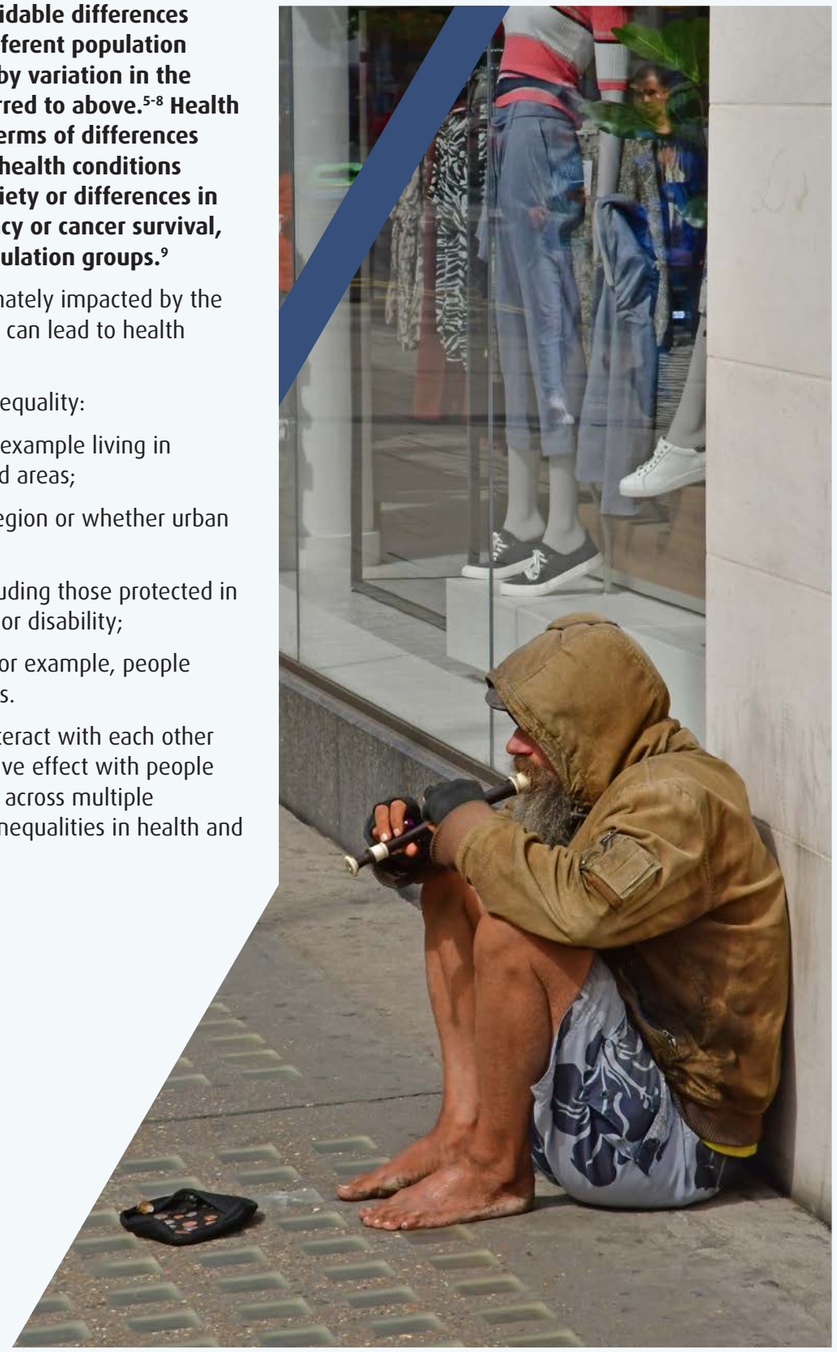
Health inequalities are "avoidable differences in health status between different population groups" and are influenced by variation in the determinants of health referred to above.[5-8] Health inequalities are evident in terms of differences in the prevalence of certain health conditions among certain groups in society or differences in outcomes (like life expectancy or cancer survival, for example) for certain population groups.[9]

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

Factors impacting on health inequality:

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

The determinants of health interact with each other and can often have a cumulative effect with people often experiencing challenges across multiple determinants contributing to inequalities in health and health outcomes.[9]



Our focus

Our focus

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

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

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

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

Ageing well
Supporting people to age healthily throughout their lives

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

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

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

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

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

We commit to reviewing this plan in line with any future programme for government framework and departmental strategies to be developed during the period of this plan.

Protecting health

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

Our ambition

That our population is protected from threats to health arising from infectious diseases and environmental hazards and that we reduce death and ill health through effective screening.

Protecting our population's health is one of our core functions. We do this through surveillance, identification and timely response to threats to public health; providing advice and support; monitoring of threats to health; and education, training and research. This includes the prevention of infectious diseases through vaccination and early detection of disease through population screening programmes. Our focus is also on preparing and planning for potential future pandemics and other potential threats to the population's health and wellbeing.

We will work effectively across the organisation to ensure a robust coordination of the overall public health response. We will ensure that we learn from and implement recommendations from inquiries and incidents.

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

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

Priorities 2025-2030

- develop emergency response plans to support readiness to respond to incidents that may have an impact on public health for Northern Ireland;
- work collaboratively to minimise the impact of infectious disease, with a focus on antimicrobial resistance and our elimination targets for blood-borne viruses;
- deliver a high-quality and responsive health protection surveillance and epidemiology programme;
- strengthen the multidisciplinary coordinated approach to infection prevention and control across the wider HSC system though the established infection, prevention and control forums;
- ensure the delivery of high-quality screening programmes;
- lead the development and commissioning of vaccine programmes to ensure they are accessible to all, addressing the associated barriers and inequalities and ensure there is a key focus on seldom heard groups;
- scope existing evidence for public health approaches to protect people and communities from the public health impacts from the environment including climate change, and develop a PHA climate action plan;
- build public confidence and trust in public health advice, information and messaging through improving health literacy via education and engagement with the public.

Indicators

We will measure success through the following:

- surveillance data
- notifications of infectious disease
- duty room activity
- screening uptake
- vaccine uptake.

Starting well

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

Our ambition

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

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

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

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

Adverse childhood experiences can have long-term impacts on health and wellbeing. We must embed a trauma-informed approach and work with partners to prevent these from happening.

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

Priorities 2025-2030

- support families to take care of their physical and mental health, with a particular focus on the first 1,000 days;
- reduce the impact of social complexity in pregnancy;
- promote the health benefits of breastfeeding and encourage support for breastfeeding mothers;
- protect the health of children and young people through antenatal and newborn screening programmes and childhood vaccination programmes;
- deliver universal and targeted support programmes, including Healthy Child Healthy Family, Family Nurse Partnership, and Northern Ireland New Entrants service (NINES);
- work together to reduce child deaths through improved use and application of data and evidence;
- support children and young people with special education needs, their families and carers in addressing the unique health challenges and disparities they face, by enhancing access to services, resources and support systems that contribute to their physical, mental, and social wellbeing;
- support adolescents to establish patterns of behaviour that can protect their mental and physical health;
- work with others to promote the safeguarding and protection of children and young people.

Indicators

We will measure success through the following:

- screening and vaccination in pregnancy uptake
- percentage of babies born at low birth weight
- avoidable child death rates
- percentage of mothers breastfeeding on discharge
- developmental progress in pre-school
- childhood vaccination uptake
- developmental progress at pre-school
- number of children starting school at a healthy weight
- alcohol use in children and young people
- incidence of hospital attendance with self-harm/ deaths by suicide among children and young people.

Living well

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

Our ambition

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

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

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

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

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

As well as equipping people to live longer, healthier lives, we must also help protect them from becoming ill or needing health interventions. This includes access to adult immunisation programmes, screening and detection programmes and tackling issues that lead to poor health. Promoting healthy choices and healthier environments and communities, including within workplaces, will also be a key focus.

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

Priorities 2025-2030

- create the conditions for people to adopt healthier behaviours and reduce the risks to health caused by low physical activity, smoking and vaping, poor diet and sexual behaviours
- support those living with long-term conditions to live well with disease
- deliver high-quality programmes and initiatives, including prevention and early intervention approaches, to protect and improve mental health and emotional and social wellbeing
- continue to work in partnership across government and with communities, services, and families across society to reduce suicides and the incidence of self-harm
- reduce harm caused by substance use by improving access to high-quality prevention and early intervention, harm reduction, treatment and recovery services to ensure clients can access the right service at the right time delivered in the right place to best meet their needs
- support prevention and early detection of illness through vaccination and screening programmes
- provide targeted information and support to help everyone, including those who experience multiple barriers to health, to adopt healthy behaviours, avail of preventative services and access high-quality care.

Indicators

We will measure success through the following:

- percentage of people with a high GHQ-12 score, indicating a mental health problem
- tobacco use, including smoking and vaping prevalence
- suicide rates
- obesity and physical activity measures
- alcohol and substance use
- screening and vaccination uptake rates
- percentage self-reporting a physical or mental health condition or illness expected to last 12 months or more
- percentage of those living with long-term conditions reporting a reduced ability to carry out daily activities.

Ageing well

Supporting people to age healthily throughout their lives

Our ambition

That older people live healthier, independent lives.

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

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

There are many factors that impact our health and wellbeing throughout our lives and this is no different as we age. These include the environment we live in, access to health services and the impact on our health and wellbeing of poor diet, smoking, drug and alcohol misuse, low levels of physical activity and food, fuel and financial poverty.

As our older population continues to grow, we want to support and promote healthy, positive ageing both for individuals and as a society. We must enable people to live longer, healthier more fulfilling lives but also create supportive environments and communities that not only enable healthy behaviours but also support, value, respect and protect our older population.

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

We must take a lifelong approach to positive health and active ageing and work to reduce the impact of health inequalities through education and support to create conditions for people to improve their health.

Priorities 2025-2030

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

Indicators

We will measure success through the following:

- percentage of people aged 65 with a high GHQ-12 score, indicating a mental health problem
- percentage of people who report feeling lonely ‘often/always’ or ‘some of the time’
- adults aged 65+ stating health is good or very good
- obesity and physical activity measures
- falls and frailty measures
- screening and vaccination uptake.

Our organisation

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

Our organisation

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

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

As part of the health and social care family, we work closely with the Strategic Planning and Performance Group (SPPG) of the Department of Health (DoH), local Health Trusts (HSC Trusts), the Business Services Organisation (BSO) and the Patient Client Council (PCC).

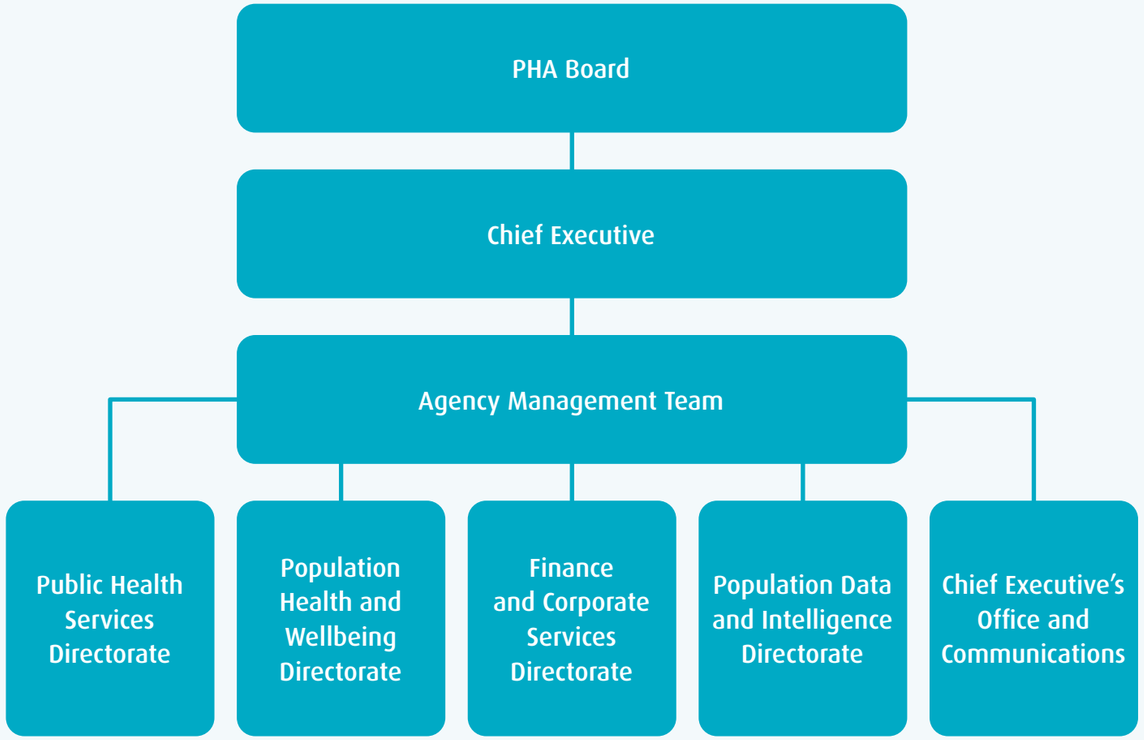
Central to our main responsibilities is working in close partnership with individuals, groups and organisations from all sectors – community, voluntary and statutory.

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

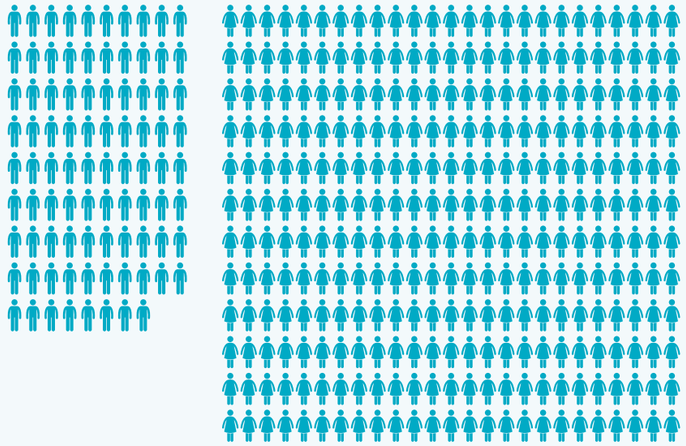
As part of this programme, our organisational structure has changed and is outlined below.

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

PHA organisation chart



Staff at 31 March 2024



Budget

Revenue resource budget in 2023/24

£139.4m

Our ambition

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

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

In fulfilling this ambition, we are committed to:

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

People

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

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

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

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

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

Priorities 2025-2030

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

Partnership

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

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

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

Priorities 2025-2030

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

Process

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

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

Priorities 2025-2030

- establish and embed robust financial governance in line with new financial management arrangements as part of the ongoing transformative restructure;
- review, refresh and embed key corporate and information governance policies and procedures, ensuring that staff across the PHA understand their responsibilities and implement these ensuring good governance in how we do our business;
- develop the planning and procurement arrangements in the PHA, ensuring the necessary skills, expertise and capacity to work alongside programme leads and together progress the PHA planning and procurement plans, to meet the health and wellbeing needs of the population ensuring best use of public monies;
- continue to implement the multidisciplinary public health planning structure.

Digital

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

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

Priorities 2025-2030

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

Research and evidence

The availability, analysis and interpretation of good data and evidence is essential for effective planning and delivery of services. As an organisation, we wish to bring together evidence and learning from both national and international sources and continually seek to develop and improve our data sources and analytic capability. We have a wealth of experience and knowledge in health intelligence, data management and surveillance, and it is essential that we invest in and further develop this over the coming years to both inform PHA policy and actions and crucially to use this to inform the policy, actions and plans of our partners, to improve the health and wellbeing of the population.

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

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

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

Priorities 2025-2030

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

Summary table

Summary table

Summary of PHA priorities and indicators for each strategic theme

Protecting health

Priorities	Indicators
• develop emergency response plans to support readiness to respond to incidents that may have an impact on public health for Northern Ireland; • work collaboratively to minimise the impact of infectious disease, with a focus on antimicrobial resistance and our elimination targets for blood-borne viruses; • deliver a high-quality and responsive health protection surveillance and epidemiology programme; • strengthen the multidisciplinary coordinated approach to infection prevention and control across the wider HSC system though the established infection, prevention and control forums; • ensure the delivery of high-quality screening programmes; • lead the development and commissioning of vaccine programmes to ensure they are accessible to all, addressing the associated barriers and inequalities and ensure there is a key focus on seldom heard groups; • scope existing evidence for public health approaches to protect people and communities from the public health impacts from the environment, including climate change, and develop a PHA climate action plan; • build public confidence and trust in public health advice, information and messaging through improving health literacy via education and engagement with the public.	• surveillance data • notifications of disease • duty room activity • screening uptake • vaccine uptake

Starting well

Priorities	Indicators
• support families to take care of their physical and mental health, with a particular focus on the first 1,000 days; • reduce the impact of social complexity in pregnancy; • promote the health benefits of breastfeeding and encourage support for breastfeeding mothers; • protect the health of children and young people through antenatal and newborn screening programmes and childhood vaccination programmes; • deliver universal and targeted support programmes, including Healthy Child Healthy Family, Family Nurse Partnership, and Northern Ireland New Entrants service (NINES); • work together to reduce child deaths through improved use and application of data and evidence; • support children and young people with special education needs, their families and carers in addressing the unique health challenges and disparities they face, by enhancing access to services, resources and support systems that contribute to their physical, mental, and social wellbeing; • support adolescents to establish patterns of behaviour that can protect their mental and physical health; • work with others to promote the safeguarding and protection of children and young people.	• screening and vaccination in pregnancy uptake • percentage of babies born at low birth weight • avoidable child death rates • percentage of mothers breastfeeding on discharge • number of children starting school at a healthy weight • developmental progress at preschool • alcohol use in children and young people • incidence of hospital attendance with self-harm/deaths by suicide among children and young people

Living well

Priorities	Indicators
• create the conditions for people to adopt healthier behaviours and reduce the risks to health caused by low physical activity, smoking and vaping, poor diet and sexual behaviours • support those living with long-term conditions to live well with disease • deliver high-quality programmes and initiatives, including prevention and early intervention approaches, to protect and improve mental health and emotional and social wellbeing • continue to work in partnership across government and with communities, services, and families across society to reduce suicides and the incidence of self-harm • reduce harm caused by substance use by improving access to high-quality prevention and early intervention, harm reduction, treatment and recovery services to ensure clients can access the right service at the right time delivered in the right place to best meet their needs • support prevention and early detection of illness through vaccination and screening programmes • provide targeted information and support to help everyone, including those who experience multiple barriers to health, to adopt healthy behaviours, avail of preventative services and access high-quality care.	• percentage of people with a high GHQ-12 score, indicating a mental health problem • tobacco use, including smoking and vaping prevalence • suicide rates • obesity and physical activity measures • alcohol and substance use • screening and vaccination uptake rates • percentage of people with a high GHQ-12 score indicating a mental health problem • number of people reporting a physical or mental health condition expected to last 12 months or more • percentage of those living with a long-term condition reducing their ability to carry out daily activities

Ageing well

Priorities	Indicators
• implement the World Health Organization (WHO) Age-friendly movement across Northern Ireland • reduce and prevent falls and home accidents, including the development and implementation of a regional model for safer mobility • reduce the impact of frailty by raising awareness and increase early detection • support prevention and early detection of illness through vaccination and screening programmes for older adults • increase levels of physical activity and promote opportunities to stay active • work with key partners to identify and reduce levels of loneliness and social isolation and to improve mental health and emotional wellbeing • champion the voice of older people and the issues that impact on their health and wellbeing • lead and implement initiatives to ensure people who live with long-term conditions and those who live in care homes have good health and wellbeing and improved quality of life • work with partners to support individuals and families at their end of their life through advance care planning • build and develop a strong research and evidence base to support ageing well programmes in Northern Ireland.	• percentage of people aged 65+ with a high GHQ-12 score, indicating a mental health problem • percentage of people who report feeling lonely ‘often/always’ or ‘some of the time’. • adults 65+yrs stating health is good or very good • obesity and physical activity measures • falls and frailty measures • screening and vaccination uptake

Glossary of useful terms

Glossary of useful terms

Term	Definition
Age-friendly	An WHO initiative to create liveable communities that are inviting and accessible for people of all ages – especially older adults.
Area Integrated Partnership Board (AIPB)	A local planning body with the overarching aim of improving health and social care outcomes and reducing health inequalities for its local population.
Collaboration	The action of working with someone to produce something.
Coronavirus disease/ COVID-19	An infectious disease caused by the SARS-CoV-2 virus.
Delivering Together 2026	Approach launched by the then Minister of Health, Michelle O'Neill, on 25 October 2016 and driven by the Northern Ireland Executive's draft Programme for Government, setting out an ambition to support people to lead long, healthy and active lives.
Department of Health (DoH)	A devolved government department in the Northern Ireland Executive.
Diabetic retinopathy	TBA
EDI	Equality, diversity and inclusion.
GHQ-12	General Health Questionnaire (Goldberg & Williams, 1988) consisting of 12 items, each one assessing the severity of a mental problem.
Health and wellbeing	The combination of factors contributing to a person's physical, mental, emotional and social health.
Health inequalities	Unfair and avoidable differences in health across the population and between different groups within society.
Health intervention	A treatment, procedure or other action taken to prevent or treat disease, or improve health in other ways.
Health literacy	The ability to access, understand, appraise and use information and services in ways that promote and maintain good health and wellbeing.
Healthy life expectancy	The average number of years of full health that a newborn could expect to live.
Health and Social Care (HSC)	Publicly funded healthcare system in Northern Ireland. Although created separately to the National Health Service, it is nonetheless considered a part of the overall national health service in the United Kingdom.

Term	Definition
Integrated Care System Northern Ireland (ICS NI)	The new (2024) commissioning framework for Northern Ireland. It is a single planning system that will help us to improve the health and wellbeing of our population.
Life course approach	An inclusive approach that considers people's health needs and opportunities across all age groups.
Live Better initiative	A series of planned initiatives set out by the Health Minister in October 2024 to help tackle health inequalities in Northern Ireland and bring targeted health support to communities that need it most.
Making Life Better, the NI Public Health Framework	A strategic framework for public health designed to provide direction for policies and actions to improve the health and wellbeing of people in Northern Ireland and to reduce health inequalities.
MMR Vaccine	Vaccine against measles, mumps and rubella.
Mortality	In medicine, a term also used for death rate, or the number of deaths in a certain group of people in a certain period of time.
Personal and Public Involvement (PPI)	Active and meaningful involvement of service users, carers, their advocates and the public in the planning, commissioning, delivery and evaluation of Health and Social Care (HSC) services, in ways that are relevant to them.
Programme for Government (PfG)	The Draft Programme for Government 2024-2027 Our Plan: Doing What Matters Most outlines the Executive's priorities for making a real difference to the lives of people here.
Public Health	The science and art of preventing disease, prolonging life and promoting health through the organised efforts of society.
Public Health Agency (PHA)	Established in April 2009 as part of the reforms to Health and Social Care (HSC) in Northern Ireland, responsible for providing health protection and health and social wellbeing improvement to every member of every community in Northern Ireland.
Smoking cessation	The process of discontinuing tobacco smoking.
SPPG	Strategic Planning and Performance Group.
Whole system approach	A strategic integrated approach to planning and delivering services.
World Health Organization	(WHO) The World Health Organization sets standards for disease control, healthcare and medicines; conducts education and research programs; and publishes scientific papers and reports.

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HSC Public Health Agency

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www.publichealth.hscni.net

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Equality and Human Rights Screening Template

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

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

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

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

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

For advice & support on screening contact:

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

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SCREENING TEMPLATE

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

(1) INFORMATION ABOUT THE POLICY OR DECISION

1.1 Title of policy or decision

Public Health Agency (PHA) Corporate Plan 2025-2030

1.2 Description of policy or decision

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

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

This Plan is being developed during a period of reform both for our organisation and for Health and Social Care (HSC) and in a time of significant financial constraint. However, we have embraced the opportunity provided by this time of change and constraint to set out our vision and ambitions for health and wellbeing in Northern Ireland and reiterate our call for a continued focus on improving health and reducing health inequalities across HSC and wider society.

The plan is focussed around our strategic outcomes:

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

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

The Corporate Plan also incorporates how PHA will work going forward as an organisation working closely with the Strategic Planning and Performance Group (SPPG) of the Department of Health (DoH), local Health Trusts (HSC Trusts), the Business Services Organisation (BSO) and the Patient Client Council (PCC), considering best practice to ensure we work effectively whilst being committed to people, partnerships, processes, digital capacity and be research and evidence driven.

1.3 Main stakeholders affected (internal and external)

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

Internal: Public Health Agency staff

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

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

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

1. Fair Society, Healthy Lives the Marmot Review, 2010. Available via www.parliament.uk
2. Health Equity in England: The Marmot Review 10 Years On, 2020. Marmot M, Allen J, Boyce T, Goldblatt P, Morrison J. [Internet]. Available via The Institute of Health Equity
3. PHA Corporate Plan 2017-2021. Available via PHA website.
4. Compassionate Leadership Available via The Kings Fund.
5. Guidance on quality and safety – National Institute for Clinical Excellence
6. Francis Report
7. Guidance relating to governance, finance etc – Belfast: DoH
8. Policy guidance in relation to health improvement, health protection, service development, screening, quality & safety – Belfast: DoH
9. PHA Board meetings
10. Community Planning - led by each local Council
11. Systems, Not Structures: changing health and social care (Bengoa Report). Expert Panel Report, 2016. Belfast: DoH
12. Health and Wellbeing 2026: Delivering Together. Belfast: DoH, 2016

13. Making Life Better: a whole system strategic framework for public health 2013– 2023. Belfast: Department of Health Social Services and Public Safety (DHSSPS), Jun 2014
14. Doing What Matters Most Draft Programme for Government (PfG) Framework 2024–27. Belfast: NIE, 2024
15. Integrated Care System for Northern Ireland Framework (ICSNI), May 2024. Belfast: DoH
16. Mental Health Strategy 2021-2031. Belfast: DoH, 2021
17. Mental Health Strategy – Early Intervention and Prevention Action Plan 2022-2025. Belfast: DoH, 2022
18. Live Better Initiatives. Belfast: DoH, 2024
19. Equality and Disability Action Plans 2023-2028. PHA, 2023
20. Protect Life 2 Strategy for Preventing Suicide and Self Harm, 2019. Belfast: DoH
21. Functions and standards of a Public Health System [Internet] 2020. Faculty of Public Health
22. Creating Healthy Places: Perspectives from NHS England's Healthy New Towns Programme [Internet]. The King's Fund
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26. Breastfeeding - A Great Start: A Strategy for Northern Ireland 2013-2023 [Internet], 2013. DHSSPS
27. A Fitter Future for All 2 [Internet], 2019. DHSSPS
28. Ten-Year Tobacco Control Strategy for Northern Ireland [Internet], 2012. DHSSPS
29. Preventing Harm, Empowering Recovery A Strategic Framework to Tackle the Harm from Substance Use (2021-31) 2 Substance Use Strategy 2021-31 [Internet], 2021. DoH
30. A Cancer Strategy for Northern Ireland (2022-2032) [internet], 2022. DoH

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

2.1 Data gathering

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

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

Further engagement will take place throughout the consultation period Involved stakeholders, views of colleagues, service users, staff side or other stakeholders.

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2.2 Quantitative Data

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

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

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	may not have felt it was safe to do so. Of the 262,000 people (0.5%) who answered "No", indicating that their gender identity was different from their sex registered at birth: • 118,000 (0.24%) answered "No" but did not provide any further information • 48,000 (0.10%) identified as a trans man • 48,000 (0.10%) identified as a trans woman • 30,000 (0.06%) identified as non-binary • 18,000 (0.04%) wrote in a different gender identity Data from other sources indicate that the Census figures may understate the size of the trans and gender diverse population. The Gender Identity Research and Education Society (GIRES) estimate the number of gender nonconforming employees and service users, based on the information that GIRES assembled for the Home Office (2011) and subsequently updated (2014): • gender variant to some degree 1% • have sought some medical care 0.025% • having already undergone transition 0.015%. The numbers who have sought treatment seems likely to continue growing at 20% per annum or even faster. Few younger people present for treatment despite the fact that most gender variant adults report experiencing the condition from a very early age. Yet, presentation for treatment among young people is growing even more rapidly (50% p.a.). Organisations should assume that there may be nearly equal numbers of people transitioning from male to female (trans women) and from female to male (trans men). Applying GIRES figures to NI population (using NISRA mid-year population estimates for June 2018) N=1,881,600: • 18,816 people who do not identify with gender assigned to them at birth • 470 likely to have sought medical care • 282 likely to have undergone transition. A 30-Country Ipsos Global Advisor Survey reflects 3.1% of people saying they were trans, non-binary, gender queer or gender fluid, Agender or another gender that was not male or female.
Age	Census 2021 Population Statistics reflect there are 365,200 children in Northern Ireland aged 0 to 14, a 10,500 increase compared from the 354,700 children in 2011. In contrast the number of persons aged

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	65 and over has increased from 263,700 in 2011 to 326,500 in 2021. The ageing of the population can also be seen in the median age of the population (the age at which half the population are above or below), which over the last decade has increased by two years from 37 in 2011 to 39 in 2021. Children (defined as those aged 0 to 14) make up 19.2% of the Northern Ireland population. This percentage varies across Local Government Districts and is highest in Mid Ulster where the proportion is 21.7%, and lowest in Ards and North Down where the proportion is 17.0% Older People People over 60 make up 19% of the population, according to Census 2021. This represents a near 25% increase from 2011 and demonstrates the scale of population change due to ageing. People aged 65 and over account for 326,500 people or 17.2% of the Northern Ireland population. (Census 2021) The number of people aged 85 and over in Northern Ireland was estimated to be 39,500 in mid-2020, an increase of 700 people (1.9 per cent) since mid-2019. Over the decade, the population aged 85 and over grew by 8,700 people (28.1 per cent) (Census Bulletin 2021) By mid-2027, the number of people aged 65 and over is projected to overtake the number of children. By mid-2045, almost 1 in 4 people in Northern Ireland are projected to be aged 65 and over (NISRA Bulletin 2020) NI Age Profile Band /Population/ Percentage 0-14 365,200 19.2% 15-64 1,211,500 63.7% 15-39 594,400 31.2% 40-64 617,100 32.4% 65+ 326,500 17.2% 65-84 287,100 15.1% 85+ 39,400 2.1% (Census 2021)

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<table>
<tr><td></td><td>PHA Workforce (as of Sept 2024)

<table><tr><th>Age Group</th><th>%</th></tr><tr><td>16-24</td><td>6.21%</td></tr><tr><td>25-29</td><td>7.52%</td></tr><tr><td>30-34</td><td>5.51%</td></tr><tr><td>35-39</td><td>9.12%</td></tr><tr><td>40-44</td><td>8.52%</td></tr><tr><td>45-49</td><td>10.32%</td></tr><tr><td>50-54</td><td>12.83%</td></tr><tr><td>55-59</td><td>14.73%</td></tr><tr><td>60-64</td><td>11.42%</td></tr><tr><td>>=65</td><td>13.83%</td></tr></table></td></tr>
<tr><td>Religion</td><td>In Northern Ireland, the main current religions are Catholic (42.3%), Presbyterian (16.6%), and Church of Ireland (11.5%). Other Christian denominations and other religions make up the remaining 24.7 (Census Bulletin; Religion 2021)

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

Religion or Religion brought up in
The 2021 Census, regarding religious background, highlights four of the six NI counties had a Catholic majority and two had a Protestant majority.
Just under one person in five (19.0%) either had ‘no religion’ (17.4%) or ‘religion not stated’ (1.6%).
The equivalent percentages for the main religions were:
• Catholic (42.3%);
• Presbyterian Church in Ireland (16.6%);
• Church of Ireland (11.5%);
• Methodist (2.4%);
• Other Christian denominations (6.9%);
and • Other non-Christian Religions (1.3%).

Census Statistics 2021 bringing together information on current religion and religion of upbringing, 45.7% of the population were either Catholic or brought up as a Catholic, while 43.5% were recorded as ‘Protestant and other Christian (including Christian related)’. Again,</td></tr>
</table>

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bringing together information on current religion and religion of upbringing, 1.5% of the population are classified as 'other religions' and 9.3% of the population identified that they neither belonged to nor were brought up in a religion ('None').

PHA Workforce (as of Sept 2024)

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

Political Opinion

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

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

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

NI survey suggests 50% neither unionist nor nationalist - BBC News

Half of the population of Northern Ireland describe themselves as "neither unionist nor nationalist", according to new research (2019)

Just over a quarter (26%) replied that they considered themselves to be unionists, while just over a fifth (21%) described themselves as nationalists.

The responses were also broken down by gender, religious background and age. There was only a 2% difference between the proportion of men and women who identified as nationalist (22% and 20% respectively).

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	Among unionists, there was a gap of eight percentage points between men and women, with 31% of men describing themselves as unionist, compared with 23% of women. In terms of age, the group most likely to pick a side in the border debate was pensioners aged 65 and over, while people under the age of 45 were more likely to say there were neutral on the union. The age group with the highest number of neutrals was the 35 to 44-year-olds' bracket, outstripping their younger 25 to 34-year-old peers by 10 percentage points. The youngest age bracket (between 18 and 24 years old) also had a high number of neutrals, with 59% saying they were neither unionist nor nationalist. However, in that age group young unionists outnumbered young nationalists significantly, with a quarter of 18 to 24-year-old respondents describing themselves as unionist, and just 14% who said they were nationalists. At the other end of the scale, there was an even bigger political split between the over-65s. Just under a fifth (19%) of pensioners described themselves as nationalist while more than twice that number (41%) replied that they were unionist. Pensioners were also the least likely to say they were neutral on the union, with just 38% of over-65s falling into that category. As regards religious background, exactly half of the Catholics surveyed identified as nationalist and more than half (55%) of Protestants identified as unionist. People who said they had no religion were most likely to say they had no political affiliation to unionism or nationalism. Political Attitudes in NI update151.pdf In the above NILT 2022 report, the breakdown of self-described community identities in Northern Ireland is unionist (31%), nationalist (26%) and 'neither' (38%) PHA Workforce (as of Sept 2024) Broadly Nationalist 0.70% Other 2.30% Broadly Unionist 0.90% Not assigned 94.49% Do not wish to answer 1.60%
Marital Status	46% (693,000 adults) were married or in a civil partnership in 2021. This made up 46% of our population aged 16 and over. In contrast 577,000 adults (38%) were single (never married/civil partnered) Of the adult population living in households, just over half lived as part of a couple within the household (53% or 794,000 people in a married,

civil partnership or co-habiting couple). The remaining 695,000 adults (47%), did not live as part of a couple within the household. (NISRA Bulletin)

Census 2021 findings highlight following population data:
Single (never married/civil partnered) 576,700 (38.1%)
Married 690,500 (45.6%)
In a civil partnership 2,700 (0.2%)
Separated [note 1] 57,300 (3.8%)
Divorced [note 1] 91,100 (6.0%)
Widowed [note 1] 96,400 (6.4%)

Note 1: These classifications include both the married and civil partnership equivalents. 'Separated' is 'separated (still legally married or still legally in a civil partnership)', 'divorced' is 'divorced or formerly in a civil partnership now dissolved' and 'widowed' is 'widowed or surviving partner from a civil partnership'

The rise in the 'single' population and the fall in the 'married' population here is in line with results from recent censuses in England and Wales. These figures mirror changes in society and specifically in personal relationships that has been witnessed over the last 50 years.

Northern Ireland Life and Times Survey (2018):
• Single (never married) - 32%
• Married and living with husband/wife - 51%
• A civil partner in a legally-registered civil partnership - 0%
• Married and separated from husband/wife - 3%
• Divorced - 6% • Widowed - 7%

PHA Workforce (as of Sept 2024)

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

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Dependent Status	There are over 220,000 people providing unpaid care for a sick or disabled family member or friend in Northern Ireland. Despite the multi-billion-pound savings they deliver here each year, too many local carers are being driven to breaking point by unrelenting caring duties, few opportunities for a break, poverty and patchy support from Health and Social Care services. (A New Deal for unpaid carers in Northern Ireland | Carers UK 2023) CarersNI State of Caring 2023 Annual survey (UK wide, including NI) This report examines the impact of unpaid caring on health and wellbeing in Northern Ireland, based on data from Carers NI's State of Caring 2023 survey. It shows: • 1 in 4 carers in Northern Ireland are suffering mental ill-health. • 50% feel lonely at least some of the time. • 43% identify more breaks as among their main needs as a carer. • More than 1 in 3 have put off health treatment for themselves because of the demands of caring. *(Available at State of Caring 2023: The impact of caring on health in Northern Ireland | Carers UK)* **Carers NI (State of Caring 2022 report)** There are over 290,000 people providing some form of unpaid care for a sick or disabled family member or friend in Northern Ireland – around 1 in 5 adults. (Carers UK, 2022). Of those participating in the survey: • 82% identified as female and 17% identified as male. • 4% are aged 25-34, 17% are aged 35-44, 33% are aged 45-54, 31% are aged 55-64 and 14% are aged 65+. • 24% have a disability. • 98% described their ethnicity as white. • 28% have childcare responsibilities for a non-disabled child under the age of 18 alongside their caring role. • 56% are in some form of employment and 18% are retired from work. • 31% have been caring for 15 years or more, 16% for between 10-14 years, 25% for 5-9 years, 25% for 1-4 years, and 3% for less than a year. • 46% provide 90 hours or more of care per week, 13% care for 50-89 hours, 23% care for 20-49 hours, and 19% care for 1-19 hours per week. • 67% care for one person, 25% care for two people, 5% care for three people and 3% care for four or more people.

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

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

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

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

- No unpaid care 87.58%
- 1-19 hours unpaid care per week 5.63%
- 20-34 hours unpaid care per week 1.38%
- 35-49 hours unpaid care per week 1.57%
- 50+ hours unpaid care per week 3.84%

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<table>
<tr><td></td><td>PHA Workforce (as of Sept 2024)

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

('Day-to-day activities limited' covers any health problem or disability (including problems related to old age) which has lasted or is expected to last for at least 12 months.)
The 2021 census also set out the following types of long-term condition held by the population:</td></tr>
</table>

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

Health Survey NI (2021-22) Two-fifths of respondents (41%) have a physical or mental health condition or illness expected to last 12 months or more (similar to 2019/20). This increased with age from 27% of those aged 16-24 to 69% of those aged 75 and over. Half (50%) of those living in the most deprived areas reported a long-term condition compared with less than two-fifths (37%) of those in the least deprived areas. Less than a third (29%) of respondents have a long-standing illness that reduces their ability to carry out day-to-day activities (similar to 2019/20). Prevalence increased with age with 13% of those aged 16-24 reporting a limiting long-term condition compared with 56% of those aged 75 and over. Most of those (88%) with limiting long-term conditions reported their ability to carry out day-to-day activities had been reduced for 12 months or more.

PHA Workforce as of Sept 2024

No	15.13%
Not assigned	83.87%
Yes	1.00%

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Ethnicity

Census 2021 data highlights that In 2021 the number of people with a white ethnic group was 1,837,600 (96.6% of the population). Conversely, the total number of people with a minority ethnic group stood at 65,600 people (3.4% of the population). Within this latter classification, the largest groups were Mixed Ethnicities (14,400), Black (11,000), Indian (9,900), Chinese (9,500), and Filipino (4,500). Irish Traveller, Arab, Pakistani and Roma ethnicities also each constituted 1,500 people or more.

2021 Census

Ethnic group	Population number	Population Percentage
White	1,837,600	96.60%
Black	11,000	0.60%
Indian	9,900	0.50%
Chinese	9,500	0.50%
Filipino	4,500	0.20%
Irish Traveller	2,600	0.10%
Arab	1,800	0.10%
Pakistani	1,600	0.10%
Roma	1,500	0.10%
Mixed Ethnicities	14,400	0.80%
Other Asian	5,200	0.30%
Other Ethnicities	3,600	0.20%
All usual residents	1,903,200	100.00%

PHA Workforce (as of Sept 2024)

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

Sexual Orientation

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

- 31,600 people aged 16 and over (or 2.1%) identified as LGB+ ('lesbian, gay, bisexual or other sexual orientation'),
- 1.364 million people (90.0%) identified as 'straight or heterosexual' and
- 119,000 people (7.9%) either did not answer the question or ticked 'prefer not to say'.

Public Health Agency

- • 4.1% of adults (1 in 25) in Belfast identified as LGB+, while 1.1% of adults in Mid Ulster identified as LGB+.
- • 4.6% of people aged 16 to 24 identified as LGB+, this falls to 0.3% of people aged 65 and over.
- • Across England, Wales and Northern Ireland, Northern Ireland (2.1%) has the lowest percentage of people who identify as (LGB+), thereafter comes Wales with 3.0% of people who identify as LGB+ and then England with 3.2% (Census 2021)

PHA Workforce (Sept 2024)

Do not wish to answer	0.50%
Not assigned	94.19%
Opposite sex	4.71%
Both Sexes	
Same sex	0.60%

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

2.3 Qualitative Data

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

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

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

- *the PHA's "Health Briefings"*

Public Health Agency

www.publichealth.hscni.net/directorate-operations/communication-and-knowledge-management/health-intelligence

the HSC document on "Section 75 Groups - Emerging Themes"

ECNI - Equality Commission for Northern Ireland

alongside the regular DoH, Social Services and Public Safety publication on inequalities monitoring

Equality Screenings 2018 to 2024 - Business Services Organisation (BSO) Website
www.hscbusiness.hscni.net/pdf/NI_HSC_inequalities_monitoring_pdf_744KB.pdf, no one screening exercise or EQIA can do justice in giving consideration to all these aspects.

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

Category	***Needs and Experiences***
Gender	
Age	
Religion	
Political Opinion	
Marital Status	
Dependent Status	
Disability	
Ethnicity	

Sexual Orientation	

2.4 Multiple Identities

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

please also see the comments at the start of 2.3

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

2.5 Making Changes

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

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
The Corporate Plan development included ensuring that it fully reflected the PHA role in reducing health inequalities. Some of these explicitly aim to address key equality issues. Using our Communication department's expertise in public information the Corporate Plan was written in a style to make it accessible and understandable for a wide range of external stakeholders as well as PHA staff. When preparing the Plan, we took the opportunity to review the purpose, vision and values to ensure its continued relevance to our work	The key actions and focus on reducing health inequalities contained within the plan will guide the work of the PHA throughout the five years and will be closely monitored through a variety of established performance monitoring systems. Information will be gathered throughout the consultation period to further screen and consider the potential impact. The Corporate Plan will be widely accessible and will be available in alternative formats. As actions are taken forward in line with the outcomes of the Corporate Plan, equality issues will be reviewed and addressed as appropriate. Service leads have been reminded to keep

and our population.	under constant review the need for screening at an early stage when planning. Service leads will be asked during development of each Annual Business Plan to review the need for screening at an early stage in planning and to consider and identify the actions, strategies and policies they will be progressing that will be screened and/or impact assessed. We will also continue to implement the actions detailed in our action plan which accompanies our Equality Scheme. Ultimately, however, we remain committed to equality screening, and if necessary equality impact assessing, the policies we develop and decisions we take.

2.6 Good Relations

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

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

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

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

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

Please tick:

Major impact	
Minor impact	
No further impact	√

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

Yes	
No	√

Please give reasons for your decisions.

The PHA Corporate Plan sets out the focus and direction for the PHA from 2025-2030.

Tackling health and wellbeing inequalities and improving health and wellbeing through early intervention and prevention is the essence of the Plan and complements the Section 75 Agenda, whilst promoting a shift across the health service, to the prevention of disease.

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

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

Public Health Agency

(4) CONSIDERATION OF DISABILITY DUTIES

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

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

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

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

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(5) CONSIDERATION OF HUMAN RIGHTS

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

ARTICLE	Yes/No
Article 2 – Right to life	No
Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment	No
Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour	No
Article 5 – Right to liberty & security of person	No
Article 6 – Right to a fair & public trial within a reasonable time	No
Article 7 – Right to freedom from retrospective criminal law & no punishment without law	No
Article 8 – Right to respect for private & family life, home and correspondence.	No
Article 9 – Right to freedom of thought, conscience & religion	No
Article 10 – Right to freedom of expression	No
Article 11 – Right to freedom of assembly & association	No
Article 12 – Right to marry & found a family	No
Article 14 – Prohibition of discrimination in the enjoyment of the convention rights	No
1st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property	No
1st protocol Article 2 – Right of access to education	No

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

HSC Public Health Agency

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

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

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

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

HSC Public Health Agency

(6) MONITORING

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

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

Approved Lead Officer: _____

Position: Assistant Director Planning and Business Services

Date: _____

Policy/Decision Screened by: Julie Mawhinney

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

Template produced June 2011

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

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

HSC Public Health Agency

Annex: PHA Corporate Plan Suggested Indicators

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

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

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

HSC Public Health Agency

References

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

PfG Indicators Measurement Annex – available at:

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

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

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

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

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

Appendix B - Rural Needs Impact Assessment (RNIA) Template

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

1A. Name of Public Authority.

Public Health Agency

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

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

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

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

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

Public Health Agency Corporate Plan 2025-2030

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

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

The Plan is being developed during a period of reform both for our organisation and for Health and Social Care (HSC) and in a time of significant financial constraint. However, we have embraced the opportunity provided by this time of change and constraint to set out our vision and ambitions for health and wellbeing in Northern Ireland and reiterate our call for a continued focus on improving health and reducing health inequalities across HSC and wider society.

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

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

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

Our Focus

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

Over the next five years, as we work to fulfil our purpose and advance towards our visionwe will focus on delivering a number of key public health priorities for Northern Ireland, under 5 strategic outcomes:

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

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

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

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

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

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

Details of alternative definition of 'rural' used.

N/A

Rationale for using alternative definition of 'rural'.

N/A

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

N/A

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

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

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

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

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

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

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

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

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

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

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

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

N/A

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

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

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

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

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

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

N/A

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

N/A

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

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

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

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

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

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

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

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

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

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

N/A

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

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

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

SECTION 6 - Documenting and Recording

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

I confirm that the RNIA Template will be retained and relevant information compiled. [x]

Rural Needs Impact Assessment undertaken by:	
Grade:	
Directorate:	
Signature:	
Date:	
Rural Needs Impact Assessment approved by:	
Grade:	
Directorate:	
Signature:	
Date:	

HSC Public Health Agency

item 10

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	21 November 2024
Title of paper	Performance Management Report
Reference	PHA/02/11/24
Prepared by	Stephen Murray / Rossa Keegan
Lead Director	Leah Scott

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

1 Purpose

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

2 Key Issues

The attached paper provides a summary of progress made, as at end of September 2024, on achieving the actions set out in the PHA Annual Business Plan 2024/25.

Of the 33 actions, 3 are currently rated Blue (Action completed). 15 are currently rated Green, 9 are currently rated Amber, 6 are currently rated Red

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

The Performance Management Report was approved by the Agency Management Team at its meeting on 13 November 2024, and will be considered by the Planning, Performance and Resources Committee at its meeting on 18 November 2024.

3 Next Steps

The next quarterly Performance Management Report update will be brought to the Board in February 2025.

HSC Public Health Agency

PERFORMANCE MANAGEMENT REPORT

Monitoring of KPIs Identified in

The Annual Business Plan 2024 – 2025

As at 30 September 2024

HSC Public Health Agency

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

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

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

BRAG Status:

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

Of the 33 actions, 15 are currently rated Green, 9 are currently rated Amber, 6 are currently rated Red and 3 currently rated Blue.

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

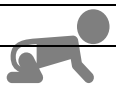
HSC Public Health Agency

Protecting Health

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

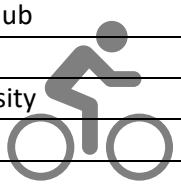
Starting Well

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



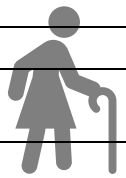
Living Well

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



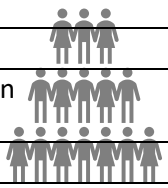
Aging Well

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



Our Organisation and People

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



HSC Public Health Agency

As at end of September 2024 there were 15 KPIs identified with an Amber or Red BRAG status. Further details of these KPIs below.

For details on all the actions please click on the file here -> Q2 Performance report 20245 Full Fir

KPI	Description	Progress	Jun	Sep	Dec	Mar	Lead Director
KPI 1	Implement the provision of BBV screening through low threshold and inclusion services to individuals at risk of hepatitis C, hepatitis B and HIV through injecting drug use or sharing drug taking paraphernalia, by March 2025	Pilot project currently being developed to introduce rapid antibody screening through a community provider in Belfast. Pilot project for development of a regional dried blood spot testing service currently being planned by BHSCT Regional Virology Lab. Additional funding will need to be secured to support this regional service once outcomes from the pilot are assessed – on track.					Joanne McClean
	Further details if Amber/Red (Timescales, mitigating actions etc.)	Pilot project currently being developed to introduce rapid antibody screening through a community provider in Belfast – progress has been impacted by a recent attack on the premises of Belfast Inclusion Health Service. Belfast Trust is responsible for securing new accommodation. PHA will work with BIHS to support ongoing service provision and work on testing pilot will recommence when BIHS service in a position to support.					
KPI 5	Appraisal of flu vaccination delivery programme including development of options for programme management (including budget control) completed and agreed with DoH by March 2025. (Quarterly updates provided June/September/December	Flu vaccine procured. Operational plans in progress for campaign start. Review of financial arrangements underway.					Joanne McClean
	Further details if Amber/Red (Timescales, mitigating actions etc.)	An action plan has been developed in order to mitigate against a falling trajectory in uptake. This includes a particular focus on health and social care workers which has seen a lower uptake compared to the same stage in last year's campaign.					

KPI	Description	Progress	Jun	Sep	Dec	Mar	Lead Director
		Furthermore, the team is reminding all GP practices who request additional vaccine that all vaccines must be recorded on VMS as soon as possible after administration to ensure uptake is recorded in a timely and accurate manner.					
KPI 6	Vaccine uptake rates for Pertussis and MMR stabilised with particular emphasis on those with the greatest risk of experiencing health inequalities by March 2025. (Quarterly updates provided June/September/December)	MMR coverage at 5 years – D1 93.3%% , D2 85.6% - decrease in 0.9% and 2.3% respectively since Dec 2023. MMR catch up campaign completed and included outreach to schools with lowest uptake. Pertussis (pregnancy) position May 2024 – 50.4% (decrease of 4% since Apr 2024) (SEHSCT excluded from reporting).					Joanne McClean
	Further details if Amber/Red (Timescales, mitigating actions etc.)	Actions continue to be taken as part of the Improving childhood vaccine uptake working group with actions taking place under the following workstreams: • Improving data • Access to services • Communications • Education and training • Operational management Furthermore, HSC Trusts will continue to offer pertussis vaccination in pregnancy through antenatal clinics to increase convenience for those who are pregnant and ensure opportunistic offer.					
KPI 7	Develop an action plan, in partnership with Encompass, to replace and strengthen the existing child health system and its links to other key data systems by March 2025	IT Programme Board for CHS and Encompass has been established. CHS current workplan is being reviewed in line with the timeline proposed by Encompass. Encompass are working on the project update for CHS which should include the revised project plan. An options paper to extend the time of Go Live to February 2026 was agreed at the Delivery & Readiness Board September 2024.					Paul McWilliams / Stephen Wilson/ Leah Scott/ Heather Reid

KPI	Description	Progress	Jun	Sep	Dec	Mar	Lead Director
	Further details if Amber/Red (Timescales, mitigating actions etc.)	Based on an assessment of the work to be completed within the time frame, the go live state has been extended to February 2026. Progress against this work is severely limited by encompass capacity (ongoing roll out to Trusts is prioritised.)					
KPI 9	Develop a framework to our approach for tackling health inequalities by December 2024	This action has been delayed by 3 months due to the absence of key staff and the re-alignment of key staff to support the Live Better initiative in Qtr 2. This has resulted in the Health Inequalities workshop, as part of Reshape and Refresh Programme, being postponed until Qtr 3. Desktop research to inform the workshop and the develop of a framework has been completed in preparation.					All Directors/Joanne McClean
	Further details if Amber/Red (Timescales, mitigating actions etc.)	Preparation work has been completed in advance of hosting an internal workshop. Additional staff will be aligned to support this action in Qtr 3 and 4. A revised timeline for this action has been agreed, with a workshop to inform the development of the framework planned for Qtr 3.					
KPI 13	Continue to reduce smoking prevalence across NI by a minimum of 1% during 24/25. (i.e. from 14% to 13% by March 2025)	Over 500 HSCT, Community Pharmacy & Community based Stop Smoking Services continue to provide services & support to individuals who want to quit smoking in Northern Ireland. Service delivery data is tracked via the ELITE system and is being incorporated into a PHA Stop Smoking Dashboard. Data for the period April -September 2024 will be available in November 2024. The Health Survey Smoking Trends & the Statistics on NI Smoking Cessation Services will be published shortly.					Joanne McClean
	Further details if Amber/Red (Timescales, mitigating actions etc.)	The Elite service monitoring data has been shared with the DoH Public Health Information & Research Branch to facilitate the publication of the annual statistics on smoking cessation services In NI: 4 week follow up figures for 2023/24, and 52 week follow up figures for 2022/23. The Health Survey Smoking Trends (prevalence) will be published Dec 24.					

KPI 18a	Level 1-3 Education and Training Tools for Advanced Care Planning Programme will be in place and quality assured by December 2024	This action cannot sit outside wider implementation of ACP. On request from the DoH, an options proposal has been submitted to outline resource required to progress this work.					Heather Reid
	Further details if Amber/Red (Timescales, mitigating actions etc.)	Discussed at PHA /DoH ground clearing mtg. PHA Board updated. Currently awaiting a formal response from the DOH. Key stakeholders have been informed of position. Consider pausing the monitoring of actions 18a and b until further information available form DoH.					
KPI 18b	Implementation structures for the RESPECT programme will be in place and implementation underway including public messaging by December 2024	As above					All Directors/Heather Reid
	Further details if Amber/Red (Timescales, mitigating actions etc.)	As above					
KPI 19	A 5% increase in uptake rate in seasonal flu vaccination programme for care home staff by March 2025	Programme to commence in October 2024.					Joanne McClean
	Further details if Amber/Red (Timescales, mitigating actions etc.)	A number of actions have been undertaken to promote vaccinations in this cohort including • Education and promotion through a dedicated Care Home Clinical Forum session on 10th September (focus on flu, COVID-19 and RSV) • Promotion through virtual sessions (care home leads meetings, Meaningful Engagement ECHO, IHCP webinar) • Promotion by Nurse Consultant at in person sessions (teaching session with BHSCT care homes, Frailty Conference, planned presentation at NISCC forum) • Social media communications • Written communications					
KPI 23	PHA procurements to be progressed in line with the agreed Procurement Plan for 2024/25 by March 2025 - (quarterly updates provided June/September/December)	Planned Tenders under Phase 1 of Drug and Alcohol, relating to Adult Step 2 services and Workforce Development are progressing and it is anticipated that the newly tendered services will be operational by 1 April 2025. The SHIP tender process has concluded and new services will be in place by 1 November 2024. The Shared Reader tender was completed on					Leah Scott

		time but had to be stood down due to TUPE issues that came to light post evaluation of tenders received. The tender was re-advertised in August 2024 and the new service should be in place by 1 January 2025. The Raising Awareness and Promoting Informed Choice for Cancer Screening re-tender has been postponed to allow a wider review of the service to be completed. Planned tenders for Workplace health and The Elevate programme will not be completed within the planned timelines. This has been due to key staff having been off on significant periods of staff absence and also staff involved in these tenders now having to re-prioritise their time to take forward the Ministers 'Live better' Initiative						
	Further details if Amber/Red (Timescales, mitigating actions etc.)	• **Raise Awareness of Cancer Screening** – The existing contract with the provider has been extended using a DAC for a further year to 31 March 2025, to allow time for the review to be completed and a new model of service agreed that will most effectively help address inequalities across all screening programmes. • **Workplace Health** – Due to staff-capacity and to provide continuity of service it is proposed that the current contract will be extended via a DAC. • **Elevate** –Due to staff-capacity and to provide continuity of service it is proposed that the current DAC is extended.						
KPI 24	New Partnership Agreement in place with DoH by December 2024	Final amendments are being discussed with DoH colleagues. Timescales for completion will be slightly delayed.						Leah Scott
	Further details if Amber/Red (Timescales, mitigating actions etc.)	PHA is currently responding to DoH on a number of specific queries. Subject to queries being resolved, it is intended that a finalised document can be agreed shortly. The draft Partnership Agreement will be presented to PHA board in January 2025 for approval.						
KPI 25	PHA Digital and Data Strategy approved by Board and Implementation Plan developed by September 2024	A draft Strategy has been developed on data and digital. However, in moving this forward and following discussions with EY, it is felt that it would be more appropriate to appoint a Director to take this work forward.						Aidan Dawson
	Further details if Amber/Red (Timescales, mitigating actions etc.)	A job description for a Director is being finalised with a view to this being submitted for evaluation shortly.						

KPI 28	New PHA R&D office to be set up and HSC R&D Strategy to be issued for consultation by March 2025	The review of the current HSC R&D strategy is complete. A workshop is planned for 12 September 2024 to endorse the evaluation, open up engagement and receive feedback to allow the mapping of the new Strategy. Strategy workshop was held on 12.09.24 with approx. 100 attendees. Excellent feedback was received from stakeholders and will now be incorporated into the new strategy.					Joanne McClean/Leah Scott Janice Bailie (Strategy)
		Work is progressing to establish a PHA research and development office within the PHA which will complement the work undertaken by the Agency and support staff to collaborate on public health R&D with local higher educational institutions. A bid is currently being developed which will resource the office.					Grainne Cushley (new PHA R&D Office)
	Further details if Amber/Red (Timescales, mitigating actions etc.)	R&D office establishment may take longer than planned and is likely to be delayed due to the need to have further explorative discussions with key stakeholders. A bid is currently being developed which will resource the office which will be finalised before the end of 2024.					
KPI 31	An approach to health inequalities and associated training will be delivered to all staff across the organisation by March 2025	This action has been delayed by 3 months due to the absence of key staff and the re-alignment of key staff to support the Live Better initiative in Qtr 2. PHA currently commission the provision of health inequalities training through a contracted provider. This provider has developed abridged training, which for consistency will be the starting point for the development of staff training for the Agency. There will be no additional cost to PHA for support in the development of this training. Working with staff from across the organisation, a codesign phase will be delivered in quarter 4 with feedback gathered on content, duration and level of training. This will inform the development of future training ensuring appropriateness of training across staffing levels. Training will be available for all staff in Qtr 1 2025/26 following codesign phase period.					All Directors Joanne McClean

	Further details if Amber/Red (Timescales, mitigating actions etc.)	Additional staff will be aligned to support this action in Qtr 3 and 4. A revised timeline has been agreed with the current contract provider. Delivery of a co-design test phase with staff is scheduled between mid-January to mid-February 2025. A tailored syllabus will be available in Qtr 1 2025/26.	
KPI 32	PHA in membership / co-leading new SPPG/PHA commissioning teams by September 2024	• PHA continue to engage closely with SPPG in establishing Planning and Commissioning Teams (PCTs). A small number of teams have started to meet. • Core team comprising members from SPPG and PHA developing a 'playbook' to support joint working (ToR, governance, decision making, escalation etc). This work will also be discussed with AMT. • Consideration being given to how the PCTs will sit within Reshape and Refresh Structures and link with existing SPTs from operational and strategic perspective • Work to establish these teams is progressing. SPPG and PHA chief executive/chief operating officer are reviewing arrangements for joint working. • Joint chair workshop has been held and an additional workshop is planned • PHA co-chairs have attended AMT in October to provide an update.	All Directors Heather Reid
	Further details if Amber/Red (Timescales, mitigating actions etc.)	Commissioning teams are not currently in place with no clear timeline for establishment of the structures required to support. Impacted by change in SPPG leadership and implementation of wider ICS processes. PHA Cx and SPPG COO working to re-establish JAM in a different format to support commissioning processes. Further gaps in support for groups remain to be addressed – currently limited by existing capacity – e.g. information. Directors from SPPG and PHA to meet beginning of December to progress plans.	

HSC Public Health Agency

PHA Annual Business Plan Monitoring 24/25

Quarter Ending September 30th 2024

BRAG Status:

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

Table completion:

KPI	Description	Progress (100 words max)	Jun	Sep	Dec	Mar	Lead Director
KPI from Annual Business Plan	Outcome Measure from Annual Business Plan	Progress to date against Outcome Measure. Be concise.	BRAG status for the current quarter				Lead Director assigned responsibility for delivery of outcome.
	Further details if Amber/Red (Timescales, mitigating actions etc.) (50 words max)	Further details on what we're doing to rectify/mitigate the issues/barriers of those actions at significant risk of delay or failure to deliver.					

HSC Public Health Agency

Protecting Health

KPI	Description	Progress (100 words max)	Jun	Sep	Dec	Mar	Lead Director
KPI 1	Implement the provision of BBV screening through low threshold and inclusion services to individuals at risk of hepatitis C, hepatitis B and HIV through injecting drug use or sharing drug taking paraphernalia, by March 2025	Pilot project currently being developed to introduce rapid antibody screening through a community provider in Belfast. Pilot project for development of a regional dried blood spot testing service currently being planned by BHSCT Regional Virology Lab. Additional funding will need to be secured to support this regional service once outcomes from the pilot are assessed – on track.					Joanne McClean Samantha McAllister
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**	Pilot project currently being developed to introduce rapid antibody screening through a community provider in Belfast – progress has been impacted by a recent attack on the premises of Belfast Inclusion Health Service. Belfast Trust is responsible for securing new accommodation. PHA will work with BIHS to support ongoing service provision and work on testing pilot will recommence when BIHS service in a position to support.					
KPI 2	The public health component of a Northern Ireland One Health AMR Action Plan will be developed by March 2025 (early draft agreed by end of December 2024)	This action is on track to deliver. Workstreams are in the process of finalising deliverables for the next 5 year implementation plan with the exception of the Primary Care Antimicrobial Stewardship workstream. Due to resource pressures and competing priorities this workstream are slightly behind schedule by approximately 4-5 months but should still be able to deliver by March 2025. The plan has buy-in and agreement from primary care representative bodies (RCGP, GPC/BMA, CPNI, GPNI) and secondary care clinicians and Trust directors, SPPG and PHA.					Joanne McClean Bronagh McBrien
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**						

HSC Public Health Agency

KPI	Description	Progress (100 words max)	Jun	Sep	Dec	Mar	Lead Director
KPI 3	Development of a unified, regular surveillance report and risk assessment for DoH and HSC system by March 2025	Joint working has progressed within the health protection/surveillance teams. A weekly situational awareness report is shared with DOH colleagues and continues to develop in accordance with signals of concern identified through routine surveillance and horizon scanning.					Joanne McClean Declan Bradley
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**						
KPI 4	Establishment of outbreak detection through statistical exceedance reporting completed by end of October 2024	The establishment of this outbreak detection reporting has been completed for E Coli cases using Flexible Farrington algorithm integrated into an Infectious Disease Surveillance tool developed in R Shiny. Work continues to develop further codes to link the tool with the data streams from NIHAP.					Joanne McClean Declan Bradley / Trudy Reid
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**						
KPI 5	Appraisal of flu vaccination delivery programme including development of options for programme management (including budget control) completed and agreed with DoH by March 2025. (Quarterly updates provided June/September/December	Flu vaccine procured. Operational plans in progress for campaign start. Review of financial arrangements underway.					Joanne McClean Rachel Spiers
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**	An action plan has been developed in order to mitigate against a falling trajectory in uptake. This includes a particular focus on health and social care workers which has seen a lower uptake compared to the same stage in last year's campaign. Furthermore, the team is reminding all GP practices who request additional vaccine that all vaccines must be recorded on VMS as soon as possible after administration to ensure uptake is recorded in a timely and accurate manner.					

HSC Public Health Agency

Starting Well

KPI	Description	Progress (100 words max)	Jun	Sep	Dec	Mar	Lead Director
KPI 6	Vaccine uptake rates for Pertussis and MMR stabilised with particular emphasis on those with the greatest risk of experiencing health inequalities by March 2025. (Quarterly updates provided June/September/December)	MMR coverage at 5 years – D1 93.3%% , D2 85.6% - decrease in 0.9% and 2.3% respectively since Dec 2023. MMR catch up campaign completed and included outreach to schools with lowest uptake. Pertussis (pregnancy) position May 2024 – 50.4% (decrease of 4% since Apr 2024) (SEHSCT excluded from reporting).					Joanne McClean Rachel Spiers
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**	Actions continue to be taken as part of the Improving childhood vaccine uptake working group with actions taking place under the following workstreams: • Improving data • Access to services • Communications • Education and training • Operational management Furthermore, HSC Trusts will continue to offer pertussis vaccination in pregnancy through antenatal clinics to increase convenience for those who are pregnant and ensure opportunistic offer.					
KPI 7	Develop an action plan, in partnership with Encompass, to replace and strengthen the existing child health system and its links to other key data systems by March 2025	IT Programme Board for CHS and Encompass has been established. CHS current workplan is being reviewed in line with the timeline proposed by Encompass. Encompass are working on the project update for CHS which should include the revised project plan. An options paper to extend the time					Paul McWilliams / Stephen Wilson/ Leah Scott/ Heather Reid

HSC Public Health Agency

KPI	Description	Progress (100 words max)	Jun	Sep	Dec	Mar	Lead Director
		of Go Live to February 2026 was agreed at the Delivery & Readiness Board September 2024.					Heather Reid
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**	Based on an assessment of the work to be completed within the time frame, the go live state has been extended to February 2026. Progress against this work is severely limited by encompass capacity (ongoing roll out to Trusts is prioritised.)					
KPI 8	Review unmet need and risk factors associated with social complexity in pregnancy by December 2024	Starting Well SPT held a cross-directorate workshop to inform and develop 24/25 action-plan. Regional data sets to identify health inequality have been reviewed. Meetings planned with Trust midwives currently working in the area of social complexity to understand their role including mapping current practice against the Maternity Disadvantage Assessment tool. A range of involvement exercises are underway with number of key groups (inclusive of Section 75). An analysis of PCE within maternity has been carried out. Utilising current contracts an evidence scope is under way with support from Health Intelligence and NCB. Social Complexity practitioner survey has now been circulated with pilot group. Responses will be collated and used to test data analysis. Feedback will inform final tweaks before the survey is circulated more widely.					Heather Reid Deirdre Ward / Alison Little / Michelle Harrison (SWSPT) Geraldine Teague/ Emily Roberts/ Maurice Meehan
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**						

HSC Public Health Agency

Living Well

KPI	Description	Progress (100 words max)	Jun	Sep	Dec	Mar	Lead Director
KPI 9	Develop a framework to our approach for tackling health inequalities by December 2024	This action has been delayed by 3 months due to the absence of key staff and the re-alignment of key staff to support the Live Better initiative in Qtr 2. This has resulted in the Health Inequalities workshop, as part of Reshape and Refresh Programme, being postponed until Qtr 3. Desktop research to inform the workshop and the develop of a framework has been completed in preparation.					All Directors Joanne McClean
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**	Preparation work has been completed in advance of hosting an internal workshop. Additional staff will be aligned to support this action in Qtr 3 and 4. A revised timeline for this action has been agreed, with a workshop to inform the development of the framework planned for Qtr 3.					
KPI 10	Complete the Discovery exercise for the development of a NI Mental Health Hub by September 2024	The Digital Discovery exercise has been completed and findings presented to AMT. Work is underway to disseminate the reports and to consider opportunities to take forward the recommendations.					Leah Scott/Stephen Wilson Stephen Murray/Sinead Malone
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**						

HSC Public Health Agency

KPI	Description	Progress (100 words max)	Jun	Sep	Dec	Mar	Lead Director
KPI 11	Approval of Commissioning Framework for Alcohol and Drugs Complete Phase 1 and commence Phase 2 of Regional Drugs & Alcohol Services Procurement by April 2025.	The Substance Use Strategic Commissioning Framework and Implementation Plan has been approved and launched on 28 June 2024. Adult Step 2: • Business case approved by AMT • Tender strategy, market engagement, Specification development progressing well and will be completed by end of Oct. Awaiting GDPR/IG clauses from DLS. Workforce Development: • Business case approved by AMT • Regional Training Needs Analysis completed • Tender strategy, market engagement, Specification development progressing well and will be completed by end of Oct. Awaiting GDPR/IG clauses from DLS. Phase 2 of procurement: • Pre-procurement work (rural needs assessment, equality screening, cyber security, PPI, business case being drafted for Problematic Parental Substance Use Service and Youth Treatment Service. All pre-procurement work expected to be completed by end of November. • CAG nominations for both service areas have been submitted via PAL's for Director of Finance and Corporate Services approval.					Joanne McClean Kevin Bailey
	Further details if Amber/Red (Timescales, mitigating actions etc.) (50 words max)						

HSC Public Health Agency

KPI	Description	Progress (100 words max)	Jun	Sep	Dec	Mar	Lead Director
KPI 12	Implementation phase 1 – 3 of a Whole Systems Approach Obesity in line with PHE/Leeds Beckett University methodology across early adopter sites, with 2 or 3 completed by March 2025	6 of 11 Councils have agreed to collaborate with PHA on developing and implementing a Whole System Approach (WSA) to Obesity within their Council areas. Phase 1 Set up: Derry City & Strabane District Council have agreed their set up and governance structure, with a Leadership group established. In Belfast, a general awareness training workshop was delivered in May. Phase 2 Building the Local Picture: A workshop took place in Belfast in July with 26 attendees and a follow up Action Mapping (current & future interventions) Proforma for Belfast developed and circulated for completion Online Proforma Link: https://forms.office.com/e/1vVR5RABLj Belfast Asset and hazards mapping is currently being developed with support of Belfast City Council. Phase 3 – Systems Mapping: No bids were received following the procurement exercise. A DAC is being developed to work with a company to deliver this work. This will take place in Q3. The Shared Learning Network has met to support each of the Councils with WSA work across the early adopter sites.					Joanne McClean David Tumilty

KPI	Description	Progress (100 words max)	Jun	Sep	Dec	Mar	Lead Director
		PHIRST research and engagement is ongoing, with a visit planned in November 2024. Plans are in place to write to two more early adopter sites in October 2024, to engage them in phase 1.					
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**						
KPI 13	Continue to reduce smoking prevalence across NI by a minimum of 1% during 24/25. (i.e. from 14% to 13% by March 2025)	Over 500 HSCT, Community Pharmacy & Community based Stop Smoking Services continue to provide services & support to individuals who want to quit smoking in Northern Ireland. Service delivery data is tracked via the ELITE system and is being incorporated into a PHA Stop Smoking Dashboard. Data for the period April -September 2024 will be available in November 2024. The Health Survey Smoking Trends & the Statistics on NI Smoking Cessation Services will be published shortly.					Joanne McClean Denise McCallion
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**	The Elite service monitoring data has been shared with the DoH Public Health Information & Research Branch to facilitate the publication of the annual statistics on smoking cessation services In NI: 4 week follow up figures for 2023/24, and 52 week follow up figures for 2022/23. The Health Survey Smoking Trends (prevalence) will be published Dec 24.					
KPI 14	Develop a cancer prevention action plan, including the actions outlined in the Cancer Strategy 2022 agreed by December 2024	Key staff have been identified to support the development of a Cancer Prevention Action Plan across PHA. Work is underway to gather information on the range of services and actions across the organisation which will be used to formulate the Cancer Prevention Action Plan. A multi-disciplinary working group will be established to oversee this work and implementation of the Action Plan.					Joanne McClean Colette Rogers

KPI	Description	Progress (100 words max)	Jun	Sep	Dec	Mar	Lead Director
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**						
KPI 15	Action plan to address inequalities in participation in screening programmes developed by March 2025	Working group established and member of staff in post in the health improvement team to support this work. Initial scoping of options relating to existing health improvement contracts completed. Internal resource secured from the screening team to commence a review of evidence and approaches elsewhere, along with a scoping of baseline activities across each screening programme.					Joanne McClean Tracy Owen / Paddy McEldowney
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**						

HSC Public Health Agency

Ageing Well

KPI	Description	Progress (100 words max)	Jun	Sep	Dec	Mar	Lead Director
KPI 16	A new regionally agreed, evidence based safer mobility model across NI completed by March 2025	• Comprehensive review completed of exiting PHA work on safer mobility (services commissioned, investment, acute hospital falls pathway, care home pathway etc) • Gap analysis against population and risk completed. • Template based on NICE Guidelines issued to all Trusts to capture Trust activity. Continuing to collate peer reviewed evidence and data/intelligence to support actions, outcomes measurement, KPIs and evaluation. • All trust returns have been received and are currently being analysed • Data relating to NI is being reviewed and a literature review is being planned • Community and Voluntary Safer Mobility Survey has been developed and disseminated, completion end of October. • Service User Carer Regional Safer Mobility Survey being developed • PHA are planning and leading a stakeholder workshop in November					Heather Reid Sandra Aitcheson / Diane McIntyre/Michelle Laverty/Jeff Scroggie/ Ceara Gallagher

HSC Public Health Agency

KPI	Description	Progress (100 words max)	Jun	Sep	Dec	Mar	Lead Director
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**						
KPI 17	All HSC care homes will have implemented the care homes fall pathway initiative - by December 2024 and a further 10% of the Independent care home sector will have adopted the pathway by March 2025	• Of 468 care homes, 46 are statutory • Falls pathway has been reviewed with some minor adjustments agreed with senior clinical input including GPs, emergency medicine, NIAS and independent sector (IS) providers • The falls pathway metrics have been embedded into encompass for statutory care homes (currently rolled out in SEHSCT and BHSCT). • Trusts have all been asked to implement the falls pathway within statutory care home. Pathway already implement in 17 care homes. Supporting implementation in minimum additional 40 homes • Scoped extent of implementation in Independent Sector homes. • Meetings have been held in 3 trust areas with residential staff from both stat and independent sector. Meetings will be held with remaining trusts after Q4 due to vaccinations and seasonal pressures • Independent Health Care Providers webinar held in September for all care home staff • Revisions to post falls guidance and risk assessment may delay uptake but at this stage progress continues to be made.					Heather Reid Sandra Aitcheson / Caroline Lecky / Ceara Gallagher
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**						

HSC Public Health Agency

KPI	Description	Progress (100 words max)	Jun	Sep	Dec	Mar	Lead Director
KPI 18a	Level 1-3 Education and Training Tools for Advanced Care Planning Programme will be in place and quality assured by December 2024	This action cannot sit outside wider implementation of ACP. On request from the DoH, an options proposal has been submitted to outline resource required to progress this work.					Heather Reid Sandra Aitcheson / Sally Convery
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**	Discussed at PHA /DoH ground clearing mtg. PHA Board updated. Currently awaiting a formal response from the DOH. Key stakeholders have been informed of position. Consider pausing the monitoring of actions 18a and b until further information available form DoH.					
KPI 18b	Implementation structures for the RESPECT programme will be in place and implementation underway including public messaging by December 2024	As above					All Directors Heather Reid
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**						
KPI 19	A 5% increase in uptake rate in seasonal flu vaccination programme for care home staff by March 2025	Programme to commence in October 2024.					Joanne McClean Rachel Spiers
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**	A number of actions have been undertaken to promote vaccinations in this cohort including • Education and promotion through a dedicated Care Home Clinical Forum session on 10th September (focus on flu, COVID-19 and RSV) • Promotion through virtual sessions (care home leads meetings, Meaningful Engagement ECHO, IHCP webinar) • Promotion by Nurse Consultant at in person sessions (teaching session with BHSCT care homes, Frailty Conference, planned presentation at NISCC forum) • Social media communications Written communications					

HSC Public Health Agency

Our Organisation and People

KPI	Description	Progress (100 words max)	Jun	Sep	Dec	Mar	Lead Director
KPI 20	New PHA Corporate Plan to be developed by March 2025	In progress. Project structure established and PID developed and approved. Stakeholder mapping and scoping work underway. Pre-consultation plans agreed and stakeholder engagement underway.					CEO/All Directors Julie Mawhinney
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**						
KPI 21	New PHA Operational structures and operating model, implemented by March 2025. (Quarterly updates provided June/September/December)	Phase 3 of the Reshape Refresh Programme is currently underway which oversees the Implementation of the Target Operating model. A workplan with key milestones has been developed to take forward the key components which includes: - Introduction of new organisational structure - Development of revised governance / accountability model including the further roll out of cross organisational planning teams.					CEO/All Directors Grainne Cushley

KPI	Description	Progress (100 words max)	Jun	Sep	Dec	Mar	Lead Director
		- Development of data & Intelligence including establishment of a clear vision / strategy for Agency in this area. - Focus on people, roles & responsibility including the introduction of a skills development framework and work relating to purpose and vision. Continued focus on improving culture & engagement through the establishment of the Organisational Development & Engagement forum and a robust internal communications plan.					
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**						
KPI 22	Revised Business Continuity Plan developed and training rolled out by December 2024	Individual Directorate/Service Area Business Continuity Plans have been developed. The PHA Business Continuity Project Team has been re-established. Project Team members are due to have completed a review of the Corporate BCP against their Directorate BCPs and advised any changes required to the Corporate BCP by 19 November. The updated Corporate BCP will be presented to AMT by end November 2024. Work is progressing to prepare a TNA for BCP training across the organisation – it is likely that this will not be completed until 31 March 2025 (as per the timescale indicated in the Business Continuity Audit 23/24).					Leah Scott Karen Braithwaite
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**						
KPI 23	PHA procurements to be progressed in line with the agreed Procurement Plan for 2024/25 by March 2025 - (quarterly updates provided June/September/December)	Planned Tenders under Phase 1 of Drug and Alcohol, relating to Adult Step 2 services and Workforce Development are progressing and it is anticipated that the newly tendered services will be operational by 1 April 2025. The SHIP tender process has concluded and new services will be in place by 1					Leah Scott Stephen Murray

KPI	Description	Progress (100 words max)	Jun	Sep	Dec	Mar	Lead Director
		November 2024. The Shared Reader tender was completed on time but had to be stood down due to TUPE issues that came to light post evaluation of tenders received. The tender was re-advertised in August 2024 and the new service should be in place by 1 January 2025. The Raising Awareness and Promoting Informed Choice for Cancer Screening re-tender has been postponed to allow a wider review of the service to be completed. Planned tenders for Workplace health and The Elevate programme will not be completed within the planned timelines. This has been due to key staff having been off on significant periods of staff absence and also staff involved in these tenders now having to re-prioritise their time to take forward the Ministers 'Live better' Initiative					
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**	• **Raise Awareness of Cancer Screening** – The existing contract with the provider has been extended using a DAC for a further year to 31 March 2025, to allow time for the review to be completed and a new model of service agreed that will most effectively help address inequalities across all screening programmes. • **Workplace Health** – Due to staff-capacity and to provide continuity of service it is proposed that the current contract will be extended via a DAC. • **Elevate** –Due to staff-capacity and to provide continuity of service it is proposed that the current DAC is extended.					
KPI 24	New Partnership Agreement in place with DoH by December 2024	New Partnership Agreement has been reviewed by AMT and final amendments being agreed with DoH colleagues. On track to have the Agreement in place by December 2024.					Leah Scott Stephen Murray
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**	Likely to be delayed – no Board meeting in December					

HSC Public Health Agency

KPI	Description	Progress (100 words max)	Jun	Sep	Dec	Mar	Lead Director
KPI 25	PHA Digital and Data Strategy approved by Board and Implementation Plan developed by September 2024	A draft Strategy has been developed on data and digital. However, in moving this forward and following discussions with EY, it is felt that it would be more appropriate to appoint a Director to take this work forward.					CEO
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**	A job description for a Director is being finalised with a view to this being submitted for evaluation shortly.					
KPI 26	PHA Skills and Development Framework approved by September 2024	The PHA Skills & Development Framework was been approved at AMT on 17th April with endorsement at the PPR Committee on 2nd May and shared with the Board for information on 16th May 2024 and was released for 'soft launch' as a working draft document along with Appraisal documents at end of April 2024. Introductory Sessions are planned across the year for purposes of familiarisation by existing and new staff Feedback will begin to be collected from October 2024 and will be used to inform the next iteration which will be available from April 2025.					Leah Scott Karyn Patterson
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**						
KPI 27	Launch of new PHA People Plan by June 2024	The PHA People Plan was approved at AMT on 17th April 2024 with endorsement at the PPR Committee on 2nd May and shared with the Board for information on 16th May 2024. A launch of the People Plan was conducted through in person engagement sessions led by the Chief Executive during June 2024.					Leah Scott Karyn Patterson
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**						

HSC Public Health Agency

KPI	Description	Progress (100 words max)	Jun	Sep	Dec	Mar	Lead Director
KPI 28	New PHA R&D office to be set up and HSC R&D Strategy to be issued for consultation by March 2025	The review of the current HSC R&D strategy is complete. A workshop is planned for 12 September 2024 to endorse the evaluation, open up engagement and receive feedback to allow the mapping of the new Strategy. Strategy workshop was held on 12.09.24 with approx. 100 attendees. Excellent feedback was received from stakeholders and will now be incorporated into the new strategy.					Joanne McClean/Leah Scott Janice Bailie (Strategy)
		Work is progressing to establish a PHA research and development office within the PHA which will complement the work undertaken by the Agency and support staff to collaborate on public health R&D with local higher educational institutions. A bid is currently being developed which will resource the office.					Grainne Cushley (new PHA R&D Office)
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**	.R&D office establishment may take longer than planned and is likely to be delayed due to the need to have further explorative discussions with key stakeholders. A bid is currently being developed which will resource the office which will be finalised before the end of 2024.					
KPI 29	PHA will be in membership of each AIPB by January 2025	DoH has confirmed that all 5 AIPB's are due to be convened no later than January 2025 and PHA nominated Strategic leads have been agreed. PHA nominated Strategic leads have been agreed and induction workshops planned initially for Southern, South Eastern and Western Trust areas.					All Directors Joanne McClean
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**						
KPI 30	PHA will achieve financial breakeven position at end of year March 2025	Financial Plan 2024/25 was approved by PHA Board in June 2024, showing a forecast breakeven position for the year. Regular updates are being provided to AMT and Board					All Directors Leah Scott

KPI	Description	Progress (100 words max)	Jun	Sep	Dec	Mar	Lead Director
		outlining the revised position as the year progresses, and robust processes are in place to manage any slippage and pressures which arise to allow PHA to achieve a breakeven position at year-end.					
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**						
KPI 31	An approach to health inequalities and associated training will be delivered to all staff across the organisation by March 2025	This action has been delayed by 3 months due to the absence of key staff and the re-alignment of key staff to support the Live Better initiative in Qtr 2. PHA currently commission the provision of health inequalities training through a contracted provider. This provider has developed abridged training, which for consistency will be the starting point for the development of staff training for the Agency. There will be no additional cost to PHA for support in the development of this training. Working with staff from across the organisation, a codesign phase will be delivered in quarter 4 with feedback gathered on content, duration and level of training. This will inform the development of future training ensuring appropriateness of training across staffing levels. Training will be available for all staff in Qtr 1 2025/26 following codesign phase period.					All Directors Joanne McClean
	Further details if Amber/Red (Timescales, mitigating actions etc.) **(50 words max)**	Additional staff will be aligned to support this action in Qtr 3 and 4. A revised timeline has been agreed with the current contract provider. Delivery of a co-design test phase with staff is scheduled between mid-January to mid-February 2025. A tailored syllabus will be available in Qtr 1 2025/26.					

HSC Public Health Agency

KPI	Description	Progress (100 words max)	Jun	Sep	Dec	Mar	Lead Director
KPI 32	PHA in membership / co-leading new SPPG/PHA commissioning teams by September 2024	• PHA continue to engage closely with SPPG in establishing Planning and Commissioning Teams (PCTs). A small number of teams have started to meet. • Core team comprising members from SPPG and PHA developing a 'playbook' to support joint working (ToR, governance, decision making, escalation etc). This work will also be discussed with AMT. • Consideration being given to how the PCTs will sit within Reshape and Refresh Structures and link with existing SPTs from operational and strategic perspective • Work to establish these teams is progressing. SPPG and PHA chief executive/chief operating officer are reviewing arrangements for joint working. • Joint chair workshop has been held and an additional workshop is planned • PHA co-chairs have attended AMT in October to provide an update.					All Directors Heather Reid
	Further details if Amber/Red (Timescales, mitigating actions etc.) (50 words max)	Commissioning teams are not currently in place with no clear timeline for establishment of the structures required to support. Impacted by change in SPPG leadership and implementation of wider ICS processes. PHA Cx and SPPG COO working to re-establish JAM in a different format to support commissioning processes. Further gaps in support for groups remain to be addressed – currently limited by existing capacity – e.g. information. Directors from SPPG and PHA to meet beginning of December to progress plans.					

Public Health Agency

minutes

Planning, Performance and Resources Committee Meeting

Date and Time 19 August 2024 at 3.00pm

Venue Fifth Floor Meeting Room, 12/22 Linenhall Street

Present

Mr Colin Coffey	-	Chair
Mr Craig Blaney	-	Non-Executive Director
Professor Nichola Rooney	-	Non-Executive Director

In Attendance

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

Apologies

Ms Anne Henderson	-	Non-Executive Director

19/24	**Item 1 – Welcome and Apologies**
19/24.1	The Chair welcomed everyone to the meeting. Apologies were noted from Ms Anne Henderson.
20/24	**Item 2 – Declaration of Interests**
20/24.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.
21/24	**Item 3 – Minutes of Previous Meeting held on 2 May 2024**
21/24.1	Members **APPROVED** the minutes of the meeting held on 2 May 2024.

22/24 **Item 4 – Matters Arising**

22/24.1 The Chair noted that there was an action regarding reviewing the terms of reference for the Committee and said that he was content with the current terms of reference unless members had any specific issues. Ms Scott said that there had been a discussion about delegating authority to the Committee, but the Chair said that he did not wish the Committee to approve papers, as that should be the role of the Board, but rather the Committee would recommend approval. The Chair commented that the papers being presented today were all excellent.

Trust Expenditure 2024/25

22/24.2 Mr Murray explained that the spreadsheet shared with members gives a breakdown of the expenditure PHA provides to Trusts across all programmes and gives members an idea of the breadth and range of investments. He said that this allows PHA to keep track of all expenditure and ensure that its funding is visible in Trust baselines. He noted that this information is about outputs rather than outcomes and so it needs to be linked with other supporting information to give the totality of investment in certain areas to then link that with PHA's Corporate Plan or Ministerial targets. Professor Rooney commented that PHA needs to be able to monitor the performance to determine how it is making a difference.

22/24.3 The Chair commented that there is a lot of information, including a reference to funding administration staff for example. Mr Murray assured members that there will be an audit across all Trust baselines to pick up areas like this where PHA should not be providing this type of funding.

At this point the Chief Executive joined the meeting.

22/24.4 Mr Murray advised that in the future, he would envisage that through the planning teams the Committee would get a report on the totality of investments across particular areas in order to be able to determine the impact of PHA investment. The Chief Executive said that there needs to be a wider discussion with the Department and the Trusts regarding the commissioning system and this would have an impact on PHA as it would change the nature of its relationship with Trusts and SPPG. He advised that he had attended a meeting of Trust Chief Executives, which the Permanent Secretary joined and gave an overview of what arrangements will be put in place following the departure of the head of SPPG. He explained that an interim arrangement will be put in place while thought is given to what the commissioning framework will look like going forward. The Chair said that he hoped any changes would have a positive impact on PHA and with regard to the investment reports, he said that these should be the basis for reporting on outcomes.

22/24.5 Mr Blaney noted that there have been discussions at the Board about PHA priorities, and that by looking at the information here, it outlines that the areas of mental health and suicide prevention receive the largest

amount of funding, and that early years receives the least. He asked if this is an accurate reflection of PHA's priorities or if the spending has followed a particular pattern. Mr Murray replied that there are historical reasons for these levels of spend. He added that PHA would receive ringfenced funding against particular initiatives, e.g. Protect Life 2. He acknowledged that mental health is a large area of expenditure and said that could be a discussion as to whether the level of spend is proportionate. Mr Blaney asked if there is a way of seeing what funding is not ringfenced. Mr Murray said that PHA's ability to re-engineer its funding has improved with less monies being ringfenced, but there would need to be a strong case for moving investments.

22/24.6 The Chief Executive advised that last week he had hosted a meeting of the 4 UK nations public health bodies where there had been a discussion that statistics would suggest that the biggest areas of spend should be smoking, cancer, mental health and obesity because these cause the greatest ill health and lead to health inequalities. He said that he has discussed this with Dr Joanne McClean and Ms Heather Reid and has asked them to get an understanding of where PHA's funding is going and is spread over the life course. He noted that areas such as vaccination are seen as "business as usual".

22/24.7 The Chief Executive noted that due to the success of the Family Nurse Partnership programme, there has been a reduction in teenage pregnancies so he asked whether the same level of investment is now needed in that area. Mr Blaney said that educating young people about eating healthily, and areas such as mental health and suicide prevention would be beneficial and that it would be worthwhile investing more in young people. The Chief Executive agreed adding that among young people there is a decrease in alcohol consumption. Mr Murray pointed out that the budgets are arbitrary because there could be work in one area in school settings where PHA is working with children and families.

22/24.8 The Chair said that PHA's new Corporate Plan will show where its priorities are as well as the strategic plans below that. Mr Blaney suggested that once the new Corporate Plan is in place Early Years may be ranked higher in terms of priority. Mr Murray replied that PHA will have choices to make. The Chair said that those discussions would have to be led by the professionals who have the knowledge. The Chief Executive pointed out that whilst young people are consuming less alcohol, they are the fastest growing economically inactive group, which is leading to mental health and musculo-skeletal issues. Mr Blaney said that if issues like this are not addressed early, it will affect young people for the rest of their lives. The Chair reiterated that this will form part of the new Corporate Plan and will be guided by the science.

22/24.9 The Chief Executive advised that PHA has been asked to prepare a public health needs assessment for the Department for the first meeting of a new group looking at the Integrated Care System. He said that this will be a significant opportunity for PHA to influence the direction of travel.

22/24.10	Professor Rooney stated that PHA needs to have a strategy and priorities which are based on evidence. She said that information and intelligence are important and that PHA has the expertise. Within the information provided, she noted that there is a reference to spend on health inequalities and asked what that related to. Mr Murray replied that this is a historic budget line and would relate to funding given to Local Councils for a range of programmes. He said that he could get a more detailed breakdown if required.
22/24.11	The Chief Executive reiterated that there will be an exercise carried out to review historic budgets, particularly in areas where PHA has no influence and which could be moved to Trust or SPPG baselines. He noted that there are areas which are not core to PHA and when PHA is asked to meet a savings target, it gives a false economy so they need to be cleared out.
22/24.12	Mr Blaney queried why it is that the South Eastern Trust receives the least amount of funding for health protection, health improvement and screening. Mr Murray replied that this is not the totality of funding in those areas for that Trust as there may have been other legacy providers so does represent the full picture. Mr Blaney said that it would be important to have an idea of what each Trust does receive as a resident in a particular Trust would be wondering why one Trust receives £2m less than another. Mr Murray advised that there is a narrative behind all of the figures. The Chief Executive said that how money is spent across the HSC is very complex. He explained that it is usually done on a capitation basis, but as this treats everyone equally, it does not pick up on areas of greater inequality. He cited that within the Western Trust there is the highest number of areas of deprivation, but it gets the lowest percentage within the capitation formula.
22/24.13	The Chair commented that this is why stakeholder engagement is important. The Chief Executive said that PHA has an opportunity to influence commissioning in health. He explained that he and Dr McClean had met with the Northern Trust earlier today to discuss the issue of a potential change in the delivery of general surgery and had asked the Trust to ensure that there would be no impact on those in areas of deprivation.
22/24.14	The Chief Executive said that there should be better access to healthcare for those with the worst health and worst outcomes. Mr Blaney noted that there are areas of deprivation within affluent areas. The Chair said that these are discussions for the development of the Corporate Plan.
22/24.15	Professor Rooney asked about resources for performance management following the Reshape and Refresh review. She noted that PHA needs to be implementing recommendations from Public Inquiries. Ms Scott replied that the new Finance and Corporate Services directorate is still being established and that there will be a dedicated resource for performance management. She said that posts are in the process of being filled and work is ongoing to realign the finance systems to new

Strategic Planning Teams (SPTs). She added that although it is a work in progress, it will not be completed soon.

22/24.16 The Chief Executive asked if there are new posts. Mr Murray explained that the draft structure has a number of planning managers supporting a senior planning manager and there is a need to get that setup fully embedded. Professor Rooney recalled that there were staff in post who were moved out. Mr Murray acknowledged that resources did need to be realigned to support the pandemic response. However, he said that there are now three managers in post so there is a skeletal infrastructure. Professor Rooney said that PHA has a shortfall in its management and administration budget and that resources for performance management should be a priority. The Chair asked if there is currently no one in post, but Ms Scott replied that there will be a senior post, but it needs to align with the Corporate Plan. The Chair said that the Board would need to be able to understand that alignment and that it needs to know what the plan is and the timeline. Ms Scott advised that there is a timetable and the Chair said that the Board would need to be able to see it. Mr Murray said that there is a draft infrastructure that has been designed so that there is additional capacity. The Chair reiterated the need to see the plan and suggested there could be a separate briefing for NEDs on this **(Action 1 – Ms Scott)**.

23/24 Item 5 – Planning

Update on Development of Corporate Plan 2025/30

23/24.1 Ms Mawhinney delivered a short presentation outlining the timetable for the development of the Corporate Plan as well as detailing what consultation and engagement will take place and the approach as to how the Plan will be developed. She gave an overview of the priorities to be included following a discussion with the Department.

23/24.2 The Chair asked if the draft Corporate Plan will also have an operational plan. Ms Mawhinney replied that the draft can be used to develop the Annual Business Plan. Mr Murray added that more detailed plans can be developed over a period of time as they will require a level of engagement and consultation with stakeholders.

23/24.3 Professor Rooney noted that what PHA is aiming to achieve will take a long time to be realised and so what PHA comes up with has to be at that macro level. Mr Blaney said that PHA is aiming to tackle issues now to improve the future for individuals, but noted that these are issues that could have been prevented had they been tackled 30 years ago.

23/24.4 The Chair asked who would be in attendance at the Board workshop in September. Ms Mawhinney advised that it would be an internal workshop. The Chair said that there is a need to be clear on milestones. Mr Murray commented that PHA can only control what it is in control of. The Chair said that this is why stakeholder engagement is important. Ms Mawhinney advised that a list of stakeholders has been compiled. The Chair said that he wanted PHA to be proactive. Ms Scott advised

	that there is an oversight group and additional resources have been brought in. The Chair stated that PHA also needs to have a Communications Strategy for the next 5 years.
23/24.5	Members noted the update on the development of the Corporate Plan.
24/24	**Item 6 – Performance**
	Performance Management Report Quarter 1 2024/25
24/24.1	Mr Murray advised that this is the first Performance Management Report in this new format. He outlined in the summary position in that 25 targets are rated "green", 3 are rated "amber", 2 are rated "red" and 3 are rated "blue", and that there is further information on those targets which are rated "amber" or "red". In terms of the 2 that are rated "red", he explained that this is due to a lack of funding to progress this work.
24/24.2	Professor Rooney asked about what point those targets rated "amber" will change to "green", and Mr Murray explained that based on the information provided, the projected target dates are those that are in the report.
24/24.3	The Chair said that he had enjoyed reading the document. He noted that within the Business Plan there are outcome measures, strategic initiatives and KPIs and he sought assurance that these are all joined up. The Chief Executive advised that a series of quarterly accountability meetings has taken place with Directors and those have included discussions around the Corporate Plan, appraisals, objective setting and development. He said that he still had some concern that directorate plans are not linked to the Corporate Plan, but felt that the process will become more refined. The Chair agreed that this is an evolutionary process, and that some of the outcomes from PHA activities will take years, but said that the Board need to know that the direction of travel will lead to these outcomes.
24/24.4	The Chief Executive noted that as part of the Reshape and Refresh programme, the functions of HSCQI are transferring to RQIA and the Connected Health team is moving into the Department so PHA is getting back to carrying out its core functions as per legislation.
24/24.5	The Chair asked if there could be an assurance that the activities that PHA is carrying out are delivering on the ground and the Chief Executive replied that these are the questions being raised at accountability meetings. Mr Murray added that there are discussions about the thematic teams and whether they are delivering what they need to do.
24/24.6	Professor Rooney said that many of the targets are around developing plans or initiatives and the only one that had a measure was around smoking prevalence. The Chief Executive said that PHA has been successful at reducing smoking. He added that there is a need to increase tax on alcohol, cigarettes and sugar. The Chair said that this

should form part of the discussion on the Corporate Plan. The Chief Executive stated that if PHA is undertaking a population health needs assessment, then it should be showing leadership and driving discussions and telling the Department what its priorities should be.

24/24.7 The Chair said that he hoped there will be a good discussion on this Report at the Board and he asked that members are also sent a copy of the Business Plan for reference **(Action 2 – Mr Graham)**.

24/24.8 Mr Blaney asked how PHA ensures that although it has a list of initiatives all rated "green", that these were the best approaches and if another approach should have been taken. Mr Murray said that this links back to the Corporate Plan and PHA ensuring that it does not do anything in isolation.

24/24.9 The Chair said that the progress against the Business Plan should be shared with all staff at the December event.

24/24.10 Members noted the Performance Management Report.

Community and Voluntary Sector Contract Performance Report 2023/24

24/24.11 Mr Murray explained that following a recommendation from an Internal Audit report, this report on performance against Community and Voluntary sector contacts has been prepared. He advised that PHA invests around £22m in 125 organisations and that there are over 300 contracts. He said that £13.8m is invested in large scale contracts (over £100k), but there is a lot of small-scale investment. He outlined that 63% of the funding is across 73 contracts.

24/24.12 Mr Murray advised that there are large organisations which receive large amounts of money but where in the past an organisation may have had 8 contracts managed by different individuals in PHA, there is now 1 individual managing that contract.

24/24.13 Mr Murray said that work is ongoing to update PEMS (Programme Expenditure Monitoring System) so that it can collect information to show how quickly payments are made. He advised that PHA receives a lot of Performance Management Reports (PMRs) but explained that there are some anomalies in the figures whereby some contractors with more than one contract would submit one PMR.

24/24.14 Mr Murray outlined that going forward there will be work undertaken so that there is more of a focus on outcomes and this will be brought to the Committee.

24/24.15 Mr Blaney said that he found the report interesting and he agreed with the approach of having one individual looking after the bigger contracts. He expressed concern that having searched through the websites of the larger organisations that PHA does business with, none of them reference PHA on their site or on their social media and he asked if PHA

should be reviewing this. Mr Murray said that this is a valid point as organisations should be referencing PHA in their literature.

24/24.16 Professor Rooney said that this was a useful report. In terms of the outcomes, she asked whether PHA expected a different standard of information from those organisations that receive the most money and how that will balance with smaller organisations. Mr Murray said that there is a need to be proportionate and co-design a better contract management system. As part of that system, he advised that PHA would ask for a particular report on outcomes as part of moving to a more outcomes-based monitoring approach. He said that PHA needs to be able to see the impact that its interventions are having.

24/24.17 The Chair noted that the Department of Finance is seeking to change the rules around procurement. Mr Murray advised that more is being sought from organisations in terms of reporting and oversight. He added that the bigger ask is in terms of contract management and expectation. He noted that one positive is that there will be a move away from procurement to a grant award process for smaller contracts which allows for greater flexibility. The Chair asked if PHA's procurement is on target. Mr Murray replied that there are some challenges with respect to timelines. It was agreed that this would be further discussed outside of the meeting **(Action 3 – Mr Murray)**.

24/24.18 Members noted the Community and Voluntary Sector Contract Performance Report 2023/24.

25/24 Item 7 – Resources

Our People Report

25/24.1 Ms Patterson said that the latest Report shows that PHA's staff numbers are increasing with there being an increase in the number of permanent staff and a reduction in the number of temporary staff. She reported that appraisals are being undertaken with the aim of having these completed by end of the summer. She advised that KPIs in relation to recruitment are improving.

25/24.2 Ms Patterson reported that sickness absence has decreased in comparison to this time last year, but the greater proportion of absence relates to long term sickness. In terms of the work being carried out as part of the workforce development programme, she reported that of the 28 targets in the People Plan, 9 have been completed and the majority of the rest are on track. The Chair asked why the workforce planning programme has not yet commenced and if this is linked to the Reshape and Refresh programme. Ms Patterson confirmed that there is a link.

25/24.3 The Chair noted that there had been a suggestion that Ms Patterson and Ms Gráinne Cushley would visit local offices to meet with staff. Ms Patterson said that an offer was made, but there was low uptake. She added that Ms Cushley plans to visit other offices over the next period.

25/24.4	The Chair said that this next period of the Reshape and Refresh Programme is one where there will be real change. Ms Patterson agreed and said that there will be support for the individuals involved.
25/24.5	Professor Rooney asked when the work on climate and PHA being a sustainable organisation will commence. Ms Patterson explained that while some of the workstreams have not commenced, there have been discussions.
25/24.6	Members noted the Our People Report.
26/24	**Item 8 – Any Other Business**
26/24.1	There was no other business.
27/24	**Item 9 – Details of Next Meeting**
	To be agreed
	Signed by Chair:
	Date:

chief executive and directors' report

Update from Chief Executive

COVID Inquiry

I appeared before the Regional COVID-19 Inquiry in London on 5 November 2024. The testimony was in response and supplementary to our statement on Module 3, with regard to Health and Social Care services and the impact of COVID-19 on them. The Public Inquiries Programme Board is considering the debrief.

HSCQI and IHI European Meeting

HSCQI has now transferred to RQIA as of 1 November 2024. As Chair of HSCQI Alliance I had the opportunity to address the IHI European meeting in Belfast on 13 November 2024. As well as presenting on the Health challenges facing the Northern Ireland population and our HSC system I spent 30 minutes discussing with European partners how best we address our black and ethnic minorities population by creating better health equality in Northern Ireland.

Staff Engagement

I have completed another round of staff team engagement sessions across all PHA offices. These were informed sessions with the opportunity to have a cup of tea and an open discussion on a wide range of topics.

Update from Director of Public Health

Cervical screening

Intensive work to complete reports relating to the review of cervical screening in SHSCT has taken place. The reports are now in draft.

The single regional laboratory for cervical screening in Northern Ireland became operational on 1st November 2024. The service commenced with a backlog of 4099 rather than the projected 2500 samples. This was due to the need to close down and transfer equipment from Northern Trust into Belfast and equipment failure in Western Trust. This meant that no testing took place for a period of 2 weeks. Since provision moved to Belfast on 1 November the backlog has increased to 6000; equipment failures have resulted in downtime and sample re-runs and staff are new to the laboratory and still in an induction process. In addition to seeking to optimise existing capacity through over time / extended days, the Trust is exploring other means of reducing the backlog quickly. This includes using a second machine for the

first step of the process and/or outsourcing some of the backlog to an appropriately accredited UK NHS laboratory. An update on what the backlog means in terms of delays in the issue of reports to women and the plan to pull back is expected from the Trust in the middle of w/c 15th November.

This backlog will be quicker to clear than the post COVID backlog as it is for HPV testing and only a proportion of samples (about 12%) will need to go on to cytology.

Health Protection

Business as usual. The flu season has commenced and DoH have been advised to issue "flu letter" which triggers permissions to prescribe anti-viral medications to certain groups. Flu and COVID programmes continue. Uptake looks lower than last year, particularly among health and social care workers.

Health improvement and health protection teams have been involved in responding to an increase in transmission of blood borne viruses among people who inject drugs in Belfast (briefing attached at Appendix 1). PHA chair the incident management team and we are involved in various multi-agency groups relating to this. Control measures include increasing availability of specialist clinical teams, increasing testing availability and also access to needle and syringe exchange. Non-recurrent funding has been identified to support the response to this situation.

Service Development

The team have been supporting SPPG and the Trust in relation to the sustainability of maternity services in Daisy Hill Hospital. This is in line with our legislative requirement to provide professional input to commissioning of health services.

Update from Director of Nursing, Midwifery and AHPs

On 23 May 2023, the Department of Health in NI commissioned Professor Mary Renfrew to review Midwifery Services. The report entitled; 'Enabling Safe, Quality Midwifery Services and Care in Northern Ireland' was launched on 22nd October 2024. Thirty two systems level recommendations for policy, practice, education and research are outlined to enable safe, equitable, quality care and services for women, babies and families.

The report was commissioned as part of a wider of work to receive assurance on the safety of maternity and neonatal services for NI. It resulted from two related developments:

- A request from the Coroner that the Department of Health NI investigates her concerns following an inquest into the death of a baby that raised questions about care in Freestanding midwifery led units, and

- Several other reports, both local and national, highlighting concern of the safety of services for pregnant women, new mothers, and babies (RQIA, Ockenden, Kirkup)

Context

The report acknowledged that socioeconomic deprivation in NI is a significant factor in the health and wellbeing of the population and NI has the highest proportion of the population living in the most deprived quintile of the United Kingdom (UK).

There is a legacy of political instability with adverse impact on funding of public services including the health service. There has been no regional maternity strategy in place since 2018 was highlighted along with longstanding workforce shortages.

It also highlighted higher rates of perinatal mortality than the rest of the UK. Similar to the rest of the UK, induction of labour (38%) and caesarean sections (40%) have risen rapidly in the past decade.

At the time of writing the report, almost all births were in hospital and all freestanding midwifery led units were closed.

Key findings

- Women and staff repeatedly reported that women are not consistently receiving the quality of care they need and expect in pregnancy, labour and birth, and postpartum.
- Some women and partners described disrespectful and damaging interaction with staff.
- There are deficits in care across the maternity journey, most notably in information and education for women in pregnancy, care in late pregnancy/early labour, postnatal care, and safe options for care in labour and birth outside of labour ward.
- Midwives and the wider interdisciplinary team are working in conditions where they cannot consistently give the quality of care that they know is needed and that they want to provide, and their concerns are not always heard. Services are fragmented and there is a disconnect between hospital and community services and a core focus on treating problems, not on prevention and support. The high rates of induction of labour and caesarean birth in the context of significant workforce pressures are leading to an increasingly task-focussed service and a culture that is negatively affecting both women and staff.
- There is insufficient interdisciplinary support for midwives caring for women in labour in midwifery units and at home, especially women who wish options for care ‘outside of guidance’. These factors are resulting in inadequate care for some women and babies, stress and moral distress for many staff, experienced staff choosing to leave, and students and newly qualified staff not getting the experience they need.

- Also important to recognise that many women experience good quality care provided by midwives and the wider interdisciplinary team despite the challenging working conditions. There are examples of excellent, positive and innovative service provision across NI
- There are talented and committed staff in clinical practice, management, and education. Work is being put in place to improve safety, and there is a strong evidence base to guide the development and transformation of services.

Summary of recommendations

The report advocates for the following changes:

- A shared strategic vision for safe, quality midwifery and wider maternal and newborn services in Northern Ireland with a regional framework for action.
- A reconfigured relationship with women, families and communities, ensuring respectful personalised care for all and a genuine voice in shaping services.
- A consistent, region-wide, evidence-informed approach to planning, funding, standards, provision, monitoring, and review of maternity and neonatal services.
- Improving clinical, psychological, and cultural safety and equity for women, babies and families across the whole continuum of care and in all settings.
- Changing the prevailing work culture to implement an enabling environment for all staff and managers, including ensuring midwives are represented at senior management levels, tackling silo working, and developing an open learning culture at every level of the system.
- Supporting midwives to provide quality midwifery care and services across the whole continuum of maternal and newborn care, with investment in community as well as hospital services, and increasing midwives' influence over the safety and quality of care and services.
- Better oversight through improved accountability, monitoring, evaluation, and research.
- A unified approach to education and training of all staff, including leadership development - especially for midwives - and capacity building for the future.

Professor Renfrew said:

"Northern Ireland is not alone in experiencing substantial challenges to quality maternity care but there is now a real opportunity for NI to create a system that works for all. "This review has found both serious weaknesses and real strengths in the current provision of midwifery and wider maternity care for mothers and their babies.

"It proposes an ambitious evidence-based plan to transform maternity services for all women, babies and families and to improve safety and quality and tackle inequalities across Northern Ireland. It includes requirements for the safe provision of community midwifery units and home births, regional strategic developments to

support staff and ensure safe, quality and equitable care and services, improved data and monitoring, and building for the future.

"Key requirements include acceptance by senior leaders that radical change is needed, together with investment that reflects the level of need.

"At the heart of the changes must be a new relationship with women, families and communities, with an enabling environment for all staff and students, and better informed, better implemented monitoring, commissioning and governance.

'What happens in pregnancy, birth, and following birth affects women, babies, and families for the rest of their lives. Improving maternity care must be a priority for the health services and for society.

"Investing in improvement will contribute to better physical and mental health for women, better health, well-being and development for babies, better attachment and family relationships, better population health and reduced inequalities, better health and well-being for staff with improved staff retention, and better use of health service resources."

Next steps

Maternity Engagement Event planned for 10th December 24. Further conversation with Professor Renfrew and opportunity for consultation with stakeholders on priorities and next steps.

Establishing a perinatal partnership will be critical in implementation of action plan

Regional oversight and governance arrangements still to be finalised

PHA and SPPG working closely through Commissioning/planning teams.

Update from Head of Chief Executive's Office

Statutory Public Inquiries

The PHA public inquiry response remains underway.

Over recent weeks, the focus has largely been placed on the preparatory work required for the Chief Executive's formal evidence session at Module 3 (Impact of pandemic on healthcare systems in the 4 nations of the UK) of the UK Covid-19 Inquiry which took place in London on the 5 November.

The drafting of corporate PHA witness statements remains underway in respect of Module 5 (Government Procurement), Module 6 (Care Sector) and Module 7 (Test, Trace and Isolate) of the UK Covid-19 Inquiry and this work will continue into early 2025. The Agency is also now working on a supplementary statement in respect of Inquiry Module 3 that has been received by way of a follow up to the Chief Executive's oral evidence session.

Reshape and Refresh programme

The Reshape and Refresh programme is continuing to progress with the new Operating model confirmed and structures designed. Within this context the job descriptions for the posts at Tier 3 (Assistant Director level) have all been developed and job evaluated with the process for filling of these posts nearing completion. Further progress with Tier 4 will commence once the Tier 3 appointments have been finalised.

Planning is at an advanced stage for the all staff away day on 4th December which this year has a focus on staff recognition and reward.

Communications

The team worked with the Department of Health on the Live Better locations announcements launch with Health Minister Mike Nesbitt attending events at the Maureen Sheehan Centre in Belfast and Bishop's Field Centre in Derry/ Londonderry.

This month saw the launch of a bath safety campaign, with the team working with the Royal Life Saving Society (RLSS UK) to promote their campaign 'Splash Safety at Your Pad' to help ensure all parents and guardians know how to keep their child safe while in the bath and to highlight the risks of baby bath seats.

The team also supported communications on the SEN partnership project, with Education Minister Paul Givan and Health Minister Mike Nesbitt opening a conference to celebrate the first year of this jointly-funded Special Educational Needs and Disability Partnership project which is delivered by the PHA. The partnerships involve those working in education, health, local government, statutory agencies and the voluntary and community sector.

The sexual health website Home - Sexual Health NI was redeveloped and moved to a WordPress content management system. The redeveloped website provides streamlined navigation, quick access to key topics and updated content and a new design. The website was launched in October with the Living Well, *Looking after your sexual health* campaign. The campaign is running in over 500 community pharmacies and materials were also distributed to students during the QUB Student Union Health and Wellbeing event. Google analytics for the sexual health website show a 30% increase in user engagement and a 20% increase in page views per session in October.

Advice posters on mpox have been produced and distributed to the arrivals areas of airports. New leaflets have been produced on *Planning your pregnancy* as well as a number of updated reprints on the following areas: AMR, district nursing, alcohol, cervical screening and bowel screening. Information leaflets on accessing the *Self-harm Intervention Programme (Ship)* have been updated and reprinted as have the manuals for training tutors to run *I can cook it*! - the accessible version of the

community nutrition education programme. Work is also progressing on the draft version of the Corporate plan that will be issued for consultation.

Update from Director of Finance & Corporate Services

Financial management for 2024/5 continues and PHA plans to achieve the target of no more than 0.25% underspend, and an aim to breakeven by 31 March 2025. While the agency is projected to achieve the target, there are a number of inescapable pressures arising during the year which will be funded from Directorates through slippage in other areas. Prioritisation has been agreed by AMT. Funding of £3.2m has now been confirmed for Revenue Research and Development to National Institute for Health and Care Research (NIHR), and Capital budgets are on target for achieving budget targets.

The Department of Health has commissioned analysis of budgets for 2025/6 including a flat cash basis and 1% reduction. This will be submitted to the Department of Health to inform allocation and early indications are for another challenging budget settlement.

Work to complete the PHA Corporate Plan 2025-2030 is progressing positively with a draft Corporate Plan presented to Board at the November meeting. The team hosted a series of successful staff engagements, workshops with AMT and the Corporate Plan oversight group to seek input to the purpose vision and strategic ambitions for the organisation. The plan will open for public consultation in the coming weeks for 90 days after which time it will be issued and form the basis for the performance framework in PHA.

Public Health Agency

Appendix 1

Briefing notes – Health issues associated with injecting drug use

Immediate health issues

- PHA along with Belfast Health and Social Care Trust (BHSCT) and partner agencies are currently responding an increase in diagnosis of HIV and Hepatitis C in people who inject drugs in the Belfast area.
- HIV, hepatitis C and hepatitis B can be acquired through injecting drug use and this is most likely the reason for the increase observed. These conditions can also be acquired through unprotected sex. Needle stick injuries from discarded needles are a potential source of infection.
- Other physical health issues associated with injecting drug use include severe wound infections, blood clots, risk of limb amputation, severe sepsis and marked weight loss. Clinical teams have reported an increase in hospital admissions related to these complications.

Wider context

- The current increase in critical health issues associated with drug use comes on a background of changes in injecting behaviour since 2020.
- Cocaine is now the most commonly injected substance used by people who inject drugs in the Belfast area. Cocaine injecting is associated very frequent injecting - >20 times/day by comparison to 2-5 times/day with heroin. This puts people injecting cocaine at risk of serious health issues as above.
- The shift from heroin to cocaine injecting has been observed in other parts of the UK and was initially attributed to disruption in heroin supplies during the pandemic.
- The management of cocaine addiction is particularly challenging because there are very limited treatment options. For example, while treatments such as methadone can be used as a substitute for opiates to support people reducing and stopping heroin, there is no substitution therapy.
- Local options for specialist rehabilitation are limited.

Disruption to services supporting people who inject drugs

- In July 2024 there was a well-publicised attack on the premises of the Welcome Organisation (WO), situated on Townsend Street Belfast. This premises housed not only WO but also the Belfast Inclusion Health Service (BIHS), a nurse-led service provided by Belfast Health and Social Care Trust.
- The attack on the Welcome Organisation has displaced these two critical services that provide care for extremely vulnerable individuals with complex social circumstances. Specifically, there has been a loss of drop-in facilities and a reduction in the availability of needle exchange services overnight as a consequence.

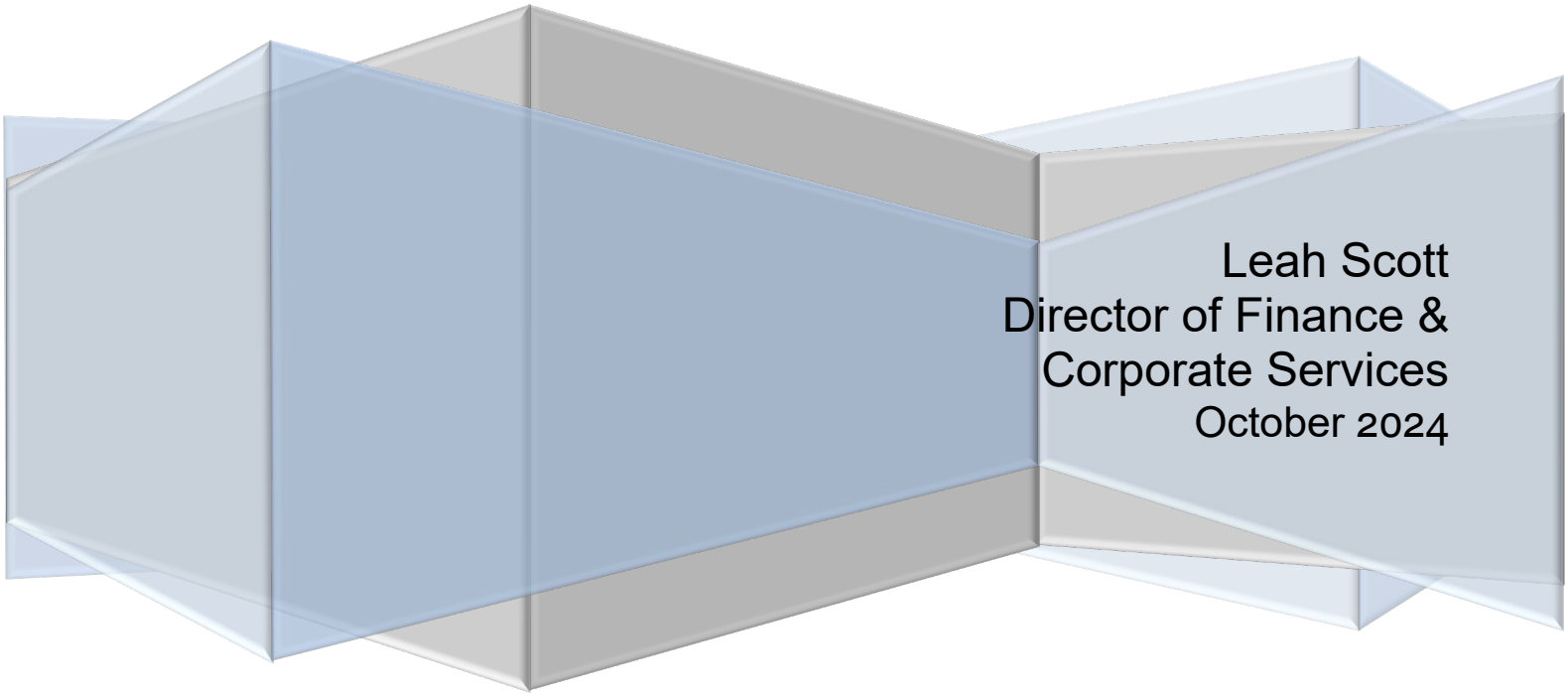
- The Belfast Inclusion Health Service and Belfast HSC Trusts have been undertaking significant efforts to secure new, stable accommodation from which their services can be delivered. Challenges to this include both cost and the need for significant engagement with the business community.

Challenges requiring a multi-agency approach

- The extreme complexities associated with injecting drug use, addictions and homelessness in parallel with the acute disruption to core services supporting vulnerable individuals requires a multi-agency response.
- Immediate priority concerns are:
    - Need for stable city centre accommodation from which specialist inclusion health services can be provided. This is likely to require engagement with and co-operation from local business communities.
    - Disruption to provision of needle and syringe exchange services – options under consideration include expansion of opening hours within current needle exchange sites, assessing capacity for provision of out-of-hours services within hostel settings and the potential for use of vending machinesHomelessness among people who inject drugs.

HSC Public Health Agency

Finance Report
September 2024



Leah Scott
Director of Finance &
Corporate Services
October 2024

Section A: Introduction/Background

1. PHA Board agreed its financial plan in June 2024 based on draft allocations funding from the Department of Health and consultation with service users and the Agency Management Team. The 2023/24 opening allocation letter applied a £5.3m recurrent savings target to the PHA budget which was rolled forward to 2024/25 opening allocation.
2. The 2024/25 Financial Plan is based on funds available, risks and uncertainties for the financial year and summarises the opening budgets against the high-level reporting areas. It also outlined how the PHA would manage the overall funding available, in the context of cash releasing savings targets applied to the organisation.
3. A final allocation was issued in July 2024, and which included an additional savings target of £1.0m. The financial plan was amended to estimate funding based on the final allocation. The total revenue budget for the PHA, including assumed allocations to be issued later in the year, currently stands at £136.3m for 2024/25.
4. This summary report reflects the draft year-end position as at the end of September 2024 (month 6) and includes a range of risks associated with the delivery of the full year budget. Supplementary detail is provided in **Annex A**.

Section B: Update – Revenue position

Update on the PHA budget allocation for 2024/25

5. During the year, the PHA baseline budget has been amended for the following changes:
    - £0.5m Fresh Start funding (ringfenced);
    - £3.0m for Shingles vaccines;
    - £1.5m for RSV and mPox vaccinations;
    - £1.5m for Covid & Flu vaccinations (ringfenced Covid funding);
    - £0.2m for various Admin costs related to posts;
    - £0.3m for various Nursing programmes (Text-a-Nurse etc.).

6. The total revenue budget for the PHA, including assumed allocations to be issued later in the year, currently stands at £136.3m for 2024-25.

7. The PHA has reports a year to date surplus at September 2024 of £0.2m (month 5, breakeven) against the annual budget for 2024/25 & is summarised in the following table:

	Annual Budget					Year to Date				
	Programme		Ringfenced	Mgt &	Total	Programme		Ringfenced	Mgt &	Total
	Trust	PHA Direct	Trust & Direct	Admin		Trust	PHA Direct	Trust & Direct	Admin	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources										
Departmental Revenue Allocation	47,204	55,519	2,247	31,328	**136,298**	23,602	25,604	201	15,133	**64,540**
Assumed Retraction	-	-	-	-	**-**	-	-	-	-	**-**
Revenue Income from Other Sources	-	27	-	625	**652**	-	27	-	359	**387**
Total Available Resources	47,204	55,547	2,247	31,953	**136,951**	23,602	25,631	201	15,493	**64,927**
Expenditure										
Trusts	47,204	-	-	-	**47,204**	23,602	-	-	-	**23,602**
PHA Direct Programme *	-	56,927	2,247	-	**59,173**	-	25,694	186	-	**25,880**
PHA Administration	-	-	-	30,573	**30,573**	-	-	-	15,207	**15,207**
Total Proposed Budgets	47,204	56,927	2,247	30,573	**136,951**	23,602	25,694	186	15,207	**64,690**
Surplus/(Deficit) - Revenue	-	(1,380)	-	1,380	-	-	(63)	15	285	**237**
Cumulative variance (%)						*0.00%*	*-0.25%*	*7.59%*	*1.84%*	*0.37%*

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

8. In respect of the year to date position:

- The annual budget for programme expenditure to Trusts of £47.2m has been profiled evenly over the year, with £23.6m expenditure reflected as at month 6 and a **nil variance** to year end budget shown.
- The remaining annual programme budget of £55.5m and expenditure of £25.7m has been recorded for the first six months of the financial year with **an overspend of £0.1m reported** (month 5, £0.1m overspend). This budget is currently projected to achieve planned overspend of £1.4m by the end of the financial year which will be used to absorb the anticipated underspend in Administration budgets outlined below.
- In Management & Administration, a year-to-date **underspend of £0.3m** (month 5, £0.1m underspend) is reported which is primarily being generated by underspends in the areas of Nursing and Operations due to high levels of vacancies, offset by the application of the balance of the 23-24 savings target held in the PHA Board (£1.2m). The year-end underspend is expected to be approximately £1.4m (month 5, £0.9m) which has increased due to more prudent estimations of the expected dates for filling vacant posts.
- Ringfenced funding comprises NI Protocol funding (£0.156m), Tackling Paramilitarism / Fresh Start (£0.528m) and COVID (£1.563m). A small variance is

reported on this budget to date, however a breakeven position is forecast for the full year.

9. The projected year-end position is breakeven (month 5, breakeven) and work will continue to identify measures to maintain this breakeven position. The month 6 position is summarised across business areas in Table 2 below.

Table 1: PHA Summary financial position - Sept 2024

	Annual Budget	YTD Budget	YTD Expenditure	YTD Variance	Projected year end surplus / (deficit)
	£'000	£'000	£'000	£'000	£'000
Health Improvement	13,496	6,748	6,748	0	
Health Protection	10,638	5,319	5,319	0	
Service Development & Screening	15,370	7,685	7,685	0	
Nursing & AHP	7,674	3,837	3,837	0	
Centre for Connected Health	0	0	0	0	
Quality Improvement	25	13	13	0	
Other	0	0	0	0	
Programme expenditure - Trusts	**47,204**	**23,602**	**23,602**	**0**	**0**
Health Improvement	31,720	12,246	12,516	(270)	
Health Protection	18,784	12,316	12,342	(26)	
Service Development & Screening	4,301	1,149	1,143	6	
Research & Development	52	0	0	0	
Campaigns	662	279	336	(57)	
Nursing & AHP	538	131	133	(2)	
Quality Improvement	18	9	35	(26)	
Other	471	0	(808)	808	
Savings target	(1,000)	(500)	0	(500)	
Programme expenditure - PHA	**55,546**	**25,632**	**25,694**	**(63)**	**(1,380)**
Subtotal Programme expenditure	**102,751**	**49,234**	**49,297**	**(63)**	**(1,380)**
Public Health	17,529	8,713	8,587	126	
Nursing & AHP	6,371	3,148	2,715	433	
Operations	6,443	3,171	2,767	404	
Quality Improvement	755	377	362	14	
PHA Board	(503)	(534)	141	(675)	
Centre for Connected Health	458	224	271	(47)	
SBNI	900	394	364	30	
Subtotal Management & Admin	**31,953**	**15,492**	**15,207**	**285**	**1,380**
Trusts	0	0	0	0	
PHA Direct	2,247	201	186	15	
Ringfenced	**2,247**	**201**	**186**	**15**	**0**
TOTAL	**136,951**	**64,927**	**64,690**	**237**	**0**

Note: Table may be subject to minor roundings.

Section C: Risks

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

11. **Current Year projected Expenditure**

    Budget holders are required to keep programme budgets under close review and report any expected slippage or pressures at an early stage. As the year progresses the risk of slippage increases as project timescales become closer. In addition, pressures arise throughout the year and AMT are challenged to prioritise and ensure funding is applied appropriately. *An exercise is in progress to identify contingency projects which can be mobilised in the latter half of 2024/5.*

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

13. **SEUPB / CHITIN income**: PHA receives income from EU partner organisations for the CHITIN R&D project. Claims are made on a quarterly basis, however PHA have experienced delays in receiving payment for claims which has been reported through internal and external audits. At 31 March 2024, the value of funding due was c£1.7m however, PHA had an equal and opposite creditor listed for monies due to other organisations. R&D staff are continuing to work closely with colleagues in partner organisations and the relevant funding body to ensure the expected full reimbursement of all claims. PHA has received £554k (€668k) from SEUPB in 2024/25 to date, and c.£1.1m remains outstanding (£1.4m at month 5).

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

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

these areas until allocations are approved and issued by DoH.

2025/6 Financial Plan and Recurrent savings to be identified recurrently

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

Section D: Update - Capital position

17. The PHA has a capital allocation (CRL) of £5m. This mainly relates to projects managed through the Research & Development (R&D) team. The overall summary position, as at September 2024, is reflected in **Table 2**, being a forecast breakeven position on capital funding.

18. R&D expenditure is managed through the R&D Division within PHA, and funds essential infrastructure for research such as information databanks, tissue banks, clinical research facilities, clinical trials units and research networks. The element relating to 'Trusts' is allocated throughout the financial year, and the allocation for 'Other Bodies' is used predominantly within universities – both allocations fund agreed projects that enable and support clinical and academic researchers. The reduction in the total CRL allocation since month 5 is because the Department has retracted £8.3m from PHA and allocated the same directly to 'Trusts' and 'Other Bodies'.

19. CHITIN (Cross-border Healthcare Intervention Trials in Ireland Network) is a cross-border partnership between the PHA in Northern Ireland and the Health Research Board in the Republic of Ireland, to develop infrastructure and deliver Healthcare Intervention Trials (HITs). The CHITIN project is funded from the EU's INTERREG

VA programme, and the funding for each financial year from the Special EU Programmes Body (SEUPB) matches expenditure claims, ensuring a breakeven position. Activity on the CHITIN project has now ended, therefore no funding is shown in Table 2 below, however a number of claims remain outstanding and the R&D team continue to actively engage with SEUPB to ensure these are paid in full. Further information on delays experienced in the reimbursement of costs is provided in Section C, above.

Table 2: PHA Summary capital position – September 2024

Capital Summary	Total CRL £'000	Year to date spend £'000	Full year forecast £'000	Forecast Surplus/ (Deficit) £'000
HSC R&D:				
R&D - Health ALBs	0	0	0	0
R&D - Trusts	0	0	0	0
R&D - Other Bodies	2,933	1,414	2,933	0
R&D - Capital Receipts	(385)	(42)	(385)	0
Subtotal HSC R&D	**2,548**	**1,371**	**2,548**	**0**
Other:				
Congenital Heart Disease Network	764	0	764	0
iReach Project	614	0	614	0
R&D - NICOLA	778	0	778	0
VMS Enhancement (Exc. Child flu)	196	0	196	0
VMS Pertussis Vaccination	45	42	45	0
VMS RSV Vaccination	45	32	45	0
Path Safe Eastewater Surveliance	752	104	752	0
Other - Capital receipts	(752)	(83)	(752)	0
Subtotal Other	**2,442**	**95**	**2,442**	**0**
Total PHA Capital position	**4,990**	**1,466**	**4,990**	**0**

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

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

Recommendation

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

Public Health Agency

Annex A - Finance Report

2024/25

Month 6 - September 2024

PHA Financial Report - Executive Summary

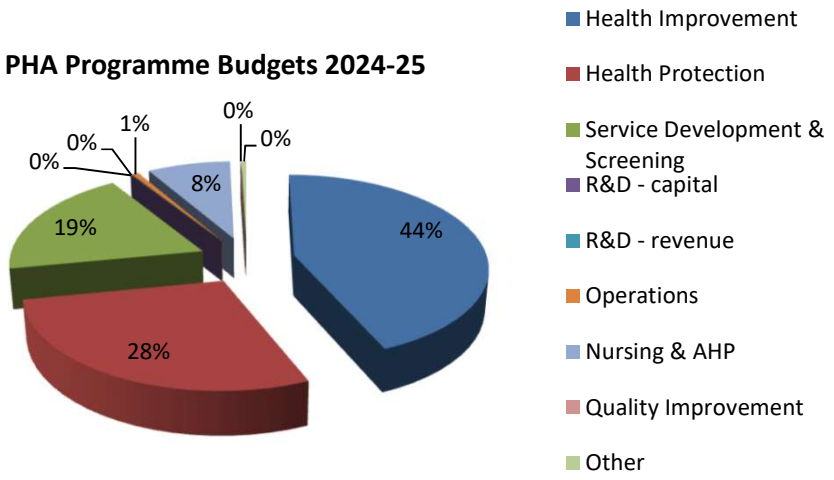
Year to Date Financial Position (page 2)

At the end of month 6, PHA is reporting a small surplus of £0.2m against its profiled budget. This position incorporates a small underspend on Admin budgets (£0.3m) being offset by a year-to-date overspend on Programme budgets (page 4).

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

Programme Budgets (pages 3&4)

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

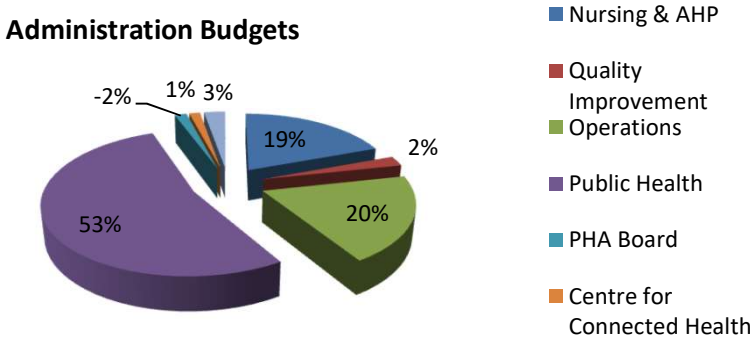


Administration Budgets (page 5)

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

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

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



Full Year Forecast Position & Risks (page 2)

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

Of the £5.3m savings target applied to PHA in 2023/24, £4.1m has been identified recurrently, and a balance of £1.2m is expected to be achieved non-recurrently from Admin budgets in 2024/25 while a recurrent source is identified. A further £1m of recurrent savings has been applied to the PHA in 2024/25 and is being met non recurrently in-year from an unrequired prior year accrual while a recurrent solution is identified.

Public Health Agency
2024/25 Summary Position - September 2024

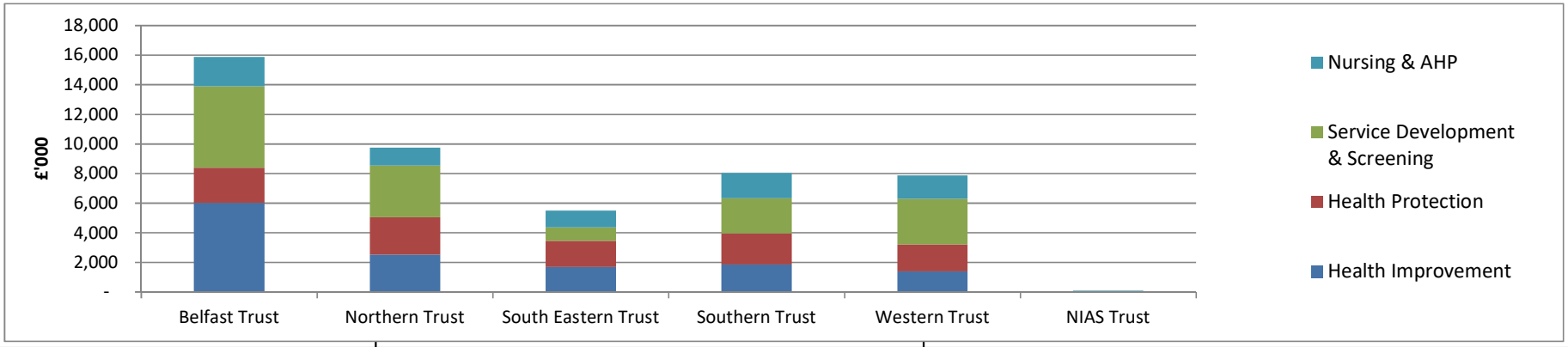
	Annual Budget					Year to Date				
	Programme		Ringfenced	Mgt &	Total	Programme		Ringfenced	Mgt &	Total
	Trust	PHA Direct	Trust & Direct	Admin		Trust	PHA Direct	Trust & Direct	Admin	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources										
Departmental Revenue Allocation	47,204	55,519	2,247	31,328	**136,298**	23,602	25,604	201	15,133	**64,540**
Assumed Retraction	-	-	-	-	**-**	-	-	-	-	**-**
Revenue Income from Other Sources	-	27	-	625	**652**	-	27	-	359	**387**
Total Available Resources	47,204	55,547	2,247	31,953	**136,951**	23,602	25,631	201	15,493	**64,927**
Expenditure										
Trusts	47,204	-	-	-	**47,204**	23,602	-	-	-	**23,602**
PHA Direct Programme *	-	56,927	2,247	-	**59,173**	-	25,694	186	-	**25,880**
PHA Administration	-	-	-	30,573	**30,573**	-	-	-	15,207	**15,207**
Total Proposed Budgets	47,204	56,927	2,247	30,573	**136,951**	23,602	25,694	186	15,207	**64,690**
Surplus/(Deficit) - Revenue	-	(1,380)	-	1,380	-	-	(63)	15	285	**237**
Cumulative variance (%)						***0.00%***	***-0.25%***	***7.59%***	***1.84%***	***0.37%***

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

The year to date financial position for the PHA shows a surplus of £0.2m, with a small underspend on Management and Admin budgets due to vacancies offset by a year-to-date overspend on Programme budgets.

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

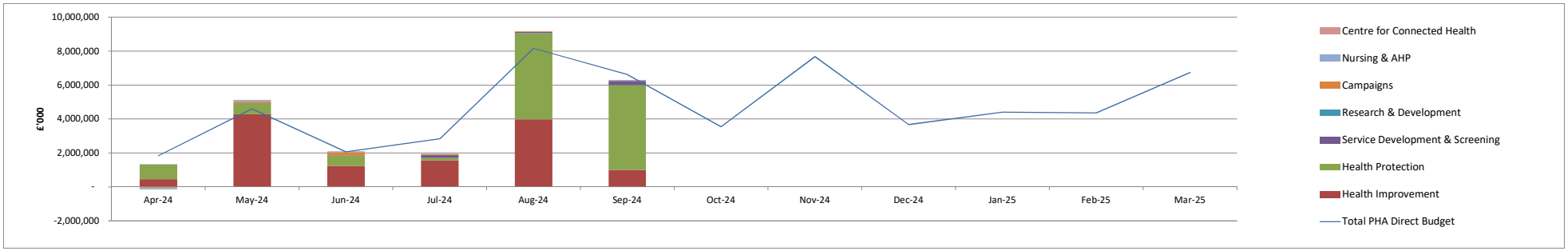
Programme Expenditure with Trusts



Current Trust RRLs	Belfast Trust	Northern Trust	South Eastern Trust	Southern Trust	Western Trust	NIAS Trust	Total Planned Expenditure	YTD Budget	YTD Expenditure	YTD Surplus / (Deficit)
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Health Improvement	6,022	2,529	1,689	1,848	1,409	-	**13,496**	6,748	6,748	-
Health Protection	2,375	2,525	1,755	2,119	1,794	70	**10,638**	5,319	5,319	-
Service Development & Screening	5,491	3,487	924	2,367	3,102	-	**15,370**	7,685	7,685	-
Nursing & AHP	1,999	1,218	1,141	1,716	1,570	30	**7,674**	3,837	3,837	-
Quality Improvement	25	-	-	-	-	-	**25**	13	13	-
Total current RRLs	**15,912**	**9,760**	**5,510**	**8,050**	**7,873**	**100**	**47,204**	**23,602**	**23,602**	-
Cumulative variance (%)										***0.00%***

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

PHA Direct Programme Expenditure



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total	YTD Budget	YTD Spend	Variance	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
Profiled Budget																	
Health Improvement	1,593	3,013	1,269	1,819	3,196	1,356	3,093	3,779	2,519	3,622	3,070	3,392	**31,720**	12,246	12,516	(270)	*-2.2%*
Health Protection	182	1,429	441	438	4,991	4,835	271	3,637	264	292	744	1,261	**18,784**	12,316	12,342	(26)	*-0.2%*
Service Development & Screening	0	150	143	452	77	327	143	172	708	366	387	1,376	**4,301**	1,149	1,143	6	*0.5%*
Research & Development	-	-	-	-	-	-	-	-	-	-	52	-	**52**	-	-	-	*0.0%*
Campaigns	-	3	155	122	- 40	40	34	63	65	43	15	162	**662**	279	336	(57)	*-20.4%*
Nursing & AHP	59	11	55	0	- 59	64	7	28	116	27	97	131	**538**	131	133	(2)	*-1.3%*
Quality Improvement	2	2	2	2	2	2	2	2	2	2	2	2	**18**	9	35	(26)	*-284.0%*
Other	-	-	-	-	-	-	-	-	-	55	-	416	**471**	-	(808)	808	*100.0%*
Savings target	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	**(1,000)**	- 500	0	(500)	
Total PHA Direct Budget	**1,753**	**4,525**	**1,980**	**2,749**	**8,083**	**6,541**	**3,466**	**7,597**	**3,590**	**4,324**	**4,281**	**6,657**	**55,546**	**25,631**	**25,695**	**(63)**	
Cumulative variance (%)																***-0.25%***	
Actual Expenditure	**1,143**	**5,313**	**2,220**	**2,037**	**8,562**	**6,419**							**25,694**				
Variance	**609**	**(788)**	**(240)**	**712**	**(479)**	**123**							**(63)**				

The year-to-date position shows an overspend of £0.1m against profile mainly caused by overspends to date in Health Improvement offset by a unmaterialised accrual from 2023-24 which is being held in the Other line and set against the 2024-25 savings target (£1m). An overall year-end Programme overspend of c£1.4m is anticipated, and this is being managed closely in order to offset a forecast underspend in Administration budgets.

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

Public Health Agency
2024/25 Ringfenced Position

	Annual Budget				Year to Date			
	Covid	NDNA	Other ringfenced	Total	Covid	NDNA	Other ringfenced	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources								
DoH Allocation	1,563	-	684	**2,247**	25	-	177	**201**
Assumed Allocation/(Retraction)	-	-	-	-	-	-	-	**-**
Total	1,563	-	684	**2,247**	25	-	177	**201**
Expenditure								
Trusts	-		-	**-**	-	-	-	**-**
PHA Direct	1,563	-	684	**2,247**	25	-	161	**186**
Total	1,563	-	684	**2,247**	25	-	161	**186**
Surplus/(Deficit)	**-**	**-**	**-**	**-**	**(1)**	**-**	**16**	**15**

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

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

PHA Administration

2024/25 Directorate Budgets

	Nursing & AHP £'000	Quality Improvement £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Annual Budget								
Salaries	6,148	742	4,944	17,283	557	408	616	**30,698**
Goods & Services	223	13	1,499	246	(1,060)	50	284	**1,255**
Total Budget	**6,371**	**755**	**6,443**	**17,529**	**(503)**	**458**	**900**	**31,953**
Budget profiled to date								
Salaries	3,049	371	2,471	8,601	147	204	308	**15,151**
Goods & Services	98	6	699	112	(681)	20	86	**341**
Total	**3,148**	**377**	**3,171**	**8,713**	**(534)**	**224**	**394**	**15,492**
Actual expenditure to date								
Salaries	2,593	359	2,027	8,066	131	183	292	**13,652**
Goods & Services	121	4	740	520	10	88	71	**1,555**
Total	**2,715**	**362**	**2,767**	**8,587**	**141**	**271**	**364**	**15,207**
Surplus/(Deficit) to date								
Salaries	456	12	444	534	16	21	15	**1,499**
Goods & Services	(23)	2	(40)	(408)	(691)	(68)	15	**(1,214)**
Surplus/(Deficit)	**433**	**14**	**404**	**126**	**(675)**	**(47)**	**30**	**285**
Cumulative variance (%)	*13.75%*	*3.81%*	*12.74%*	*1.45%*	*126.48%*	*-20.98%*	*7.61%*	***1.84%***

PHA's administration budget is showing a year-to-date surplus of £0.3m, which is being generated by a number of vacancies, particularly within the Operations and Nursing & AHP Directorates, offset by the application of the balance of the 23-24 savings target held in the PHA Board (£1.2m). Senior management continue to monitor the position closely in the context of the PHA's obligation to achieve a breakeven position for the financial year.

The full year surplus is currently forecast to be c£1.4m, and this is being managed by PHA through a managed deficit in Programme expenditure in the financial year. Whilst £4.1m of £5.3m savings target applied to PHA in 2023/24 has been achieved, the remaining £1.2m has been identified non-recurrently from Management & Administration budgets while a recurrent solution is identified.

PHA Prompt Payment

Prompt Payment Statistics

	September 2024 Value	September 2024 Volume	Cumulative position as at September 2024 Value	Cumulative position as at September 2024 Volume
Total bills paid (relating to Prompt Payment target)	£8,416,830	310	£40,267,240	2,896
Total bills paid on time (within 30 days or under other agreed terms)	£8,201,283	292	£38,897,157	2,776
Percentage of bills paid on time	**97.4%**	**94.2%**	**96.6%**	**95.9%**

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

The 10 day prompt payment performance remains above the DoH target for 2024/25 of 70%, at 82.2% on volume for the year to date.

HSC Public Health Agency

item 13

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	21 November 2024
Title of paper	Sealing of MOU between Western Trust and PHA
Reference	PHA/05/11/24
Prepared by	Robert Graham
Lead Director	Aidan Dawson

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

1 Purpose

The purpose of this paper is to seek PHA Board approval to put the PHA Seal on a Memorandum of Understanding between PHA and the Western Trust.

2 Key Issues

The PHA leases premises from the Western Trust at Tyrone and Fermanagh Hospital in a building known as Hilltop. An updated lease has recently been prepared and this has been signed and sealed by the Chief Executive of the Western Trust.

Under PHA Standing Orders, the PHA Seal should not be applied to any document without the authorisation of the PHA Board. Therefore, the Board is being asked to approve that the PHA Seal is applied to this lease. The lease has been drawn up in conjunction with the Directorate of Legal Services.

3 Next Steps

Following approval by the Board, the PHA Seal will be placed on 2 copies of the document with one document being returned to the Western Trust and the other retained by PHA.